STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235367	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norlite Nursing Center	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)
F 0675 Level of Harm - Actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Based on observation, interview, and record review, the facility failed to ensure the necessary equipment was readily available to provide care for two dependent Residents (#62 and #46) out of 18 residents reviewed for quality of life. This deficient practice resulted in emotional distress, feelings of frustration, social isolation, and physical discomfort.Findings include:Resident #62 (R62)Review of R62's Electronic Medical Record (EMR) revealed initial admission to the facility on 3/8/23 with diagnoses including hemiparesis (partial weakness, reduced strength, and/or impaired motor function on one side of the body) following cerebral infarction (stroke), multiple sclerosis (MS), muscle weakness, and need for assistance with personal care. Review of R62's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition.On 1/26/2026 at 4:03 PM, R62 was observed in bed lying in bed with greasy, unkempt hair.On 1/26/2026 at 4:06 PM, an interview was conducted with R62 regarding overall satisfaction with care at the facility. R62 stated she relied on a total lift (a mobile floor lift system that utilizes a sling and hydraulic or electric mast/boom) to transfer out of bed and into her wheelchair. R62 indicated there had been many times over the previous months where she had not been able to get out of bed, several times over an entire weekend (at least 48 hours), because the facility had run out of slings. When asked on how many occasions R62 was forced to remain in bed due to lack of slings, she replied, Many, many times. R62 also indicated there were several occasions over the previous months when she had to miss a shower due to the lack of transfer equipment.Review of R62's plan of care revealed a Problem with a start date of 3/8/23 that read, I need assistance from staff with my Activities of Daily Living (ADL's) as I have hemiplegia and hemiparesis following a stroke and also have multiple sclerosis and diabetes with the following approaches: TRANSFERS: Total assistance with [name brand] lift, edited 05/29/2025. TOILETING: [name brand] lift to toilet or use of bed pan, edited 12/18/2025. BATHING: extensive assist x1, created 3/08/2023.On 1/28/26 at 11:27 AM, a sign was observed posted on the 300 hallway that read, in part: WE HAVE A SHORTAGE OF SLINGS BECAUSE THEY ARE NOT PUT INTO LAUNDRY EVERY NIGHT.On 1/28/2026 at 9:28 AM, an interview was conducted with Certified Nursing Assistant (CNA) GG regarding facility supplies. CNA GG stated, I am only part time, but slings have been a problem before. When asked in what way slings have been a problem, CNA GG replied, Just not having enough. On 1/28/2026 9:30 AM, an interview was conducted with CNA HH who confirmed the facility experienced problems keeping slings in stock. CNA HH explained the facility sends the laundry out to a different facility. In the event there is a problem with turnaround time, the facility does not get the clean slings returned timely. CNA HH verified there had been multiple times where slings have, totally run out. CNA HH confirmed she has worked on more than one shift when she could not get residents out of bed or showered due to the lack of slings or unavailability of the correct size sling.On 1/28/2026 at 10:32 AM, an interview was conducted with Staff KK who stated, We run out of slings all the time. All the time.On 1/28/2026 at 11:46 AM, a phone interview was conducted with CNA II who stated the sling shortage has been an issue for, a couple months. CNA II explained, There's points where we totally run out [of slings] and then residents refuse to shower at times because if their sling gets wet, it has to go in the laundry after they get back into bed. the sling goes to laundry and (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 0675 Level of Harm - Actual harm Residents Affected - Few	then the resident gets stuck in bed. On 1/28/2026 at 11:35 AM, a follow-up interview was conducted with R62 regarding how the consistent equipment shortages affect her daily life. R62 stated, It pisses me off. I miss out on socialization and activities. I like playing BINGO. It's [the sling shortage] been going on for months. Sometimes I will refuse a shower because after the sling gets wet, we can't reuse them and then I'll be stuck in bed. R62 indicated intermittent problems with her skin integrity that is compounded by extended time in bed.Review of R62's plan of care revealed a, Problem with a start date of 4/20/23 that read, I am at risk for skin breakdown related to hemiplegia/hemiparesis, Muscle weakness, MS, Todd's Paresis (temporary focal weakness or paralysis), Type II DM [diabetes mellitus], urinary incontinence, CHF [congestive heart failure], anemia, and my left arm splint.Review of, Risk of Pressure Ulcers/Injuries in Section M: Skin Conditions in R62's most recent MDS assessment, dated 12/24/25, read, Is this resident at risk of developing pressure ulcers/injuries? Yes was selected.Review of R62's Weekly Resident Skin assessment, completed 1/9/26, read, in part: Any open areas, abrasions, lacerations, or skin tears? The assessor selected, Yes: .small linear split to upper gluteal cleft.Review of R62's Weekly Resident Skin assessment, completed 1/26/26, read, in part: Any rashes, pinkness, redness, ulcerations? The assessor selected, Yes: . sl [slight] redness to inner glutes.Resident #46 (R46)Review of R46's EMR revealed initial admission to the facility on 