STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235566	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Cheboygan	824 South Huron Cheboygan, MI 49721

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to intake #2661622Based on interview and record review, the facility failed to protect the right of one Resident (R1) to be free from physical and verbal abuse by a staff member of three residents reviewed for abuse. This deficient practice resulted in psychosocial harm including feelings of humiliation and fear based on the reasonable-person concept. Findings include:A facility-reported incident (FRI) investigation summary submitted to the state agency on 11/3/25 disclosed Certified Nurse Aide (CNA) A and CNA B witnessed CNA C abuse Resident #1 (R1) while rendering post-fall assistance to R1 on 10/26/25. The facility investigation substantiated the abuse. Review of the electronic medical record (EMR) of R1 revealed an admission date of 3/18/25 with a primary diagnosis of cerebral infarction (stroke). Additional diagnoses included but were not limited to: Alzheimer's disease, age-related cognitive decline, major depressive disorder, cognitive communication deficit, weakness, fatigue, and need for assistance with personal care. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] disclosed a Brief Interview for Mental Status (BIMS) score of three indicating R1 had severe cognitive impairment. A care plan documented R1 was not ambulatory and had an ADL self-care performance deficit. The care plan interventions indicated R1 required staff assistance with activities of daily living (ADL). An interview was attempted with R1 on 11/7/25 at 9:55 AM and 1:15 PM. R1 was confused and unable to answer questions appropriately or recall the incident with CNA C on 10/26/25. CNA A was interviewed on 11/7/25 at 11:01 AM regarding the event of 10/26/25. CNA A said at about 6:30AM - 7:00 AM she, CNA B, and CNA C were in R1's room because R1 fell from bed and was on the floor. CNA A alleged CNA C began kicking R1 and said, He [R1] got himself on the floor and he'll get himself back into bed! CNA A said, [CNA C] kicked [R1] at least three to five times along his left lateral lower extremity to get R1 moving toward the bed. CNA A said, I would describe the kicking as 'hard'. CNA A said R1 appeared startled, afraid, and in distress. CNA A said she exited the room and reported to Registered Nurse (RN) D that she [CNA A] was uncomfortable with the way CNA C was treating R1. RN D asked if R1 was being abused. CNA A said she shrugged her shoulders but did not answer. When asked why she did not respond to RN D's question, CNA A responded, I was taught that it's not my job to decide if something is abuse - my job is to report it. CNA A returned to R1's room and observed R1's disposable brief had fallen off. CNA A said, R1 was crawling around on the floor without anything on and fell forward onto his stomach. When R1 fell forward, CNA C struck R1 with an open hand on his buttocks and said loudly in an angry voice, You are so disgusting! to R1. CNA C said to CNA A, He is so disgusting - he doesn't listen! CNA A said CNA C grabbed R1's lower arm and began yanking hard on it to get R1 to grab the side rail to pull himself into the bed. CNA A described the action as pulling hard on [R1] arm five or six times. CNA A left the room again and reported to RN D that the Administrator (NHA) needed to be called due to the continued actions of CNA C toward R1. CNA A said she questioned if RN D reported her concerns to the NHA, so CNA A called the NHA on 10/26/25 at approximately 1:00 PM. CNA A said the NHA came to the facility within 15 minutes. CNA A witnessed CNA C obtain her personal belongings and exit the facility soon thereafter. CNA B was interviewed on 11/7/25 at 11:35 AM. CNA B confirmed she, CNA A, and CNA C were in R1's room on 10/26/25 to assist R1 back into bed after a fall. CNA B observed CNA C grab R1 by his wrist and start yanking him toward the bed rail telling him in a loud volume of voice, Get back into the bed! CNA B said she observed CNA C place her hands on the lateral torso of R1 while he was on the floor and began pushing the resident toward the bed. CNA B said the disposable brief of R1 had come off and his genitalia and buttocks were exposed. CNA C proceeded to slap R1 across the buttocks and tell him, Get going! CNA B said She [CNA C] slapped him hard but I don't think it left a mark that lasted. CNA B said CNA C appeared visibly irritated and aggressive and was speaking in a loud volume of voice. CNA B said R1 was able to get the top half of his body onto the bed before CNA C grabbed R1's legs and moved them onto the bed. CNA B said CNA A had exited the room, but RN D never came to the room. RN D was interviewed on 11/7/25 at 2:56 PM. RN D confirmed that on 10/26/25 at approximately 6:30 AM, CNA A reported she [CNA A] did not like how CNA C was treating R1. RN D asked CNA A if R1 was being abused and CNA A shrugged her shoulders. CNA A then went back into R1's room. Shortly thereafter, CNA A again approached RN D and asked her to call the NHA. RN D was asked if she went to the room of R1 when CNA A reported the concern with CNA C's treatment of R1. RN D said she did not go to R1's room on 10/26/25 until approximately 7:00 AM and none of the CNAs were in the room at that time. RN D said she called and reported CNA A's