STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to Intake MI00145936. Based on interview and record review, the facility failed to protect the one resident (R902)'s right to be free from physical abuse a resident (R903). Findings include: A review of a Facility Reported Incident (FRI) intake MI00145936 revealed an allegation of resident-to-resident physical abuse involving R903 (perpetrator) and R902 (victim) that occurred on 7/23/24 at 5:45 AM. A record review revealed R902 was admitted to the facility on [DATE] with medical diagnoses including, diabetes, chronic kidney disease, hypertension, and psychomotor deficit following a stroke. A Brief Interview for Mental status (BIMS) score assessed on 8/8/24 scored 15/15 indicating R902 was cognitively intact. A clinical record review revealed R903 was admitted to the facility on [DATE] with right sided hemiparesis (weakness on right side of body) following a stroke, asthma, and heart disease. The BIMS assessed on 8/25/24 scored 13/15 indicating R903 was cognitively intact. On 10/8/24 at 10:00 AM, A record review of the FRI documented on 7/23/24 at 5:45 AM, while providing morning care, Certified Nurse assistant (CNA) A documented they noticed R902's lip was injured. When inquired what happened, R902 said R903 punched them because they refused to turn down the TV. On 10/8/24 at 10:37 AM, an attempt was made for a telephone interview with Licensed Practical Nurse B. for confirmation of their involvement with the incident. No return call was made by the end of this survey. On 10/8/24 at 10:40 AM, a telephone interview with CNA A was conducted and confirmed when they went to provide morning care, an obvious injury to the lip was identified on R902. CNA A stated R902's lip was split open, bleeding, and swollen, and denied pain. CNA A asked R902 what happened, and R902 replied they did not turn down their TV volume and R903 got upset, walked over and punched them in the face. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When CNA A questioned R903 what had happened, they replied the volume was too high, R902 would not turn it down, and proceeded to punch R902 in the face. R903 was immediately removed from the room, they said they knew it was wrong and apologized to CNA A. CNA A confirmed R902 and R903 have never had a history of incidents, and commented the two televisions in that room always have very high volumes and this was the first time this was a problem. On 10/8/24 at 10:55 AM, R903 was observed lying in their room, quiet and alone. When questioned the recollection of the event with R902, R903 acknowledged the volume on the TV was too loud, asked R902 to turn it down, at which time they refused. R903 stated, I went over to turn off the TV and [R902] started swinging at me, and I punched them in the face. On 10/8/24 at 11:15 AM, R902 was interviewed and confirmed R903 was telling them to turn down their TV volume, R902 stated, 'I can't' and [R903] came over and punched me in the face, and my lip got hurt. On 10/8/24 at 12:05, an interview was conducted with Social Services (SS) C who also observed R902 had trauma to their lip. R903 was removed from the room and placed in another residence downstairs. SS C commented R903 recognized what they did was not right and apologized. SS C commented neither R902 or R903 ever had a conflict with each other, or other residents, and the entire incident was a shocker. Further record review revealed the local authorities were contacted on 7/23/24 at 9:00 AM and a police report was filed. Review of the facility policy title; Abuse, Neglect and Exploitation dated 11/2022 documented: .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm .