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	05/28/2026

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2801450. Based on interview and record review, the facility failed to notify the resident representative of a change in condition for one (R7) of four reviewed. Findings include:Review of the medical record reflected R7 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included paraplegia and neuromuscular dysfunction of the bladder. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/9/26, reflected R7 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the medical record, R7 had a Legal Guardian/Conservator in place. R7 discharged to the hospital on 2/12/26 and did not return to the facility. A Progress Note for 2/10/26 at 5:53 PM reflected R7 was lethargic, tired, sleeping all day and refused a meal. According to the note, R7 reported they were ok, needed to sleep and refused to go to the hospital. A Progress Note for 2/12/26 at 10:36 AM reflected R7 was alert but disoriented, confused and had abnormal vital signs, including a temperature of 103.3 (degrees Fahrenheit), a pulse of 134 (beats per minute), a respiratory rate of 22 (breaths per minute) and an oxygen saturation of 88 (percent). The note reflected R7 was placed on oxygen, tested for COVID-19 and transferred to the emergency room (ER).A grievance form, dated 2/12/26, included documentation that R7's Guardian was frustrated about not being contacted first, when R7 was transferred to the hospital. In an interview on 5/28/26 at 10:42 AM, Registered Nurse (RN) M reported if a resident was not their own responsible party, they were to call the responsible party to ask about sending a resident to the ER for evaluation. In an interview on 5/28/26 at 12:36 PM, Unit Manager (UM) P reported R7's Legal Guardian should have been notified when R7 was transferred to the hospital on 2/12/26. In the event the Legal Guardian was unavailable, the notification should have been made to the next emergency contact. UM P indicated there should have been documentation if they attempted to call the Guardian but could not reach them. According to R7's medical record, a family member, who was not listed as being R7's Legal Guardian, was notified of their transfer to the ER. The medical record did not reflect that R7's Legal Guardian was notified of the transfer.

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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(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** This citation pertains to intake numbers 2790883 and 2790891.Based on observations, interviews, and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident.Findings Include:Review of the medical record reflected Resident #4 (R4) was admitted to the facility on [DATE], with diagnoses that included pseudobulbar effect (a neurological condition causing sudden uncontrollable episodes of laughing or crying), mild cognitive impairment, chronic motor or vocal tic disorder, and severe intellectual disabilities. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/9/26, reflected R4 was marked as rarely/never understood on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected Resident #5 (R5) was admitted to the facility on [DATE], with diagnoses that included adjustment disorder with depressed mood, generalized anxiety disorder, and unspecified intellectual disabilities. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/16/26, reflected R5 scored 9 out of 15 (moderately impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R5 was independent with ambulation with the use of an assistive device. Review of the medical record reflected R6 was admitted to the facility on [DATE], with diagnoses that included post-traumatic stress disorder, unspecified dementia, and anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/1/26, reflected R6 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 5/20/26 at 2:28 pm, R4 was observed in bed. During an interview attempt, a certified nursing assistant stated that R4 was nonverbal and would not be capable of communicating back. On 5/20/26 at 12:50 PM, R5 was observed walking unassisted into the dining room using a walker. Review of R4's care plan revealed Resident has behavior(s) related to mild cognitive impairment, chronic motor or tic disorder as evidenced by: family reported combativeness as a usual behavior upon admission, screams and yells intermittently for attention, refusing care, throwing things, hitting and reaching out for attention. physical aggressive at times. Call lights being on will aggravate resident Date Initiated: 11/20/2024 . Review of a behavioral health services note stated the following; SEVERE INTELLECTUAL DISABILITIES Status: Severe, Chronicity Level: Chronic: Severe baseline cognitive and communication impairment continues to limit assessment; patient was unable to provide history today. Staff continue to report that yelling is her primary means of communication and can be attention-seeking. Patient requires ongoing 24-hour supervision and structured behavioral supports in the skilled nursing facility setting, including one-to-one staffing during dining per behavioral escalation on 5/5/2026. Continue current psychiatric regimen as above and ongoing behavioral monitoring and documentation by staff . Review of a Nurses' Note Dated 1/27/2026 at 12:55 PM reflected writer notified by staff that resident was hit by another resident [R5] in back oh head. as per head-to-toe assessment, not observed any bruises/pain/open injuries or any discomfort . brought resident in front of nursing station (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	forobservation [sic]. notified to abuse coordinator . The incident that occurred on 1/27/26 was reported to the State Agency. Review of MI-FRI (Michigan-Facility Reported Incident) 00063325, 24-hour report, revealed an incident summary (provided by Nursing Home Administrator G, that is no longer employed by the facility as of 05/19/2026) which stated, Allegation of resident-to-resident abuse. Resident [5] is alleged to have hit Resident [4]. Residents separated and safe in the facility. Both residents assessed and free of injury. Interventions in place. Notifications in progress. Investigation underway . Review of an Incident report dated 1/27/26 at 12:30 PM stated staff observed R5 enter the dining room where R4 was seated and hit [R4] in the back of the head and continued walking away. Certified Nursing Assistant Q reported, via the same incident report, that R4 was in the dining room yelling and as [R5] was coming into the dining room he lightly hit [R4] on the back of the head as he told her to knock it off . In an interview on 5/21/26 at 10:23 am, R5 reported stated that he doesn't like noisy people or people yelling in the hall. R5 stated that sometimes he will get up and slam his door during the night because of the person that yells out. R5 stated he thinks it is the same person that yells out in the dining room and stated she makes noises all the time. Review of the incident investigation revealed a lack staff interviews, assessments of like/other residents that had the potential to be impacted and did not contain documentation that incident had been reported to the police department. Review of R4's Care Plan revealed an added intervention dated 1/28/26 staff sit with resident during mealtimes and do not bring resident to dining room until tray is served. Review of a Nurses' Note dated 2/12/2026 at 5:51 PM revealed 'Resident was in the dining room before dinner meal was passed and she was screaming. Another resident came up and hit her in the face. The resident who hit her was removed from the dining room and the don, on call and admin was notified . Inquiries from current staff revealed no knowledge of this incident. The Nurses' Note dated 2/12/26 documented R4 was in the dining room before R4's tray was served when R4 was struck in the face by another resident. This demonstrated the failure to follow the care plan designed to reduce the risk of a resident-to-resident incident. Review of a Nurses' Note dated 5/5/2026 5:53 PM revealed [R4] hit another resident in the dining area today. She should be kept out of the dining area until staff is able ro [sic] be 1 on 1 with her . Review of an Incident Report dated 5/5/26 revealed a CNA came running to the nurses station stating that [R4] hit another resident [R6] and the other resident [R6] grabbed her hand and pushed her hand back. The same incident report stated, in the other info section, [R4] hits when others gets close enough to her. She was in the dining room celebrating her birthday with her family. After the family left, [R4] remaining in the dining area awaiting dinner. [R4] should be kept separated from others when she is on 1 on 1 in dining room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/20/26 at 3:53 pm, Licensed Practical Nurse (LPN) R stated that R4 was taken into the dining room for a birthday party with her family and when they left, they left R4 in the dining room. LPN R stated that a CNA reported to her that R6 hit R4. LPN R stated that she immediately called former NHA G to report the abuse allegation. In an interview on 5/20/26 3:11 pm, Director of Nursing (DON) B stated that she was aware of the incident that occurred on 5/5/26. DON B reported that the incident was discussed during morning meeting. R4 was in the dining room and R6 self-propelled in the vicinity of R4. R4 reached out and hit R6. The team discussed an intervention of ensuring R4 was not left unattended in the dining room. DON B confirmed that former NHA G was immediately notified of the abuse allegation. The incident that occurred on 5/5/26 between R4 and R6 again demonstrated the failure to follow the care plan designed to reduce the risk of a resident-to-resident incident. Further review of R5's Care plan revealed no additional intervention after the 5/5/26 incident to ensure the safety of R4 was maintained as well as the safety of others. Review of the medical record reflected R16 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia. R16 no longer resided in the facility. Review of a Nurses' Note dated 4/27/26 at 8:13 am revealed [R16] was observed in a yelling argument with [R5]. [R5] closed fist hit [R16] in the upper back. [R16] reporting, [R16] stated he came to dining room to have a quiet cup of coffee, [R5] had phone blaring and refused to turn it down. This agitated [R16] who grabbed the phone off the table, turned it off and tossed it on the chair. (R5] stood and hit him. Residents were separated, skin and pain assessed, no issues noted .'. In an interview on 5/21/26 at 10:23 am, R5 stated that he doesn't like noisy people or people yelling in the hall. R5 stated that sometimes he will get up and slam his door during the night because of the person that yells out. R5 stated he thinks it is the same person that yells out in the dining room and stated she makes noises all the time (mimicked a grunting noise). R5 recalled a separate incident which he described as one guy was mouthy and tried to shut my phone off. I said try it. He tried it and I hauled off and hit him right across the back. Review of R5's Care Plan reviewed a Focus area which stated Resident has behavior(s) as evidenced by: verbally aggressive toward other, name calling of staff members. Resident punches walls and/or doors when he is upset. Refusing medications. Not following prescribed diet, hoarding sugar, salt, cream, pepper and old metal spoons. Can become agitated by excessive noises. Resident has repeatedly cut wander guard bracelet off despite education and direction. Date Initiated: 11/25/2024 Revision on: 03/02/2026. One of the interventions stated Be aware of loud residents in the vicinity and attempt to redirect if becomes agitated. Date Initiated: 01/28/2026. Review of the facilities policy titled Abuse, Neglect, and Exploitation defines abuse as the willful infliction of injury which can include certain resident to resident altercations. Physical abuse includes but is not limited to hitting, slapping, punching, biting and kicking. Reporting/Response: Immediately, but not later than two hours if the events that cause the allegation involve abuse. Resident #2 (R2) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed R2 was admitted to the facility 06/30/2025 with diagnoses that included adjustment disorder with mixed anxiety and depresses mood, Alzheimer's Disease, osteoarthritis (wearing of cartilage between bone joints), dementia, depression, repeated falls, hypertension, and anxiety. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/2026, revealed R2 had a Brief Interview of Mental Status (BIMS) of 7 (severe cognitive impairment) out of 15. Section GG-Functional Abilities, with the same ARD of 01/06/2026, revealed that R2 was independent with wheelchair mobility. Resident #3 (R3) Review of the medical record revealed R3 was admitted to the facility 05/05/2023 with diagnoses that included Huntington's Disease (a progressive genetic disorder which leads to the breakdown of nerve cells in the brain), encephalopathy (broad term for any disease, damage, or malfunction of the brain), psychosis (loss of contact with reality), dysphagia (difficulty swallowing), restlessness and agitation, urinary retention, and chorea (neurological movement disorder characterized by involuntary, irregular, and unpredictable muscle movements). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/2026, revealed R3 had a Brief Interview of Mental Status (BIMS) that could not be completed because R3 is rarely/never understood. R3's medical record revealed that he was discharged from the facility 05/02/2026. Review of facility incident report (for event that occurred 02/16/2026 at 05:00 pm) revealed Pt (R2) was rolling herself down A hall. Pt (R3) sitting near the nurses station leaned out of his chair and struck the other Pt (R2) on the side of the head near her eye. The same incident report revealed immediate action taken Pt (R2) evaluated raised bump forming on right side of Pts (R2) head near upper portion of eye, broken skin noted where Pt(R2) was struck. Pt (R2) eyes PERRLA (Pupils Equal, Round, Reactive to Light, and Accommodation). No complaint of headache at this time. Pt (R2) states pain is minimal but she was just surprised. Review of MI-FRI (Michigan-Facility Reported Incident) 00063610, 24 hour report, revealed that the facility reported the incident on 02/17/2026 at 11:43 a.m. The same document included an incident summary (provide by Nursing Home Administrator G, that is no longer employed by the facility as of 05/19/2026) which stated, Pt (R2) was rolling herself down A hall. Pt (R3) witting near the nurses' station leaned out of his chair and struck the other Pt (R2) on the head near her eye. Scratch 2/16/2026to area, minimal pain. Pt (R3) placed on 1 to 1. Both Pt. (R2 &R3) cont. to reside at center and are safe. Investigation started. 5 day to follow. Review of the MI-FRI 00063610, 5 day investigation, revealed Correction Action (s) Taken: Following the incident, staff immediately intervened and separate the residents, moving he victim, (name of R2) to another area and evaluating her injuries, which included applying a bandage to her laceration and initiating neuro checks. To ensure ongoing facility safety and prevent further incidents, the initiator (name of R3), was promptly placed on 1:1 observations whenever he is out of his room. Review of R3's medial record did not have demonstration that R3 was placed on 1:1 supervision after this incident. R3's plan of care revealed a problem statement that stated Resident has behavior related to Huntington's Disease as evidence by: physically aggressive, hitting others, refuses medications, refuses showers, ambulates and transfers self despite redirection and offered assistance, and wanders. Interventions included: staff to be aware of proximity to resident, 1:1 staff as needed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/21/2026 at 11:33 a.m. Registered Nurse (RN) H explained that he had been the nurse that witnessed the altercation between R2 and R3 on 02/16/2026 at 05:00 p.m. RN H explained that he witnessed R2 propelling herself down the hall. RN H explained that as R2 got closer to R3 he witnessed R3 reaching out and clocking R2. RN H was asked to clarify what clocking R2 meant. RN H explained that R3 had deliberately hit R2 with a closed fist and even knocked her glasses off her face and he witnessed her head go backward from the force. RN H explained that R3 was taking back to his room but could not answer if he was placed on 1:1 supervision. RN H explained that he assessed R2' and she had a lump under her eye and the skin was broken. RN H' explained that he knew this was not the first time R3 had altercations with other residents and explained that he had a history of placing a staff member in a head lock. During observation and interview on 05/21/2026 at 01:19 p.m. R2 was observed sitting in her wheelchair in her room. R2 was asked about the event that occurred with another resident on 02/16/2026. R2 explained that she remembered the incident and that a man had punched her in the face, right under her right eye. R2 explained that it had caused her to have a 'black eye. R2 was asked to rate the pain on a scale of 1-10, with 1 being the least pain and 10 being the most pain, the pain from being punched on that date. R2 explained that her pain was a 5 on that date, but that it still bothered her at times. R2 was asked to explain why her eye still bothered her and she responded, Because someone knocked by face in. No bruising was observed on R2's face at this time. Resident #6 (R6) Review of the medical record revealed R6 was admitted to the facility 09/23/2025 with diagnoses that included encephalopathy (broad term for any disease, damage, or malfunction of the brain), chronic obstructive pulmonary disease (COPD), unsteadiness on feet, generalized muscle weakness, depression, anxiety, conversion disorder (a condition where a person experiences real physical symptoms that cannot be explained by an underlying medical disease) with seizures or convulsions, bladder cancer, adjustment disorder, gastro-esophageal reflux disease, hypertension, hyperlipidemia (high fat content in blood), obstructive sleep apnea, dementia with behavioral disturbances, urinary retention, enlarged prostate, post-traumatic stress disorder, and hypothyroidism (low thyroid hormone). The Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2026, revealed R6 had a Brief Interview of Mental Status (BIMS) of 00 (severe cognitive impairment) out of 15. Review of R3 incident report, 01/28/2026 at 03:00 p.m., revealed CNA (Certified Nursing Aide) reported that another resident (R6) was wheeling into this residents room and this resident hit the other resident (R6) in the face. A scratch was present on the left side of eye of the other resident (R6). Review of R6 incident report, 01/28/2026 at 03;00 p.m., revealed CNA (Certified Nursing Aide) reported resident (R6) was wheeling into other residents (R3) room, resident in the room (R3) hit this resident (R6) in the face, a scratch was present on left side of eye with slight blood present. Review of MI-FRI (Michigan-Facility Reported Incident) 00063344, 24 hours report, revealed Allegation of resident to resident physical contact. Resident (initials of R6) wheeled himself into Resident (initials of R3) room. Resident (initials of R3) is alleged to have hit Resident (initials of R6). Date and time of the incident reported to be 01/28/2026 at 03:25 p.m. Review of the MI-FRI 00063344, 5 day investigation, revealed Correction Action (s) Taken: Care plans (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	for bother resident we updated and stop sign was added to make the room less appealing: The section entitled Conclusion revealed Not verified- the allegation was refuted by evidence collected during the investigation. During observation and attempted interview on 05/20/2026 at 03:26 p.m. R6 was observed sitting up in his wheelchair in the hallway. R6 did not respond to verbal questions.

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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 numbers 2788433 and 2790891.Based on observations, interviews and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act.Findings Include:Review of the medical record reflected Resident #4 (R4) was admitted to the facility on [DATE], with diagnoses that included pseudobulbar effect (a neurological condition causing sudden uncontrollable episodes of laughing or crying), mild cognitive impairment, chronic motor or vocal tic disorder, and severe intellectual disabilities. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/9/26, reflected R4 was marked as rarely/never understood on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected Resident #5 (R5) was admitted to the facility on [DATE], with diagnoses that included adjustment disorder with depressed mood, generalized anxiety disorder, and unspecified intellectual disabilities. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/16/26, reflected R5 scored 9 out of 15 (moderately impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R5 was independent with ambulation with the use of an assistive device. Review of the medical record reflected R6 was admitted to the facility on [DATE], with diagnoses that included post-traumatic stress disorder, unspecified dementia, and anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/1/26, reflected R6 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R4's care plan revealed Resident has behavior(s) related to mild cognitive impairment, chronic motor or tic disorder as evidenced by: family reported combativeness as a usual behavior upon admission, screams and yells intermittently for attention, refusing care, throwing things, hitting and reaching out for attention. physical aggressive at times. Call lights being on will aggravate resident Date Initiated: 11/20/2024 . Review of a behavioral health services note stated the following; SEVERE INTELLECTUAL DISABILITIES Status: Severe, Chronicity Level: Chronic: Severe baseline cognitive and communication impairment continues to limit assessment; patient was unable to provide history today. Staff continue to report that yelling is her primary means of communication and can be attention-seeking. Patient requires ongoing 24-hour supervision and structured behavioral supports in the skilled nursing facility setting, including one-to-one staffing during dining per behavioral escalation on 5/5/2026. Continue current psychiatric regimen as above and ongoing behavioral monitoring and documentation by staff . The incident that occurred on 1/27/26 was reported to the State Agency. Review of MI-FRI (Michigan-Facility Reported Incident) 00063325, 24-hour report, revealed an incident summary (provided by Nursing Home Administrator G, that is no longer employed by the facility as of 05/19/2026) which stated, Allegation of resident-to-resident abuse. Resident [5] is alleged to have hit Resident [4]. Residents separated and safe in the facility. Both residents assessed and free of injury. Interventions in place. Notifications in progress. Investigation underway . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident report dated 1/27/26 at 12:30 PM stated staff observed R5 enter the dining room where R4 was seated and hit [R4] in the back of the head and continued walking away. Certified Nursing Assistant Q reported, via the same incident report, that R4 was in the dining room yelling and as [R5] was coming into the dining room he lightly hit [R4] on the back of the head as he told her to knock it off . In an interview on 5/21/26 at 10:23 am, R5 reported stated that he doesn't like noisy people or people yelling in the hall. R5 stated that sometimes he will get up and slam his door during the night because of the person that yells out. R5 stated he thinks it is the same person that yells out in the dining room and stated she makes noises all the time. Review of R4's Care Plan revealed an added intervention dated 1/28/26 staff sit with resident during mealtimes and do not bring resident to dining room until tray is served. Review of a Nurses' Note dated 2/12/2026 at 5:51 PM revealed 'Resident was in the dining room before dinner meal was passed and she was screaming. Another resident came up and hit her in the face. The resident who hit her was removed from the dining room and the don, on call and admin was notified . Inquiries from current staff revealed no knowledge of this incident. Review of the Michigan-Facility Reported Incident system revealed no submission for this incident and as a result, no corresponding investigation. The Nurses' Note dated 2/12/26 documented R4 was in the dining room before R4's tray was served when R4 was struck in the face by another resident. This demonstrated the failure to follow the care plan designed to reduce the risk of a resident-to-resident incident. Review of a Nurses' Note dated 5/5/2026 5:53 PM revealed [R4] hit another resident in the dining area today. She should be kept out of the dining area until staff is able ro [sic] be 1 on 1 with her . Review of an Incident Report dated 5/5/26 revealed a CNA came running to the nurses station stating that [R4] hit another resident [R6] and the other resident [R6] grabbed her hand and pushed her hand back. The same incident report stated, in the other info section, [R4] hits when others gets close enough to her. She was in the dining room celebrating her birthday with her family. After the family left, [R4] remaining in the dining area awaiting dinner. [R4] should be kept separated from others when she is on 1 on 1 in dining room. On 5/20/26 at 3:53 pm, Licensed Practical Nurse (LPN) R stated that R4 was taken into the dining room for a birthday party with her family and when they left, they left R4 in the dining room. LPN R stated that a CNA reported to her that R6 hit R4. LPN R stated that she immediately called former NHA G to report the abuse allegation. In an interview on 5/20/26 3:11 pm, Director of Nursing (DON) B stated that she was aware of the incident that occurred on 5/5/26. DON B reported that the incident was discussed during morning meeting. R4 was in the dining room and R6 self-propelled in the vicinity of R4. R4 reached out and hit R6. The team discussed an intervention of ensuring R4 was not left unattended in the dining room. confirmed that former NHA G was immediately notified of the abuse allegation. (continued on next page)

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	05/28/2026

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident that occurred on 5/5/26 between R4 and R6 again demonstrated the failure to follow the care plan designed to reduce the risk of a resident-to-resident incident. Further review of R5's Care plan revealed no additional intervention after the 5/5/26 incident to ensure the safety of R4 was maintained as well as the safety of others. Review of the Michigan-Facility Reported Incident system revealed no submission for this incident. Review of the medical record reflected R16 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia. R16 no longer resided in the facility. Review of a Nurses' Note dated 4/27/26 at 8:13 am revealed [R16] was observed in a yelling argument with [R5]. [R5] closed fist hit [R16] in the upper back. [R16] reporting, [R16] stated he came to dining room to have a quiet cup of coffee, [R5] had phone blaring and refused to turn it down. This agitated [R16] who grabbed the phone off the table, turned it off and tossed it on the chair. (R5] stood and hit him. Residents were separated, skin and pain assessed, no issues noted .'. In an interview on 5/21/26 at 10:23 am, R5 reported stated that he doesn't like noisy people or people yelling in the hall. R5 stated that sometimes he will get up and slam his door during the night because of the person that yells out. R5 stated he thinks it is the same person that yells out in the dining room and stated she makes noises all the time (mimicked a grunting noise). R5 recalled a time one guy was mouthy and tried to shut my phone off. I said try it. he tried it and I hauled off and hit him right across the back. Review of the Michigan-Facility Reported Incident system revealed no submission for this incident. Review of R5's Care Plan reviewed a Focus area which stated Resident has behavior(s) as evidenced by: verbally aggressive toward other, name calling of staff members. Resident punches walls and/or doors when he is upset. Refusing medications. Not following prescribed diet, hoarding sugar, salt, cream, pepper and old metal spoons. Can become agitated by excessive noises. Resident has repeatedly cut wander guard bracelet off despite education and direction. Date Initiated: 11/25/2024 Revision on: 03/02/2026. One of the interventions stated Be aware of loud residents in the vicinity and attempt to redirect if becomes agitated. Date Initiated: 01/28/2026. Review of the facilities policy titled Abuse, Neglect, and Exploitation defines abuse as the willful infliction of injury which can include certain resident to resident altercations. Physical abuse includes but is not limited to hitting, slapping, punching, biting and kicking. Reporting/Response: Immediately, but not later than two hours if the events that cause the allegation involve abuse. Resident #2 (R2) Review of the medical record revealed R2 was admitted to the facility 06/30/2025 with diagnoses that included adjustment disorder with mixed anxiety and depresses mood, Alzheimer's Disease, osteoarthritis (wearing of cartilage between bone joints), dementia, depression, repeated falls, hypertension, and anxiety. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/2026, revealed R2 had a Brief Interview of Mental Status (BIMS) of 7 (severe cognitive impairment) out of 15. Section GG-Functional Abilities, with the same ARD of 01/06/2026, revealed that R2 was independent with wheelchair mobility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 (R3) Review of the medical record revealed R3 was admitted to the facility 05/05/2023 with diagnoses that included Huntington's Disease (a progressive genetic disorder which leads to the breakdown of nerve cells in the brain), encephalopathy (broad term for any disease, damage, or malfunction of the brain), psychosis (loss of contact with reality), dysphagia (difficulty swallowing), restlessness and agitation, urinary retention, and chorea (neurological movement disorder characterized by involuntary, irregular, and unpredictable muscle movements). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/2026, revealed R3 had a Brief Interview of Mental Status (BIMS) that could not be completed because R3 is rarely/never understood. R3's medical record revealed that he was discharged from the facility 05/02/2026. Review of facility incident report (for event that occurred 02/16/2026 at 05:00 pm) revealed Pt (R2) was rolling herself down A hall. Pt (R3) sitting near the nurses station leaned out of his chair and struck the other Pt (R2) on the side of the head near her eye. The same incident report revealed immediate action taken Pt (R2) evaluated raised bump forming on right side of Pts (R2) head near upper portion of eye, broken skin noted where Pt(R2) was struck. Pt (R2) eyes PERRLA (Pupils Equal, Round, Reactive to Light, and Accommodation). No complaint of headache at this time. Pt (R2) states pain is minimal but she was just surprised. Review of MI-FRI (Michigan-Facility Reported Incident) 00063610, 24 hour report, revealed that the facility reported the incident on 02/17/2026 at 11:43 a.m. The same document included an incident summary (provide by Nursing Home Administrator G, that is no longer employed by the facility as of 05/19/2026) which stated, Pt (R2) was rolling herself down A hall. Pt (R3) witting near the nurses' station leaned out of his chair and struck the other Pt (R2) on the head near her eye. Scratch 2/16/2026to area, minimal pain. Pt (R3) placed on 1 to 1. Both Pt. (R2 &R3) cont. to reside at center and are safe. During an interview on 05/21/2026 at 11:33 a.m. Registered Nurse (RN) H explained that he had been the nurse that witnessed the altercation between R2 and R3 on 02/16/2026 at 05:00 p.m. RN H explained that he witnessed R2 propelling herself down the hall. RN H explained that as R2 got closer to R3 he witnessed R3 reaching out and clocking R2. RN H was asked to clarify what clocking R2 meant. RN H explained that R3 had deliberately hit R2 with a closed fist and even knocked her glasses off her face and he witnessed her head go backward from the force. RN H explained that R3 was taking back to his room but could not answer if he was placed on 1:1 supervision. RN