STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 2974196 and 2794550.Based on observation, interview and record review, the facility failed to protect the residents right to be free from physical abuse by staff and residents for four (R801, R805, R809, and R810) out of six reviewed for abuse resulting in R808 punching R801 in the jaw causing fear, pain and discoloration, attempting to choke R809, and hitting R810 in the face; and a staff member pushing R805 causing a fall.Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed the following allegation: Physical contact made from (R808) to (R801) . On 5/20/26 at 2:20 PM, an interview was conducted with R801. When queried about any physical altercations with other residents, R801 reported she was hit in the face by another resident a couple months ago. R801 reported she was walking around on the unit when a guy who was seated in a wheelchair, stood up and came behind her and hit her in the jaw. R801 closed her fist and made a punching motion to demonstrate how she was hit by the other resident. R801 stated, It hurt so much! It was sore for a while! R801 further reported she cried because it hurt and yelled for help and the other male residents in the area were yelling to call the cops to get that man out of here. R801 said she was very scared, did not understand why the other resident hit her, and that she was glad he was not in the facility any longer. A review of R801's clinical record revealed R801 was admitted into the facility on [DATE] with diagnoses that included: metabolic encephalopathy and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] and 3/30/26 revealed R801 had severely impaired cognition and no behaviors. A review of a Nurses' Notes for R801 revealed, At about 7:50AM writer was notified that Resident received physical contact on her face by (R808). Witnessed by Housekeeper .Resident assessed, was crying in pain, holding her left jaw, site noted with discoloration . A review of an Investigation Summary submitted to the SA by the facility revealed the following: On 2/12/26, a housekeeping staff person witnessed .(R808), make physical contact with his closed hand to the left lower jaw of .(R801) .(R801) had some discoloration to the left jaw and complaints of pain at the time of the incident .(R801) was interviewed. She stated she was just saying hello or good morning and the other resident hit her .(R808) was petitioned out for a psychiatric evaluation .(R808) is assigned a 1:1 caregiver for supervision. The resident is being monitored for behaviors related to agitation and hitting others . (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R808's clinical record revealed R808 was admitted into the facility on 5/23/24 and discharged on 3/15/26 with diagnoses that included: seizures and dementia. A review of a MDS assessment dated [DATE] and 3/1/26 revealed R808 had severely impaired cognition. A review of a Nurses' Notes for R808 dated 2/12/26 revealed, Resident was reported to have been physically aggressive by making contact with (R801) face .Resident was petitioned to (hospital) at about 10:am via two police officers . Further review of R808's progress notes revealed the following: On 1/23/26, the following was documented in a Nurses' Notes, Was reported to writer that Resident made contact with the palm of his hand on (R810) face by his doorway . On 2/4/26, the following was documented, Resident spent most of his day sitting guarding his doorway, to prevent other Residents from wandering into his room and sometimes roommates . On 2/8/26, the following was documented, Resident continue to guard his doorway compulsively. Gets up immediately to stop any peer attempting to go in. Only gets away from doorway for bathroom, meals, and some times wheels towards the dining room and returns right away to the door . On 3/2/26, it was documented that Resident charged toward CNA (Certified Nursing Assistant) threaten to beat his behind, called him derogatory, inappropriate names. CNA was moved off of the current assignment (1 on 1) with resident, new CNA assigned . On 3/6/26, it was documented that Resident agitated, attempted to be physical with assigned 1:1 CNA. Told CNA to stay away from him. CNA sitter was switched, staff educated to keep a safe reasonable distance while redirecting resident . On 3/12/26, it was documented that Writer was notified by 1:1 monitor that she was sitting on the right side of resident in hallway. Another Resident walked into this resident's room. Both the resident (R808) and the aide stood up. While she was standing next to the resident, she attempted to redirect the other resident to leave this resident's room. As the other resident was walking out of the room, this resident made contact with the other residents neck with both of his hands .Administrator was notified . On 3/15/26, it was documented that Writer received phone call while at home, that the resident slapped his Nurse in the face causing injury .Writer observed the Nurse with red welts and scratches to the right side of her face. The Nurse complained of a headache and being dizzy. Due to pain and bleeding to the nose and face, the Nurse was sent to the hospital for treatment . It was documented in a progress note that R808 was transferred to the hospital on 3/15/26 and then to another facility when discharged from the hospital. On 5/20/26 at 1:14 PM, an interview was conducted with Acting Administrator 'M', Regional Director 'N', and Regional Nurse 'O' in regard to the above physical altercations by R808 toward R801, R809, and R810. Regional Director 'N' reported that she did not think the physical contact made by R808 was abuse because it had to be willful. When queried about whether R808 making contact with R809's neck with both hands, making contact with the palm of his hand to R810's face as a reaction to the other resident's entering or attempting to enter his room and whether that was considered willful, a (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	response was not offered. A review of a Petition for Mental Health Treatment dated 2/12/26, revealed R808 was petitioned to the hospital as a result of that mental illness, the individual can reasonably be expected within the near future to intentionally or unintentionally seriously physically injury self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation. It was documented that R808 punched female resident in the face after she told him 'Good Morning' . On 5/20/26 at 3:30 PM, an interview was conducted with CNA 'K' (the staff member that witnessed the physical altercation between R808 and R809 on 3/12/26). When queried about what happened, CNA 'K' reported they were assigned to provide 1:1 supervision to R808 that day. CNA 'K' reported she was unaware why R808 was on 1:1 supervision and later found out there was a binder that they were supposed to document in, and it contained information about the resident. CNA 'K' explained while seated with R808 outside of his room, R809 wandered into R808's room. CNA 'K' stood up to redirect R809 from R808's room and R808 also stood up and put his (R808) hands around his (R809) neck and attempted to choke him. CNA 'K' reported R808 did not like other residents going into his room or near it. On 5/20/26 at 3:43 PM, an interview was conducted with Licensed Practical Nurse (LPN) 'L' (the staff member that witnessed the physical altercation between R808 and R810 on 1/23/26). When queried about what happened, LPN 'L' reported it happened quickly and R810 was wandering the unit as she typically did and out of nowhere R808 walked up to her and hit her in the face. LPN 'L' said it was unprovoked and said R808 used the palm of his hand to hit R810 on the side of the face. LPN 'L' reported it was not with major force but was an act of aggression. A review of an incident report for R808 dated 1/23/26 revealed LPN 'L' reported R810 was attempting to enter another resident's room (R808) and the resident assigned to that room (R808) made contact with palm of his hand to the resident. R805 A FRI (Facility Reported Incident) was reported to the State Agency (SA) detailing a physical incident that occurred between R805 and Certified Nursing Assistant (CNA) G on 3/10/26. A review of R805's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: bipolar disorder, schizophrenia, Parkinson's disease and dementia. The resident had a Brief Interview for Mental Status (BIMS) score of 4/15 (severely cognitively impaired), had been deemed incompetent and had a court appointed Legal Guardian for both medical and financial needs. The resident's Care Plan noted, in part, the following: Focus: Resident has behaviors related to dementia, bipolar disease, schizophrenia.as evidenced by verbal aggression towards staff.she has periods of manic behavior and can be impulsive(initiated 10/24/23).Interventions:.approach resident in a calm manner to avoid frustration and behavior escalation: if resident becomes agitated and show signs of escalation, re-approach later (10/24/23). A review of the facility's Incident/Accident (IA) report and accompanying documents noted the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following: Alleged Abuse: Date 3/10/2026 5:00 PM.Resident: R805.Location: Activity Room .Person Preparing Report: Nurse J.Incident Description: Writer (Nurse J) had heard Staff and Resident behind her. Staff tell the resident stand back, stop. Writer was faced forward, when writer turned around Resident was on the floor behind me, writer initially assumed, Resident.slipped to the floor. Writer was educated that the staff and resident had contact, that's how resident landed on the floor.Resident unable to give Description. .Summary of Events: On Tuesday, March 10, 2026, at 3:55 PM, nurse (herein after Nurse J) notified the Administrator of a suspected incident. The nurse reported that she had her back turned to (R805) and the CNA (G), when (R805) fell but that from her peripheral vision she thought the CNA put her arm out and touched the resident, causing the fall.The CNA was called to the Administrator's office. (CNA G) reported that she was re-directing the resident, (R805) away from the double doors that exit the unit. She states the resident was aggressive, striking the CNA in the face. The CNA states she attempted to walk away from the resident and was at the sink outside of the dining room washing her hands. The resident was behind the CNA, hitting her and yelling out. The CNA reported that she turned around with her left arm out in attempt to stop the resident from hitting her, she made physical contact at the shoulder area of the resident and the resident fell down.two staff members who were working on 2-North and witnessed the event came to the Administrator's office to report what they witnessed.CNA (H) was assigned to room [ROOM NUMBER] and was outside of the door. The door to room [ROOM NUMBER] is in the small hall outside of the dining room and near the sink where (CNA G) was washing her hands. (CNA H) stated she heard (CNA G) state, She hit me in my face followed by something that sounded like If she hits me again, I'm going to slap her.CNA H observed (R805), hitting (CNA G). CNA H observed CNA G turn around and make <sic> physical contact with one hand to the resident, (R805) fell down.The Activity Aide (Staff I), was coming out of the bathroom, across the hall from the area of the sink and entrance to the dining room. She observed (CNA G) holding he resident (R805) by the hands.(CNA G) let go of (R805's) hands and went to the sink .(Staff I) states she heard (CNA G) say something that sounds like I'm going to hit her back. R805 was hitting (CNA G) from behind while (CNA G) was washing her hands. (Staff I)observed (R805) turn around and put one hand on (R805), pushing her away and she fell and got back up.The facility suspended (CNA 'G) immediately pending investigation .Based on the investigation and statements provided.the facility believes that the allegation of physical abuse is inconclusive. However, the CNA will be terminated as an outcome of five-day investigation for failing to adhere to our standard of care in the manner in which she handled the situation with the resident. A Performance Improvement form was included in the IA packet and read, in part: .Employee name: [CNA G].Today's Date: 3/10/26.Reason for Counseling/Corrective Action: Staff reported that (CNA G) pushed a resident.[CNA G] was suspended pending investigation.Corrective Action Plan: BLANK.Time Frame for Improvement: BLANK.Employee Comments: BLANK. On 5/20/26 at approximately 11:28 AM, an interview was conducted with CNA H. CNA H reported that they had been employed by the facility for approximately seven years, first as an activity assistant and then a CNA. CNA H reported that they generally work the day shift on the memory care locked unit on 2 North where R805 resides. CNA H was asked about the incident involving R805 and CNA G on 3/10/26. CNA H reported that they were very familiar with R805 and noted at times she can be combative but easily redirected. With respect to the incident on 3/10/26 they were assigned to provide 1:1 care for another resident and observed R805, trying to push on the locked doors and observed R805 hitting CNA G. CNA G then moved to the sink located on the side of the activity room, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not far from the locked doors as R805 hit her on her nose and she had a nose ring. As CNA G was washing herself at the sink, R805 was behind her and she heard CNA G saying that if she hits her again, she was going to hit/slap her back. CNA H noted that R805 did push on CNA G and then CNA G then turned around and using both hands on her shoulders and shoved her and R805 fell to the floor. CNA H said was a terrible event and was very upset that CNA G shoved the resident and they reported the incident to the Administrator. CNA H further reported that while the resident at times can be aggressive, they can be redirected and there was no need to treat the resident like that. On 5/20/26 at approximately 11:57 AM, an interview was conducted with Staff I. Staff I reported that they had been employed by the facility for over a year as an activity aide and generally worked with residents on the locked memory unit. When asked about the 3/10/26 incident involving R805 and CNA G, Staff I reported that they were exiting out of the bathroom near the double doors and CNA G had her hands on the resident's arms. CNA G then let go of the resident's hands and let R805 go. CNA G then moved to the sink area and was trying to wipe off her nose and said if the resident tried to hit her again, she was going to knock her out. R805 then hit CNA G from behind as she was at the shower and CNA G turned around and pushed her away and the resident fell to the floor. On 5/20/26 at approximately 1:05 PM, a phone interview was conducted with CNA G. CNA G reported that they were suspended and then terminated from the facility following the incident with R805 and did not provide the termination details. On 5/20/26 at approximately 1:46 PM, an interview was conducted with the Acting Administrator. When asked about the incident and the determination that the incident was inconclusive even though CNA G was terminated, the Acting Administrator noted they were not familiar with the incident. On 5/20/26 at approximately 1:50 PM, an interview was conducted with Risk Manager B regarding the inconclusive finding and if so, why was CNA G terminated. Risk Manager B reported the facility determined CNA G did not provide R805 with needed standard of care but did not consider it abuse as the resident was not physically injured. A review of CNA G's personnel record did not contain documentation pertaining to their termination. The facility was asked to provide any documentation pertaining to the termination of CNA G. No documents were provided by the end of the Survey. On 5/20/26 at approximately 3:15 PM, an interview with Nurse J was conducted on the Memory Care -2nd floor unit. Nurse J was asked about the incident between CNA G and R805. Nurse J noted that she did not observe any of the incident and demonstrated that she was standing at her medication cart with their back facing the sink. They then heard a noise, turned around and saw R805 on the ground. Nurse J noted that they reported the incident to the Administrator. The facility policy titled, Abuse, Neglect and Exploitation (revised 1/10/24) was reviewed and read as follows: .Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Definitions: Abuse means willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish which can include staff to resident abuse and certain resident to resident altercations .Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .physical abuse includes but is not limited to hitting, slapping, punching, biting and kicking .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2794550.Based on interview and record review, the facility failed to report witnessed resident to resident physical abuse to the State Agency for two (R809 and R810) of six resident reviewed for abuse who were physically abused by R808. Findings include:A review of R808's clinical record revealed R808 was admitted into the facility on 5/23/24 and discharged on 3/15/26 with diagnoses that included: seizures and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] and 3/1/26 revealed R808 had severely impaired cognition.A review of R808's progress notes revealed the following:On 1/23/26, the following was documented in a Nurses' Notes, Was reported to writer that Resident made contact with the palm of his hand on (R810) face by his doorway .On 2/4/26, the following was documented, Resident spent most of his day sitting guarding his doorway, to prevent other Residents from wandering into his room and sometimes roommates .On 2/8/26, the following was documented, Resident continue to guard his doorway compulsively. Gets up immediately to stop any peer attempting to go in. Only gets away from doorway for bathroom, meals, and some times wheels towards the dining room and returns right away to the door .On 3/2/26, it was documented that Resident charged toward CNA (Certified Nursing Assistant) threaten to beat his behind, called him derogatory, inappropriate names. CNA was moved off of the current assignment (1 on 1) with resident, new CNA assigned .On 3/6/26, it was documented that Resident agitated, attempted to be physical with assigned 1:1 CNA. Told CNA to stay away from him. CNA sitter was switched, staff educated to keep a safe reasonable distance while redirecting resident .On 3/12/26, it was documented that Writer was notified by 1:1 monitor that she was sitting on the right side of resident in hallway. Another Resident walked into this resident's room. Both the resident (R808) and the aide stood up. While she was standing next to the resident, she attempted to redirect the other resident to leave this resident's room. As the other resident was walking out of the room, this resident made contact with the other residents neck with both of his hands .Administrator was notified .On 3/15/26, it was documented that Writer received phone call while at home, that the resident slapped his Nurse in the face causing injury .Writer observed the Nurse with red welts and scratches to the right side of her face. The Nurse complained of a headache and being dizzy. Due to pain and bleeding to the nose and face, the Nurse was sent to the hospital for treatment .It was documented in a progress note that R808 was transferred to the hospital on 3/15/26 and then to another facility when discharged from the hospital.On 5/20/26 at 11:03 AM, Acting Administrator 'M' was asked to provide any incident reports and investigations for R808 since January 2026. A review of an incident report for R808 dated 1/23/26 revealed, Per wound nurse, Resident made contact with his palm on (R810) face. It was documented the Administrator (Abuse Coordinator) was notified. A review of an incident report for R810 dated 1/23/26 revealed, Wound care nurse reported while walking over to 2 North. Resident (R810) was attempting to enter another resident (R808) room and Resident assigned to the room made contact with palm of his hand to the resident. It was documented the Administrator was notified.A review of an incident report for R808 dated 3/12/26 revealed, Writer was notified by 1:1 monitor that she was sitting on the right side of resident put in hallway. Another Resident (R809) walked into the resident's room. Both the resident and the aide stood up. While she was standing next to the resident, she attempted to redirect the other resident to leave the resident's room. As the other resident was walking out of the room, the resident made contact with the other residents neck with both of his hands. It was documented the Administrator