STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235423	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Hillman	631 Caring Street Hillman, MI 49746

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse in review of two Residents (#26 & #19) of three residents reviewed for abuse. This deficient practice resulted in Resident #19 experiencing ongoing emotional distress, including fear of a sense of safety within the facility when in proximity of Resident #26 who was the one involved in the altercation.Findings include:Resident #19 (R19)A review of R19's Electronic Medical Record (EMR) revealed admission to the facility on 1/17/24, with diagnoses including major depressive disorder, and Post-Traumatic Stress Disorder (PTSD) (a mental health condition that develops after experiencing or witnessing a traumatic event). R19 was noted to have a Brief Interview for Mental Status (BIMS) score of 14/15, indicating cognition was intact.On 9/9/25 during an initial interview at 11:15 AM, R19 stated they were hit on the head and choked by another resident, just the other day. R19 stated the resident who had hit and choked him was Resident #26(R26). A facility volunteer who was visiting R19 at the time of the interview corroborated the description of the event provided by R19, stated they were laughing and talking when R26 came over and grabbed R19 by the neck and hit R19. R19 stated that if it hadn't been for the volunteer pulling R26 off, he didn't know what would have happened.On 9/9/25 at approximately 2:35 PM, the Nursing Home Administrator (NHA) stated they had personally done several follow-up visits with R19 post resident-to-resident incident. The NHA stated R19 only randomly brought up the incident in these conversations. When the NHA was asked what psychosocial behaviors the facility should observe related to R19's PTSD, regarding this incident, the NHA did not provide a response. Review of R19's EMR indicated the NHA had done two visits post incident.A review of the form entitled Physical Aggression Received indicated that on 8/26/25 an incident involving R19 had happened. The form provided a Nursing Description: Residents were in the dining room having lunch. Resident from room [ROOM NUMBER] approached resident from room [ROOM NUMBER] (wrong patient room) and grabbed R19 near R19's neck. A facility volunteer who was present in the dining room intervened immediately and separated the residents. This resident (R19) sustained a minor scratch on R19's chest; R19 has no other complaints. The portion titled Resident description stated .The volunteer and I were talking and laughing and (R26) grabbed me. I was not talking to R26 or about R26. The Immediate Action Taken portion stated Volunteer immediately separated the residents. Both residents involved were taken back to their perspective rooms by staff. Care plan updated for safety interventions. There are no noted updates to R19's care plan for safety interventions following the 8/26/25 incident.A review of R26's EMR, indicated R26 was admitted to the facility on [DATE], with diagnosis including Wernicke's Encephalopathy (an acute neurological disorder caused by severe thiamine (vitamin B1) deficiency), adjustment disorder with anxiety, alcohol use, alcohol induced psychotic disorder with delusions, and induced psychotic disorder with delusions. R26 was noted to have a BIMS score of 6/15 indicating severe cognitive impairment. R26's EMR revealed a court appointed guardian was in place to make medical and financial decisions.While conducting a phone interview with R26's guardian on 9/9/25 at 12:34 PM, the guardian stated she had not been informed of the resident-to-resident incident between R26 and (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	another resident. The guardian stated she remembered that she requested to have R26's medication increased after a gradual dose reduction, that she felt were never a benefit for R26's mental health. A review of the form titled Physical Aggression Initiated dated 8/26/25 indicated At lunch time today resident (R26) became very upset with resident from room [ROOM NUMBER] (R19) and grabbed him. Volunteer.immediately separated residents. Administration and DON (Director of Nursing) notified, and investigation was initiated. Guardian was notified and requested that resident resume previous dose of Buspar (anti-anxiety medication used to treat generalized anxiety disorder), which was recently lowered. R26's description of the invent stated R19 was swearing at me when I walked in. R19 was being a smart ass. The Immediate Action taken stated Residents immediately separated and taken back to their own rooms.Care plan updated to