STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2712549.Based on interview and record review the facility failed to provide bed mobility in a safe manner for one Resident (Resident #2) out of three residents reviewed for accidents, hazards, and supervision.Findings include:Resident #2 (R2)Review of R2's face sheet, dated 1/21/26, revealed an original admission to the facility on [DATE] with medical diagnoses including wedge compression fractures of third, fifth, and sixth thoracic vertebra, multiple fractures of the left ribs, left clavicle fracture, depression, and obesity. R2 also admitted into rehab services at the facility.A complaint dated 1/6/26 submitted to the State Agency (SA), read in part .On 1/1/26, (R2) was being rolled over for a bed check on to see if there was any waste in his pants. Staff member, (Certified Nurse Aide [CNA] F), was assigned to do the bed check. During the bed check, (R2) was manhandled, slammed into the bedrails and his shoulder was hurt.R2's minimum data set (MDS), dated [DATE], indicated a brief interview for mental status (BIMS) of intact cognition.On 1/21/26 at 8:00 AM, an interview was conducted with R2, who was asked about the incident details in the complaint and replied, Yes! It was the evening of 12/31/25. The aide (CNA F) threw my legs over the bed like a sack of potatoes. She (CNA F) wrenched my shoulder. The way she flipped me, she manhandled me. Shoved my left shoulder up against the assist bar. I am here because I have a spinal injury for rehab and she should know that. There was another CNA (CNA I) who was assisting another resident at the time. It was just her. Since this happened it has been making my therapy difficult and more painful.R2's care plan, dated 10/4/25, read in part, .Focus: Resident has an ADL (activities of daily living) self-care performance deficit related to.Parkinson's, Arthritis, Obstructive Uropathy, Obesity, Depression. Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Interventions.BED MOBILITY: 2 Person assist.Quality Assistance Form, dated 1/2/26, read in part .Findings: Employee repositioned resident by herself when care plan states two. This lead (sic) to more effort by employee in turning causing resident to make contact with positioning bar. Plan/Action: Provide 1. employee in services. 2. Coach council employee. 3 Apologize per Little Book of Empathy.Performance Improvement Form, dated 1/5/26, disclosed that CNA F did not follow R2's care plan and received a write-up for performing resident care providing only one assist when care plan indicated resident was a two person assist with cares.Incident report statement from R2, dated 1/2/26, by unit manager Licensed Practical Nurse (LPN) D, read in part .He reported (CNA F) swung his legs into the bed as he (R2) was in a sitting position and was being placed in a laying position. He (R2) indicated (CNA F) was the only person to swing him into bed during this time. Patient (R2) also reported that she (CNA F) came to do bed check on him and upon rolling him on his side his shoulder had hit the mobility bar which caused him some pain and then he reported that she told him he was dry and clean and flopped him back onto his back.Incident report statement from CNA F, dated 1/2/26, by unit manager LPN D, read in part .Upon going into his (R2) room a little later to perform a bed check on this (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235280	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Alpena	301 Long Rapids Road Alpena, MI 49707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient, (CNA F) indicated that she turned on the light to perform a bed check, (CNA F) was in room by herself.Follow up from Social Services Director (SSD) H, dated 1/2/26, revealed R2 expressed concerns over recent care provided by CNA F, stating she wasn't gentle enough with him. R2 noted he would consider calling the cops and getting a PPO (personal protection order) on CNA F if he found it necessary.On 1/21/26 at 10:20 AM, an interview was attempted with CNA F via phone, but there was no answer, and a message was left to call back. No return call was received from CNA F prior to the end of the survey.On 1/21/26 at 10:30 AM, an interview was attempted with CNA I via phone, but there was no answer, and a message was left to call back. No return call was received from CNA I prior to the end of the survey.During an interview on 1/21/26 at 11:00 AM, unit manager LPN D confirmed there was an incident with R2 and CNA F while providing cares and there should have been two CNAs performing the care provided at the time of the incident on 12/31/25.On 1/21/26 at 10:40 AM, an interview was conducted with Doctoral Physical Therapist (DPT) J, who stated (R2) had complained about being roughed up during care he received from CNA F and that (R2) was having more neck pain after the incident on 12/31/25.The Nursing Home Administrator (NHA) on 1/21/26 at 12:20 PM, also confirmed R2 was not transferred properly in his bed by CNA F on 12/31/25. The NHA acknowledged CNA F should have had another CNA with her while performing cares.Review of policy titled, Comprehensive Care Plans, dated 1/1/2021, read in part Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.