

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/28/2026
NAME OF PROVIDER OR SUPPLIER  Norlite Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Homestead Street Marquette, MI 49855	

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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake #2687526Based on interview and record review the facility failed to implement their Policy and Procedure for Unusual Occurrence Reports for 2 Residents (#82 &amp; #90) reviewed for resolution of concerns, grievances and unusual occurrences resulting in the potential for unresolved resident concern/grievances, continued resident-to-resident incidents/occurrences and potential for decline in physical, psychosocial and mental wellbeing.Findings include:Review of an Anonymous Complaint to the State Agency dated 12/8/2025 at 1:58 PM read in part: (R82) grabbed (R90's) head aggressively, (facility staff name omitted) and (facility staff name omitted) intervened between the two. Both nurses called (the Director of Nursing [DON]) immediately after reporting the incident. (The Nursing Home Administrator [NHA]) told (staff name omitted) that he watched the video and (R82) was 'petting' (R90's) head when that was not the case. This was a resident to resident not being reported by the facility .Resident #82 (R82)Review of an admission Record revealed R82, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease.Review of a Minimum Data Set (MDS) assessment for R82, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R82 was severely cognitively impaired.Resident #90 (R90)Review of an admission Record revealed R90 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease.Review of a Minimum Data Set (MDS) assessment for R90, with a reference date of 12/2/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated R90 was cognitively impaired.In an interview on 1/26/26 at 5:00 PM., the Nursing Home Administrator (NHA) reported he was aware of a situation between R82 and R90 about a month ago. When asked, the NHA informed this surveyor he did not have a completed Unusual Occurrence Report (UOR).Review of R82's Electronic Medical Record (EMR) Behavior Charting read in part: 12/06/2025 17:00 (5:00 p.m.) Behavior Charting Behaviors exhibited by (R82): Aggression towards others see below Additional information: Resident getting ready to eat dinner and was standing next to (R90) and put his hands over her hair/eyes. further review of this behavior charting revealed LPN S documented this in R82's EMR.In an interview on 1/26/26 at 5:35 PM., Licensed Practical Nurse (LPN) S reported she was working on 12/6/25 when (R82) grabbed onto (R90's) head. LPN S reported the 2 residents were immediately separated. LPN S reported a phone call was made to the DON to report the incident because R82 was known to have extremely aggressive behaviors, especially towards staff. LPN S reported she was unsure if the DON, or any other staff member had completed an Unusual Occurrence Report, LPN S reported she did not complete a Unusual Occurrence Report. Review of a Facility Policy and Procedure read in part: SUBJECT: Unusual Occurrence Reports-revision date: 4-26-22I. DEFINITION: An Unusual Occurrence is an Event that does not usually occur in the day-to-day life of the Residents and Visitors that causes injury (or increases the potential for injury), including, but not limited to, Fall, Skin</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 235367	If continuation sheet Page 1 of 10

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Tear, Bruise, Elopement, Burn, Resident-to-Resident Altercation, etc.II. POLICY: All Events (Resident and Visitor) will be completed and investigated timely to ensure interventions to prevent recurrence are initiated, appropriate notifications are made and maintain compliance with state and federal regulations.III. PROCEDUREa. The Employee or person witnessing (or having primary knowledge of) an Event will report it immediately to the Charge Nurse (or RN Supervisor if Charge Nurse is unavailable), who will initiate the Unusual Occurrence Report / Eventb. When the Event involves a Resident, the Charge Nurse will:i. Assess the Resident for injury or potential for injuryii. Administer first aid, as appropriateiii. Start a (Electronic Medical Record-EMR) Event under the appropriate category (Fall/Bruise/etc.) and complete the Event in its entiretyiv. Complete the Resident Unusual Occurrence Report form in its entirety:1. including the Therapy Notification, if applicable2. If injury involves skin, notify Wound Carev. Make appropriate notifications to Physician and Family/RP as soon as practicable, but always within 24 hours. 1. If a message is left and there is no timely return call, the next individual on the list is to be contacted until notification is completedvi. The Unusual Occurrence Report form will be kept by the Charge Nurse until all documentation and follow-up assessments have been completed1. Obtain written statements from any relevant witnesses of the Event and include with Unusual Occurrence form2. Staff members responsible or familiar with the Resident's daily activities should be interviewed as well for investigation thoroughnessvii. Upon investigation, the Charge Nurse will determine the following:1. Is the resident unable to verbalize what occurred?2. Is the Event or injury suspicious for abuse? If so:a. Notify On-Call Nursing Supervisor and Administrator immediately3. If an injury, does the Resident require a transfer to an acute care setting? If so:a. Notify physician and RP immediately b. Initiate a Transfer to Acute Care (Hospital) Event in Matrix c. Notify On-Call Nursing Supervisor and Administratorviii. Document the Event and any injury, pain or behavior resulting in the Progress Notesix. Forward the completed Resident Unusual Occurrence Report and all accompanying documentation to the Nursing Supervisors, who will maintain and present at daily Clinical Rounds meetings for IDT review and assess for any trends, interventions, plans of correction, and resolution.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake #2687526. Based on interviews and record review the facility failed to protect the resident's right to be free from physical abuse by a resident for one Resident (#90) of two residents reviewed for abuse resulting in R82 grabbing R90's head, and based on the reasonable person concept would cause feelings of pain, fear and intimidation for Resident #90. Findings include: Review of an Anonymous Complaint to the State Agency dated 12/8/2025 at 1:58 PM read in part: (R82) grabbed (R90's) head aggressively, (facility staff name omitted) and (facility staff name omitted) intervened between the two. Both nurses called (the Director of Nursing [DON]) immediately after reporting the incident. (The Nursing Home Administrator [NHA]) told (staff name omitted) that he watched the video and (R82) was 'petting' (R90's) head when that was not the case. This was a resident to resident not being reported by the facility. Resident #82 (R82) Review of an admission Record revealed R82, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for R82, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R82 was severely cognitively impaired. In an interview on 1/26/26 at 5:00 PM., the NHA reported he was aware of the situation between R82 and R90 about a month ago. When asked, NHA informed this surveyor that he did not complete an Unusual Occurrence Report (UOR), or a Facility Reported Incident (FRI) (State Agency-SA). NHA stated I do not have video footage of the incident between R82 and R90. Review of R82's Behavior Charting read in part: 12/06/2025 17:00 Behavior Charting Behaviors exhibited by Resident (R82): Aggression towards others see below Additional information: Resident getting ready to eat dinner and was standing next to (R90) and put his hands over her hair/eyes. further review of this Behavior Charting revealed Licensed Practical Nurse (LPN) S documented this note. In an interview on 1/26/26 at 5:35 PM., LPN S reported she was working on 12/6/25 when (R82) grabbed onto (R90's) head. LPN S reported the 2 residents were immediately separated. LPN S reported a phone call was made to the DON to report the incident because R82 was known to have extremely aggressive behaviors. LPN S reported R82 has very aggressive behaviors including hitting, punching, spitting, swinging, kicking and reaching out towards others. LPN S reported when R82 grabbed R90's head, it was not gentle. Resident #90 (R90) Review of an admission Record revealed R90 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for R90, with a reference date of 12/2/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated R90 was cognitively impaired. Review of R90's Electronic Medical Record (EMR) progress notes dated 10/1/25-12/12/25 revealed no documentation of any aggressive physical or verbal interaction with any other residents, nor documentation of (R82) touching/grabbing her head on 12/6/25 being charted/documented. R90's EMR progress notes revealed that R90 was [AGE] years old, blind, hard of hearing and receiving Hospice Care (End of life contracted agency staff to assist facility staff and family). Further review of R90's EMR from Contracted Hospice Agency Social Worker (SW) progress note dated 12/3/25 read in part: SW made a visit to see (R90). Upon arrival, SW found (R90) in her broda (wheelchair) in the dining room awaiting lunch. She was asleep and appeared very comfortable. She did not arouse SW verbal or gentle touch introduction. SW sat with her and provided presence and touch. She was peaceful and did not open eyes for SW during visit. Review of a R82's EMR Progress Notes Behavior Charting read in part: 12/07/2025 17:33 (5:33 p.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others raised fists in threatening manner at activity aide. 12/09/2025 19:02 (7:02 p.m.) Behavior Charting Behaviors exhibited by</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident: (R82) following a female resident up by desk, gently placed his hand on her back upsetting her. this nurse placed self between residents while other residents sat in chair. then again when female resident was ambulating to dining room, this resident walking up beside her reaching out hand towards her back . 