reflect that residents from room [ROOM NUMBER] and room [ROOM NUMBER] will be separated at all dining times. There has been no update to R26's care plan to keep R26 separated from R19 at all dining times. A review of R26's progress notes indicated an increase in agitation as follows: on 8/15/25 at 3:08 PM, Resident came into this writer office asking when he can go home. He wants a nurse to come into his home and help with medication. This writer explained to him that he is currently here to make sure he's safe. He got upset and said I am safe you guys are f***keeping me here against my will. This writer explained to him that we are just here to keep him safe. He got upset and walked out of this writer's office.8/15/25 at 5:21 PM, Went to administer medications to pt (patient), he was speaking with social worker. Resident seemed very agitated, and said, we locked him out and he wants to get the F out of here. Res continued to be agitated stating that his house was taken away and all of his money.R26's care plan review indicated R26 Resident has a focus for impaired mood/psychiatric/ behaviors status related to alcohol induced psychosis, Wernicke's encephalopathy, poor impulse control, anxiety as evidenced by: Resident can be verbally aggressive towards other residents when he is agitated, has hallucinations of seeing people on the floor, sees rats, monkeys Delusions of thinking this is his house, thinks various things about [NAME] that cause him distress ie; thinks others are her, thinks he hears her, thinks she put him in a psych unit, spending all his money etc. Can make sexual statements to staff ie, come in bed with me as well as more aggressive statements Calls 911 - usually regarding issues with his house (here) His behaviors are unpredictable, and he can go from calm to agitated quickly without precipitating factors. Loud noises can be a trigger to behaviors. With interventions including Offer telephone to call family (daughter) which helps him to calm down. The resident's triggers for verbal aggression are other resident's yelling. The resident's behaviors are de-escalated by: distraction, food and fluid, conversation, by calling daughter. Behavioral health consults as needed. If resident presents/vocalizes self-harm, ensure resident's safety and notify Physician/NP/PA. Observe for and report to Physician/NP/PA any signs/symptoms for change in mood/acute psychosis from resident's baseline (hallucinations, delusions, inability to concentrate, depression, sleeping too much or too less, feelings of worthlessness or guilt, loss of pleasure or interest in activities, change in psychomotor skills, anxiety.There is no progress noted to indicate that the provider was notified of R26's recent change in behaviors prior to the resident-to-resident incident.Both R26 and R19 remain housed on the East wing down the hall called Jeff's Way approximately 22 feet from room [ROOM NUMBER] on the right and room [ROOM NUMBER] on the left going down that hall.On 9/10/25 at 2:58 PM, R26 was observed walking by R19's room. R26 was observed staring into room [ROOM NUMBER] as they walked by the room down the hallway. During a follow-up interview with R19 on 9/10/25 at 3:00 PM, R19 stated that they had left the facility and gone home because they were upset over some discarded food in R19's refrigerator, and R19 felt a lack of autonomy. R19 stated if they were home, they would not have to worry about what R26 might do. R19 stated that since the incident, the facility has told R19 they have made changes to R26 medications, which may be true, as R19 does not know what issues R26 has. However, R19 stated that they just don't feel safe, with R26 being so close to R19's room. R19 stated, just after the incident, any time they were in the dining room, laughing and having a good conversation with a friend, R26 would give him a mean look. R19 stated that anytime (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R26 is in the vicinity of R19, R26 looks at R19. R19 stated that R26 passes his room R26 peers into R19's room with each pass. This makes R19 very uncomfortable, and R19 just does not feel safe. The facility failed to implement timely measures to ensure R19's safety and emotional well-being. A review of the facility's Abuse Policy last reviewed/revised on 1/10/24, indicated in part It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. III Prevention of Abuse, Neglect and Exploitation.D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a safe, comfortable and homelike environment by failing to ensure proper exhaust ventilation in the facility allowing the build-up of foul odors with the potential to affect all residents in the