H explained that he assessed R2' and she had a lump under her eye and the skin was broken. RN H' explained that he knew this was not the first time R3 had altercations with other residents and explained that he had a history of placing a staff member in a head lock. During observation and interview on 05/21/2026 at 01:19 p.m. R2 was observed sitting in her wheelchair in her room. R2 was asked about the event that occurred with another resident on 02/16/2026. R2 explained that she remembered the incident and that a man had punched her in the face, right under her right eye. R2 explained that it had caused her to have a 'black eye. R2 was asked to rate the pain on a scale of 1-10, with 1 being the least pain and 10 being the most pain, the pain from being punched on that date. R2 explained that her pain was a 5 on that date, but that it still bothered her at times. R2 was asked to explain why her eye still bothered her and she responded, Because someone knocked by face in. No bruising was observed on R2's face at this time. During an interview on 05/21/2026 at 01:33 p.m. Regional Director of Operations also Nursing Home (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator (NHA)A confirmed that the NHA G had not notified the state agency within 2 hours as required and had not contacted the police as required. NHA could not explain why NHA A had not reported the incident within 2 hours and report to the police as required.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake numbers 2790883 and 2790891 Based on observation, interview, and record review the facility failed to conduct a thorough abuse investigation for 6 (R2, R3, R4, R5, R6, R16) out of 6 residents reviewed for abuse. Findings include:Review of the medical record reflected Resident #4 (R4) was admitted to the facility on [DATE], with diagnoses that included pseudobulbar effect (a neurological condition causing sudden uncontrollable episodes of laughing or crying), mild cognitive impairment, chronic motor or vocal tic disorder, and severe intellectual disabilities. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/9/26, reflected R4 was marked as rarely/never understood on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected Resident #5 (R5) was admitted to the facility on [DATE], with diagnoses that included adjustment disorder with depressed mood, generalized anxiety disorder, and unspecified intellectual disabilities. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/16/26, reflected R5 scored 9 out of 15 (moderately impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R5 was independent with ambulation with the use of an assistive device. Review of the medical record reflected R6 was admitted to the facility on [DATE], with diagnoses that included post-traumatic stress disorder, unspecified dementia, and anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/1/26, reflected R6 scored 0 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of a Nurses' Note Dated 1/27/2026 at 12:55 PM reflected writer notified by staff that resident was hit by another resident [R5] in back oh head. as per head-to-toe assessment, not observed any bruises/pain/open injuries or any discomfort . brought resident in front of nursing station forobservation [sic]. notified to abuse coordinator . Review of MI-FRI (Michigan-Facility Reported Incident) 00063325, 24-hour report, revealed an incident summary (provided by Nursing Home Administrator G, that is no longer employed by the facility as of 05/19/2026) which stated, Allegation of resident-to-resident abuse. Resident [5] is alleged to have hit Resident [4]. Residents separated and safe in the facility. Both residents assessed and free of injury. Interventions in place. Notifications in progress. Investigation underway . Review of an Incident report dated 1/27/26 at 12:30 PM stated staff observed R5 enter the dining room where R4 was seated and hit [R4] in the back of the head and continued walking away. Certified Nursing Assistant Q reported, via the same incident report, that R4 was in the dining room yelling and as [R5] was coming into the dining room he lightly hit [R4] on the back of the head as he told her to knock it off . Review of the incident investigation revealed a lack staff interviews, assessments of like/other residents that had the potential to be impacted and did not contain documentation that incident had been reported to the police department. During an interview on 05/20/2026 at 02:51 pm Regional Director of Clinical Services (RDCS) I confirmed that facility investigation file, provided for R4 and R5 incident did not contain adequate (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witness statements or review of other potential residents that could have been impacted from the event. Review of R4's Care Plan revealed an added intervention dated 1/28/26 staff sit with resident during mealtimes and do not bring resident to dining room until tray is served. Review of a Nurses' Note dated 2/12/2026 at 5:51 PM revealed 'Resident was in the dining room before dinner meal was passed and she was screaming. Another resident came up and hit her in the face. The resident who hit her was removed from the dining room and the don, on call and admin was notified . Inquiries from current staff revealed no knowledge of this incident. Review of the Michigan-Facility Reported Incident system revealed no submission for this incident and as a result, no corresponding investigation. In an interview on 5/20/26 3:11 pm, Director of Nursing (DON) B stated that she was aware of the incident that occurred on 5/5/26. DON B reported that the incident was discussed during morning meeting. R4 was in the dining room and R6 self-propelled in the vicinity of R4. R4 reached out and hit R6. The team discussed an intervention of ensuring R4 was not left unattended in the dining room. confirmed that former NHA G was immediately notified of the abuse allegation. The incident that occurred on 5/5/26 between R4 and R6 again demonstrated the failure to follow the care plan designed to reduce the risk of a resident-to-resident incident. Further review of R5's Care plan revealed no additional intervention after the 5/5/26 incident to ensure the safety of R4 was maintained as well as the safety of others. Review of the Michigan-Facility Reported Incident system revealed no submission for this incident and as a result, no corresponding investigation. Review of the medical record reflected R16 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia. R16 no longer resided in the facility. Review of a Nurses' Note dated 4/27/26 at 8:13 am revealed [R16] was observed in a yelling argument with [R5]. [R5] closed fist hit [R16] in the upper back. [R16] reporting, [R16] stated he came to dining room to have a quiet cup of coffee, [R5] had phone blaring and refused to turn it down. This agitated [R16] who grabbed the phone off the table, turned it off and tossed it on the chair. (R5] stood and hit him. Residents were separated, skin and pain assessed, no issues noted .'