6/27/18 with diagnoses including disorders of psychological development, low back pain, mixed incontinence, morbid obesity, and dependence on wheelchair. Review of R46's most recent MDS assessment, dated 12/19/25, revealed a BIMS score of 14, indicative of intact cognition.On 1/28/26 at approximately 4:30 PM, an interview was conducted with R46 regarding the availability of slings. R46 confirmed the facility ran out of slings at times. When asked how she feels when there are no slings available, R46 replied, My back hurts. Review of R46's EMR revealed the following progress note written on 11/01/2025 at 16:52 [4:52 PM]: Wt [weight] was associated from last week due to not being able to get resident up for a weight because no slings were available.Review of, Risk of Pressure Ulcers/Injuries in Section M: Skin Conditions in R46's most recent MDS assessment, dated 12/19/25, read, Is this resident at risk of developing pressure ulcers/injuries? Yes was selected.Review of R46's plan of care revealed a, Problem with a start date of 9/25/19 that read, I need assistance from staff with my Activities of Daily Living (ADL's) related to my diagnosis of weakness, incontinence and Attention/Concentration disorder with difficulty focusing at times. with the following approaches: TOILETING: Bed pan or [name brand lift] to shower chair x2, edited 12/18/2025. TRANSFERS: Total assist of 2 with [name brand] lift. Staff may leave sling in place related to my body habitus and poor mobility, edited 11/28/2023.On 1/28/26 at 4:19 PM, an interview was conducted with the Nursing Home Administrator (NHA) regarding the sling shortage. The NHA called the situation unfortunate and expressed regret sharing the same brand mobile lift system as the facility that launders the slings as he believed the slings were being left and utilized at that facility.Review of the Facility Assessment, reviewed 10/3/25, read, in part: .Physical equipment includes. lifts, lift slings.

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide sufficient staffing to address the care, needs, and safety of the entire facility population. This deficient practice resulted in unmet care needs and the potential for serious safety issues for all 82 residents of the facility.Findings include:On 1/27/26 at 2:05 PM, a confidential group interview was conducted regarding overall perception of nurse staffing levels. Six out of 14 confidential residents (CR's) expressed concerns with receiving timely assistance for care needs as well as the timely passing of meal trays. One CR stated, The place is understaffed, indicating Certified Nursing Assistants (CNAs) were often assigned to cover more than one hallway. CR10 stated the staffing shortage usually gets worse on the weekends.Review of the Resident Council Meeting Minutes revealed the following:1/6/26: .Old Business: . [Facility name] is looking to hire more CNAs to help with the shortage in nursing help concern.12/2/25: .Old Business: . Complaints from residents concerning late trays being served cold in halls. New Business: .Resident stated how only two nurses are available to pass out dining trays in the hall.11/4/25: .New Business: . Staff is pretty slow at times. Often only 1 or 2 CNA members to a hall or 1 nurse covering 2 halls.8/4/25: .New Business: .[CR1] states she does not receive meal trays down wings in a timely manner.7/1/25: .Old Business: Meal trays taking long to be served.4/1/25: .New Business: Concern about all light times were brought up.Several confidential residents voiced their frustration regarding wandering residents entering their personal living quarters. One CR stated wandering residents came into their room so often, I can't keep my door open. When asked if it takes staff a long time for staff to redirect the resident out of their room, the same CR stated, I redirect her because I don't want her near me. She follows me around all day. Another CR added, Yes, there's a problem with wanderers. She [the same resident mentioned above] stares at me and watches what I'm doing. I usually have to redirect her [instead of staff]. Yet another CR confirmed wanderers often entered her room but they were reliant on staff for redirection due to their physical limitations. Two additional CR's stated they were forced to keep their door shut to avoid wanderers even though they preferred to keep them open. On 1/26/2026 at 4:29 PM, Resident #92 (R92) was observed propelling himself in a wheelchair up and down the 300 hallway. R92 stopped at the entrance of a room and shouted, Stay in there and don't come out until I tell you! No staff intervention was observed after the verbal outburst toward another resident.Review of R92's Plan of Care revealed the following two, Approaches with a start date of 1/26/26: [R92] is on the high-risk list for increased risk of resident-to-resident altercations/behaviors. Use consistent verbal redirection when [R92] is observed attempting to entering other residents' rooms.On 1/26/26 at 4:17 PM, Resident #11 (R11), who resided on the 200 hall, was observed wandering on the 300 hallway, entering and exiting other resident rooms with no staff intervention.On 1/27/26 at 11:55 AM, R11 was observed wandering aimlessly on the 500 hallway, hugging staff and waving at other residents. No staff attempted to redirect her from the 500 hallway.On 1/28/26 at 1:00 PM, R11 was observed wandering in the dining room which was temporarily closed due to a COVID-19 outbreak. R11 wandered near the emergency exit door, attempted to push it, then proceeded to exit the dining room through a different door. No staff observed her. Review of, Wandering - Presence & Frequency in Section E: Behaviors in R11's most recent Minimum Data Set (MDS) assessment, dated 1/5/26, revealed, behavior of this type occurred daily.Resident #10 (R10)Review of R10's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE]. Review of R10's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition.Review of a, Concern/Suggestion Form, written by R10 on 1/26/26 read, in part: What is your concern or suggestion about? Woke to man in the room wearing gown! He said my bed was his! Put his gown over my legs. Handled my legs! Handled items. Moved an item! [R92] . How (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	can we address your concern/suggestion? That guy needs alarms on his doorway! Can't be allowed to wander into other people's rooms!On 1/28/2026 at 11:42 AM, an interview was conducted with Licensed Practical Nurse (LPN) G regarding the number of wandering residents in the facility. LPN G stated, We need a dementia ward, we have so many wanderers. LPN G indicated it was not sustainable to provide the wandering residents the one-on-one supervision they required given the current staffing levels.Resident #62 (R62)Review of R62's EMR revealed initial admission to the facility on 3/8/23 with diagnoses including hemiparesis (partial weakness, reduced strength, and/or impaired motor function on one side of the body) following cerebral infarction (stroke), multiple sclerosis, muscle weakness, and need for assistance with personal care. Review of R62's most MDS assessment, dated 12/24/25, revealed a BIMS score of 15, indicative of intact cognition.On 1/26/2026 at 4:06 PM, an interview was conducted with R62 regarding overall satisfaction with care at the facility. R62 expressed she had ongoing low staffing concerns. R62 stated often there were only 1-2 CNAs per hallway and during mealtimes, 1 CNA must assist in the dining room. R62 stated this leads to extensive wait times for care assistance. R62 indicated staffing is typically worse on the weekend and she frequently goes without assistance with activities for daily living for extensive periods. R62 stated, Many times I don't get washed up for the day. Just the other day, I asked three people, and finally got a new shirt at 8:20 PM. Again, that happens all the time on the weekends.Review of R62's plan of care revealed a Problem with a start date of 3/8/23 that read, I need assistance from staff with my Activities of Daily Living (ADL's) as I have hemiplegia and hemiparesis following a stroke and also have multiple sclerosis and diabetes with the following approaches: TRANSFERS: Total assistance with [name brand] lift, edited 05/29/2025. BATHING: extensive assist x1, created 3/08/2023. DRESSING: extensive assist x 1, created: 3/08/2023. HYGIENE: extensive assist x 1, created: 3/08/2023.Review of a, Concern/Suggestion Form, written by R62's Family Member (FM) FF on 1/20/26 read, in part: What is your concern or suggestion about? Due to lack of staffing [R62] is not getting her PT [physical therapy] appointment when requested. How can we address your concern/suggestion? Hire more staff. Is this an ongoing problem? This is an ongoing problem. Facility Response: We apologize for the inconvenience related to short staffing. Action to be Taken: We are always working on hiring more staff into the facility. We are considering alternate avenues for recruitment. On 1/28/2026 at 10:32 AM, an interview was conducted with Staff KK who stated, I can't believe we're still open when asked if they felt the facility had enough staff to meet the resident needs. Staff KK stated often there is one CNA scheduled per hallway (equating to four CNAs) for a facility census in the 80's. Staff KK stated residents are going without their scheduled check and changes or wash-ups and are then forced to lie in excrement for extended periods of time. Staff KK also indicated if a resident is care planned for a two-person assistant, the resident must wait until a CNA on another unit became available to help. Staff KK stated they often skipped schedule lunch and breaks to instead tend to the residents.On 1/28/2026 at 11:46 AM, a phone interview was conducted with CNA II regarding staffing levels. When asked if the facility was adequately staffed, CNA II stated, Not necessarily. When asked to elaborate, CNA II explained only one CNA per hallway or one CNA per hallway and a float were scheduled per hallway on the night shift which made it nearly impossible to deliver the expected care.Review of a scheduling lookback period from 1/11/26 - 1/25/26 revealed only four CNAs were scheduled for at least a 4-hour block on 8 of 15-night shift opportunities. Only three CNAs were scheduled for four-hour blocks (2:00 AM - 6:00 AM) on 1/12/26 and 1/14/26. The facility census ranged from 82-86 in that same timeframe.Review of the Facility Assessment, reviewed 10/3/25, read, in part: .[Facility's] goal for sufficient and efficient care of our residents is always to assure adequate staffing coverage for their respective needs. Resident acuity and specific care needs bear a lot of impact on individual staff assignments for coordination and continuity of care.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat five Residents (#10, #30, #35, #37, & #56) with a dignified dining experience out of 18 residents reviewed for dignity. This deficient practice resulted in a lack of personal dignity and feelings of embarrassment based on the reasonable person. Findings include: During dining observation on 1/27/26 the following was observed: Resident #37 (R37) At approximately 12:17 p.m., Licensed Practical Nurse (LPN) Z was observed assisting R37 with a lunch meal in their room. LPN Z was seated next to R37 and was noted to have blue gloves on during the meal service. Resident #10 (R10) At approximately 12:23 p.m., Dining Assistant/Staff BB was observed assisting R10 with a lunch meal in their room. Staff BB was seated next to R10 and was noted to have blue gloves on during the meal service. Resident #56 (R56) At approximately 1:09 p.m., Dietary Aide/Staff AA was observed assisting R56 with a lunch meal in the hallway. Staff AA was seated next to R56 and was noted to have blue gloves on during the meal service. Resident #35 (R35) Review of R35's Electronic Medical Record (EMR) revealed initial admission to the facility on 4/5/21 with diagnoses including dementia, age related physical debility, and dysphagia (difficulty swallowing). Review of, Section C: Cognitive Patterns in R35's most recent Minimum Data Set (MDS) assessment, dated 12/15/25, ranked R35's, Cognitive Skills for Daily Decision Making as, Severely impaired-never/rarely made decisions. On 1/27/2026 at 12:21 PM, Hospitality Aide (HA) X was observed feeding R35 in the hallway outside her room. HA X was observed feeding R35 with a small brightly colored spoon which had a small, shallow bowl, resembling a baby spoon. Two other similar spoons of different colors were observed on R35's tray. Review of R35's tray ticket for the lunch meal on 1/27/26 read, Pureed – Regular **PLASTIC SPOONS ONLY** On 1/28/26 at 8:27 AM, R35 was observed receiving feeding assistance from Certified Nursing Assistant (CNA) Y in the hallway outside her room. CNA Y was utilizing a brightly colored spoon, resembling a baby spoon, holding approximately one teaspoon of food to feed R35. When asked, CNA Y was unsure why R35 was served spoons with the ability to only hold small volumes of food. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/26 at approximately 9:40 AM, a telephone interview was conducted with Speech Language Pathologist (SLP) CC regarding her dietary recommendations for R35. SLP CC stated she recommended plastic spoons for R35 because she had been biting down on metallic utensils and therefore wanted to avoid any potential tooth damage. SLP CC stated since making the recommendation, she had seen the facility use both disposable plastic spoons and utensils that resembled, baby spoons. SLP CC stated she didn't not specifically recommend the utensils resembling, baby spoons and reiterated that the spoon material rather than the bite portion was of relevance. On 1/28/26 at 9:50 AM, a telephone interview was conducted with R35's Durable Power of Attorney (DPOA) DD who stated he was unaware the facility was going to be utilizing the itty bitty spoons during mealtimes. On 1/28/26 at 5:54 PM, CNA N was observed feeding R35 the evening meal with blue medical gloves donned. R35 was again observed receiving assistance with a small utensil resembling a baby spoon. Review of R35's EMR and plan of care revealed no orders nor interventions regarding adaptive dining utensils. Resident #30 (R30) Review of R30's EMR revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease and dysphagia (difficulty swallowing). Review of, Section C: Cognitive Patterns in R30's most recent MDS assessment, dated 12/5/25, ranked R30's, Cognitive Skills for Daily Decision Making as, Severely impaired-never/rarely made decisions. On 1/28/2026 at approximately 8:30 AM, R30 was observed receiving feeding assistance from Dining Assistant (DA) EE. R30 was observed receiving food via a small brightly colored spoon with a small, shallow bowl, resembling a baby spoon. When asked, DA EE was unsure why R30 was served these specific spoons. On 1/28/2026 at 12:44 PM, R30 was again observed receiving assistance with a small brightly colored spoon with a small, shallow bowl, resembling a baby spoon. Review of R30's EMR and plan of care revealed no orders nor interventions regarding adaptive dining utensils. Review of the product description on the spoon manufacturer's website read in part, .Baby & Toddler Utensils. Long Handle Weaning Spoons. [for ages] 4+ Months. Easy for parents to hold. Perfect for baby's first foods. Bright, fun colors stimulate baby's senses. Review of the facility policy titled, Resident Rights, revised 12/10/14, read, in part: Policy: To ensure humane care and treatment with consideration consistent with Recognition of Residents' dignity. Upon admission, the Patient/Resident [NAME] of Rights will be given to the Resident and/or Resident Representative. The contents will be reviewed and explained. Review of a document titled, Rights of Residents in Michigan Nursing Facilities, dated 11/28/16, read, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in part: .You have the right to be treated with respect and dignity.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide advanced written notification of a room change for 3 Confidential Residents (CR's) of 14 residents during the resident group interview and one Resident (#6) of one resident reviewed for room changes.Findings include:Resident #6 (R6)Review of R6's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including Alzheimer's disease, panic disorder, generalized anxiety disorder, and obsessive compulsive disorder.Review of Section C: Cognitive Patterns in the most recent Minimum Data Set (MDS) assessment for R6, dated 11/10/25, ranked Cognitive Skills for Daily Decision Making as, Moderately impaired-decisions poor; cues/supervision required.On 1/27/2026 at 9:56 AM, an interview was conducted with the Durable Power of Attorney (DPOA) FF for R6 regarding any care concerns at the facility. DPOA FF indicated the facility had changed R6's room, awhile back without any explanation or written notification. When asked if he had given the