STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235433	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observations, interviews, and record reviews the facility failed to provide appropriate and consistent interpreter and/or translation services for three (R's 704, 708 & 711) of five residents reviewed for abuse/mistreatment. Findings include: R704 Review of the medical record revealed R704 was initially admitted to the facility in 2017, with a readmitted [DATE] and diagnoses that included: dementia, hemiplegia and hemiparesis affecting the right dominant side, chronic kidney disease and most recently a fracture of the fourth metacarpal bone. A Brief Interview for Mental Status (BIMS) score completed on 4/25/24 documented a score of 3, which indicated severely impaired cognition. R704 required staff assistance for all Activities of Daily Living (ADLs). Review of a care plan titled Alteration in Communication r/t (related to) Language barrier documented in part . My primary language is Arabic/Chaldean and I also speak English . Communication board have been provided . The care plan documented the following interventions in part . Involve family in translating / communication prn (as needed) . On 5/1/24 at 10:28 AM, the Human Resource Director (HRD) A was identified by a facility staff member as the facilities interpreter. HRD A was asked if the facility had interpreter services not affiliated with the facility that the surveyor can utilize to interview R704 regarding an abuse allegation that involved one of the facility's staff members and HRD A responded they were unaware of any services and the facility utilized their own staff to translate. At 10:29 AM, the Administrator was interviewed and asked what services the surveyor can utilize to speak to R704 or any other resident that did not speak or understand English and the Administrator responded that the facility use their own staff or a communication board. The Administrator was asked to provide the facility's policy on communication and/or interpreter services. On 5/1/24 at 10:33 AM, HRD A accompanied the surveyor to translate the interview with R704. HRD A was asked to be honest in the translation of the surveyor's questions and R704's responses. R704 was observed sleeping up right in a geri chair wearing a green shirt and black pants. R704's right hand and fingers was visibly swollen and yellow in color. R704 was awakened by verbal prompts from HRD A and asked R704 how their hand became injured, R704 stated a male pressed on his right hand and hurt him. R704 did not know the name of the male. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R708 Review of the medical record revealed R708 was initially admitted to the facility in 2011 and readmitted to the facility on [DATE] with diagnoses that included: dementia, epilepsy, and falls. R708 required staff assistance for all ADLs. Review of a care plan titled Alteration in communication r/t Language barrier AEB (as evidence by) . primary language is Arabic . speaks little English . documented the goal of Resident will be provided an interpreter to for communication purposes PRN and the following interventions in part . Assess for need to use a communication board . Communication board or paper and pencil to communicate as needed . Involve family in translating / communicating prn . On 5/2/24 at 9:13 AM, Registered Nurse (RN) E was the assigned nurse for R708, and RN E was asked what services could be utilized to conduct an interview with R708 and RN E stated they would usually communicate with R708 using a board. RN E was asked if they could provide the board for the surveyor to use. RN E went into R708's room and searched, however could not find the communication board for R708. RN E stated they could also call a facility staff to interpret the interview and RN E went to locate a facility staff member. At 9:19 AM, RN E returned and stated they had a picture book that could possibly be used. Review of the picture book revealed facial expressions and other pictures, however, would not have been sufficient for the surveyor to conduct an interview with R708. At 9:20 AM, Activity Aide (AA) D was sent up to provide translation services. AA D was asked before the interview to be honest when translating the surveyor's questions and R708's responses. AA D was asked to ask R708 if they had had a lot of falls in the facility and without asking R708 AA D responded Yes. AA D was asked to ask R708 the question for a response. R708 acknowledged they had a lot of falls at the facility and a brief interview was attempted, however AA D stated the R708 was no longer answering the questions appropriately. After the interview, AA D was asked if they could provide translation services for one more resident and AA D stated they could ask another activity aide, because they had other duties to fulfill. AA D explained the facility staff are all very close knit and the facility was like a little community. AA D stated they would find another staff to provide translation services for the next resident. R711 Review of the medical record revealed R711 was initially admitted to the facility in 2018, with a readmitted [DATE] and required staff assistance for all ADLs. On 5/2/24 at 9:29 AM, a second Activity Aide (AA II) F approached the surveyor with AA D and AA D stated AA II F would provide translation services for the next resident. AA II F was asked to be honest when translating the surveyor's questions and R711's responses. R711 was observed lying on their back in bed. When asked R711 stated they weren't treated well by some of the workers and didn't feel safe at the facility. R711 requested to go back to their previous facility. When asked how the staff was treating them, R711 stated they did not feel they were getting treated as they should or getting the care they feel they should have. R711 would not elaborate when asked about specific incidents and/or staff. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at approximately 11:50 AM, the Administrator, Assistant Director of Nursing (ADON) who covered in the Director of Nursing (DON)'s absence and the Regional Nurse Consultant (RNC) G was interviewed and asked why the facility had not implemented translator services that did not include the use of the facility staff and/or the resident's family due to HIPAA (Health Insurance Portability and Accountability Act) concerns, concerns with facility staff and residents being put in uncomfortable positions of possibly having to translate information on concerns voiced by residents that may involve their friends and/or co-workers they are close to during mistreatment/abuse or neglect allegations. The Administration staff was also asked about the possibility of the wrong information to have been translated or received by the translator, and RNC G stated the facility is currently in the process of implementing a third-party translation service. No further explanation and/or documentation was provided by the end of the survey.

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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** 41415 This citation pertains to intake(s): MI00144245 & MI00144212. Based on observation, interviews, and record reviews the facility failed to protect the resident's right to be free from physical restraints and/or mistreatment during care for one (R704) of five residents reviewed for mistreatment and/or abuse by Certified Nursing Assistant (CNA) K, resulting in R704 to have a fracture of the fourth digit to their right hand. Findings include: Review of the medical record revealed R704 was initially admitted to the facility in 2017, with a readmitted [DATE] and diagnoses that included: dementia, hemiplegia and hemiparesis affecting the right dominant side, chronic kidney disease and most recently a fracture of the fourth metacarpal bone. A Brief Interview for Mental Status (BIMS) score completed on 4/25/24 documented a score of 3, which indicated severely impaired cognition. R704 required staff assistance for all Activities of Daily Living (ADLs). On 5/1/24 at 10:33 AM, accompanied by Human Resource Director (HRD) A to act as an interpreter in translating the interview with R704 (whose primary language is Arabic/Chaldean) and the surveyor. HRD A was asked to be honest in the translation of the surveyor's questions and R704's responses. R704 was observed sleeping up right in a geri chair wearing a green shirt and black pants. R704's right hand and fingers was visibly swollen and yellow in color. R704 was awakened by verbal prompts from HRD A and asked R704 how their hand became injured, R704 stated a male pressed on his right hand and hurt him. R704 did not know the name of the male. R704 stated they had seen the male since the incident occurred and R704 stated they kicked them out of their room and the male left. When asked, R704 stated the same male had hurt them in the past, however R704 would not elaborate on the prior incidents. R704 was asked if they felt safe in the facility and R704 responded No. When asked why R704 stated that, it was because of the incident that happened to their right hand. R704's roommate who spoke English was in the room at the time of the interview. HRD A was asked to exit the room and R704's roommate was interviewed. R704's roommate was asked if they had witnessed any staff members hurting R704 and the roommate responded yes and then stated they would not answer any further questions. R704's roommate stated in part . It's best if I stayed out of it . Despite further attempts R704's roommate declined to be interviewed further. Review of an incident report dated 4/24/24 at 12:12 PM, documented in part . Resident observed with right hand swelling (back of hand) and swelling to 4th and 5th digits . Resident is alert to name with confusion. When asked what happened to his hand, he shook his head no while guarding his hand . notified (physician name) new order STAT (immediate) right hand x-ray 2 views related to pain and swelling . Review of a right-hand radiology report dated 4/24/24, documented in part . Pain in right hand . Multiple views of the right hand show a fracture of the fourth digit at the P1 segment . IMPRESSION: Acute fracture of the fourth digit at the P1 segment . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a statement obtained by the facility from CNA H (the aide assigned to R704 on 4/24/24 day shift, who first identified an abnormality with R704's right hand, reported the following in part . When I went into the room (4/24/24 Day shift) the patient was holding his hand and expressing that it hurt I noticed his finger looked blue/gray but not bruised. I was trying to also ask (R704's name) what happened but he wasn't able to fully communicate anything regarding his hand which is how some days are for him. I immediately notify the nurse . On 5/1/24 at 11:18 AM, a telephone interview was attempted with CNA H however unsuccessful. CNA H never returned the surveyor's phone call. Review of the facility's staff assignment sheet documented Certified Nursing Assistant (CNA) K assigned to R704 on the evening of 4/23/24 and CNA J assigned to the same hallway as CNA K but assigned to a different set of residents. Review of the facility's investigation file revealed no statement obtained from CNA J. On 5/1/24 at 11:18 AM, an attempt to conduct a telephone interview was made with CNA J, however unsuccessful. A voicemail was left for CNA J to return the call. At 11:50 AM, CNA J returned the call and was asked if they knew anything about the incident of R704 right finger fracture and CNA J stated in part, . No, I don't give care with (CNA K) . I don't assist him at all . CNA J stated they had never helped CNA K with R704 using the Hoyer lift. CNA J explained there was an incident when they first started working at the facility (CNA J's start date was 3/6/24) where . (CNA K) was very aggressive with his tone of voice to me and the resident (another resident). I felt uncomfortable so I stepped outside the room and told the nurse . CNA J stated CNA K basically told the resident to stop yelling and to let him do his job. CNA J stated I told CNA K it's not okay to yell at (another resident) and he told me to stop talking to the resident. CNA J then stated CNA K said . didn't I tell you to stop talking to them, just do your job! CNA J stated they just stay away from CNA K now and get another CNA from a different unit if they need help with a resident. Review of CNA K's statement (no date), documented in part ADON (assistant director of nursing) asked (CNA K) did he work Tuesday afternoon and did anything happen the last time that he worked. He responded, 'yes I worked' but could not recall anything of importance happening on his shift Tuesday. ADON asked did he have any issues with any resident being combative, or who refused care. (CNA K) said, 'umm no'. He did state that on Wednesday afternoon he noticed swelling to (R704's) finger. I informed (CNA K) regarding the allegations and then he stated that (R704) is combative with care, he does resist care from him and when he does that, he (CNA K) gets assistance from (CNA M) who speaks the same language as R704. (CNA K) does recall a time last week when he was transferring resident (R704) from chair to bed to perform a bed bath because resident was combative and refusing a shower, that <sic> when he was trying to change him that (CNA M) held his (R704) hands to stop him from swinging <sic> them. Review of R704's medical record revealed R704 required a two-person assistance for bed mobility, toilet use and transfer with a mechanical lift. This indicated CNA K should not have attempted to transfer R704 initially without a second staff present to assist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/1/24 at 2:18 PM, a telephone interview was conducted with CNA K, when asked CNA K explained they were suspended and would be called by the Administration after the investigation. CNA K went on to state that R704 is very combative sometimes when they are providing R704's care. CNA K went on to say how R704's hands was held because they were swinging at them (CNA K and CNA M) but would not clarify when asked who held R704's hands down. Review of CNA M's statement dated 4/30/24, documented in part . (CNA M name) was interviewed and recalls on 4/15/24 that she was approached by another CNA to help assist with care due to resident being incontinent of stool. (CNA M) does report having to hold his hands due to him pinching, biting, and trying to punch her in the face. Even though he was combative she did not want to leave him with stool on him, so his hands were held during peri care . On 5/2/24 at 9:07 AM, a voice message was left on CNA M's voicemail to return the call for a telephone interview. At 10:10 AM, CNA M returned the call and when asked about the incident that involved themselves, CNA K and R704, CNA M stated that CNA K usually comes to get them when CNA K needs help and the residents refuse care. CNA M stated CNA K came to them and stated they tried to change R704, however R704 wouldn't let CNA K change them. CNA M stated they tried to talk to R704 because they had had a big bowel movement. CNA M stated in part . (R704) tried to punch me and pinch me. So, I said okay (R704's name) I have to change you, so (CNA K) tried to protect me, and held (R704's) hand so that I can change (R704) . Review of R704's care plans revealed no care plan implemented for combative behaviors identified by the facility staff. Review of the medical record revealed no documentation of R704 to have been combative with staff. Review of the facility documents noted the date of 4/15/24, of the alleged incident of CNA K and CNA M holding the hands of R704 due to combativeness. The incident happened more than a week prior to the identification of R704's hand to have been swollen, discolored, and confirmed as fractured. Review of a statement obtained from Unit Manager (UM) I documented in part . 4/25/24 at approx. 1030 AM myself (RN Unit Manager), (Human Resource Director - HRD A), and (previous Social Worker) were in the room interviewing (R704). Patient was asked questions to obtain an understanding/description of the person that he alleged bent his finger back. (HRD A name) is being translator for conversation. Patient was asked what does he look like? (R704) describes the man as regular brown hair, long face, no beard, unsure about moustache, older man but not old enough to have gray hair. Patient was asked what the person was wearing he explains sometimes he wears jeans, always wears a jacket. Patient explains that his jacket is similar to mine in color (I have on navy blue). Patient also explains that he thinks he works here, he sees him all the time and that the man has hurt him before. When patient was asked about what time of day the incident occurred the patient stated he is unsure of time of day because it always seems like day light because of people coming up and down the hallway/walking past his room. Patient explains that he has never hurt him as bad as this time but has hurt him many times before. Patient states the man has changed him and fed him before. (R704) also goes into explanation that he asks the man 'why do you hurt me?' and the man will not respond. Also (R704) explains that when the man hurts him he will cuss at the man, and after ask for forgiveness the man will say I don't forgive you and walk away . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/1/24 at 12:10 PM, a telephone interview was conducted with UM I who explained they were no longer employed with the facility as of the day before (4/30/24) due to the following investigation involving R704. UM I went on to say how they were instructed to interview the staff and residents regarding the abuse allegation incident that involved R704, as well as the other unit managers were also assigned to do the same. The unit managers were assigned different units to ensure all residents were interviewed in the facility. UM I stated the description provided by R704 of the alleged perpetrator identified CNA K. CNA K was assigned to R704 on 4/23/24, the evening before R704's right hand swelling and pain was identified. UM I stated the previous Social Worker (PSW) L , HRD A were both present for the interview with R704 when the resident stated the man was abusing R704 for a long time but it hasn't been this bad. UM I went on to state how R704 described CNA K as the alleged perpetrator. UM I went on to state how R704 described the man as white complexion, not African American and that CNA K is the only male CNA who is not African American in the facility. On 5/2/24 at 9:01 AM, a telephone interview was attempted with the previous Social Worker (PSW) L, however initially unsuccessful. A message was left to return the call. At 11:03 AM, PSW L returned the call and when asked stated they were in attendance when R704 was interviewed by UM I. PSW L had explained they put in a 30-day notice to the facility and their last day was supposed to be May 19th 2024, however they were approached on Monday (4/29/24) by the Administration and asked to terminate their employment with the facility that day with no loss of wages. PSW L then stated on the day of the interview R704's hand was visibly black in color from front to back. PSW L stated they didn't feel comfortable with HRD A translating the interview with R704 because R704 kept saying he didn't say that. PSW L then stated, CNA K was identified as the alleged perpetrator through the resident's description. PSW L stated in part . (R704's) BIMS (Brief Interview for Mental Status) score was low but when it came down to the incident (R704) was very clear. He kept saying it and repeating it . Review of a Facility Investigation dated 4/29/24, documented in part, . Swelling was observed on 4/24/2024 by nursing assistant and