12/10/2025 01:18 (1:18 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others aggressive w/staff during cares, Combativeness aggressive with staff and hitting staff during cares. 12/10/2025 09:47 (9:47 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others backhanded CNA across face, grabbed arm leaving red gauge marks . 12/11/2025 16:04 (4:04 p.m.) (R82) with increasing behaviors and agitation resulting in fear, discomfort, agitation, anger, and dangerous actions to care staff. There have been instances that (R82) has reached out toward other residents . 01/06/2026 08:41 (8:41 a.m.) Noted in (R82's) (EMR-facility name omitted) charting that on1/3/26 (R82) had combative behaviors causing injury to staff; spilled coffee on self, 3 CNAs assisted (R82) in changing clothes. 'He proceeded to hit, punched, and pulled back CNA finger back.' Also was noted that he is spitting that CNAs face. 01/08/2026 17:06 (5:06 p.m.) (Hospice Registered Nurse RN documented) (R82) has experienced decline in the last 2 months. (R82) has experienced agitation involving violence toward other residents. 12/07/2025 17:33 (5:33 p.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others raised fists in threatening manner at activity aide . 12/09/2025 19:02 (7:02 p.m.) Behavior Charting Behaviors exhibited by Resident: (R82) following a female resident up by desk, gently placed his hand on her back upsetting her. this nurse placed self between residents while other resident sat in chair. then again when female resident was ambulating to dining room, this resident walking up beside her reaching out hand towards her back . 12/10/2025 01:18 (1:18 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others aggressive w/staff during cares, Combativeness aggressive with staff and hitting staff during cares. 12/10/2025 09:47 (9:47 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others backhanded CNA across face, grabbed arm leaving red gauge marks . 12/11/2025 16:04 (4:04 p.m.) (R82) with increasing behaviors and agitation resulting in fear, discomfort, agitation, anger, and dangerous actions to care staff. There have been instances that (R82) has reached out toward other residents . 01/08/2026 17:06 (5:06 p.m.) (Hospice Registered Nurse RN documented) (R82) has experienced decline in the last 2 months. (R82) has experienced agitation involving violence toward other residents. 01/13/2026 12:25 (12:25 p.m.) with cares., Combativeness with staff during cares . At one time the resident pushed CNA at her chest into the wall to where her back and head hit the wall. At another time resident punched CNA in the head with both fists while he was trying to get his pants back up after cares for him. 01/14/26 (R82's) becoming increasingly difficult to redirect; he seems to be more skeptical of staff prompts to initiate cares, often stopping at his room doorway or shower doorway and refusing to follow staff inside. The IDT is having difficulty in identifying new techniques to keep staff safe, as several incidents have resulted in staff injuries.Review of a Facility Policy and Procedure read in part: SUBJECT: Abuse; Investigative and Reporting. REVISION DATES: 03-20-19. POLICY: To ensure prompt and thorough investigation of all reported allegations and/or suspicions of abuse. PROCEDURE: A. The facility must ensure that all alleged violations involving mistreatment (inappropriate treatment or exploitation of a resident), neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately (within two hours of occurrence). Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse and mental abuse .B. An Unusual Occurrence report (Matrix Event) will be completed by the Charge Nurse for all allegations or</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>suspicious of abuse, especially with harm associated, and immediate investigation is begun, if indicated. The Administrator will be notified by the Charge Nurse of Event.D. Upon receipt of complaint, within twenty-four (24) hours of occurrence, alleging actual or suspected abuse, the Administrator and/or Director of Nursing will investigate the incident with the assistance of appropriate and designated personnel.E. The investigation may be guided by the use of the attached Investigation Checklist .F. The investigation may consist of, but not limited to: 1. Review of completed facility Unusual Occurrence Report / Event with harm to residents associated. 