STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235495	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Marshall	879 East Michigan Ave Marshall, MI 49068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #1286451Based on observations/interviews/record review, the facility failed to protect the resident's (Resident #1) right to be free from verbal abuse and physical abuse by Certified Nursing Assistant (CNA) IFindings include:Review of the clinical record revealed Resident #1 (R1) was under hospice care, review of the Minimum Data Set (MDS) dated [DATE] revealed R1 scored 12 out of 15 (cognitively intact) on the Brief Interview Mental Score. On 07/16/25 at 9:45am during a bedside interview, R1 was resting in bed, when queried about his care and treatment it was reported that there were no concerns with the exclusion of an incident that occurred about a year earlier that involved a Certified Nursing Assistant (CNA). R#1 reported to this surveyor he had been verbally and physically abused by a CNA that was employed at the facility but was unable to recall her name. R1 provided a physical description of (CNA) I. R1 reported about a year earlier CNA I was in his room and told him he was going to have a room change, R1 stated CNA I kept talking and badgering him about a room change, R1 readily admitted he told CNA I to shut up and get out of his room. R1 stated CNA I then yelled at him, called him names and hit him in the head with the roll of something, possibly a paper towel but he was not certain. R1 stated he reported the incident at the time, and CNA I still works at the facility but was not assigned to care for him. Review of the facility reported incident dated 5/28/24 revealed R1 reported CNA hit him in the head with a roll of something after arguing about a room change. The investigation had a statement from CNA I who denied the allegation and Licensed Practical Nurse (LPN) H who reported not witnessing the event but repeated the allegation in her statement as it was told to her by R1, which was consistent with what was told to this surveyor on 7/16/25. On 7/16/25 at 10:15 during an interview with staff member D she reported she didn't witness any abuse specifically related to R1 but was very aware that CNA I had a bad attitude and was well known to be gruff with everyone including residents. Staff member D reported management staff was very well aware of allegations of abuse as it pertained to CNA I. On 07/16/25 at 10:27 am during an interview with CNA E she reported that she didn't see abuse specifically related to R1 but did witness CNA I be both verbally and physically aggressive with other residents and it was reported to management. On 07/16/25 at 10:48 am during an interview with CNA F, it was reported there was no eye witnessed abuse with R1 but had witnessed CNA I verbally and physically abuse another resident, which was reported to management. On 07/16/25 at 11:09 am during an interview with CNA G when queried if she had any knowledge of CNA I verbally or physically abusing R1 or other residents, CNA G stated she had witnessed CNA I be verbally aggressive with residents, when asked to elaborate, CNA G declined and stated God sees everything and will take care of it. On 7/16/25 at 11:20 am during a phone interview with LPN H, it was reported she had witnessed CNA I be verbally abusive toward R1, and several other residents. LPN H stated she didn't specifically witness CNA I hit R1 in the head with a roll of garbage bags, she had no reason not to believe him as she had witnessed CNA I abuse other residents. LPN H stated she reported the incident and management moved CNA I to another hall. On 7/16/25 at 11:51 am during an interview with LPN J she had not eye witnessed abuse with R1 but had witnessed CNA I verbally and physically abuse another resident, which was reported to management. On 7/17/25 at 12:48 pm during an interview with Director of Nursing (DON) B and Nursing Home Administrator (NHA) A, DON B reported that former Nursing Home Administrator L was the facility's abuse prevention coordinator at the time of R1's allegation and handled the investigation and determined the outcome. Review of the facility policy titled Abuse, Neglect and Exploitation dated 01/10/24 page 4. IV. B. Possible indicators of abuse include, but are not limited to:Resident, staff, or family report of abuse .5. Verbal abuse of a resident is overheard. 6. Physical abuse of a resident observed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake #1286451Based on observation, interview, and record review, the facility failed to report allegations of abuse to the State Agency for 6 (Resident #2, #3, #5, #9, #10, #11) of 8 reviewed, resulting in allegations of abuse that were not reported to the State Agency and the potential for further allegations of abuse to go unreported. Findings include:Resident #2 (R2)Review of the clinical record revealed Resident #2 (R2) was [AGE] years old and was admitted to the facility on [DATE], Review of the Minimum Data Set (MDS) with an Assessment Reference Date ARD) [DATE] reflected R2 scored 8 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). On [DATE] at 11:09am during an interview with CNA G when queried if she had witnessed abuse while employed at the facility, CNA G reported she had witnessed CNA I be verbally aggressive with R2 and say mean things to R2. When asked to elaborate, CNA G declined and stated God sees everything and will take care of it. When queried if she had reported this to the facility abuse coordinator, she stated her Nurse did report it but nothing happens, elaborating