facility permission for the move, DPOA FF stated, No, they [facility] told me a team of people came to the decision.Review of a facility census report revealed confirmation of R6's room change on 12/30/25.Review of R6's EMR revealed no written notification of the room change.On 1/28/26 at 8:43 AM, an interview was conducted with Social Worker (SW) L regarding facility protocol when changing resident rooms. SW L indicated there was no consent form that is signed by the resident and/or representative prior to conducting a room change. When asked if the reason for the transfer was documented anywhere in the EMR, SW L stated, Not usually, no. If it's an emergency situation where we're worried about a resident-to-resident [incident], we usually do. but regardless, we should be documenting all the time.On 1/27/26 at 2:05 PM, a confidential group interview was conducted where three residents voiced their frustration regarding room changes without prior consent/notification. One confidential resident (CR) stated, They seem to move people around a lot. After the heat went out, they moved him [points at another resident] into my room without telling me, so when I rolled into my room one day, he scared the crap out of me. Another CR added, They don't consult us [about changing rooms] . it's like a little prison. The last CR stated they experienced at least one room change in the previous year without proper notification.Review of the census reports for those three CR's verified room changes in the previous year. Neither the reason for the room changes nor the written notification for the room change were located in their respective EMRs.On 1/28/26 at 4:19 PM, an interview was conducted with the Nursing Home Administrator (NHA) who stated he was unaware residents and/or resident representatives had to be provided with advanced written notification of a room change. The NHA stated given the number of resident behaviors in the facility, room changes were often indicated and providing written notifications of room changes would be difficult for the facility to manage.Review of the facility policy titled, Room Changes, revised 12/30/15, read, in part: .The reason for the room change will be documented by the Social Services Department.Review of a document titled, Rights of Residents in Michigan Nursing Facilities, dated 11/28/16, read, in part: .You have the right to be treated with respect and dignity, including: .the right to receive written notice, including the reason for change, before your room or roommate in the facility is changed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a homelike environment by ensuring resident room temperatures were maintained within the acceptable parameters for two Confidential Residents (CR's) out of 14 residents from a resident group interview and 2 Residents (#39 & #62) of 18 residents reviewed for environmental concerns.Findings include:Resident #62 (R62)Review of R62's Electronic Medical Record (EMR) revealed initial admission to the facility on 3/8/23 with diagnoses including hemiparesis (partial weakness, reduced strength, and/or impaired motor function on one side of the body) following cerebral infarction (stroke), multiple sclerosis, muscle weakness, and need for assistance with personal care. Review of R62's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition.On 1/26/2026 at 4:06 PM, an interview was conducted with R62 regarding overall satisfaction with care at the facility. R62 indicated the facility had experienced a furnace failure around the Christmas holiday and her hallway unit was without heat for approximately six days. R62 stated she was told some type of belt broke on the furnace and it had smelled so badly of burning rubber, she was forced to wear a mask while in her room in an effort mitigate the strong odor. R62 disclosed the facility brought in electric space heaters but they did a poor job keeping her warm due to the location of her bed [R62's bed was located on the exterior wall, with the foot of the bed adjacent to a window]. R62 said she had extra blankets and slept in several sweaters but still got cold despite the space heater due to the draftiness of the window. R62 recalled a staff member was intermittently taking room temperatures and reported the temperature of the exterior wall to be 62 degrees. When asked if the facility offered to relocate her to a different room during the furnace failure, R62 stated, No. R62 indicated she would have moved rooms given the opportunity.Review of R62's EMR revealed a progress note written on 1/1/26 at 16:26 [4:26 PM] which read: [R62] refused her weekly shower due to being too cold.Resident #39 (R39)Review of R39's EMR revealed initial admission to the facility on 4/4/23 with diagnoses including intracerebral hemorrhage (stroke), generalized anxiety disorder, morbid obesity, and low back pain. Review of R39's most recent MDS assessment, dated 1/15/26, revealed a BIMS score of 14, indicative of intact cognition.On 1/26/2026 at 4:28 PM, an interview was conducted with R39 who stated the facility was without heat for an extended period during the Christmas and New Year holiday. R39 recalled the facility had brought in an electric space heater but it, didn't do much to keep her warm. R39 indicated the facility did not offer to temporarily relocate her to a warmer room.On 1/27/26 at 2:05 PM, a confidential group interview was conducted where two confidential residents (CR's) voiced their concerns regarding the furnace failure. One of the CR's stated the facility had no heat for six days and, every day they said it would be fixed and it was not fixed. The CR continued and stated the facility put, little heaters in the room and gave the residents, a bunch of extra blankets that didn't help much. The same CR recalled he had to resort to going to the nurse's station to warm up. Another CR expressed frustration stating, It was a maintenance problem. Nobody looks at anything. This CR indicated the facility didn't offer to temporarily relocate him to a warmer room. The same CR stated, I had to use extra blankets. it was cold. It was like winter camp.Review of an After Action Report, written by the Nursing Home Administrator (NHA) and Director of Nursing (DON) read, in part: Incident: HVAC (Heating, ventilation, and air conditioning) Failure - 300 Wing.Date(s) of Incident: 12/29/25 - 1/3/26. Event Summary: On 12/29/2025 at approximately 1800 hours (6:00 PM), [facility name] experienced a partial heating system failure (HVAC motor and heat exchanger) affecting the 300-wing following a severe blizzard. As a result of the heating failure, resident room temperatures on the affected wing decreased gradually over the next 19 hours to a low reading of 62 F near exterior walls and windows at 1300 [1:00 PM] on 12/30/25. Thermostats in adjacent hallways were increased to 76 F and hallway fans (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norlite Nursing Center	701 Homestead Street Marquette, MI 49855

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were placed directing warmer air down the 300 Wing in an attempt to stabilize temperatures in resident rooms. When this intervention did not sufficiently improve room temperatures, alternative measures were initiated. Residents were provided with additional blankets and comfort measures as needed. Portable space heaters were purchased on 12/30/25. they were then in resident rooms away from clutter on the 300 Wing as a temporary heating solution. Safe operation required limiting heaters to medium or lower heat settings to avoid exceeding breaker capacity.Review of a written temperature log provided by the NHA which listed rooms still containing occupants, read in part: 1/1/26 at 1430 [2:30 PM]:[Room] 307 - 65 308 - 65 310 - 64 1/1/26 at 2015 [8:15PM]:307 - 66 311 - 67 314 - 67 1/1/26 at 2200 [10:00 PM]:307 - 66 310 - 69 311 - 68 314 - 67 1/2/26 at 0235 [2:35 AM]:307 - 66 308 - 68 310 - 68 311 - 66 314 - 68 1/2/26 at 0340 [3:40 AM]:307- 66 308 - 68 310 - 66 311 - 66 314 - 68 1/2/26 at 0545 [5:45 AM]:307 - 65 308 - 65 310 - 66 311 - 68 314 - 66 Review of the facility's Emergency Preparedness plan, read, in part: SEVERE WEATHER PROCEDURES: .Cold Weather: Temperature below 72 degrees for 12 continuous hours. Facility must evacuate the room(s).Review of a document titled, Rights of Residents in Michigan Nursing Facilities, dated 11/28/16, read, in part: .you have a right to a safe, clean, comfortable and homelike environment.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure appropriate food temperatures and palatability for nine Confidential Residents (CR) of fourteen residents reviewed for food satisfaction.Findings include:On 1/27/26 at 2:05 PM, food palatability, food choices, and mealtimes were discussed at a confidential group interview. 9 out of 14 residents stated their food is almost always cold. One CR stated, [Food] temperature is a problem. Another CR said, Last night's dinner was inedible it was so cold. 6 out of 14 residents stated meals were served at inconsistent times. Yet another CR stated, You have to guess [what time meals will be served]. During the lunch meal, which was specified to hallway trays only due to an infectious outbreak, the following was observed: Hallway trays began on the 500 hall at approximately 12:04 p.m. and ended at 12:14 p.m. It was observed that all meal trays were passed out to resident rooms, even when a resident was not in their room or hallway. Hallway trays began on the 300 hall at approximately 12:23 p.m. and ended at 12:30 p.m. It was observed that all meal trays were passed out to resident rooms, even when a resident was not in their room or hallway. Hallways trays began on the 400 hall at approximately 12:57 p.m. and ended at 1:09 p.m. It was observed that all meal trays were passed out to resident rooms, even when a resident was not in their room or hallway. Hallway trays began on the 200 hall at approximately 1:19 p.m. and ended at 1:30 p.m. It was observed that all meal trays were passed out to resident rooms, even when a resident was not in their room or hallway. An interview was conducted with the Nursing Home Administrator (NHA) on 1/28/26 at 1:39 p.m. during the Quality Assurance Performance Improvement (QAPI) task. The NHA stated that mealtimes have been a known issue since the summer of 2025, acknowledging that weekends and supper times have been a concern. In an interview on 1/27/2026 at 10:14 AM., Certified Nurse Aide (CNA) E stated, when meal carts with resident meal trays are delivered to the units there's a magnet timer on the side of the metal meal cart. CNA E reported when passing meals out the timer is pressed and set at 15 minutes. CNA E reported staff were supposed to get all the meal trays to residents before the 15-minute timer goes off. CNA E reported any meal trays that are left on the meal carts when the timer goes off (after 15 minutes) staff take the meal tickets to the kitchen and the dietary staff make a new meal for any of the residents whose meal tray was on the meal cart after the time allotted. Review of Resident Council Minutes read in part: Dietary: 7/1/2025 Old Business: Old Business: Meal trays are taking long to be served states this is still happening with ALL meals. Residents want nursing staff to be reminded to make sure that they are all done eating before taking plates away even if the plate looks empty . Review of Resident Council Minutes read in part: Dietary: 8/5/2025 Old Business: Meal trays are still taking long.New Business: Dietary Concerns:. (Residents) state. meal trays down all the (units) wings (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(are note delivered/served) in a timely manner: (Residents) state that most nights (Residents) doesn't get dinner until 7 pm.