. In an interview on 5/21/26 at 10:23 am, R5 reported stated that he doesn't like noisy people or people yelling in the hall. R5 stated that sometimes he will get up and slam his door during the night because of the person that yells out. R5 stated he thinks it is the same person that yells out in the dining room and stated she makes noises all the time (mimicked a grunting noise). R5 recalled a time one guy was mouthy and tried to shut my phone off. I said try it. he tried it and I hauled off and hit him right across the back. Review of the Michigan-Facility Reported Incident system revealed no submission for this incident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and as a result, no corresponding investigation. During an interview on 05/21/2026 at 01:33 p.m. Regional Director of Operations also Nursing Home Administrator (NHA) A explained that he was the current Nursing Home Administrator (NHA) at the facility. NHA A explained that the previous NHA G 's last date of employment was 05/19/2026. NHA A explained that he had reviewed the investigation file of the incident that occurred between R4 and R5. NHA A acknowledged the absence of investigations for the abuse allegations that occurred on 2/12/26, 5/5/26 NHA A explained that it was his expectation that the facility investigation should include the following: Resident statements, witness statements, complete incident report, Guardian/DPOA/Responsible Party notified, Physician notified, initial report to state, police notified, root cause determined, Pain assessment completed, skin assessment completed, Physician see the resident, Psychological services to see resident, Medication review, Social work following, and care plan updated. NHA A confirmed that facility had not contacted the police as required, and had not completed an adequate investigation of the incident that had occurred between R4 and R5. NHA A could not explain why a complete investigation had not been conducted for the resident-to-resident altercations between R4, R5, and 16 and the lack of reporting and investigating the abuse allegations involving R4, R6, and R16. Review of the facilities policy titled Abuse, Neglect, and Exploitation defines abuse as the willful infliction of injury which can include certain resident to resident altercations. Physical abuse includes but is not limited to hitting, slapping, punching, biting and kicking. Reporting/Response: Immediately, but not later than two hours if the events that cause the allegation involve abuse. Resident #2 (R2) Review of the medical record revealed R2 was admitted to the facility 06/30/2025 with diagnoses that included adjustment disorder with mixed anxiety and depresses mood, Alzheimer's Disease, osteoarthritis (wearing of cartilage between bone joints), dementia, depression, repeated falls, hypertension, and anxiety. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/06/2026, revealed R2 had a Brief Interview of Mental Status (BIMS) of 7 (severe cognitive impairment) out of 15. Section GG-Functional Abilities, with the same ARD of 01/06/2026, revealed that R2 was independent with wheelchair mobility. Resident #3 (R3) Review of the medical record revealed R3 was admitted to the facility 05/05/2023 with diagnoses that included Huntington's Disease (a progressive genetic disorder which leads to the breakdown of nerve cells in the brain), encephalopathy (broad term for any disease, damage, or malfunction of the brain), psychosis (loss of contact with reality), dysphagia (difficulty swallowing), restlessness and agitation, urinary retention, and chorea (neurological movement disorder characterized by involuntary, irregular, and unpredictable muscle movements). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/2026, revealed R3 had a Brief Interview of Mental Status (BIMS) that could not be completed because R3 is rarely/never understood. R3's medical record revealed that he was discharged from the facility 05/02/2026. Review of facility incident report (for event that occurred 02/16/2026 at 05:00 pm) revealed Pt (R2) was rolling herself down A hall. Pt (R3) sitting near the nurses station leaned out of his chair and struck the other Pt (R2) on the side of the head near her eye. The same incident report revealed immediate action taken Pt (R2) evaluated raised bump forming on right side of Pts (R2) head near (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upper portion of eye, broken skin noted where Pt(R2) was struck. Pt (R2) eyes PERRLA (Pupils Equal, Round, Reactive to Light, and Accommodation). No complaint of headache at this time. Pt (R2) states pain is minimal but she was just surprised. Review of MI-FRI (Michigan-Facility Reported Incident) 00063610, 24 hour report, revealed that the facility reported the incident on 02/17/2026 at 11:43 a.m. The same document included an incident summary (provide by Nursing Home Administrator G, that is no longer employed by the facility as of 05/19/2026) which stated, Pt (R2) was rolling herself down A hall. Pt (R3) witting near the nurses' station leaned out of his chair and struck the other Pt (R2) on the head near her eye. Scratch 2/16/2026to area, minimal pain. Pt (R3) placed on 1 to 1. Both Pt. (R2 &R3) cont. to reside at center and are safe. Investigation started. 5 day to follow. Review of the MI-FRI 00063610, 5 day investigation, revealed Correction Action (s) Taken: Following the incident, staff immediately intervened and separate the residents, moving he victim, (name of R2) to another area and evaluating her injuries, which included applying a bandage to her laceration and initiating neuro checks. To ensure ongoing facility safety and prevent further incidents, the initiator (name of R3), was promptly placed on 1:1 observations whenever he is out of his room. Review of R3's medial record did not have demonstration that R3 was placed on 1:1 supervision after this incident. Review of the facility investigation file involving the incident between R2 and R3 on 02/16/2026 at 05:00 p.m. did not include a list of persons interviewed, did not include a review of like/other residents that had the potential to be impacted. During an interview on 05/20/2026 at 02:51 p.m. Regional Director of Clinical Services (RDCS) I confirmed that facility investigation file, provided for R2 and R3 incident on 02/26/2026, did not contain witness statements or review of other potential residents that could have been impacted from the event. During an interview on 05/21/2026 at 11:33 a.m. Registered Nurse (RN) H explained that he had been the nurse that witnessed the altercation between R2 and R3 on 02/16/2026 at 05:00 p.m. RN H explained that he witnessed R2 propelling herself down the hall. RN H explained that as R2 got closer to R3 he witnessed R3 reaching out and clocking R2. RN H was asked to clarify what clocking R2 meant. RN H explained that R3 had deliberately hit R2 with a closed fist and even knocked her glasses off her face and he witnessed her head go backward from the force. RN H explained that R3 was taking back to his room but could not answer if he was placed on 1:1 supervision. RN H explained that he assessed R2' and she had a lump under her eye and the skin was broken. RN H' explained that he knew this was not the first time R3 had altercations with other residents and explained that he had a history of placing a staff member in a head lock. During an interview on 05/21/2026 at 01:33 p.m. Regional Director of Operations also Nursing Home Administrator (NHA) A explained that he was the current Nursing Home Administrator (NHA) at the facility. NHA A explained that the previous NHA G 's last date of employment was 05/19/2026. NHA A explained that he had reviewed the investigation file of the incident that occurred between R2 and R3 on 01/16/2026. NHA A explained that it was his expectation that resident to resident altercations would be reported to the appropriate state agency within 2 hours of the incident. NHA A also explained that the facility investigation should include the following: Resident statements, witness statements, complete incident report, Guardian/DPOA/Responsible Party notified, Physician notified, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initial report to state, police notified, root cause determined, Pain assessment completed, skin assessment completed, Physician see the resident, Psychological services to see resident, Medication review, Social work following, and care plan updated. NHA A confirmed that the NHA G had not completed an adequate investigation of the incident that had occurred between R2 and R3 on 01/16/2026. NHA A could not explain why the items listed previously had not been completed by NHA G. Resident #6 (R6) Review of the medical record revealed R6 was admitted to the facility 09/23/2025 with diagnoses that included encephalopathy (broad term for any disease, damage, or malfunction of the brain), chronic obstructive pulmonary disease (COPD), unsteadiness on feet, generalized muscle weakness, depression, anxiety, conversion disorder (a condition where a person experiences real physical symptoms that cannot be explained by an underlying medical disease) with seizures or convulsions, bladder cancer, adjustment disorder, gastro-esophageal reflux disease, hypertension, hyperlipidemia (high fat content in blood), obstructive sleep apnea, dementia with behavioral disturbances, urinary retention, enlarged prostate, post-traumatic stress disorder, and hypothyroidism (low thyroid hormone). The Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2026, revealed R6 had a Brief Interview of Mental Status (BIMS) of 00 (severe cognitive impairment) out of 15. Review of R3 incident report, 01/28/2026 at 03:00 p.m., revealed CNA (Certified Nursing Aide) reported that another resident (R6) was wheeling into this residents room and this resident hit the other resident (R6) in the face. A scratch was present on the left side of eye of the other resident (R6). R3's incident report did not contain any witness statements and did not identify the name of the CNA Review of R6 incident report, 01/28/2026 at 03;00 p.m., revealed CNA (Certified Nursing Aide) reported resident (R6) was wheeling into other residents (R3) room, resident in the room (R3) hit this resident (R6) in the face, a scratch was present on left side of eye with slight blood present. R6's incident report did not contain any witness statements and did not identify the name of the CNA. Review of the MI-FRI 00063344, 5 day investigation, revealed Correction Action (s) Taken: Care plans for bother resident we updated and stop sign was added to make the room less appealing: The section entitled Conclusion revealed Not verified- the allegation was refuted by evidence collected during the investigation. Review of the facility investigation file for the resident to resident altercation between R3 and R6 did not reveal witness statements or interviews, any documentation demonstrating that the police were notified, no conclusion summary. During an interview on 05/20/2026 at 02:51 p.m. Regional Director of Clinical Services (RDCS) I confirmed that facility investigation file, provided for R3 and R6 incident on 01/28/2026 , did not contain witness statements, review of other potential residents that could have been impacted from the event, identification of the who witness had been, and a summary of the investigation. During an interview on 05/21/2026 at 01:33 p.m. Regional Director of Operations also Nursing Home Administrator (NHA) A explained that he was the current Nursing Home Administrator (NHA) at the facility. NHA A explained that the previous NHA G 's last date of employment was 05/19/2026. NHA A (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explained that he had reviewed the investigation file of the incident that occurred between R3 and R6 on 01/28/2026. NHA A explained that it was his expectation that the facility investigation should include the following: Resident statements, witness statements, complete incident report, Guardian/DPOA/Responsible Party notified, Physician notified, initial report to state, police notified, root cause determined, Pain assessment completed, skin assessment completed, Physician see the resident, Psychological services to see resident, Medication review, Social work following, and care plan updated. NHA A confirmed that facility had not contacted the police as required, and had not completed an adequate investigation of the incident that had occurred between R3 and R6 on 01/28/2026. NHA A could not explain why a complete investigation had not been conducted for the resident to resident altercations between R3 and R6.

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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** This citation pertains to intake 2741317. Based on observation, interview and record review, the facility failed to conduct root cause analysis and develop interventions to prevent falls for one (R1) of three reviewed for falls. Findings include:Review of the medical record reflected R1 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included hypothyroidism, low back pain and Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/21/26, reflected R1 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R1 was always incontinent of bowel and bladder, and a trial of a urinary toileting program had not been attempted.On 5/21/26 at 11:23 AM, R1 was observed seated in a wheelchair, in the dining room, self-propelling with their feet. Non-skid socks were observed on both feet. Anti-rollback brakes were observed on the wheelchair.An Incident Report, for an unwitnessed fall on 2/2/26 at 12:00 PM, reflected R1 was observed sitting on the floor and stated they were walking to the bathroom. According to the report, R1 was cleaned and changed, after the fall.R1's Care Plan reflected an intervention for a medication review, which was initiated 2/2/26 and revised 2/3/26. An Incident Report, for an unwitnessed fall on 3/6/26 at 3:35 AM, reflected R1 was lying on their right side, near the foot of the bed, with non-skid socks on. R1 stated, I think I fell. Upon assessment, R1 was observed to have redness to their left elbow and an abrasion to their right upper back. R1 was incontinent at the time of the fall.R1's Care Plan reflected an intervention for rearranging furniture, dated 3/6/26.An Incident Report, for an unwitnessed fall on 3/24/26 at 3:00 AM, reflected R1 was sitting on their buttocks, near the head of the bed. Non-skid footwear was in place, and the bed was in the lowest position and locked. R1 was unable to give a description of what they were doing at the time of the fall. It was documented that R1 had an episode of bowel incontinence. The Incident Report reflected the intervention was to place a fall mat next to the bed. R1's Care Plan reflected an intervention for a floor mat at the left side of the bed, which was initiated on 3/24/26 and revised and resolved (changed/removed) on 3/30/26. An intervention for the bed against the wall to promote independence and clutter reduction was initiated on 3/26/26 and revised 4/30/26. An Incident Report, for an unwitnessed fall on 3/27/26 at 4:10 PM, reflected R1 was sitting on the floor, with their legs extended and gripper socks in place. As an intervention, R1 was placed in their wheelchair and escorted in front of the nursing station for observation. R1's Care Plan reflected an intervention to remove the mat from the side of the bed was initiated on 3/27/26. The intervention was revised and resolved on 4/17/26. An Incident Report, for an unwitnessed fall on 5/7/26 at 4:40 AM, reflected when going in for a two-hour check and change, staff observed R1 seated in front of their wheelchair. The floor around R1 was wet, and a broken water glass was beside them. R1 was wearing non-skid socks, and their wheelchair was locked. The report reflected there was a scant amount of blood from an undetermined source from R1's mouth. The report reflected R1 was incontinent at the time of the fall.R1's Care Plan reflected an intervention was initiated on 5/8/26 for a bedside floor mat to the left side of the bed, when R1 was resting in bed.In an interview on 5/27/26 at 2:24 PM, Director of Nursing (DON) B reported she would assume R1 was incontinent at the time of the fall on 2/2/26, due to notation that R1 was cleaned and changed. DON B stated if the fall involved incontinence, a medication review would not have addressed the root cause, but it may have assisted. During the same interview, DON B reported there was an episode of incontinence at the time of R1's fall on 3/6/26. DON B reported the bed was moved against the wall as an intervention. Regarding R1's fall on 3/24/26, DON B reported there was a pattern with the time of morning for R1's falls. DON B reported R1 was incontinent of bowel, and the intervention was to place a fall mat next to the bed. DON B stated a fall mat would not prevent a fall but may help prevent an injury. During the interview on 5/27/26 at 2:24 PM, DON B reported she did not see an intervention (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after R1's fall on 3/27/26, other than moving R1 to the nursing station for observation. DON B acknowledged that she would have expected to see an additional intervention. Regarding R1's fall on 5/7/26, DON B reported R1 was incontinent at 4:40 AM, and she would have expected a different intervention than placing a mat at the side of the bed. DON B reported the facility should have identified a root cause sooner and been more proactive in preventing falls.