reported to the staff nurse . The floor nurse ordered an X-ray to the right hand and the results were read on 4/25/24. The results showed a fracture of the 4th digit at P1 segment . The resident stated a white man with regular brown hair long face no beard older but no gray hair who works here came in 3-4 days ago and hurt him twisted his hand I told him to stop but he kept going. It's very painful .Fracture to 4 digit on right hand . Police was notified and arrived on 4/25/24 @ (at) 1600 (4:00 PM) . Immediate suspicion of staff member based on the resident description and who cared for the resident was preliminary suspended pending investigation . Resident interview with translator: 4/25/24 Resident stated that he seen a white male, somebody from here came and hurt me, not my roommate, but a white man who walks up and down on unit. Resident further stated, I don't know what day (it happened)-3 or 4 days ago unsure. [NAME] man maybe speaks to roommate and makes jokes with him. He twisted my hand. I told him to stop but he kept on going and it was very painful . stated that he feels safe the man just needs to apologize . Staff schedule was reviewed for 4/23/24 and 4/24/24. A staff member matching that description was reviewed and suspended pending completion of investigation . Staff member (CNA K) reports caring for the resident on 4/23/24 and remembers the hand swelling but also knows the resident is combative and does sometimes resist care. He also reports when these situations occur, he gets another staff member to hold his (R704's) hands . Conclusion . it is determined the fracture was contributed to the resident having comorbidities with lead induced gout and osteoarthritis around the joints and the factors of the staff assisting him with hygiene during outburst, that the fracture located at the 4th digit P1 segment most likely occurred when the hands were held and the resident was moving his hands around. Due to the outcome of the investigation and in abundance of caution the facility completed re-education to all Nurses and Nursing Assistance <sic> on how to respond to resident during a Catastrophic Reaction . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/1/24 at 3:56 PM, the Administrator (who also serves as the facility's Abuse Coordinator) and HRD A was interviewed and asked when they were first notified of the allegation of abuse reported by R704 and the Administrator stated they were notified on 4/25/24 by the ADON. The Administrator was asked why they were not notified on 4/24/24 of R704's right hand swelling and the Administrator stated they were not notified until the X-ray confirmed the fracture of unknown origin. The Administrator stated that is when their investigation began. The Administrator was asked how it is possible that none of the Administration team followed up with R704 on 4/24/24 to ask how their unexplained and unwitnessed swelling of the hand occurred, the Administrator stated they were unsure. When asked who conducted the abuse allegation investigation the Administrator stated themselves, the ADON and the Regional Nurse Consultant (RNC) G. On 5/2/24 at 11:20 AM, the Administrator, ADON, and RNC G was interviewed together with UM I in attendance via speaker phone. Each party was asked their role in the investigation of R704's allegation of abuse and the Administrator stated they made sure all of the information was handed in by the timeline. The ADON stated they typed some statements, conducted interviews, spoke to the police officers with UM I. The ADON stated when they were done, they handed the folder to the Administrator on Friday morning. RNC G stated they witnessed a few interviews with the ADON and helped to type the report. UM I stated they obtained statements from staff members and residents and provided the statements to the ADON. The Administrator was then asked the results of the facility's investigation and the Administrator stated they could not substantiate the abuse allegation. The Administrator was asked if they took into consideration the statement provided by R704 on 4/25/24 and considered the fact that R704 was still consistent with their statement when interviewed by the surveyor on 5/1/24 and the Administrator stated they took the residents statement into account and that is why CNA K was suspended. The Administrator was then asked how they believed R704's fractured finger occurred, and the Administrator stated they were not sure if R704 was abused or if they caught their finger in their wheelchair. The Administrator was asked the employment status for CNA K and the Administrator stated they were awaiting the results of the investigation. When asked what investigation results, they were waiting for being that the facility had concluded their investigation, the Administrator did not specify. UM I then stated they were called into the Administrator's office on 4/29/24 and was asked by Regional Director of Operation (RDO) N to edit the statement UM I obtained from CNA J. UM I stated they refused to edit the statement of CNA J and was terminated on the next day on 4/30/24. At this time the Administrator was asked why CNA J's statement was missing from the investigation file and the Administrator was unsure. RDO N asked to review the file to find CNA J's statement and was unable to find the statement. At 2:01 PM, the Administrator emailed CNA J's statement to the surveyor. Review of CNA J's statement documented in part, . Not when providing care. He (R704) does hit or grab only when you are attempting to put him in <sic> Hoyer lift. He grabs the sling, but he does not flail his arms. I stopped going into patients' rooms with (CNA K) because he makes me uncomfortable and feel scared, he talks aggressively to staff and sometimes patients and one time I experienced him talking to (another resident's name) in a different language and she became very upset screaming at him to get out, he had to of said something that he wasn't supposed to say to her . Review of a facility policy titled Abuse dated 5/23/24, documented in part . Residents have the right to be free from abuse . mistreatment . This includes, but is not limited to . any physical .restraint that is not required to treat the patient/resident's medical symptoms .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00144245. Based on interviews, and record reviews the facility failed to ensure the signage of employee rights related to retaliation against the employee for reporting a suspected crime was posted in the facility and failed to prohibit and prevent the retaliation of one employee (Unit Manager- UM I) who was terminated during the investigation conducted for an alleged allegation of abuse for (R704) and an alleged verbal allegation of abuse for (R705) two of five residents reviewed for Abuse/Mistreatment, resulting in the likelihood for mistreatment and/or abuse to occur, the termination of UM I and the likelihood of unreported mistreatment and/or abuse to be reported by the facility staff in fear of retaliation from the facility Administration. Findings include: On 5/1/24 at approximately 1:55 PM, the Assistant Director Of Nursing (ADON) was asked to complete a walk through of the facility with the surveyor and show every staff break room and boards of the facility where signage is hung for the staff to review. The second-floor signage boards, basement break room, basement hallway signage boards and the first-floor signage boards were reviewed and contained abuse signage that documented the contact information of a previous Administrator and previous Director of Nursing (DON). There was no signage posted that contained information regarding staff rights related to the retaliation against an employee for reporting a suspected crime. Review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 4/25/24 documented an injury of unknown origin, an X-ray positive for a hand fracture for R704 and the perpetrator Unknown. Review of the medical record revealed R704 was initially admitted to the facility in 2017, with a readmitted [DATE] and diagnoses that included: dementia, hemiplegia and hemiparesis affecting the right dominant side, chronic kidney disease and most recently a fracture of the fourth metacarpal bone. A Brief Interview for Mental Status (BIMS) score completed on 4/25/24 documented a score of 3, which indicated severely impaired cognition. R704 required staff assistance for all Activities of Daily Living (ADLs). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at 12:10 PM, a telephone interview was conducted with UM I who explained they were no longer employed with the facility as of the day before (4/30/24) due to the following investigation involving R704. UM I went on to say how they were instructed to interview the staff and residents regarding the abuse allegation incident that involved R704, as well as the other unit managers were also assigned to different units to ensure all of the residents were interviewed that resided in the facility. UM I stated they were called into the Administrator office on Monday (4/29/24), the Administrator and the Regional Director of Operation (RDO) N were present. UM I stated RDO N asked them to edit the statement they obtained from Certified Nursing Assistant (CNA) J. UM I stated RDO N wanted the statement edited because CNA J had made an allegation of witnessing an alleged verbal abuse incident with CNA K and another facility resident that resided in the facility (later identified as R705). UM I stated they felt uncomfortable about what was being asked of them and they had a conversation with the Regional Nurse Consultant (RNC) G and informed them that RDO N asked UM I to edit the statement of CNA J and asked RNC G what they should do. UM I stated RNC G told them not to do anything they felt uncomfortable doing. UM I stated they went to inform the Administrator and RDO N that they felt uncomfortable editing CNA J's statement and asked them to reinterview CNA J so they could obtain their own statement from CNA J. After informing the Administrator and RDO N of their decision, UM I then stated RDO N then stated that UM I obtained the statement of a resident (R705) that documented the allegation of verbal abuse. UM I stated they informed the Administrator and RDO N that they did not interview R705, and the interview was obtained by another Unit Manager (later identified as UMII O). UM I stated RDO N began getting in their face and stated they knew I did the interview for R705 and then told me to get out of the office. UM I stated they were called in the office the next day (4/30/24) at 8 AM and RDO N informed them they were being fired for dishonesty. UM I stated, I asked RDO N what I was dishonest about. UM I stated, I informed RDO N that I had never been written up for a disciplinary action and always maintained good work ethics and UM I stated RDO N replied well, that's your opinion . Unfortunately, well maybe not unfortunately we are letting you go . UM I stated they asked for a copy of their termination letter and RDO N refused to provide it. Review of UM I's employee file contained one Employee Counseling & Corrective Action Record dated 4/29/24, however signed off by the Administrator and RDO N on 4/30/24. The form documented in part, . Termination . (UM I name) violated (facility company name) honesty statement from the mission statement of the handbook as evidence by . see attached statement from (RDO N name) . Review of the attached statement signed by RDO N documented in part, . On 4/29/24 I was reviewing the investigation file (case that we reported to State of Michigan on injury of unknown origin) which contained several statements from employees etc. I had to question (UM I) about one statement where she provided extra information about another patient. That statement indicated that that Resident (R705) . was very upset etc. I asked (UM I) how she addressed that situation. First, she said that it was addressed, and she had a file about it. I asked her to bring the file. (UM I) stated she does not have it. Then I asked her to please talk to the patient. (UM I) said that she already talked to the patient and patient said that she is ok. I asked (UM I) to write it down. (UM I) stated that she already gave a statement in that regard. I asked (UM I) to show it to me. She took investigation file that I was already reviewing (see beginning of this statement) and she gave it to me. See attached Exhibit A. I questioned (UM I) about this contradictory information, and she stated that it was not her who interviewed the resident and that it was another nurse manager. The statement was then signed of by RDO N. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an attached email addressed to RDO N from the facility Corporate HR (Human Resources) Business Partner dated 4/29/24 at 7:59 PM, documented in part . Subject: Termination . Here is the Honesty statement from the Mission Statement in the handbook. We work in a truthful manner and adhere to the highest ethical standards. Here is the Integrity statement . The Facility recognizes that it has an obligation to its patients, its payers, its employees, and the communities it serves to observe and maintain high standards of integrity and business ethics. These standards must be adhered to by all Facility employees during their day-to-day activities of caring for patients and conducting business. The Facility's Code of Conduct provides the general principles to guide all employees in meeting these standards. However, it does not cover every situation that a Facility employee will face. Therefore, each employee must exercise good judgment and be committed to upholding the Facility's standards of integrity and business ethics . Let me know if you need anything else . The email was signed off by the Corporate HR Business Partner. Review of R705's statement, which was attached to UM I termination as Exhibit A documented the following in part, . Date: 4/25/24 . Residents Name: (R705) . Has anyone every hurt you in this facility? Yes, 2-person, (1) person description- fat, (2) person is pregnant . Do you feel safe in this facility? No, because of that she (R705) is afraid . Review of an attached statement from the Administrator documented in part . I requested assistance from Regional Director regarding investigation for injury of unknow <sic> origin. The day incident was discovered I was unable to start my investigation due to some prior engagements. As we were going over the information which was gathered by ADON and Unit Manager/staff development she was asking questions pertaining to the findings. ADON answered all the questions which were asked to her, and which matched with her statements. When Unit manager (UM I) was asked about statement from residents, she said no one had any concerns. (RDO N) the regional director asked again if there any concerns from the resident (R705's name), Exhibit A (who had concerns and did not feel safe). Regional Director told her as a key staff member she should be honest and review everything correctly. There should be no room for errors when you are doing your investigation. She also instructed her on proper investigation process . The statement was then signed by the Administrator. Review of additional attached statements documented the following: On 4/26/23 (incorrect date) . Today in the morning meeting during Clinicals, we all witnessed very unprofessional and rude behavior from one of our unit managers toward the administrator making it a very uncomfortable work environment. Unfortunately, I do not feel comfortable and safe disclosing my name . On 4/26/24 statement from Administrator . During morning meeting while discussing the incident with clinical staff. (Administrator) stated to clinical staff you cannot give name of the individual based on description to the Police. (UM I name) was very rude and was extremely hostile towards administrator. She in a very sharp tone expressed her dissatisfaction towards writer in front of other clinical staff stating that I have no room to talk . Review of another attached statement documented the following, . In morning meeting on Friday April 26th, 2024, the (Administrator) was talking about the incident that had happened on Thursday with one of our residents and I was in the room when (UM I) was unprofessional and had a <sic> attitude to the administrator. This statement was signed off by the facility's MDS (Minimum Data Set) coordinator. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The above three statements were attached to the termination of UM I, however UM I was never issued a disciplinary action or education on the above alleged incident. On 5/1/24 during the initial interview with UM I, UM I stated the facility's Administrator held a meeting and told the facility staff to not ever tell the police officer the name of the alleged abuser, which UM I did not agree with. On 5/1/24 at 1:12 PM, Unit Manager II (UMII) O (identified as the unit manager who obtained the statement from R705) was interviewed and asked their role in the investigation for R704's allegation of abuse and UMII O stated they had interviewed residents. UMII O was asked if they obtained the statement from R705 regarding the alleged allegations of abuse and feeling unsafe in the facility and UMII O confirmed they did obtain the statement from R705. UMII O was asked who they informed of R705 allegations and UMII O stated they had not informed anyone, they placed the statements they obtained in a folder and put it under the door of the ADON. UMII O stated RDO N, and the Administrator called them into the office and asked if they obtained the statement from R705 and UMII O stated they confirmed the handwriting as theirs and confirmed they obtained the statement from R705 and was instructed by RDO N to notify the Administration next time immediately for any allegations of Abuse. This interview with UMII O confirmed the statement from R705 which was marked as Exhibit A was obtained by UMII O and not UM I. UMII O placed the statement with other statements they obtained in a folder and put it under the ADON's door. UM I would not have seen nor reviewed the statement from R705 as they were not the unit manager who obtained R705's statement. On 5/1/24 at 1:38 PM, the ADON was interviewed and when asked stated (UM I name) came out of the Administrator office on Monday and stated (RDO N name) asked them to edit the statement of CNA J. UM I asked the ADON what they should do and the ADON stated I told (UM I) if it was me, I wouldn't change the statement. The ADON stated UM I then called RNC G for further directive. The ADON stated the RDO N informed them that UM I lacked integrity and was incompetent. The ADON then stated RDO N stated . Moving up in the company you sometimes have to do things that make you uncomfortable if you want to move up in the company . The ADON then went on to say that RDO N stated UM I was dishonest and showed the statement of R705. Then ADON then stated they informed the RDO N that R705 statement was not UM I handwriting. When asked about the meeting on 4/26/24 with the clinical team, the ADON stated the Administrator insulted the ADON and Unit Managers regarding the investigation into the alleged abuse regarding R704 and later identified allegation of abuse from R705 and UM I stated . why didn't you do it (investigation) if we did such a bed job . The ADON then stated the Administrator had informed the clinical team to never give the police the name of the abuser and asked why the police was called. The ADON then asked the surveyor if they did the right thing in calling the police. On 5/1/24 at 2:46 PM, the Director of Nursing (DON) was interviewed via telephone (at the time of the survey the DON was out on medical leave), when asked the DON stated they received a call from UM I on Monday (4/29/24) and UM I stated RDO N, and the Administrator wanted them to change the statement they obtained from CNA J. The DON stated I told (UM I) not to change it because it is ethically wrong. I told her if she can't go to bed at night because she is asked to do something wrong then she should not do it. The DON stated the next thing they knew UM I was terminated. The DON stated I never had any issues or problems with (UM I) ever, no write up ever. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 11:03 AM, the Previous Social Worker (PSW) L (was the social worker at the facility at the start of the allegation of abuse for R704 and who was in attendance for some of the interviews obtained by UM I) was interviewed via telephone and when asked stated in part, . I put a 30-day notice in. My last day was supposed to be May 19th 2024 . they (Administration) came in on Monday (4/29/24) and asked me to leave early (with no loss of wages) and the next thing I know the very next day (UM I name) was terminated . PSW L stated they have been a social worker for over 20 something years. PSW L stated they (Administration) had been asked in the past to retype statements and retype trauma stuff and I cannot cover up. PSW L stated . I know how they (Administration) are and I'm not like that, that's why I left . On 5/2/24 at 11:20 AM, the Administrator, ADON and RNC G was interviewed together, with UM I in attendance via speaker phone. UM I was asked to repeat the statement made by RDO N and the Administrator regarding the statement obtained by CNA J and UM I stated in part . I was called in the office and (RDO N) explained to me why I needed to alter the statement. I need to take the entire potion out of there about CNA K. (RDO N) stated they were supposed to interview about (R704) being combative and I told (RDO N) that we were also instructed to ask about CNA K's interactions. (RDO N) then stated we have no proof that CNA K was aggressive, and I told her that was not true because he had recently walked off his job . I asked RNC G for guidance . I told them (RDO N and Administrator) I didn't feel comfortable, and you can tell she (RDO N) was upset, and she then asked if I made (R705's) statement. She (RDO N) called me incompetent and said that she knew I took the statement, and I kept telling her that I didn't take the statement. RNC G was asked if UM I informed them of the situation as stated and if they reached out to them for further guidance and RNC G confirmed UM I details of events as stated. The Administrator was then asked about UM I' 's version of the details of the event and stated in part . What I remember is (RDO N) never asked her (UM I) to change the statement. She did say that the paragraph didn't belong there, and I do remember her (RDO N) questioning about R705. UM I then stated, Well, she (RDO N) told me to completely erase everything else about (CNA K) . The Administrator then stated I don't recall. She (RDO N) never told you to change the statement . she did say that wasn't a part of the investigation, however she did say that didn't belong in there. UM I was then asked why they were terminated and UM I stated they were told it was because of their dishonesty policy as per (RDO N). UM I stated, I clarified that I was being terminated because you (RDO N) told me that paper was mine and I told her that I didn't take the statement? The Administrator was then asked if it was identified by them and RDO N that UM I did not obtain the statement form R705 during their investigation, but the decision was still made to terminate UM I for the statement and the Administrator confirmed that to be true. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/24 at 2:33 PM, an initial attempt to interview RDO N via telephone was made and unsuccessful. At 2:43 PM, RDO N returned the call and when asked stated the Administrator didn't feel comfortable with the unit managers. RDO N stated in part . I asked (UM I) if she investigated it (R705's statement) and she said that she would clarify it. She (UM I) then said I am not going to change it. I asked her if she leaves it as it is and asked if she went back and asked (R705) and she said she asked her and she is fine and good. She said she talked to the resident and said that she was fine and said that a statement is already in the file. In the statement the resident is saying that people have hurt her, and she doesn't feel safe. That is why I let her (UM I) go, before that the Administrator said she couldn't work with (UM I) or (ADON) because they don't give her (Administrator) the right information . RDO N was then asked about the statement of staff having to be put in uncomfortable positions if they want to move up in the company and the RDO N denied making the statement. The RDO N then stated in part . (UM I) said she talks <sic> to the patient (R705) and the patient said she was good, and she said that she already wrote it down . Those three (UM I, ADON and DON-confirmed with RDO N) don't give her (Administrator) the right picture . When asked to provide incidents of UM I, ADON and the DON to not give the right picture, RDO N did not state any known incidents. The RDO N then stated, . (Administrator) was scared of them. I couldn't believe it . These are dangerous employees because (Administrator) was crying, she is scared of them . RDO N was asked why UM I was terminated although UMII O admitted to obtaining the statement from R705 and RDO N stated The nurse manager (UMII O) was honest with me . RDO N then went on to state how the Administrator feels very intimidated and this is how they (RDO N) got involved in the investigation. When asked if they asked UM I to edit the statement of CNA J, RDO N denied it. On 5/2/24 at 3:10 PM, the Administrator was re-interviewed and asked why RDO N got involved in the investigation for R704 and the Administrator stated they were so overwhelmed and needed help to investigate the incident properly. The Administrator was then asked if they felt afraid of the DON, ADON and UM I and stated in part . I'm not afraid of my DON but I don't really feel like the answers that I am getting are accurate . When asked if they were afraid of UM I, the Administrator nodded their head yes and stated UM I would snap at them and intimidate them. The Administrator was asked if they had any documented incidents of UM I alleged behavior and the Administrator stated they did not, however recalled the meeting where UM I . blew up in front of everyone . The Administrator was asked if they were afraid of the ADON and the Administrator stated when it's just them working, the ADON works well with them. The Administrator then went on to say . I was having a hard time dealing with them. I never had to deal with that . On 5/2/24 at 3:29 PM, the RNC G was re-interviewed and asked the work ethics and character of the DON, ADON and UM I and stated the DON has changed a lot of the clinical systems to the positive in a short period of time and is receptive to the education provided to them. RNC G stated UM I has always done their job duties as told and has been receptive to education, however, can be a little short fused but stated nursing can be like that sometimes when you are in a management position. RNC G stated UM I still had a lot to learn, and management was a new role for them, however they had no concerns and felt UM I could be trained into their new role. RNC G was asked about the ADON and stated the ADON was very receptive to learning and following directive. Never witnessed aggressive behavior, however, was vocal about their decisions. The RNC G stated the Administrator informed them that the DON, ADON and UM I acted in a negative nature when RNC G was not in the building. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Abuse updated 5/24/23, documented in part . Reporting reasonable suspicion of a crime by covered individuals without fear or reprisal or retaliation. Content will include but is not limited to: what is reportable as a reasonable suspicion of a crime, each covered individual's obligation to report a reasonable suspicion of a crime against a resident to the administrator immediately as well as to the State Survey agency and Law Enforcement . Providing . staff information on how and to whom they report any allegations of abuse . mistreatment . injuries of unknown origin, concerns incidents, and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed . The facility supports and protects patients . and staff from harm during an investigation of alleged abuse including retribution and retaliation . A notice of employee rights, including the right to file a complaint with the State Survey Agency if they believe the facility as retaliated against an employee/individual who reported a suspected crime and how to file such a complaint will be clearly posted . No further explanation or documentation was provided before the end of the survey.

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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** 41415 This citation pertains to intake(s): MI00144212 & MI00144245. Based on interviews, and record reviews the facility failed to develop and/or implement policies and procedures for ensuring the timely reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act, for an injury of unknown origin (R704), failed to report an allegation of a suspicion of verbal abuse (R705), failed to report an allegation of physical abuse (R708) and failed to report an accurate investigation to the State Agency regarding an injury of unknown origin (R704), for three of five residents reviewed for abuse. Findings include: Review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 4/25/24 documented in part the following, . Resident Name: (R704) . Was Harmed? Yes . Type of Injury/Harm: Physical . Type of Alleged Perpetrator: Unknown . Type of Alleged Incident: Injury of unknown Source . Suspected Crime: No . Date/Time Incident Discovered: 4/25/2024 10:00 AM . Incident Summary: Nurse reported a swollen hand. Resident was assessed for pain. X-ray was ordered with positive fracture. Investigation was initiated immediately. Resident is safe in the facility . Review of a Facility Investigation submitted by the facility to the SA dated 4/29/24, documented in part . (R704) requires extensive assistance with ADLs and transfers with 1-to2-person assistance . Swelling was observed on 4/24/24 by nursing assistant and reported to the staff nurse . ordered an X-ray for the right hand and the results were read on 4/25/24. The results showed a fracture of the 4th digit at P1 segment . The resident stated a white man . who works here came in 3-4 days ago and hurt him twisted his hand I told him to stop but he kept going. It's very painful . Immediate suspicion of staff member based on the resident description and who cared for the resident was preliminary suspended pending investigation . As a result of the allegation stated by resident, all residents on the unit were interviewed regarding safety and if they were being treated inappropriately by any staff member specifically male staff care givers. In addition, if the resident were not interview able <sic> they had a head-to-toe skin evaluation completed. There were no negative findings . Staff schedule was reviewed for 4/23/24 and 4/24/24. A staff member matching that description was reviewed and suspended pending completion of investigation. An interview was conducted with staff member. Staff member (CNA K) reports caring for the resident on 4/23/24 and remembers the hand swelling but also knows the resident is combative and does sometimes resist care. He also reports when these situations occur, he gets another staff member to hold his hands . An interview was conducted with the ADON (Assistant Director of Nursing) who reports receiving a phone call from the facility on 4/15/24 from nurse on shift reporting the (CNA K) was refusing to provide the resident a shower. The ADON interviewed (CNA K) regarding the shower refusal. (CNA K) reported the resident was combative when offering the shower so he went to get another (CNA M). ADON confirmed the resident was combative while I went to get the Hoyer from (CNA M) . Conclusion . It is determined the fracture was contributed to the resident having comorbidities with lead induced gout and osteoarthritis around the joints and the factors of the staff assisting him with hygiene during outburst, that the fracture located at the 4th digit P1 segment most likely occurred when the hands were held, and the resident was moving his hands around . An onsite investigation was conducted regarding the injury of unknown origin. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed R704 was initially admitted to the facility in 2017, with a readmitted [DATE] and diagnoses that included: dementia, hemiplegia and hemiparesis affecting the right dominant side, chronic kidney disease and most recently a fracture of the fourth metacarpal bone. A Brief Interview for Mental Status (BIMS) score completed on 4/25/24 documented a score of 3, which indicated severely impaired cognition. R704 required staff assistance for all Activities of Daily Living (ADLs). Review of a Nursing note dated 4/24/24 at 12:20 PM, documented in part . Assigned CENA (Certified Nurse Assistant) notified writer that while providing routine ADL care, he noticed resident's right hand was swollen. Once writer arrived, writer observed swelling to the back of resident's right hand and swelling to the 4th and 5th digit. Writer asked resident what happened to his hand, resident replied, no while attempting to guard his hand. Writer obtained residents vitals, assessed resident for pain and notified (physician name). Resident is alert to name only and requires total assistance with ADL care and assistance with meals. Resident is currently sitting upright in geri-chair inside the main dining room . Another note was documented by the nurse that noted a STAT (immediate) x-ray ordered to R704's right hand. This note indicated the facility was aware and had identified the unwitnessed and unexplained swelling to the right hand of R704 on 4/24/24, not 4/25/24 as indicated as the date and time discovered as reported to the SA. Review of the radiology report dated 4/24/24 and signed by the physician who interpreted the report documented the date of 4/24/24 at 9:42 PM. This indicated the facility was aware of the Acute fracture of the fourth digit at the P1 segment as documented on the radiology report on 4/24/24. Review of the Incident report revealed the facility reported this incident to the SA and local police dept a day later on 4/25/24. Further review of the incident report revealed the facility started the investigation into the injury of unknown origin on 4/25/24. Review of a facility policy titled Abuse updated 5/24/23, documented in part . The facility will ensure that all allegations involving abuse . mistreatment, injuries of unknown source . are reported immediately to the Administrator and Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to the other officials . law enforcement . Review of the incident report to the SA reported the perpetrator to be Unknown initially, although the facility was in possession of R704's interview that contained a description of the perpetrator, and matched the description of CNA K, an aide who had cared for the resident on 4/23/24 evening shift. Further review of the facility investigation documented the suspension of CNA K pending the results of the alleged abuse investigation. Review of the facility's investigation documented R704 required extensive assistance with ADLs and transfers with 1-to-2-person assistance. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R704's care plans revealed R704 required a two-person assistance for bed mobility, toilet use and transfers with the use of the mechanical lift. The facility did not report an accurate transfer assistance level for R704 to the SA. Review of the facility's investigation report documented the screening and assessment of all residents for safety, being treated inappropriately by any staff member, specifically male staff care givers and There was no negative findings. Review of a statement obtained by Unit Manager II (UMII) O during the investigation and screening of the facility residents documented R705 reported the following on 4/25/24, . Has anyone ever hurt you in this facility? Yes, 2-person (1) person description - Fat, (2) person is pregnant . Do you feel safe in this facility? NO because of that she is afraid . The facility failed to acknowledge R705's statement on the investigation report, failed to report it to the SA and investigate R705's allegations. Review of a statement obtained from Certified Nursing Assistant (CNA J) documented in part (no date), . (R704) does hit or grab only when you attempting to put him in Hoyer lift. He grabs the sling but does not flail his arms. I stopped going into patient's rooms with (CNA K) because he makes me uncomfortable and feel <sic> scared he talks aggressively to staff and sometimes patients, and one time I experienced him talking to (R705's name) in a different language and she became very upset screaming at him to get out, he had to of said something that he wasn't supposed to say to her. This statement was not provided initially from the Administrator when asked by the surveyor for the facility's investigation in its entirety regarding the injury of unknown origin for R704 on 5/1/24. On 5/2/24 at approximately 11:33 AM, the Administrator (who also serves as the facility's Abuse Coordinator) was asked why CNA J's statement was not provided in the investigation file provided and the Administrator stated they were unsure. At 2:01 PM, the Administrator emailed CNA J's statement to the surveyor. CNA J's statement contained an allegation of verbal abuse and/or mistreatment that was not reported to the SA. Review of R704's record revealed no care plan implemented that identified the resident to be combative with staff while they provided care. Review of the medical record revealed no documentation of the resident to have been identified to be combative during care performed by the facility staff and no other incidents of unexplained swelling despite having the diagnosis of lead-Induced Gout. Review of the Medical Diagnosis for R704, revealed no documentation of the resident to have a diagnosis of osteoarthritis as reported by the facility to the SA on their investigation. On 5/2/24 at 11:23 AM, the Administrator, ADON (who filled in for the Director of Nursing while they were out on medical leave), and the Regional Nurse Consultant (RNC) G were interviewed together. The Administrator was asked why the facility did not report the injury of unknown origin on 4/24/24 when the unexplained and unwitnessed swelling of R704's right hand was first identified, and the Administrator stated they were not informed of the swelling until the x-ray results were read on 4/25/24. The Administrator was then asked why the verbal abuse/mistreatment allegations that involved R705 was not reported to the SA and the Administrator did not respond. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R708 Review of the medical record revealed R708 was admitted to the facility initially in 2011, with a readmitted [DATE] and diagnoses that included: dementia and epilepsy and required staff assistance for all ADLs. Review of a progress note dated 4/22/24 at 9:51 AM, documented in part . Pt (patient) sister (R708's sister name) stated to writer that resident told her that during day shift while he was in front of dietary supervisor's office someone in a white coat punched him in the back. Pt has a language barrier and sister reported incident. Pt was assessed no injury noted to back, per sister resident is complaining of pain and Tylenol was given. Administrator, DON, MD (medical doctor) and responsible party notified. Order given by MD for back x-ray. Vitals taken, within normal limits . On 5/2/24 at 2:23 PM, the Administrator was interviewed and asked if the incident of the allegation of abuse for R708 was reported to the SA and to provide all of the documentation of the investigation into the incident. The Administrator stated they called R708's sister the next day and the sister stated no one hit R708. The Administrator stated they did not have a file on it. At 2:25 PM, an attempt to contact R708's sister via telephone was made, however unsuccessful. At 3:50 PM, the Administrator informed the surveyor that R708's sister was in the room with R708 visiting. On 5/2/24 at 4:00 PM, R708's sister and R708 was observed in R708's room. When asked, R708's sister stated that another resident in the facility that was wearing a white coat punched their brother in the back. R708's sister stated they told the staff they would let it go this time but if it happened again, they wanted it investigated. This allegation of resident-to-resident abuse was not reported to the SA. No further explanation or documentation was provided by the end of the survey.