facility.Findings include: On 09/10/2025 at 10:30 AM, observed that the ventilation fan was not working in room [ROOM NUMBER]. A tissue test at the exhaust grille over the toilet noted that it was not pulling air in. During a facility tour with MD I, it was noted that the vent fans were not working in the 100 wing and were also not working in the two hundred wing, rooms 211-217, and rooms 216 through 228.On 09/10/2025 at 11:32 AM, a strong odor of urine was observed in hall 210-217 Eagle Lane.On 09/10/2025 at 12:00 PM, MD I printed a copy of the work history report for the last 12 months, documented weekly, showing that the Exhaust Fans Task had been completed and the task signed off on 9/5/2025.On 09/11/2025 at 11:05 AM, during interview with MD I, he stated he had gone up on the roof yesterday afternoon and discovered the ventilation units located on the roof of the facility were not functioning.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview, the facility failed to maintain safe water temperatures at two hand washing sinks which could result in the potential for scalding risk to all residents that use these sinks.Findings include: On 09/09/25 at 11:20 AM, the water temperature at the handwashing sink in the dining room was measured with a rapid read thermometer to be 149 degrees Fahrenheit. The dining room was further observed to be accessible to all residents.On 09/09/2025 at 12:30 PM, the water temperature at the hand sink in the activities room called the Cowboy Lounge was measured with a rapid read thermometer to be 150 degrees Fahrenheit. On 09/10/2025 at 10:18 AM, interview with Head of Maintenance, Staff J noted that the sinks noted were on the same loop as the Laundry and they do not have individual mixing valves installed at the sink fixture.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an adaptive call light to accommodate a physical impairment for one Resident (#14) of one Resident reviewed for accommodations of needs and preferences.Findings include: Resident #14 (R14)Review of R14's Electronic Medical Record (EMR) revealed initial admission to the facility on [DATE] with diagnoses including bipolar disorder, stiffness of the left hand, stiffness of the right hand, cognitive communication deficit, repeated falls, and need for assistance with personal care. Review of R14's most recent Minimum Data Set (MDS) assessment, dated 8/4/25, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderate cognitive impairment.On 9/9/25 at 11:22 AM, R14 was observed lying in bed. R14's left hand was observed to be contracted into a tight fist. R14's right hand was observed contracted into a tight fist with both the middle and ring fingers extended. A bedside table was positioned to the right of R14 with what appeared to be a video monitor with surgical tape covering the camera lens. When R14 was questioned about the purpose of the camera, she replied, That's how I alert the front desk. R14 explained she couldn't operate a standard call light due to the condition of her hands.Review of R14's EMR revealed the following progress notes:10/11/24 at 20:57 [8:57 PM]: .She [R14] is physically unable to to [sic] put enough pressure for her call light to go off. Three different styles were tried using her hands, head, shoulders and feet all unsuccessful.10/12/24 at 13:36 [1:36 PM]: .Res [resident] is unable to use a call light due to her crippling hands but does yell out when something is needed.10/13/24 at 13:48 [1:48 PM]: .Res is unable to use a call light due to her crippling hands but does yell out when something is needed.Review of R14's plan of care revealed a Focus, initiated 10/10/24, that read, Resident has an ADL [activities of daily living] self-care performance deficit related to muscle weakness and stiffness to left and right hand.The following intervention was initiated on 10/18/24: .Baby Monitor in place of call light, camera to be place [sic] away from resident for privacy, receiver to be with staff. Review of R14's EMR revealed the following physician order, initiated 3/25/25: Baby monitor with camera facing awat [sic] from resident to be used in place of call light due to resident physical inability to use standard call light.On 9/10/2025 at 9:22 AM, an interview was conducted with Certified Nursing Assistant (CNA) C who confirmed R14 had a baby monitor in her room in lieu of a call light. The baby monitor receiver was observed sitting at the nurse's station. CNA C explained the baby monitor transmitted continuous audio enabling R14 to speak into the camera when she required help. CNA C was unable to explain how privacy was provided while staff was performing cares or if R14 had a visitor as by-passers