was notified. On 5/20/26 at approximately 12:40 PM, an interview was conducted with Acting Administrator 'M'. Acting Administrator 'M' was asked about the facility protocol for reporting witnessed resident to resident abuse and reported the Administrator (who was not available during the survey) was the Abuse Coordinator and Risk Management Coordinator 'B' would be able to answer any abuse reporting and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation questions. On 5/20/26 at approximately 12:45 PM, an interview was conducted with Risk Management Coordinator 'B'. When queried about her role, Risk Management Coordinator 'B' explained when there was an allegation of abuse, she was responsible to do the reporting and investigating at the directive of the Administrator. The Administrator was the person who made the decision whether an allegation was reportable to the State Agency or not. Risk Management Coordinator 'B' reported that if an allegation of abuse was not made by the resident (victim) and there was no injury, then it would not be reported to the State Agency, but an investigation would be done. Risk Management Coordinator 'B remembered the physical altercations by R808 toward R809 and R810 and said they were not reported to the State Agency.On 5/20/26 at 1:14 PM, an interview was conducted with Acting Administrator 'M', Regional Director 'N', and Regional Nurse 'O' in regard to the above physical altercations by R808 toward R809, and R810. When queried about why the incident of R808 hitting R810 in the face and putting his hands on R809's neck were not reported to the State Agency, Regional Director 'N' reported that she did not think the physical contact made by R808 was abuse because it had to be willful, that no allegation of abuse was made, and there was no injury. When queried about whether R808 making contact with R809's neck with both hands, making contact with the palm of his hand to R810's face as a reaction to the other resident's entering or attempting to enter his room and whether that was considered willful, a response was not offered. When queried about whether a reasonable person would experience emotional or psychosocial distress after being hit or choked, Regional Nurse 'N' reported that would be subjective. When queried about why an allegation of abuse had to be made if the incidents were witnessed by staff, Regional Nurse 'N' stated, Being witnessed does not mean it is abuse. At that time, the facility's investigation was reviewed and those present were queried about what the specific contact was that R808 made with R809's neck and R810's face and how it could have been determined that it was not abuse without gathering additional information about the contact. There was no evidence provided that specific information about the physical contact was investigated by the facility.On 5/20/26 at 3:30 PM, an interview was conducted with CNA 'K' (the staff member that witnessed the physical altercation between R808 and R809 on 3/12/26). When queried about what happened, CNA 'K' reported they were assigned to provide 1:1 supervision to R808 that day. CNA 'K' reported she was unaware why R808 was on 1:1 supervision and later found out there was a binder that they were supposed to document in, and it contained information about the resident. CNA 'K' explained while seated with R808 outside of his room, R809 wandered into R808's room. CNA 'K' stood up to redirect R809 from R808's room and R808 also stood up and put his (R808) hands around his (R809) neck and attempted to choke him. CNA 'K' reported R808 did not like other residents going into his room or near it. On 5/20/26 at 3:43 PM, an interview was conducted with Licensed Practical Nurse (LPN) 'L' (the staff member that witnessed the physical altercation between R808 and R810 on 1/23/26). When queried about what happened, LPN 'L' reported it happened quickly and R810 was wandering the unit as she typically did and out of nowhere R808 walked up to her and hit her in the face. LPN 'L' said it was unprovoked and said R808 used the palm of his hand to hit R810 on the side of the face. LPN 'L' reported it was not with major force but was an act of aggression. A review of R809's clinical record revealed R809 was admitted into the facility on 7/17/25 with diagnoses that included: Alzheimer's Disease and bipolar disorder. A review of a MDS assessment dated [DATE] revealed R809 had severely impaired cognition.A review of R810's clinical record revealed R810 was admitted into the facility on 6/27/17 with diagnoses that included: Alzheimer's Disease and schizoaffective disorder. A review of a MDS assessment dated [DATE] revealed R810 had severely impaired cognition and behaviors that included wandering. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/24, revealed, in part, the following: .The facility will have written procedures that include .Reporting of alleged violations to the Administrator, state agency .and to all other required agencies .within specified timeframes and required by state and federal regulations .immediately, but not later than 2 hours after the allegation is made, if the vents that cause the allegation involve abuse or result in serious bodily injury .