2. Interview with person[s] reporting incidents or suspicions.3. Interview with any witnesses to alleged actual or suspected incident.4. If possible, interview with residents.5. Review of resident's medical records.6. Interviews with staff members having contact with the residents during the period/shift of the reported actual or suspected incident.7. Interviews with resident's roommate, family members, visitors, or any others.10.Review of all circumstances surrounding the alleged actual or suspected incident. **Interviews with all the above may not be completed based on circumstances surrounding the incident. **I. The Administrator will keep the resident or his/her representative of the findings of the investigation and corrective action taken.J. Allegations of abuse, of any nature, will be reported to (State Agency) .within 24 hours of the incident .M. If the incident reported results in injury or sexual assault, the immediate welfare of the resident is priority. The physician and resident representative will be updated and together will determine if a hospital emergency room visit is indicated. The Administrator will be contacted, unusual occurrence report will be initiated, and the internal investigation will begin immediately.INVESTIGATION CHECKLIST for IDT (To be used for allegation of abuse to facilitate investigations when obvious root cause is not evident).Resident(s) involved.Date and Time of Event: .Type of Event: .Who reported Event: .Date and time incident reported to the DON/ADON/Administrator: . Identify and Interview Like Residents - if applicable.What Residents need to be interviewed? .Like Diagnosis or situation (cognition, dependent, etc.)? .Develop questions to be asked of like residents.Ensure issue is not a pattern issue that needs to be addressed.Identify and Interview Involved Employees.What Employees need to be interviewed? .Develop questions to be asked of Employees? .CNAs for that shift:.NURSE for that shift:Other staff on the unit that shift:The goal is to develop a timeline going back several hours (beginning of shift or previous shift) or days (if necessary) reviewing resident behavior &amp; activity leading up to the event to help identify a root cause.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake# 2687526Based on interviews and record review, the facility failed to fully implement its Abuse Program Policy and Procedure and immediately identify and thoroughly investigate incidents of resident to resident abuse for 2 Residents (Residents #82 &amp; #90) from 18 residents reviewed for abuse and based on the reasonable person concept would cause feelings of pain, fear and intimidation for Residents #90, and the potential for continued resident abuse to go unreported and/or undetected.Findings include:Review of an Anonymous Complaint to the State Agency dated 12/8/2025 at 1:58 PM read in part: (R82) grabbed (R90's) head aggressively, (facility staff name omitted) and (facility staff name omitted) intervened between the two. Both nurses called (the Director of Nursing [DON]) immediately after reporting the incident. (The Nursing Home Administrator [NHA]) told (staff name omitted) that he watched the video and (R82) was 'petting' (R90's) head when that was not the case. This was a resident to resident not being reported by the facility . Resident #82 (R82)Review of an admission Record revealed R82, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease.Review of a Minimum Data Set (MDS) assessment for R82, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R82 was severely cognitively impaired.In an interview on 1/26/26 at 5:00 PM., the NHA reported he was aware of a situation between R82 and R90 about a month ago. When asked, NHA informed this surveyor that he did not complete an Unusual Occurrence Report (UOR), or a Facility Reported Incident (FRI) (State Agency-SA). NHA stated I do not have video footage of the incident between R82 and R90. Review of R82's Behavior Charting read in part: 12/06/2025 17:00 Behavior Charting Behaviors exhibited by Resident (R82): Aggression towards others see below Additional information: Resident getting ready to eat dinner and was standing next to (R90) and put his hands over her hair/eyes. further review of this Behavior Charting revealed Licensed Practical Nurse (LPN) S documented this note.In an interview on 1/26/26 at 5:35 PM., LPN S reported she was working on 12/6/25 when (R82) grabbed onto (R90's) head. LPN S reported the 2 residents were immediately separated. LPN S reported a phone call was made to the DON to report the incident because R82 was known to have extremely aggressive behaviors. LPN S reported R82 has very aggressive behaviors including, hitting, punching, spitting, swinging, kicking and reaching out towards others. LPN S reported when R82 grabbed R90's head, it was not gentle. Review of a R82's EMR Progress Notes Behavior Charting read in part: 12/07/2025 17:33 (5:33 p.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others raised fists in threatening manner at activity aide . 12/09/2025 19:02 (7:02 p.m.) Behavior Charting Behaviors exhibited by Resident: (R82) following a female resident up by desk, gently placed his hand on her back upsetting her. this nurse placed self between residents while other resident sat in chair. then again when female resident was ambulating to dining room, this resident walking up beside her reaching out hand towards her back . 12/10/2025 01:18 (1:18 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others aggressive w/staff during cares, Combativeness aggressive with staff and hitting staff during cares. 12/10/2025 09:47 (9:47 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others backhanded CNA across face, grabbed arm leaving red gauge marks . 12/11/2025 16:04 (4:04 p.m.) (R82) with increasing behaviors and agitation resulting in fear, discomfort, agitation, anger, and dangerous actions to care staff. There have been instances that (R82) has reached out toward other residents . 