(Residents) states that dinner in the dining room doesn't get served until closer to 7 and causes those in the dining room to feel rushed so it can be cleaned before bingo. Review of Resident Council Minutes read in part: Dietary: 9/2/25 New Business: (Residents) states that food (Residents) is still being received very late and felt like it came at midnight.(Residents) stated that 6 out of the last 7 days meals have been late.Expressed concern with it affecting/delaying cares, showers, medications, treatments, and even some activities. (Residents) stated that it is hard when there is a new nurse on the wing almost every day.(Residents) states that it causes confusion especially with treatments.(Residents) have to explain to each new nurse the treatment . Review of Resident Council Minutes read in part: Dietary: 10/8/25 Old Business: Meals still late. New Business: Dietary food over the weekend was 1.5 hours late started at 8:30. Sometimes orders are completely wrong. Things that are ordered are not being put on trays and things not ordered are being put on trays.Food is often cold; at least one item cold with each meal . Review of Resident Council Minutes read in part: Dietary: 11/4/25 Complaints from residents concerning late trays being served cold in the halls was discussed. Activities.Late meals prevented residents from being able to attend activities directly following mealtimes.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 1/27/2026 at 3:30 PM, three boxes of single serve items, including cups and lids, were observed sitting on the storage room floor. The boxes were opened with some of the contents used. When asked about deliveries, Dietary Manager (DM) T stated that the last delivery came in the day before.According to the 2022 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLEUSE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted.On 1/27/2026 at 3:45 PM, the Roundup plate warmer, model HPD-2 was observed with the lid open and the gasket seal from the lid was missing, with some degraded parts of the gasket and adhesive still left in the groove of the lid. This unit had been unplugged, but plates were still warm as it was used for lunch service, per interview with DM T at this time.According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. On 1/27/2026 at 4:10 PM, staff member V was observed cleaning a large steam jacket soup kettle with soapy water and a brush. When asked how this unit was cleaned, DM T stated it was washed with hot soapy water and then rinsed out with clean hot water. DM T stated that they had never been told any other way to clean it.According to the 2022 FDA Food Code section 4-702.11 Before Use After Cleaning. UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT shall be SANITIZED before use after cleaning.On 1/27/2026 at 4:15 PM, in a utensil drawer, the tray the utensils were lying in was observed with dried up syrup and food debris stuck to the bottom of the drawer.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 1/27/2026 at 4:25 PM, boxes of canned soup, canned beans and other boxes of canned food items were observed sitting on the floor in the dry storage room.According to the 2022 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.On 1/27/2026 at 4:30 PM, kitchen staff W was observed as he ran a tray of dirty utensils through the dish machine and then reached in and pulled a lid out of the chemical dispensing trough on the side of the unit and placed the dirty lid back onto the dirty side of the dish machine table to be ran through again. Staff W then proceeded to unload clean utensils with unwashed hands. According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (E) After handling soiled EQUIPMENT or UTENSILS

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #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 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 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 residents sat in chair. then again when (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 & activity leading up to the event to help identify a root cause.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 & #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 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 (continued on next page)

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	235367	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norlite Nursing Center	701 Homestead Street Marquette, MI 49855

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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/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 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 (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 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 & activity leading up to the event to help identify a root cause.

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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 #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/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 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 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 & activity leading up to the event to help identify a root cause.

