STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to interact with a resident in a dignified and respectful manner for one (R505) of two residents reviewed for dignity and respect. Findings include: On 9/30/24 at 11:05 AM, during an interview with R505, Nurse Aide (NA) 'I' knocked on R505's door, entered, asked R505 if their call light was in reach. R505 said that was the first time anyone asked her that and asked why it was only asked when the State Agency was in the building. NA 'I' breathed out as if irritated, did not say anything further to R505, turned around, walked quickly out of the room, and aggressively pulled the door closed, which made a loud noise. At that time, R505 reported NA 'I' was a non-certified Nurse Aide who did tasks such as changing linens and passing water. R505 reported they frequently acted unprofessionally toward the resident. On 9/30/24 at approximately 11:30 AM, an interview was conducted with NA 'I'. When asked her name, NA 'I' stated, What did I do? NA 'I' was asked their name again and provided their first name. When asked their last name, NA 'I' stated, What's yours? At that time, NA 'I' was queried about their interaction with R505 and if it was appropriate to not respond to the resident and slam the door behind them when walking out. NA 'I' stated, I didn't slam the door. On 9/30/24 at approximately 11:35 AM, the above observation and interaction was shared with the Director of Nursing (DON). The DON reported that it was no acceptable conduct and they would provide discipline and education to NA 'I'. A review of R505's clinical record revealed R505 was admitted into the facility on [DATE] with diagnoses that included: hyperlipidemia, chest pain, and rheumatoid arthritis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R505 had intact cognition.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Southfield		STREET ADDRESS, CITY, STATE, ZIP CODE 26715 Greenfield Rd Southfield, MI 48076	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00146090. Based on interview and record review, the facility failed to protect the residents' right to be free from verbal abuse by staff and verbal abuse (as witnessed by R514) by a resident for two (R501 and R502) of five residents reviewed for abuse. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency on [DATE] revealed an allegation of verbal and physical abuse by Certified Nursing Assistant (CNA) 'J' toward R501. A review of an incident report for R501 dated [DATE] at 2:14 PM revealed R501 reported to Licensed Practical Nurse (LPN) 'M' that on [DATE] during the evening shift, the assigned Certified Nursing Assistant (CNA) shuffle him to the wheel chair while he was adjusting the temperature and also shuffle him to the bed. It was documented R501 informed the charge nurse on the night shift and called the police. It was further noted that R501 was alert and oriented to person, place, time, and situation. A review of the documented investigation conducted by the facility into the above mentioned allegation revealed, On [DATE], (R501) reported that he entered his room where (CNA 'J') was caring for his roommate (R514). (R501) stated that (R514) asked (CNA 'J') if she could adjust the air conditioning unit as he felt it was stuffy in there. (R501) did not want the air on and went in front of the A/C (air conditioning) unit. (CNA 'J') then grabbed the handles on his wheelchair and pushed him out of his way. (R501) stated that he started calling (CNA 'J') a 'Bitch' and stated that he will make her lose her job and sue her for everything she has. He then stated that the CNA stated, 'I am a Christian woman' and started telling him bible verses. (R501) then stated that as he was walking over to his bed, the CNA shoved him onto the bed and started swearing at him . It was documented that R501's roommate (R514) who had intact cognition, was interviewed and confirmed CNA 'J' called R501 a Bastard after R501 called CNA 'J' a Bitch. The investigation noted the facility substantiated verbal abuse by CNA 'J' toward R501 and CNA 'J' was terminated from working in the facility. On [DATE] at 8:45 AM, an interview was conducted with R501. However, R501 was fixated on talking about other things and did not engage about the above incident. On [DATE] at approximately 2:30 PM, a second interview was attempted with R501. However, R501 was not available for an interview. A review of R501's clinical record revealed R501 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: bipolar disorder. A review of R501's Minimum Data Set (MDS) assessment dated [DATE] revealed R501 had intact cognition and verbal and other behaviors, including rejection of care. Further review of R501's clinical record revealed a progress note dated [DATE] that documented R501's roommate (R502) accused R501 of verbal and threatening behavior. R501 was petitioned to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Southfield		STREET ADDRESS, CITY, STATE, ZIP CODE 26715 Greenfield Rd Southfield, MI 48076	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of R502's clinical record revealed R502 was admitted into the facility on [DATE] and expired in the facility on [DATE] with diagnoses that included prostate cancer, anxiety disorder, and bipolar disorder. A review of a MDS assessment dated [DATE] revealed R502 had intact cognition and no behaviors. R502 received hospice services. Further review of R502's clinical record revealed a progress note dated [DATE] that noted R502's brother reported to the nurse that R502's roommate (R501) is threatening him. It was documented the nurse spoke with R502 and R502 was observed crying, saying, 'I'm not moving out of the room for him and I don't feel safe with him' . A review of R502's progress notes revealed a Social Services Progress Note written on [DATE] (two days after the incident mentioned above) that read, .Resident was asked if he felt safe in the facility and he replied, 'no' . A review of a Social Services Progress Note dated [DATE] noted, .Resident informed writer that his former roommate came to his room last night but was 'nice' to him . A review of an investigation conducted by the facility in regards to the alleged incident mentioned above between R501 and R502 revealed the following: .(R502's) brother reported to the nurse that (R502) was upset because his roommate (R501) was yelling and swearing at him. His brother stated to the nurse, (R501) stated to (R502) 'Your ass will be out of this room by Monday!' This made (R502) upset and he started to cry . a (CNA) that was caring for (R502) stated she did witness (R501) being verbally aggressive toward (R502) . In conclusion, after a thorough investigation, which included staff and resident interviews, the investigation did show that the facility was able to substantiate (R502's) allegation of verbal abuse by (R501) . Further review of R501's progress notes revealed multiple incidents of aggressiveness toward other residents prior to the verbal abuse toward R502 on [DATE], as follows: On [DATE], it was documented in a Nurses' Note that R501 was yelling very loud and pointing his finger at the other resident. On [DATE], it was documented in a Nurses' Note that R501 was displaying aggressive behavior with other residents and staff, and has also threatening <sic> other resident with violence. Resident is posing harm to other residents and staff . On [DATE], it was documented in a Social Services Progress Note that R501 was observed yelling, pointing his finger in peer resident's face, and threatening harm to peer resident on this date . On [DATE], it was documented in a Nurses' Note that R501 came to the nursing station where two residents were sitting and talking. R501 asked a visiting resident about the resident meeting. When the visiting resident respond to his question he proceeded to say F*** you B***h and other derogatory words as he rolled away. On [DATE], it was documented in a Nurses' Note that R501 told his roommate, Next time you wake me up I will give you the reason why you will be going back to the hospital. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Medilodge of Southfield		STREET ADDRESS, CITY, STATE, ZIP CODE 26715 Greenfield Rd Southfield, MI 48076	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE], it was documented by the former Assistant Administrator (AA 'A') in a progress note, Staff reported to writer that other staff are afraid of resident d/t (due to) his extremely aggressive behaviors. Resident has been verbally abusing staff . On [DATE] at 2:00 PM, an interview was conducted with the Administrator, who was the Abuse Coordinator for the facility. The Administrator acknowledged that CNA 'J' verbally abused R501 on [DATE] and R501 verbally abused R502 on [DATE]. The Administrator, who had periods of absence from the facility during that timeframe and AA 'A' would have been in charge, denied knowing about any other resident to resident incidents perpetrated by R501.