01/06/2026 08:41 (8:41 a.m.) Noted in (R82's) (EMR-facility name omitted) charting that on1/3/26 (R82) had combative behaviors causing injury to staff; spilled coffee on self, 3 CNAs assisted (R82) in changing clothes. 'He proceeded to hit, punched, and pulled back CNA</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>finger back.' Also was noted that he spitting that CNAs face. 01/08/2026 17:06 (5:06 p.m.) (Hospice Registered Nurse RN documented) (R82) has experienced decline in the last 2 months. (R82) has experienced agitation involving violence toward other residents. 12/07/2025 17:33 (5:33 p.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others raised fists in threatening manner at activity aide . 12/09/2025 19:02 (7:02 p.m.) Behavior Charting Behaviors exhibited by Resident: (R82) following a female resident up by desk, gently placed his hand on her back upsetting her. this nurse placed self between residents while other resident sat in chair. then again when female resident was ambulating to dining room, this resident walking up beside her reaching out hand towards her back . 12/10/2025 01:18 (1:18 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others aggressive w/staff during cares, Combativeness aggressive with staff and hitting staff during cares. 12/10/2025 09:47 (9:47 a.m.) Behavior Charting Behaviors exhibited by Resident: Aggression towards others backhanded CNA across face, grabbed arm leaving red gauge marks . 12/11/2025 16:04 (4:04 p.m.) (R82) with increasing behaviors and agitation resulting in fear, discomfort, agitation, anger, and dangerous actions to care staff. There have been instances that (R82) has reached out toward other residents . 01/08/2026 17:06 (5:06 p.m.) (Hospice Registered Nurse RN documented) (R82) has experienced decline in the last 2 months. (R82) has experienced agitation involving violence toward other residents. 01/13/2026 12:25 (12:25 p.m.) with cares., Combativeness with staff during cares . At one time the resident pushed CNA at her chest into the wall to where her back and head hit the wall. At another time resident punched CNA in the head with both fists while he was trying to get his pants back up after cares for him. 01/14/26 (R82's) becoming increasingly difficult to redirect; he seems to be more skeptical of staff prompts to initiate cares, often stopping at his room doorway or shower doorway and refusing to follow staff inside. The IDT is having difficulty in identifying new techniques to keep staff safe, as several incidents have resulted in staff injuries. Resident #90 (R90) Review of an admission Record revealed R90 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for R90, with a reference date of 12/2/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated R90 was cognitively impaired. Review of R90's Electronic Medical Record (EMR) progress notes dated 10/1/25-12/12/25 revealed no documentation of any aggressive physical or verbal interaction with any other residents, nor documentation of (R82) touching/grabbing her head on 12/6/25 charted/documentated. R90's EMR progress notes revealed that R90 was [AGE] years old, blind, hard of hearing and receiving Hospice Care (End of life contracted agency staff to assist facility staff and family). Further review of R90s EMR from Contracted Hospice Agency Social Worker (SW) progress note dated 12/3/25 read in part: SW made a visit to see (R90). Upon arrival, SW found (R90) in her broda (wheelchair) in the dining room awaiting lunch. She was asleep and appeared very comfortable. She did not arouse SW verbal or gentle touch introduction. SW sat with her and provided presence and touch. She was peaceful and did not open eyes for SW during visit .Review of a Facility Policy and Procedure read in part: SUBJECT: Abuse; Investigative and Reporting. REVISION DATES: 03-20-19. POLICY: To ensure prompt and thorough investigation of all reported allegations and/or suspicions of abuse. PROCEDURE: A. The facility must ensure that all alleged violations involving mistreatment (inappropriate treatment or exploitation of a resident), neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately (within two hours of occurrence). Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse and mental abuse .B. An Unusual Occurrence report</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/28/2026