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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 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** Based on observation, interview, and record review, the facility failed to provide the necessary supervision to prevent wandering residents entering private resident rooms resulting in feelings of frustration for five Confidential Residents (CR's) out of 14 residents in a confidential group interview and one Resident (#10) out of 18 residents reviewed for quality of care.Findings include:On 1/27/26 at 2:05 PM, a confidential group interview was conducted where several residents voiced their frustration regarding wandering residents entering their personal living quarters. One CR stated, wandering residents came into their room so often, I can't keep my door open. When asked if it takes staff a long time for staff to redirect the resident out of their room, the CR stated, I redirect her because I don't want her near me. She follows me around all day. Another CR added, Yes, there's a problem with wanderers. She [the same resident mentioned above] stares at me and watches what I'm doing. I usually have to redirect her [instead of staff]. Another CR confirmed wanderers often entered her room but they were reliant on staff for redirection due to their physical limitations. The same CR voiced, They wander all night long. Two additional CR's stated they were forced to keep their door shut to avoid wanderers even though they preferred to keep them open. On 1/26/2026 at 4:29 PM, Resident #92 (R92) was observed propelling himself in a wheelchair up and down the 300 hallway. R92 stopped at the entrance of a room and shouted, Stay in there and don't come out until I tell you! No staff intervention was observed after the verbal outburst toward another resident.Review of R92's Plan of Care revealed the following two Approaches with a start date of 1/26/26: [R92] is on the high-risk list for increased risk of resident-to-resident altercations/behaviors. Use consistent verbal redirection when [R92] is observed attempting to entering other residents' roomsOn 1/26/26 at 4:17 PM, Resident #11 (R11), who resides on the 200 hall, was observed wandering on the 300 hallway, entering and exiting other resident rooms with no staff intervention.On 1/27/26 at 11:55 AM, R11 was observed aimlessly wandering on the 500 hallway, hugging staff and waving at other residents. No staff attempted to redirect her from the 500 hallway.On 1/28/26 at 1:00 PM, R11 was observed wandering in the dining room which was temporarily closed due to a COVID-19 outbreak. R11 wandered near the emergency exit door, attempted to push it, then proceeded to exit the dining room through a different door. No staff observed her. Review of, Wandering - Presence & Frequency in Section E: Behaviors in R11's most recent Minimum Data Set (MDS) assessment, dated 1/5/26, revealed, behavior of this type occurred daily.Resident #10 (R10)Review of R10's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE]. Review of R10's most recent Minimum Data Set (MDS) assessment, dated 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition.Review of a, Concern/Suggestion Form, written by R10 on 1/26/26 read, in part: What is your concern or suggestion about? Woke to man in the room wearing gown! He said my bed was his! Put his gown over my legs. Handled my legs! Handled items. Moved an item! [R92]. How can we address your concern/suggestion? That guy needs alarms on his doorway! Can't be allowed to wander into other people's rooms!On 1/28/2026 at 11:42 AM, an interview was conducted with Licensed Practical Nurse (LPN) G regarding the number of wandering residents in the facility. LPN G stated, We need a dementia ward, we have so many wanderers. LPN G indicated it was not sustainable to provide the wandering residents the one-on-one supervision they required given the current staffing levels.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain appropriate standards of infection control practices to prevent the spread of pneumonia for one Resident (R36) of one Resident reviewed for infection control practices. This deficient practice resulted in the potential for continued spread of pneumonia to other residents residing within the facility. Findings include:Review of R36's Progress Notes, read, in part, 1/27/26 at 9:24 a.m., This RN (Registered Nurse) notified by wing change nurse that resident appears to have had a change in condition.droplet precautions initiated, RN supervisor notified and to speak with emergency contact. Wing staff updated on precautions.On 1/27/26 at approximately 1:30 p.m., Hospitality Aide/Staff Y was observed assisting hallway meal trays. To the right of R36's door, a sign was observed which stated R36 was on precautions. Staff Y proceeded to enter R36's room without Personal Protective Equipment (PPE) to drop off her lunch tray. When exiting, Staff Y stated that she should have worn PPE into R36's room.An interview was conducted with Infection Preventionist (IP) H on 1/27/26 at approximately 1:45 p.m. IP H confirmed Staff Y should have worn PPE.Review of the facility's Transmission Based Precautions policy revised on 10/5/22 read, in part, Upon suspicion by a nurse that a resident has an infections/communicable disease the facility will implement the appropriate Transmission Based Precautions and Isolation (if required) to effectively prevent transmission of the infections agent.Droplet Precautions are required when respiratory droplets carrying microorganisms are transferred directly from the respiratory tract to susceptible mucous surfaces of the recipient. Droplets are generated when the infection person talks, coughs, or sneezes or during procedures such as suctioning. PPE will include, but is not limited to, gloves, gowns and masks. Droplets can travel 6-10 feet.