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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 - Some	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** 32568 This citation pertains to Intake Number(s): MI00146327 and MI00146090. Based on interview and record review, the facility failed to report an allegation of neglect and multiple resident to resident abuse incidents to the Administrator and the State Agency for two (R507 and R501) of five residents reviewed for abuse and three unknown residents, resulting in the allegations not being investigated and the potential for unidentified and continued abuse and neglect. Findings include: R507 A review of a complaint submitted to the State Agency alleged R507 had a change in condition that was not addressed in a timely manner, did not receive adequate tracheostomy (trach - a tube surgically placed into the windpipe to assist with breathing) care, and needed to be changed. The complainant alleged a nurse was yelling in the hallway. On [DATE] at approximately 10:00 AM, an interview was conducted with an individual who wished to remain anonymous (Person 'N'). Person 'N' expressed concern about a situation they witnessed on [DATE]. They heard a nurse yelling at a Certified Nursing Assistant (CNA) for sleeping during the midnight shift and the nurse yelled at another nurse for not properly taking care of R507's trach, not cleaning them up, and not sending them to the hospital sooner. Person 'N' reported they heard the nurse talking about how R507 was wet and soiled with bowel movement (BM) and their trach was dirty and needed to be suctioned. Person 'N' reported CNA 'B' worked a double on that unit (2 South) and there was a nurse (Licensed Practical Nurse - LPN 'G') who worked the front of the 2 South Unit from 3:00 PM until 11:00 PM and they moved to the set on the back hall of the 2 South Unit at 11:00 PM until 7:00 AM. It was reported that LPN 'F' came in for the shift that started at 11:00 PM but was late. LPN 'F' yelled at LPN 'G' because they did not inform them of R507's change in condition. Person 'N' heard LPN 'G' talking about R507's oxygen level and that they needed to be suctioned and LPN 'F' said they were not going to take full responsibility for R507's condition because they were like that when they arrived for their shift. A review of R507's clinical record revealed R507 was admitted into the facility on [DATE] and discharged to the hospital on [DATE] with diagnoses that included: respiratory failure. R507 had a tracheostomy, a PEG tube, and a colostomy. A review of R507's progress notes revealed the following: A Nursing Summary dated [DATE] that documented R507 was non-verbal, had a trach with continuous oxygen delivered via the trach mask at 10 liters per minute, an indwelling urinary catheter, a PEG tube, and a colostomy. It was documented R507 had a low grade fever of 99.8 (degrees Fahrenheit - F). A Nurses' Note dated [DATE] at 9:33 AM documented R507's heart rate was 122 and temperature was 101. 1 degrees F. R507 was given Tylenol and the physician ordered a STAT (right away) chest X-Ray. (continued on next page)

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	235296	A. Building B. Wing	10/01/2024

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Medilodge of Southfield	26715 Greenfield Rd Southfield, MI 48076

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There were no progress notes written during the afternoon shift (3:00 PM to 11:00 PM) or the midnight shift (11:00 PM to 7:00 AM) on [DATE] for R507. A review of the nursing staff schedule and assignment sheet for [DATE] revealed LPN 'G' worked the afternoon shift and was assigned to the front hall of the 2 South Unit and LPN 'F' worked the midnight shift and was assigned to the back hall of the 2 South Unit. A review of LPN 'F's time punches revealed they punched in at 11:25 PM on [DATE]. On [DATE] at 2:50 PM, an interview was conducted with LPN 'F' over the telephone. When queried about what occurred with R507 on the midnight shift of [DATE], LPN 'F' reported they were concerned that LPN 'G' neglected R507 and explained that if they did not check on R507 when they did, R507 could have died . LPN 'F' explained, they arrived late for their shift around 11:15 PM and when they checked on R507, the resident was unstable. There was no nurse on the hallway to give report to LPN 'F' so they were unsure what was going on. LPN 'F' reported R507's vital signs were very abnormal (Heart rate was high and oxygen was low) and they needed to be sent out to the hospital immediately. LPN 'F' reported R507's colostomy was bursting due to being full and BM leaked onto the resident and the bed. R507's trach appeared clogged and dirty according to LPN 'F'. LPN 'F' explained they immediately called the Registered Nurse (RN) in the building, RN 'H', since R507 was unstable and because they wanted a witness to the condition of R507. LPN 'F' reported they eventually found the other nurse who worked that hall on the afternoon shift, which was LPN 'G', and they were at the other medication cart on their cell phone. LPN 'F' said that LPN 'G' refused to give report from the afternoon shift. When queried about how LPN 'F' obtained the keys to the medication cart and whether the controlled substances were counted with LPN 'G', LPN 'F' reported they did not count the controlled substances and LPN 'G' threw the keys at me. LPN 'F' said they had to send R507 out to the hospital and LPN 'G' refused to print a face sheet and just sat on his phone. RN 'H' came to the unit and assessed and provided care to R507 while LPN 'F' called 911 and got paperwork together. LPN 'F' explained they told the CNAs they had to clean R507 up before the ambulance came because they could not send the resident to the hospital in that condition. When queried about whether they contacted the Administrator or Director of Nursing (DON) regarding their concern that R507 was neglected, LPN 'F' reported they did not report it to anyone other than the other nurses in the building (RN 'H' and LPN 'C') because patient safety was my concern at the time. LPN 'F' stated, (LPN 'G') does not care about his residents. He neglects them. On [DATE] at 4:05 PM, an interview was conducted over the telephone with RN 'H'. When queried about what occurred with R507 on the midnight shift of [DATE], RN 'H' reported the midnight nurse called them because a resident (R507) was in distress and the nurses wanted to call 911. RN 'H' assessed R507 and their heart rate was very high, their oxygen level was low, and they were having difficulty breathing. RN 'H' administered a breathing treatment to R507 while LPN 'F' called 911 and got the paperwork together. RN 'H' reported when they arrived to the 2 South Unit, LPN 'F' and LPN 'G' were arguing in the hallway. RN 'H' denied knowing why they were arguing, but said LPN 'F' was upset when they received R507 and things were not in place. When queried about what that meant, RN 'H' said R507's colostomy leaked onto the bed sheets. RN 'H' did not provide any additional information. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On [DATE] at 7:52 AM, an interview was conducted over the telephone with CNA 'B'. When queried about R507 on the midnight shift of [DATE], CNA 'B' reported they were not assigned to R507 on the midnight shift. The midnight shift nurse, LPN 'F', was upset because R507 needed to go to the hospital and had BM on her from the colostomy and had a wet brief. CNA 'B' reported they assisted with cleaning R507 up before they went to the hospital.

On [DATE] at 8:13 AM, an interview was attempted with LPN 'C' via the telephone. LPN 'C' was not available for an interview prior to the end of the survey.

On [DATE] at 9:40 AM and 10:04 AM, an interview was attempted with LPN 'D', an orientee assigned with LPN 'H' on [DATE]. LPN 'D' was not available prior to the end of the survey.

On [DATE] at 10:25 AM, an interview was attempted with CNA 'E', the CNA assigned to R507 on the afternoon shift of [DATE]. CNA 'E' was not available for an interview prior to the end of the survey.

On [DATE] at 10:41 AM, an interview was conducted with the Director of Nursing (DON). When queried about the facility's protocol for the incoming and outgoing nurses, the DON reported the outgoing nurse was to stay on the unit previously assigned to until the incoming nurse arrived, report was given, and controlled substances were counted. When queried about who was responsible to ensure CNAs provided appropriate care, the DON reported the assigned nurse was. When queried about whether they were made aware of any concerns about R507's condition on the midnight shift of [DATE], the DON reported she only knew that R507 had a change in condition and was sent to the hospital. When queried about who was supposed to be notified if someone had a concern of neglect of a resident by a staff member, the DON reported they would be notified as well as the Administrator. The DON denied being notified of allegations of neglect toward R507.

On [DATE] at approximately 11:00 AM, an interview was conducted with the Administrator, who was the facility's Abuse Coordinator. The Administrator reported they began working in the facility in [DATE], but was on leave until [DATE]. In their absence, Assistant Administrator (AA) 'A' was the facility's Abuse Coordinator, but they no longer worked at the facility. When queried about the facility's protocol when there was concerns about neglect of a resident, the Administrator reported, the Abuse Coordinator was to be contacted immediately. The Administrator reported they were not aware of any allegations of neglect for R507.

On [DATE] at 11:25 AM, a telephone interview was attempted with AA 'A'. AA 'A' was not available for an interview prior to the end of the survey.

R501

On [DATE] at 8:45 AM, an interview was conducted with R501. R501 did not answer questions directly and engaged in tangential conversation.

A review of R501's clinical record revealed R501 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: bipolar disorder. A review of R501's Minimum Data Set (MDS) assessment dated [DATE] revealed R501 had intact cognition and had verbal and other behaviors, including rejection of care.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235296	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024