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F 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number 2801450 Based on interview and record review, the facility failed to ensure appropriate urostomy care for one resident (resident #7) out of three reviewed, resulting in a hospitalization for a diagnosis of septic shock secondary to a urinary tract infection. Findings include:Review of the medical record reflected Resident #7 (R7) was admitted to the facility on [DATE], with diagnoses that included neuromuscular dysfunction of bladder and paraplegia. R7 no longer resided in the facility.On 5/27/26 at 3:04 PM, R7s Family Member (FM) S stated that she frequently visited R7 at the facility when he resided there and expressed concerns regarding the provision of urostomy care. FM S reported several occasions observing towels on the floor covered in urine and R7's urostomy pouch so full of pee that the seams would give away. R7 stated that the facility reduced the frequency of urostomy pouch changes and reported R7's urostomy pouches were dirty which she believed contributed to recurrent urinary tract infections. FM S stated they had several meetings with facility staff and filled out grievance forms related to these concerns, however, no changes occurred. Review of R7's Physician Orders revealed the following:An order stating change ileovesicotomy (surgical procedure that creates a connection between the ileum, part of the small intestine, and the urinary bladder) with [NAME] premier urostomy pouch every evening shift every 3 day(s) related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED . This order was discontinued on 7/23/2024 and changed to Change ileovesicotomy with [NAME] premier urostomy pouch as needed which was an active order until R7 discharged from the facility to the hospital on 2/12/26.Review of the Electronic Medical Record did not provide a rational for why the order for the pouch change was changed from every three days to as needed. Additionally, the medical record did not define the criteria or circumstances under which a pouch change would be considered necessary. Further review of the Physician orders and Care plan revealed no documented guidance regarding the frequency for emptying R7's urostomy pouch. Review of the Treatment Administration Record for the months of December 2025, January and February 2026 revealed that R7's urostomy pouch was documented as changed a total of two times during that period. A Nurses' Note dated 2/12/26 at 10:36 am stated this morning, as per assessment resident (R7) is alert but disoriented, confused and abnormal vitals like bp (blood pressure) 125/90 pulse 134 respiration 22 temp is 103.3 and 02 (oxygen saturation) is 88 (percent) so started o2 (oxygen) on 5 lit (liters) by nasal cannula, after few min o2 raised 95%. covid test is negative. as per notified to residents' sister, want to send in ER for further evaluation and treatment .A Nurses Note dated 2/12/2026 at 12:39 PM stated per phone conversation with [FM], resident admitted to hospital for sepsis, UTI and possible Pneumonia . Review of R7's hospitalization paperwork revealed R7 was diagnosed and admitted for septic shock secondary to urinary tract infection and bacteremia. In an interview on 5/28/26 at 11:41 am Certified Nursing Assistant (CNA) O recalled R7 and stated that R7's urostomy bag frequently became detached requiring nursing staff to put the bag back on but in the meantime, staff would use towels to collect and clean up the urine. CNA O stated that R7 was not typically on her assignment however, she would assist with answering call lights and care and had observed R7's urostomy bag full of urine and bulging on multiple occasions. CNA O stated that R7's room frequently smelled of urine and attributed these observations to a lack of timely urostomy bag emptying and the use of spilled urine. In an interview on 5/28/26 at 12:28 PM Licensed Practical Nurse (LPN) P confirmed that it was the standard of care to change a urostomy pouch every 3 days or as needed to empty the urostomy pouch every shift and as needed. LPN P reviewed R7's electronic medical record and confirmed there were no physician orders, care plan interventions, or certified nursing assistance tasks regarding the frequency of changing the urostomy pouch or emptying the pouch. According to the Wound, Ostomy and Continence Nurses Society (WOCN), urostomy pouching system should be changed every three to (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	seven days or sooner if leaking occurs. The WOCN further identifies inadequate urostomy management, including leaving a urostomy bag unemptied for too long can increase the risk of urinary tract infections (UTIs) and other complications. Bacteria can enter the urinary system through the stoma or ureters, especially if urine remains stagnant in the pouch. Stagnant urine is more likely to harbor bacteria, which can travel to the ureters and kidneys, causing infection.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. This citation pertains to intake number 3013328 Based on observation and interview, the facility failed to ensure meals were served in a manner that maintained an appetizing appearance and palatability. Findings include:On 5/21/26 at 11:46 am a test tray was provided to the survey team. The stated lunch meal, per the facility provided menu, consisted of stuffed pepper casserole, buttered corn, and mocha fudge cake. The meal provided was observed to be stuffed pepper casserole, corn and not mocha fudge cake but rather a pistachio cake. The stuffed pepper casserole lacked an appetizing appearance, as it consisted primarily of rice and a meat sauce, and did not contain visible peppers. the casserole was tasted and determined to lack flavor. The corn lacked flavor as well. The meal served did not match the posted menu and overall deemed unappealing in appearance and palatability. In an interview on 5/21/26 at 2:19 pm, Resident #11 was interviewed regarding the lunch meal. Resident #11 rated the stuffed pepper casserole as nasty with no flavor.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number 3013328 Based on observation, interview, and record review the facility failed to honor resident food preferences in one (Resident #12) out of three reviewed for food preferences. Findings include:Review of the medical record reflected Resident #12 (R12) was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/20/26, reflected R12 scored 9 out of 15 (moderate impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).On 5/20/26 at 11:13 am, R12 was observed in her room reviewing a stack of paperwork. R12 was groomed, appropriately dressed, and answered questions appropriately. R12 was sharing her frustration regarding dining staff not following her tray ticket, which lists her food dislikes. R12 showed me her tray ticket from her breakfast meal, which had a list of dislikes on it. One if the dislikes listed was pork. During the interview, R12's lunch tray was delivered. R12 lifted the cover on her plate and an observation of ham on her lunch plate was made. R12 abruptly stopped the Certified Nursing Assistant who delivered her tray and requested an alternative main entree. R12 confirmed that she did not like pork, which included the ham that was delivered on her plate and confirmed that this had been discussed with dietary staff on more than one occasion.