STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235430	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Neighborhoods of White Lake	10770 Elizabeth Lake Road White Lake, MI 48386

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number: MI00149932 and MI00150088. Based on interview and record review, the facility failed to ensure physical restraints were not used for staff convenience for one (R702) of two residents reviewed for abuse, resulting in staff tying the resident's drawstring pants in the back so that he could not remove them. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 1/21/25 that noted R702 expressed a grievance on 1/16/25 regarding a concern they had with bed positioning during a brief change while being assisted by Certified Nursing Assistant (CNA) 'A'. An unannounced, onsite investigated was conducted on 2/27/25. A review of R702's clinical record revealed R702 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: cerebral infarction, hemiplegia affecting right dominant side, prostate cancer, and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R702 had severely impaired cognition, no behaviors, was frequently incontinent of urine, and did not use restraints. A review of R702's nursing progress notes revealed R702 was continent of urine, but wore a brief. On 12/25/24, R702 was observed on the floor with a soiled brief next to him. On 1/7/25, Resident was observed with brief balled up and thrown off the bed. Pad rolled up and noted on floor next to resident. Resident wearing only t-shirt, blanket soiled with urine . A review of an investigation conducted by the facility in regards to R702's grievance against CNA 'A' revealed the following: An .Investigation Summary . documented, On 1/16/2025 (R702) reported concern to Nurse .regarding being changed on the previous midnight shift. Resident said the CNA kept moving him from side to side when she was changing him . (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Staff Interview Summary indicated CNA 'A' was interviewed on 1/21/25. The summary of the statement/interview included the following: .(CNA 'A') indicated (R702) was not wet but when she began changing him he started going (urine) .Resident stated, 'I'm not playing with myself' as his pants were down partially per CNA when she came into room. (CNA 'A') .did indicate when putting PJ's on (drawstring in back) he raised his arm .(CNA 'A') indicated (R702) said, 'I don't want them tight' referring to his pajamas. (CNA 'A') states she told (Registered Nurse - RN 'C') about the interaction . On 2/27/25 at 10:58 AM, an interview was conducted with CNA 'A' via the telephone. CNA 'A' indicated they worked at the facility but they were terminated from employment on 1/27/25. When queried about what occurred with R702 on 1/16/25, CNA 'A' reported the resident said they tried to roll him off the bed and then tried to hit CNA 'A' because he thought he was going to fall. CNA 'A' further explained R702 became anxious and said I can't breathe! when CNA 'A was putting the resident's pajama pants back on after a brief change. According to CNA 'A', R702 said he did not want the pajamas tied too tight and CNA 'A' assured him that they would be loose enough. CNA 'A' explained they tied the drawstring to R702's pajamas pants in the back instead of the front that night because that was what the other CNAs had been doing. CNA 'A' reported she previously notified RN 'C' about the other CNAs tying R702's pants in the back and RN 'C' said she was aware. CNA 'A' reported it was the first time that she tied the pants in the back that night (1/16/25) and since the nurse was aware she did not think it was a problem. When queried about why R702's pants were being tied in the back instead of the front, CNA 'A' stated, He kept stripping and peeing all over himself and the bedding. It slows him down and he wasn't getting them off like that. CNA 'A' reported she first found out about tying R702's pants in the back from CNA 'E' who said they had been doing that with R702 to prevent him from taking his pants off. On 2/27/25 at 12:43 PM, a telephone interview was attempted with RN 'C'. RN 'C' was not available prior to the end of the survey. On 2/27/25 at 2:16 PM, a telephone interview was attempted with CNA 'E'. CNA 'E' was not available prior to the end of the survey. A review of CNA 'A's personnel file revealed a document titled, Termination dated 1/16/25. The Corrective Action reason was Policy Violation. The following was documented, For resident 1 person assist did not use gait belt and did not follow the proper procedure as well as resident restraint. On 2/27/25 at 1:30 PM, an interview was conducted with the Administrator who was the designated Abuse Coordinator for the facility. When queried about the investigation conducted by the facility in regards to R702's grievance about the care provided by CNA 'A', the Administrator reported R702 said CNA 'A' 'turned him from side to side when giving care' and he did not feel like she needed to do that. The Administrator reported CNA 'A' was immediately removed from R702's care and the concern was reported to the State Agency as an allegation of abuse. When queried about why turning the resident from side to side was considered abuse and was there anything else that was concerning, the Administrator stated, There was also something about her (CNA 'A') putting his (R702) pants on incorrectly. When queried about what happened with R702's pants, the Administrator reviewed the facility's investigation and stated, Never mind. There is nothing about the pants. When queried about the Termination document in CNA 'A's personnel file that documented resident restraint as part of the reason they were terminated from employment, the Administrator stated, There were no restraints. When queried about tying a resident's pants in the back so that they were unable to remove them, the Administrator reported that would be considered a restraint. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at approximately 1:45 PM, an interview was conducted with the Regional Human Resources Director, HR 'D' and the Administrator. HR 'D' reported CNA 'A' was terminated for not using a gait belt with another resident. When queried about why it was documented that CNA 'A' was also terminated for resident restraint, HR 'D' reported CNA 'A' told them that she tied R702's pants backwards and R702 had already been discharged from the facility. When queried about what was done to ensure not other staff were restraining residents this way, the Administrator reported CNA 'A' just reported it during an interview and no other action was taken to ensure other residents were not being restrained. A review of a facility policy titled, Restraint Free Environment dated May 2008 revealed, It is the intention and goal of this community to strive to be a restraint free community. To provide the elder/resident with the choices, dignity and independence that they deserve living in this community as they would from their individual home .

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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 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 This citation pertains to Intake Number: MI00150088. Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse for one (R702) of two residents reviewed for abuse. Findings include: A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 1/21/25 that noted R702 expressed a grievance on 1/16/25 regarding a concern they had with bed positioning during a brief change while being assisted by Certified Nursing Assistant (CNA) 'A'. An unannounced, onsite investigated was conducted on 2/27/25. A review of R702's clinical record revealed R702 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: cerebral infarction, hemiplegia affecting right dominant side, prostate cancer, and dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R702 had severely impaired cognition, no behaviors, was frequently incontinent of urine, and did not use restraints. A review of an investigation conducted by the facility in regards to R702's grievance against CNA 'A' revealed the following: An .Investigation Summary . documented, On 1/16/2025 (R702) reported concern to Nurse .regarding being changed on the previous midnight shift. Resident said the CNA kept moving him from side to side when she was changing him . It was further documented that R702 put his arm up and the CNA (CNA 'A') said, You don't have the authority to touch me. The summary noted, During interview with (CNA 'A') .she recalled caring for (R702) .Resident was noted to have a pull up on at the time. (CNA 'A') indicated he was not soiled but was going to put a brief on. Resident's pants were partially pulled down and resident indicated, 'I am not playing with myself'. (CNA 'A') indicated that resident assisted in rolling from side to side to place the brief. CNA indicated that when rolling putting his pajamas back on the resident raised his arm. CNA indicated she thought the resident was attempting to strike her and said, 'You don't touch me'. (CNA 'A') indicated the resident then said, 'I don't want them tight', referring to his pajama bottoms . A Staff Interview Summary indicated CNA 'A' was interviewed on 1/21/25. The summary of the statement/interview included the following: .(CNA 'A') indicated (R702) was not wet but when she began changing him he started going (urine) .Resident stated, 'I'm not playing with myself' as his pants were down partially per CNA when she came into room. (CNA 'A') .did indicate when putting PJ's on (drawstring in back) he raised his arm .(CNA 'A') indicated (R702) said, 'I don't want them tight' referring to his pajamas. (CNA 'A') states she told (Registered Nurse - RN 'C') about the interaction . It should be noted that CNA 'A' statement about putting R702's pajamas on with the drawstring in the back was not included in the investigation summary provided to the State Agency and there was no additional documented investigation provided regarding why R702's pajama pants were tied in the back or if other staff were doing that as well. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 10:58 AM, an interview was conducted with CNA 'A' via the telephone. CNA 'A' indicated they worked at the facility but they were terminated from employment on 1/27/25. When queried about what occurred with R702 on 1/16/25, CNA 'A' reported the resident said they tried to roll him off the bed and then tried to hit CNA 'A' because he thought he was going to fall. CNA 'A' further explained R702 became anxious and said I can't breathe! when CNA 'A was putting the resident's pajama pants back on after a brief change. According to CNA 'A', R702 said he did not want the pajamas tied too tight and CNA 'A' assured him that they would be loose enough. CNA 'A' explained they tied the drawstring to R702's pajamas pants in the back instead of the front that night because that was what the other CNAs had been doing. CNA 'A' reported she previously notified RN 'C' about the other CNAs tying R702's pants in the back and RN 'C' said she was aware. CNA 'A' reported it was the first time that she tied the pants in the back that night (1/16/25) and since the nurse was aware she did not think it was a problem. When queried about why R702's pants were being tied in the back instead of the front, CNA 'A' stated, He kept stripping and peeing all over himself and the bedding. It slows him down and he wasn't getting them off like that. CNA 'A' reported she first found out about tying R702's pants in the back from CNA 'E' who said they had been doing that with R702 to prevent him from taking his pants off. On 2/27/25 at 12:43 PM, a telephone interview was attempted with RN 'C'. RN 'C' was not available prior to the end of the survey. On 2/27/25 at 2:16 PM, a telephone interview was attempted with CNA 'E'. CNA 'E' was not available prior to the end of the survey. A review of CNA 'A's personnel file revealed a document titled, Termination dated 1/16/25. The Corrective Action reason was Policy Violation. The following was documented, For resident 1 person assist did not use gait belt and did not follow the proper procedure as well as resident restraint. On 2/27/25 at 1:30 PM, an interview was conducted with the Administrator who was the designated Abuse Coordinator for the facility. When queried about the investigation conducted by the facility in regards to R702's grievance about the care provided by CNA 'A', the Administrator reported R702 said CNA 'A' 'turned him from side to side when giving care' and he did not feel like she needed to do that. The Administrator reported CNA 'A' was immediately removed from R702's care and the concern was reported to the State Agency as an allegation of abuse. When queried about why turning the resident from side to side was considered abuse and was there anything else that was concerning, the Administrator stated, There was also something about her (CNA 'A') putting his (R702) pants on incorrectly. When queried about what happened with R702's pants, the Administrator reviewed the facility's investigation and stated, Never mind. There is nothing about the pants. When queried about the Termination document in CNA 'A's personnel file that documented resident restraint as part of the reason they were terminated from employment, the Administrator stated, There were no restraints. When queried about tying a resident's pants in the back so that they were unable to remove them, the Administrator reported that would be considered a restraint. (continued on next page)

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The Neighborhoods of White Lake	10770 Elizabeth Lake Road White Lake, MI 48386

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at approximately 1:45 PM, an interview was conducted with the Regional Human Resources Director, HR 'D' and the Administrator. HR 'D' reported CNA 'A' was terminated for not using a gait belt with another resident. When queried about why it was documented that CNA 'A' was also terminated for resident restraint, HR 'D' reported CNA 'A' told them that she tied R702's pants backwards. When queried about what was done to investigate CNA 'A' restricting R702's access to his body by restraining him by tying his pants in the back, the Administrator and HR 'D' reported they only found out about it because CNA 'A' told them she tied the pants in the back and at the time, R702 was already discharged from the facility and when he was interviewed about the original grievance he never mentioned it. When queried about what was done to ensure no other staff were restraining any other residents that way and what was done to find out why CNA 'A' restrained R702, the Administrator reported CNA 'A' just reported it during an interview, no additional questions were asked, and no other action was taken to ensure other residents were not being restrained. When queried about why the information about R702 being restrained was not included in the investigation summary submitted to the State Agency, the Administrator reported she did not find out until the investigation was complete. It should be noted that CNA 'A' was interviewed on 1/21/25 and the investigation was submitted to the State Agency on 1/27/25.

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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 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** 34275 This citation pertains to Intake #MI00149932 Based on observation, interview and record review the facility failed to ensure residents were transferred with a gait belt per facility protocol for one (R701) of two residents reviewed for care. Findings include: A FRI (facility reported incident) was submitted to the State Agency (SA) that reported R701 alleged that they were treated roughly by CNA (certified nursing assistant) A. A review of the intake provided to the SA and accompanied investigation forms documented, in part, the following: .Grievance reported by another resident .When social worker interviewed like resident on 1/20/25, R701 indicated that CNA A is rough with transfers placing her hard on toilet seat and wheelchair .CNA remains suspended pending further investigation .Conclusion: Based on investigation and interview the facility cannot substantiate abuse or neglect .Staff Interview Summary .Do you recall if she landed hard in her wheelchair or on toilet? I can remember a few times she landed hard in her wheelchair. I just guide her when transferring .I did not use a gait belt because I just guide her . A Summary of Investigation and findings noted the following: . Resident transfers to wheelchair likely resulted in resident sitting down hard .only guiding resident. Staff correction action related to use of gait belt for all transfers with residents . On 2/27/25 at 10:58 AM, an interview was conducted with CNA 'A' via the telephone. CNA 'A' indicated they worked at the facility but they were terminated from employment on 1/27/25. CNA A was queried as to allegations made by R701 and why they were terminated from the facility. CNA A reported they were interviewed about how they provided care for R701. CNA A explained they were told they did not use a gait belt during a transfer. CNA A reported that they did not understand why they were terminated for failing to use a gait belt as other staff did not use a gait belt and they felt the resident just needed supervision. On 2/27/25 at approximately 1:05 PM, R701 was observed sitting in their room in their wheelchair. The resident was asked how staff helped them get from their bed to their wheelchair and they stated that staff will put their hands on their chair and then staff will say, one, two, three and then lift them up under their arms. When asked if a gait belt was used, they indicated no. CNA F who was assigned to R701 was interviewed in R701's room. CNA F was asked how they transferred R701 and reported that they use their gait belt. During the interview, again R701 noted that they did not believe staff used a gait belt to transfer them. A review of R701's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: peripheral vascular disease, type II diabetes, and unsteadiness on feet. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at approximately 1:30 PM, the Administrator/Abuse coordinator was interviewed regarding the FRI that was submitted based on R701's allegation of rough treatment by CNA A. The Administrator reported that R701 made allegations that they were treated roughly by CNA 'A specifically when being placed on the toilet. They indicated that following an interview with CNA A they determined that CNA A was not using a gait belt per facility policy and that could have contributed to R701's allegation. A review of the facility policy titled, Safe Lifting/Handling/Repositioning of Resident (11/2022) documented, in part, .To provide a safe working environment focused on associate safety, resident safety and overall injury protection .Employees are required to successfully complete appropriate training use .equipment when necessary .2. Gait Belts: To be used with residents who need assistance with transfers/standing/walking or balances .The gait belt provides a secure firm hold to help stabilize and handle residents during ambulation and transfer .