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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 - Some	A review of R501's progress notes revealed multiple documented incidents of resident to resident abuse perpetrated by R501, as follows: 1. On [DATE] it was documented R501 was yelling, pointing finger in peer resident's face and threatening harm to peer. 2. On [DATE], it was documented R501 said F*** you B***h to another resident an other derogatory words. 3. On [DATE], it was documented R501 threatened their roommate and stated if he woke him up he would give him a reason to be going back to the hospital A review of a progress note written by AA 'A' on [DATE] revealed staff reported they were afraid of R501 due to his extremely aggressive behavior. On [DATE] at 1:05 PM, the Administrator was asked to provide all incident reports and investigations related to resident to resident incidents for R501 since [DATE]. On [DATE] at 2:00 PM, an interview was conducted with the Administrator. The Administrator reported they had an incident report from [DATE], but did not have any others related to the above documented incidents. When queried about when resident to resident incidents would be reported to the State Agency, the Administrator reported if there was verbal abuse, including threatening behavior, and physical abuse. The Administrator reported the above incidents on [DATE], [DATE], and [DATE] were not reported to the State Agency and AA 'A' was the acting Administrator during that time frame. On [DATE] at 2:05 PM, an interview was conducted with the DON. When queried about any knowledge of the resident to resident incidents documented in R507's clinical record on [DATE], [DATE], and [DATE], the DON denied knowing about them. The DON reported all allegations or incidents of resident to resident abuse were to be reported to the DON and Administrator. The DON and the Administrator were unable to identify the other residents involved. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised on [DATE], revealed, in part, the following: .verbal abuse means the use of oral, written, or gestured communication or sounds that willfully includes disparaging and derogatory terms to resident .or within their hearing distance regardless of their age, ability to comprehend, or disability .The facility will have written procedures that include .reporting of alleged violations to the Administrator, state agency .immediately, but not later than 2 hours after the allegation is made, if the vents that cause the allegation involve abuse .

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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** 32568 Based on interview and record review, the facility failed to investigate multiple incidents of resident to resident abuse perpetrated by one (R501) of five residents reviewed for abuse, resulting in the potential for continued and unidentified abuse and the lack of identifying three victims to ensure their safety and well being. Findings include: On 9/30/24 at 8:45 AM, an interview was conducted with R501. R501 did not answer questions directly and engaged in tangential conversation. A review of R501's clinical record revealed R501 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: bipolar disorder. A review of R501's Minimum Data Set (MDS) assessment dated [DATE] revealed R501 had intact cognition and verbal and other behaviors, including rejection of care. A review of R501's progress notes revealed multiple documented incidents of resident to resident abuse perpetrated by R501, as follows: 1. On 5/3/24 it was documented R501 was yelling, pointing finger in peer resident's face and threatening harm to peer. 2. On 5/6/23, it was documented R501 said F*** you B***h to another resident an other derogatory words. 3. On 6/3/24, it was documented R501 threatened their roommate and stated if he woke him up he would give him a reason to be going back to the hospital. A review of a progress note written by AA 'A' on 6/11/24 revealed staff reported they were afraid of R501 due to his extremely aggressive behavior. On 10/1/24 at 1:05 PM, the Administrator was asked to provide all incident reports and investigations related to resident to resident incidents for R501 since May 2024. On 10/1/24 at 2:00 PM, an interview was conducted with the Administrator. The Administrator reported they had an incident report from 5/1/24, but did not have any others related to the above documented incidents. The Administrator reported they were not aware of the documented incidents on 5/3/24, 5/6/24, and 6/3/24 as they were on leave at the time. The Administrator reported they could not locate any investigations related to those incidents and did not know who the alleged victims were. The Administrator reported the above incidents on 5/3/24, 5/6/24, and 6/3/24 were not reported to the State Agency and AA 'A' was the acting Administrator during that time frame. AA 'A' was no longer an employee of the facility at the time of the survey. On 10/1/24 at 11:25 AM, a telephone interview was attempted with AA 'A'. AA 'A' was not available for interview prior to the end of the survey. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/1/24 at 2:05 PM, an interview was conducted with the DON. When queried about any knowledge of the resident to resident incidents documented in R507's clinical record on 5/3/24, 5/6/24, and 6/3/24, the DON denied knowing about them. The DON reviewed the documentation in R501's clinical record at that time and was unable to identify the other residents involved. When queried about how it was ensured the alleged victims felt safe and were unharmed by the verbal abuse by R501, the DON reported that would have been determined at the time of the investigation. The DON was unable to provide any evidence of investigations into the documented verbal abuse and threatening behaviors by R501 on 5/3/24, 5/6/24, and 6/3/24. A review of a facility policy titled, Abuse, Neglect and Exploitation, revised on 1/10/24, revealed, in part, the following: .An immediate investigation is warranted when suspicion of abuse .or reports of abuse .occur .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm .during and after the investigation .