they just move CNA I around to different halls/units. CNA G elaborated that CNA I's aggression with residents was well known by everyone including management staff. On [DATE] at 11:51 during an interview with Licensed Practical Nurse (LPN) J she reported she had witnessed CNA I verbally and mentally abuse R2. LPN J stated she had reported this to the Director of Nursing (DON) B and the prior Nursing Home Administrator (NHA) L on numerous occasions. Including abuse that involved Resident #3 and #5. Resident 3 (R3)Review of the clinical record revealed Resident #3 (R3) was [AGE] year-old female admitted to facility on [DATE] and expired at facility on [DATE]. Review of the MDS reflected long and short-term memory impairment with severely impaired daily decision-making skills. During the above interview with LPN J she reported she witnessed CNA I grab R3's 3 arms, she was rough with her and verbally abusive. This too was reported to DON B and prior NHA L. During a phone interview with LPN H on [DATE] at 11:20am, she stated she was passing medication and entered R3's room unbeknownst to CNA I who was already in the room. LPN H stated she observed CNA I being very rough and throwing R3 around like she was a rag doll. LPN H stated this too was reported to DON B and former NHA L. Resident 5 (R5)Review of the clinical record revealed Resident #5 (R5) was admitted to the facility on [DATE]. Review of the MDS with an ARD date of 5/27 BIMS reflected R3 scored 3 out of 15 (severe cognitive impairment) on the BIMS. During the same interview with LPN J she reported CNA I was frequently mentally and verbally abusive to R5. LPN J stated R5 did not always have the best hygiene and would refuse or resist to having her brief changed, when this occurs LPN J stated she will overhear CNA I bully/publicly humiliate R5 into receiving care by telling R5 she peed her pants or she stinks. Resident #9 (R9)Review of the clinical record revealed Resident #9 (R9) was admitted to the facility on [DATE] and expired at facility on [DATE]. Review of the MDS with an ARD date of [DATE] reflected R9 was never/rarely understood, and there was no BIMS score. During a phone interview with LPN H on [DATE] at 11:20 am she reported R9 had a stroke and difficulty speaking. LPN H stated she overheard CNA I yell at R9 and tell him if he couldn't speak and tell her what he wanted she would no longer answer his call light then she slammed his door. LPN H stated this too was reported to DON B and former NHA L. Resident #10 (R10)Review of the clinical record including the MDS with an ARD of [DATE] reflected Resident #10 (R#10) scored 5 out of 15 (severe cognitive impairment) was admitted on [DATE] expired on [DATE]. On [DATE] at 11:51 during an interview with LPN J she reported she overheard CNA I yell and verbally abuse R#10 and reported the incident to management. Resident #11 (R11) Review of the clinical record revealed Resident #11 (R11) was a [AGE] year-old female admitted to the facility on [DATE] and expired on [DATE]. Diagnoses included morbid obesity and anxiety. The MDS with an ARD of [DATE] revealed R11 had a BIMS score of 12 (cognitively intact). On [DATE] at 10:48 am, during an interview with CNA F she reported in November of 2024 she was assisting CNA I with providing incontinence care for R11. CNA F reported R11 was a very large women and had difficulty opening her legs to be cleaned. CNA F stated CNA I aggressively shook R11's legs and started yelling at R11 in disgust saying, What am I supposed to do with all that? pointing and waving her hand in irritation at R11's upper thighs and vaginal area. CNA F stated R11 then began to cry. There was a text message thread that was read and revealed CNA F reported the incident to DON B. There was no report made to the State Agency.On [DATE] at 12:48 pm during an interview with DON B and current NHA A all of the above scenarios were reviewed, NHA A was not employed at the facility during the above reported allegation time frames. DON B reported

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #1286451Based on interview and record review the facility failed to thoroughly investigate allegations of abuse for seven residents (#2, #3, #4, #5, #9, #10, and #11) of 8 reviewed for abuse.Findings include:Resident #2 (R2)Review of the clinical record revealed Resident #2 (R2) was [AGE] years old and was admitted to the facility on [DATE], Review of the Minimum Data Set (MDS) with an Assessment Reference Date ARD) [DATE] reflected R2 scored 8 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). On [DATE] at 11:09am during an interview with CNA G when queried if she had witnessed abuse while employed at the facility, CNA G reported she had witnessed CNA I be verbally aggressive with R2 and say mean things to R2. When asked to elaborate, CNA G declined and stated God sees everything and will take care of it. When queried if she had reported this to the facility abuse coordinator, she stated her Nurse did report it but nothing happens, elaborating they just move CNA I around to different halls/units. CNA G elaborated that CNA I's aggression with residents was well known by everyone including management staff. On [DATE] at 11:51 during an interview with Licensed Practical Nurse (LPN) J she reported she had witnessed CNA I verbally and mentally abuse R2. LPN J stated she had reported this to the Director of Nursing (DON) B and the prior Nursing Home Administrator (NHA) L on numerous occasions. Including abuse that involved Resident #3 and #5. There was no investigation initiated regarding the allegation of abuse. Resident 3 (R3)Review of