NAME OF PROVIDER OR SUPPLIER  Norlite Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Homestead Street Marquette, MI 49855	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>(Matrix Event) will be completed by the Charge Nurse for all allegations or suspicions of abuse, especially with harm associated, and immediate investigation is begun, if indicated. The Administrator will be notified by the Charge Nurse of Event.D. Upon receipt of complaint, within twenty-four (24) hours of occurrence, alleging actual or suspected abuse, the Administrator and/or Director of Nursing will investigate the incident with the assistance of appropriate and designated personnel.E. The investigation may be guided by the use of the attached Investigation Checklist .F. The investigation may consist of, but not limited to: 1. Review of completed facility Unusual Occurrence Report / Event with harm to residents associated. 2. Interview with person[s] reporting incidents or suspicions.3. Interview with any witnesses to alleged actual or suspected incident.4. If possible, interview with residents.5. Review of resident's medical records.6. Interviews with staff members having contact with the residents during the period/shift of the reported actual or suspected incident.7. Interviews with resident's roommate, family members, visitors, or any others.10.Review of all circumstances surrounding the alleged actual or suspected incident. **Interviews with all the above may not be completed based on circumstances surrounding the incident. **I. The Administrator will keep the resident or his/her representative of the findings of the investigation and corrective action taken.J. Allegations of abuse, of any nature, will be reported to (State Agency) .within 24 hours of the incident .M. If the incident reported results in injury or sexual assault, the immediate welfare of the resident is priority. The physician and resident representative will be updated and together will determine if a hospital emergency room visit is indicated. The Administrator will be contacted, unusual occurrence report will be initiated, and the internal investigation will begin immediately.INVESTIGATION CHECKLIST for IDT (To be used for allegation of abuse to facilitate investigations when obvious root cause is not evident).Resident(s) involved.Date and Time of Event: .Type of Event: .Who reported Event: .Date and time incident reported to the DON/ADON/Administrator: . Identify and Interview Like Residents - if applicable.What Residents need to be interviewed? .Like Diagnosis or situation (cognition, dependent, etc.)? .Develop questions to be asked of like residents.Ensure issue is not a pattern issue that needs to be addressed.Identify and Interview Involved Employees.What Employees need to be interviewed? .Develop questions to be asked of Employees? .CNAs for that shift:.NURSE for that shift:.Other staff on the unit that shift:.The goal is to develop a timeline going back several hours (beginning of shift or previous shift) or days (if necessary) reviewing resident behavior &amp; activity leading up to the event to help identify a root cause.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake #2687526. Based on interviews and record review the facility failed to implement their policy and procedure for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act and as a result of the facility's failure to implement the facility Abuse Policy and ensure resident safety, resulted in R82's physical abuse to continue and placed all residents at risk for serious injury, physical and psychosocial harm, and impairment. Review of an Anonymous Complaint to the State Agency dated 12/08/2025 1:58 PM read in part: (R82) grabbed (R90's) head aggressively, (facility staff name omitted) and (facility staff name omitted) intervened between the two. Both nurses called (Director of Nursing-DON) immediately after reporting the incident. (Nursing Home Administrator-NHA) told (staff name omitted) that he watched the video and (R82) was petting (R90's) head when that was not the case. This was a resident to resident not being reported by the facility. Resident #82 (R82) Review of an admission Record revealed R82, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for R82, with a reference date of 1/14/2026 revealed a Brief Interview for Mental Status (BIMS) score of 99/15 which indicated R82 was severely cognitively impaired. In an interview on 1/26/26 at 5:00 PM., Nursing Home Administrator (NHA) reported he was aware of a situation between R82 and R90 about a month ago NHA indicated he did not report or investigate the occurrence between R82 and R90 because he felt it did not rise to the occasion as a reportable or needing investigating NHA indicated that he no longer had video footage of the occurrence between R82 and R90. Review of R82's Behavior Charting read in part: 12/06/2025 17:00 (5:00 p.m.) Behavior Charting Behaviors exhibited by Resident (R82): Aggression towards others see below Additional information: Resident getting ready to eat dinner and was standing next to (R90) and put his hands over her hair/eyes. further review of this Behavior Charting revealed LPN S documented this note. In an interview on 1/26/26 at 5:35 PM., LPN S reported she was working on 12/6/25 when (R82) grabbed onto (R90's) head. LPN S reported the 2 residents were immediately separated. LPN S reported a phone call was made to the Director of Nursing (DON) to report the incident because R82 was known to have extremely aggressive behaviors. LPN S reported R82 has very aggressive behaviors including hitting, punching, spitting, swinging, kicking and reaching out towards others. LPN S reported when R82 grabbed R90's head, it was not gentle. Review of R82's Behavior Charting read in part: 12/07/2025 17:33 Behavior Charting Behaviors exhibited by Resident: Aggression towards others raised fists in threatening manner. Review of a R82's EMR read in part: 12/09/2025 19:02 Behavior Charting Behaviors exhibited by Resident: (R82) following a female resident up by desk, gently placed his hand on her back upsetting her. this nurse placed self between residents while other resident sat in chair. then again when female resident was ambulating to dining room, this resident walking up beside her reaching out hand towards her back. Resident #90 (R90) Review of an admission Record revealed R90 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for R90, with a reference date of 12/02/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated R90 was cognitively impaired. Review of R90's Electronic Medical Record (EMR) progress notes dated 10/1/25-12/12/25 revealed no documentation of any aggressive physical or verbal interaction with any other residents, nor documentation of (R82) touching/grabbing her head on 12/6/25 charted/documentated. R90's EMR progress notes revealed that R90 was [AGE] years old, blind, hard of hearing and receiving Hospice Care (End of life contracted agency staff to assist facility staff and family). Further review of R90s EMR from Contracted</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Hospice Agency Social Worker (SW) progress note dated 12/3/25 read in part: SW made a visit to see (R90). Upon arrival, SW found (R90) in her broda (wheelchair) in the dining room awaiting lunch. She was asleep and appeared very comfortable. She did not arouse SW verbal or gentle touch introduction. SW sat with her and provided presence and touch. She was peaceful and did not open eyes for SW during visit .Review of a Facility Policy and Procedure read in part: SUBJECT: Abuse; Investigative and Reporting. REVISION DATES: 03-20-19. POLICY: To ensure prompt and thorough investigation of all reported allegations and/or suspicions of abuse. PROCEDURE: A. The facility must ensure that all alleged violations involving mistreatment (inappropriate treatment or exploitation of a resident), neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately (within two hours of occurrence). Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse and mental abuse .B. An Unusual Occurrence report (Matrix Event) will be completed by the Charge Nurse for all allegations or suspicions of abuse, especially with harm associated, and immediate investigation is begun, if indicated. The Administrator will be notified by the Charge Nurse of Event.D. Upon receipt of complaint, within twenty-four (24) hours of occurrence, alleging actual or suspected abuse, the Administrator and/or Director of Nursing will investigate the incident with the assistance of appropriate and designated personnel.E. The investigation may be guided by the use of the attached Investigation Checklist .F. The investigation may consist of, but not limited to: 1. Review of completed facility Unusual Occurrence Report / Event with harm to residents associated. 2. Interview with person[s] reporting incidents or suspicions.3. Interview with any witnesses to alleged actual or suspected incident.4. If possible, interview with residents.5. Review of resident's medical records.6. Interviews with staff members having contact with the residents during the period/shift of the reported actual or suspected incident.7. Interviews with resident's roommate, family members, visitors, or any others.10.Review of all circumstances surrounding the alleged actual or suspected incident. **Interviews with all the above may not be completed based on circumstances surrounding the incident. **I. The Administrator will keep the resident or his/her representative of the findings of the investigation and corrective action taken.J. Allegations of abuse, of any nature, will be reported to (State Agency) .within 24 hours of the incident .M. If the incident reported results in injury or sexual assault, the immediate welfare of the resident is priority. The physician and resident representative will be updated and together will determine if a hospital emergency room visit is indicated. The Administrator will be contacted, unusual occurrence report will be initiated, and the internal investigation will begin immediately.INVESTIGATION CHECKLIST for IDT (To be used for allegation of abuse to facilitate investigations when obvious root cause is not evident).Resident(s) involved.Date and Time of Event: .Type of Event: .Who reported Event: .Date and time incident reported to the DON/ADON/Administrator: . Identify and Interview Like Residents - if applicable.What Residents need to be interviewed? .Like Diagnosis or situation (cognition, dependent, etc.)? .Develop questions to be asked of like residents.Ensure issue is not a pattern issue that needs to be addressed.Identify and Interview Involved Employees.What Employees need to be interviewed? .Develop questions to be asked of Employees? .CNAs for that shift:.NURSE for that shift:.Other staff on the unit that shift:.The goal is to develop a timeline going back several hours (beginning of shift or previous shift) or days (if necessary) reviewing resident behavior &amp; activity leading up to the event to help identify a root cause.</p>		