could overhear the receiver audio.On 9/10/25 at 12:06 PM, a follow-up interview was conducted with CNA C regarding the reliability of the baby monitor as a means of a call light. When asked if nursing staff could always hear R14 through the receiver if they were not at the nurses' station, CNA C stated staff tried to carry it around with them during rounds. CNA C acknowledged the reception range was limited depending on location in the building.On 9/10/2025 at 4:07 PM, the receiver was observed at the nurses' station with no staff in the vicinity.On 9/11/2025 at 8:22 AM, the receiver was observed at the nurses' station with no staff in the vicinity.On 9/11/2025 at 9:43 AM, the receiver was observed at the nurses' station with no staff in the vicinity.On 9/10/2025 at 4:05 PM, a follow-up interview was conducted with R14 regarding staff responsiveness to the baby monitor. R14 stated if staff doesn't respond to the baby monitor, her room is located close to the nurses' station so she could, Try to yell.Review of R2's MDS Assessment, dated 8/4/25, revealed she was dependent for all aspects of functional mobility and self-care activities.On 9/11/2025 at 9:58 AM, an interview was conducted with the Director of Nursing (DON), the Nursing Home Administrator (NHA), and Regional Director of Clinical Services (RDCS) F regarding the privacy and reliability concerns of the baby monitor. All parties agreed with the concerns and stated they would investigate a more appropriate adaptive call light system.Review (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility policy titled, Resident Rights, reviewed 10/30/23, read, in part: .Upon admission, the resident and/or the resident's representative will be informed of the resident's rights and responsibilities.Review of the Hospitality Guide found in the admission Packet, read, in part: .The resident has a right to be treated with respect and dignity, including: .the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.Review of the facility policy titled, Call Lights: Accessibility and Timely Response, reviewed, 12/28/23, read, in part: .Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to act upon pharmacist recommendations for one Resident (#2) of five residents reviewed for medication regimen review.Findings include:Resident #2 (R2)Review of R2's Electronic Medical Record (EMR) revealed initial admission to the facility on 3/15/24 with diagnoses including major depressive disorder and bipolar disorder. Review of R2's most recent Minimum Data Set (MDS) assessment, dated 3/23/25, revealed a Brief Interview for Mental Status (BIMS) score of 1, indicative of severe cognitive impairment.Review of R2's EMR revealed the following physician orders:Risperidone Intramuscular Suspension Reconstituted ER [extended release] 50 MG [milligram](Risperidone Microspheres). Inject 50 mg intramuscularly one time a day every 14 day(s), initiated 5/11/24.Ziprasidone HCl Oral Capsule 40 MG (Ziprasidone HCl). Give 1 capsule by mouth two times a day, initiated 5/3/24.Review of a pharmacy recommendation, dated 5/5/25, read, This resident is currently being treated with Risperidone and ziprasidone, both atypical antipsychotics, that may cause adverse metabolic or endocrine effects. Consider an EKG [electrocardiogram (a medical test that records the electrical activity of the heart)] at this time and every 6-12 months.On 5/7/25, Medical Director (MD) H responded, Will discuss with [Mental Health Service] - they manage her [R2's] antipsychotics.Review of R2's EMR revealed no communication or follow-up with mental health services.Review of a pharmacy recommendation, dated 8/25/25, read, In many cases, the combined use of two or more antipsychotic medications has not been demonstrated to be more effective than a single agent and has the potential for increased side effects. Please review the duplicate antipsychotic therapy. This combination will increase the risk of QT prolongation [a heart rhythm that causes fast, chaotic heartbeats]. Check an ECG [electrocardiogram] at this time.On 8/25/25, Medical Director (MD) H selected Other under the heading Physician/Prescriber Response without including clinical rationale.On 9/11/25 at 9:15 AM, an interview was conducted with Regional Director of Clinical Services (RDCS) H who verified R2 had not underwent an ECG and no follow-up documentation could be located in the EMR.Review of the facility policy titled, Addressing Medication Regimen Review Irregularities, reviewed 12/28/23, read, in part: .the pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon. The attending physician must document in the resident medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.