the clinical record revealed Resident #3 (R3) was [AGE] year-old female admitted to facility on [DATE] and expired at facility on [DATE]. Review of the MDS reflected long and short-term memory impairment with severely impaired daily decision-making skills. During the above interview with LPN J she reported she witnessed CNA I grab R3's 3 arms, she was rough with her and verbally abusive. This too was reported to DON B and prior NHA L. During a phone interview with LPN H on [DATE] at 11:20am, she stated she was passing medication and entered R3's room unbeknownst to CNA I who was already in the room. LPN H stated she observed CNA I being very rough and throwing R3 around like she was a rag doll. LPN H stated this too was reported to DON B and former NHA L. There was no investigation initiated regarding the allegation of abuse. Resident #4 (R4)Review of the clinical record revealed Resident #4 (R4) was a [AGE] year old female admitted on [DATE] with a diagnosis of cerebral palsy and profound intellectual disabilities. R4 was admitted to the facility on [DATE] and discharged home on [DATE]. The MDS with an ARD of [DATE] revealed R4 had severe cognitive impairment and was unable to communicate her needs. Review of the Facility Reported Incident (FRI) dated [DATE] completed by former NHA L revealed an allegation of abuse by an anonymous witness that alleged CNA I pinched R4's nose in order for R4 to stop biting her hands and slapped her hands while in the shower room. The FRI reported the witness was anonymous and not available for an interview. The FRI also reflected that interview was conducted with the Charge Nurse and the Unit manager, yet there were no such interviews included. The FRI reflected the allegation was discovered on [DATE] and had occurred on 6/24. During the state survey onsite investigation, it was revealed that the anonymous complaint was a student from the local community college where they were learning clinical skills. Student M who accompanied CNA I to the shower room with R4 on 6/23. On [DATE] during a phone interview with Doctor K she reported student M came to her upset about witnessing CNA I abuse R4 while providing a shower. Doctor K stated she and student M reported the allegation in person to DON B on [DATE]. Doctor K further stated she was certain the date was [DATE] because [DATE] was a half day and the students were testing. The phone number for student M was obtained by Doctor K but was not in service and student M was not able to be interviewed. On [DATE] at 12:48 pm, DON B stated former NHA L completed the FRI and she could not account for discrepancy of the dates from Doctor K interview, where the missing interviews from the Charge Nurse or the Unit Manager were, why it stated the FRI was from an anonymous witness or why a statement was not obtained from student M. Resident 5 (R5)Review of the clinical record revealed Resident #5 (R5) was admitted to the facility on [DATE]. Review of the MDS with an ARD date of 5/27 BIMS reflected R3 scored 3 out of 15 (severe cognitive impairment) on the BIMS. During the same interview with LPN J she reported CNA I was frequently mentally and verbally abusive to R5. LPN J stated R5 did not always have the best hygiene and would refuse or resist to having her brief changed, when this occurs LPN J stated she will overhear CNA I bully/publicly humiliate R5 into receiving care by telling R5 she peed her pants or she stinks. There was no investigation initiated regarding the allegation of abuse. Resident #9 (R9)Review of the clinical record

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1286453Based on observation, interview, and record review the facility failed to provide scheduled bathing and complete nail care for one resident (R6) of three residents reviewed for activities of daily living. Findings include: Review of the medical record reflected R6 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included aphasia and cerebral infarction due to embolism. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4-8-25, reflected R6 was described as rarely/never understood.On 7/17/25 at 10:32 am, R6 was observed in bed. R6's fingernails and toenails were observed and noted to be excessively long. R6's hair was matted and R6 had an unpleasant odor.Review of the Activities of Daily Living Care Plan revealed R6 required staff assistance of one person for bathing and personal hygiene.Review of the MDS dated [DATE] revealed R6 was coded as dependent for shower/bathing.Review of the Task list revealed R6's showers were scheduled for Sundays and Wednesdays.Review of the Task documentation revealed R6 did not receive a shower or bed bathe on her scheduled days of 7/13/25 and 7/16/25.Review of the electronic medical record revealed no documentation that nail care had been completed.Review of the medical record revealed no evidence that a podiatry consult had been requested to address the long length of R6's toenails.Review of the facility policy titled Activities of Daily Living revised on 12/28/23 .activities of daily living include.bathe, dress groom.a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, personal and oral hygiene.Review of a Nursing Evaluation Summary dated 7/12/25 10:10 AM Resident (R6) is alert and non-verbal. Unable to assess orientation. Resident is bed bound, incontinent of bowel and bladder, and is unable to make her needs known. Needs must be anticipated.In an interview on 7/17/25 at 12:49 PM, Director of Nursing B stated that the expectation would be to provide bathing on residents scheduled shower days and to complete nail care as part of grooming.