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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** 41415 This citation pertains to intake: MI00144212. Based on observation, interviews, and record reviews the facility failed to consistently implement preventative interventions to prevent falls for one (R708) of one resident reviewed for falls. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns frequent falls for R708 and unreported injuries. Review of the medical record revealed R708 was admitted to the facility initially in 2011, with a readmitted [DATE] and diagnoses that included: dementia, falls and epilepsy and required staff assistance for all ADLs. Review of the Facility Incident reports for falls, compared to R708's progress notes, revealed the following: On 1/7/24 at 10:52 PM, an unwitnessed fall, that resulted in a deep cut to the left eye. The IDT (Interdisciplinary team) implemented a scoop mattress on 1/8/24 identifying the root cause as seizures. On 1/10/24 at 12:15 PM, an incident of an unwitnessed fall. The IDT team implemented frequent rounding and to complete a urinalysis and culture and sensitivity test. On 1/13/24 at 8:17 PM, witnessed fall, no further interventions implemented by the IDT team. On 1/14/24 at 2:08 PM, a progress note documented an unwitnessed fall. No documentation of review by the IDT team. On 1/17/24 at 4:15 AM, an incident of an unwitnessed fall. The IDT team implemented to offer to take pt (patient) to restroom prior to end of the shift. On 1/17/24 at 2:30 PM, unwitnessed fall, no further interventions implemented by the IDT team. On 1/22/24 at 1 PM, an incident of an unwitnessed fall. On 1/24/24 the IDT educated the staff on toileting resident and keeping wheelchair in room at all times. On 1/24/24 at 5:10 PM, unwitnessed fall. At 6:50 PM, another unwitnessed fall. On 1/25/24 the IDT team documented they were awaiting culture and sensitivity results, pt educated with interpreter and a medication review was completed with the medical doctor. On 1/25/24, 1/27/24 & 1/29/24 all unwitnessed falls. The IDT team on 1/29/24 implemented low profile mat next to bed, On 1/30/24 Administrator and MD (medical doctor) to call guardian to discuss options and on 1/31/24 place wheelchair in hallway to reduce fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/24 and 2/7/24, unwitnessed falls. On 3/11/24 the IDT team implemented non slip pad between wheelchair seat and cushion, orient to surroundings and use of call light, pillows to help resident define edges of bed, provide assistance to transfer and ambulate as needed, bed at transfer height with assistive device, bed in low position when in bed, do not leave on toilet unattended, educate family to notify staff when they are leaving the facility, encourage non-skid footwear to be worn when resident is out of bed. On 3/24/24 at 4:04 PM, unwitnessed fall. The IDT referred the resident to PT (physical therapy)/OT (occupational therapy) services for an evaluation. On 4/25/24 the IDT team implemented, seizure monitoring, additional grab bar in bathroom, approach in calm non hurried manner and encourage to allow assist with ADLs transfers, continue frequent rounding and encourage resident to allow staff to assist him with ADLs. On 5/1/24 at 8:27 PM, sister of (R708) calling out for help, observed by staff holding the resident in the bathroom, stated the resident tried to assist self from toilet to the wheelchair and lost their balance. On 5/2/24 at 9:20 AM, R708 was observed sitting on the side of their bed. No fall mat was observed by the bed side. A brief interview was conducted with Activity Aide (AA) D translating the questions to R708 and interpreting R708's responses. The resident's wheelchair was observed at the bed side of the resident. The resident bed mattress was not a scoop mattress as documented by the facility IDT team in January 2024 and a fall mat was not on the side of the bed as implemented in the care plan. On 5/2/24 at 1:58 PM, a Director of Nursing II (DON) P sent from a sister facility to help the facility on the current survey (in the absence of the facility's DON) was asked to accompany the surveyor to R708's room. Once in the room DON II P was asked if R708's mattress was a scoop mattress as implemented by the IDT team on 1/8/24 and DON II P confirmed it was not. DON II P was informed of the observation made earlier in the day of R708 sitting on the edge of their bed with no fall mat in place by the bedside and the DON II P stated with their knowledge of the resident a fall mat would not be a good intervention. The DON II P was informed it was implemented by the facility's IDT. The mat was found folded in the R708's closet. DON II P stated they would follow up with the facility staff. Review of the IDT notes revealed no documentation of the IDT team to have changed the resident mattress from the scoop mattress implemented on 1/8/24. No further explanation or documentation was provided by the end of the survey.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. 41415 Based on interviews and record reviews the facility failed to consistently implement their Compliance and Ethics Program, for two (R's 704 and 705) of five residents reviewed for abuse/mistreatment and had the potential to affect all 81 residents that resided in the facility, Resulting in the failure of the Administration staff to report suspected violations, prohibit the retributions of employees who report suspected violations (Unit Manager- UM I), failed to consistently identify and respond to violations, and implemented appropriate disciplinary mechanisms for reportable violations (Certified Nursing Assistant- CNA K). Findings include: Review of the facility policy titled Compliance and Ethics Program Policy with the issue date of 11/1/2019, documented in part . This facility is committed to compliance and high ethical standards. The facility has designed, implemented, and enforced a Compliance and Ethics program for promoting quality of care and preventing and detecting criminal, civil and administrative violations . As part of the facility's culture of compliance, the facility provides development and distribution of written standards of conduct, policies, procedures, and protocols that promote the facility's commitment to compliance with areas of potential . abuse, quality of care issues . Established standards of conduct apply to everyone involved in the company. The facility is responsible for the enforcement of standards through disciplinary guidelines. All staff, including individuals providing services under a contract, committing violations of the compliance and ethics program will be subject to disciplinary actions, up to and including termination. It is the duty of each employee to promptly report any suspected violations of . abuse or any other illegal activity . (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/1/24 at 12:10 PM, a telephone interview was conducted with UM I who explained they were no longer employed with the facility as of the day before (4/30/24) due to the investigation that involved R704. UM I stated how they were instructed to interview the staff and residents regarding the abuse allegation incident that involved R704, as well as the other unit managers who were also assigned to different units to ensure all of the residents were interviewed that resided in the facility. UM I stated they were called into the Administrator office on Monday (4/29/24), the Administrator and the Regional Director of Operation (RDO) N was present. UM I stated RDO N asked them to edit the statement they obtained from Certified Nursing Assistant (CNA) J. UM I stated RDO N wanted the statement edited because CNA J had made an allegation of witnessing an alleged verbal abuse incident with CNA K and another facility resident (later identified as R705). UM I stated they felt uncomfortable about what was being asked of them and they had a conversation with the Regional Nurse Consultant (RNC) G and informed them that RDO N asked UM I to edit the statement of CNA J and UM I asked RNC G for further directive on them feeling uncomfortable in editing the statement of CNA J. UM I stated RNC G told them not to do anything they felt uncomfortable doing. UM I stated they went to inform the Administrator and RDO N that they felt uncomfortable editing CNA J statement and asked them to reinterview CNA J so they could obtain their own statement from CNA J. After informing the Administrator and RDO N of their decision, UM I then stated RDO N then stated that UM I obtained the statement of a resident (R705) that documented the allegations of abuse. UM I stated they informed the Administrator and RDO N that they did not interview R705, and the interview was obtained by another Unit Manager (later identified as UMII O). UM I stated RDO N began getting in their face and stated they knew they did the interview for R705 and then told me to get out of the office. UM I stated they were called in the office the next day (4/30/24) at 8 AM and RDO N informed them they were being fired for dishonesty. UM I stated I asked RDO N what I was dishonest about. UM I stated I informed RDO N that I had never been written up for a disciplinary action and always maintained good work ethics and UM I stated RDO N replied well, that's your opinion . Unfortunately, well maybe not unfortunately we are letting you go . UM I stated they asked for a copy of their termination letter and RDO N refused to provide it. On 5/1/24 at 1:38 PM, and interview was conducted with the facility's Assistant Director Of Nursing (ADON) that confirmed UM I consulted with them on 4/29/24 on what they should do in regards of being asked by RDO N to edit the statement they had obtained from CNA J. On 5/2/24 at 11:20 AM, it was confirmed by RNC G that they were consulted by UM I on what they should do in regards of being asked by RDO N to edit the statement they had obtained from CNA J. Review of UM I employee file contained one Employee Counseling & Corrective Action Record dated 4/29/24, however signed off by the Administrator and RDO N on 4/30/24. The form documented in part, . Termination . (UM I name) violated (facility company name) honesty statement from the mission statement of the handbook as evidence by . see attached statement from (RDO N name) . (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the attached statement signed by RDO N documented in part, . On 4/29/24 I was reviewing the investigation file (case that we reported to State of Michigan on injury of unknown origin) which contained several statements from employees etc. I had to question (UM I) about one statement where she provided extra information about another patient. That statement indicated that that Resident (R705) . was very upset etc. I asked (UM I) how she addressed that situation. First, she said that it was addressed, and she had a file about it. I asked her to bring the file. (UM I) stated she does not have it. Then I asked her to please talk to the patient. (UM I) said that she already talked to the patient and patient said that she is ok. I asked (UM I) to write it down. (UM I) stated that she already gave a statement in that regard. I asked (UM I) to show it to me. She took investigation file that I was already reviewing (see beginning of this statement) and she gave it to me. See attached Exhibit A. I questioned (UM I) about this contradictory information, and she stated that it was not her who interviewed resident and that it was another nurse manager. The statement was then signed off by RDO N. The extra information about another patient that the RDO N is speaking of is a verbalized allegation of possible mistreatment, abuse and/or verbal abuse provided by R705. Review of R705's statement, which was attached to UM I termination as Exhibit A documented the following in part, . Date: 4/25/24 . Residents Name: (R705') . Has anyone ever hurt you in this facility? Yes, 2-person, (1) person description- fat, (2) person is pregnant . Do you feel safe in this facility? No, because of that she (R705) is afraid . On 5/1/24 at 1:12 PM, Unit Manager II (UMII) O (identified as the unit manager who obtained the statement from R705). UMII O was asked if they obtained the statement from R705 regarding the alleged allegations of abuse and feeling unsafe in the facility and UMII O confirmed they did obtain the statement from R705. UMII O also confirmed they had not notified the Abuse Coordinator of the allegations and did not elaborate further with R705 of the reported statement. UMII O stated RDO N, and the Administrator called them into the office and asked if they obtained the statement from R705 and UMII O stated they confirmed the handwriting as theirs and confirmed they obtained the statement from R705 and was instructed by RDO N to notify the Administration next time immediately for any allegations of abuse. The verbalized allegations from R705 were not reported to the State Agency. On 5/2/24 at 11:20 AM, the Administrator, ADON and RNC G was interviewed together, with UM I in attendance via speaker phone. The Administrator was asked about UM I' version of the details that led to UM I termination and stated in part . What I remember is (RDO N) never asked her (UM I) to change the statement. She did say that the paragraph didn't belong there, and I do remember her (RDO N) questioning about R705's (statement) . UM I then stated, Well, she (RDO N) told me to completely erase everything else about (CNA K) . The Administrator then stated I don't recall. She (RDO N) never told you to change the statement . she did say that wasn't a part of the investigation, however she did say that it didn't belong in there. UM I was then asked why they were terminated and UM I stated they were told it was because of their dishonesty policy as per (RDO N). UM I stated, I clarified that I was being terminated because you (RDO N) told me that paper was mine and I told her that I didn't take the statement. The Administrator was then asked if it was identified by them and RDO N that UM I did not obtain the statement from R705 during their investigation, but the decision was still made to terminate UM I for the statement and the Administrator confirmed that to be true. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During this interview the Administrator was asked if it was identified by them and RDO N that UM I did not obtain the statement form R705 during their investigation, and yet the decision was still made to terminate UM I for the statement and the Administrator confirmed that to be true. This indicated that what was initially reported by UM I was being approached by the Administrator and RDO N to change the statement they obtained from CNA J and when they refused, was then accused of obtaining a statement from R705 that documented suspicions of allegations of abuse and/or mistreatment and not reporting it to the Abuse Coordinator that resulted in their termination. It was confirmed through interviews with the facility staff regarding the concerns of UM I to have been approached to edit the statement of CNA J and confirmed that UMII O was the staff member who obtained R705's abuse screening interview. Despite knowing all of the above information, UM I was terminated based off of the facility's dishonesty policy, per RDO N. On 5/2/24 at 2:43 PM, an interview was conducted via telephone with RDO N, when asked, RDO N stated the Administrator didn't feel comfortable with the unit managers. RDO N stated in part . I asked (UM I) if she investigated it (R705's statement) and she said that she would clarify it. She (UM I) then said I am not going to change it. I asked her if she leaves it as it is and asked if she went back and asked (R705) and she said she asked her and she is fine and good. She said she talked to the resident and said that she was fine and said that a statement is already in the file. In the statement the resident is saying that people have hurt her, and she doesn't feel safe. That is why I let her (UM I) go, before that the Administrator said she couldn't work with (UM I) or (ADON) because they don't give her (Administrator) the right information . RDO N was then asked regarding the staff having to be put in uncomfortable positions if they want to move up in the company (as stated by the ADON) and the RDO N denied making the statement. The RDO N then stated in part . (UM I) said she talks to the patient (R705) and the patient said she was good, and she said that she already wrote it down . Those three (UM I, ADON and DON- confirmed with RDO N) don't give her (Administrator) the right picture . When asked to provide incidents of UM I, ADON and the DON to not give the right picture to the Administrator, RDO N did not state any known incidents. The RDO N then stated, . (Administrator) was scared of them. I couldn't believe it . These are dangerous employees because (Administrator) was crying, she is scared of them . RDO N was asked why UM I was terminated although UMII O admitted to obtaining the statement from R705 and RDO N stated The nurse manager (UMII O) was honest with me . RDO N then went on to state how the Administrator feels very intimidated and this is how they (RDO N) got involved in the investigation. When asked if they asked UM I to edit the statement of CNA J, RDO N denied it. CNA K Review of an investigation conducted due to CNA K to have been identified as the perpetrator in a suspected alleged abuse/mistreatment incident with R704, who acquired a fracture of the fourth digit at the P1 segment of the right hand, uncovered additional violations regarding concerns of CNA K's work ethic and care. Review of CNA K personnel file contained one disciplinary action that documented the incident with R704 of an allegation of abuse dated 4/25/24. No other verbal, written warnings or disciplinary actions was found in the file. (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/1/24 at 1:12 PM, Unit Manager II (UMII) O (the manager on duty on the evening shift of 4/20/24) was interviewed and when asked stated the nurse made the schedule for the evening shift and CNA K stated they wanted the front assignment on the North unit and informed the nurse that they would go home if they did not assign them that unit. UMII O stated they tried to reason with CNA K and offered them additional units on the facility to work on, however CNA K stated they were not going to another unit and they wanted the front assignment unit on the North unit. UMII O stated I informed CNA K that it would be abandonment of their duties if they clocked out and CNA K' stated they didn't care and clocked out and left. UMII O stated they tried to call in additional staff to cover CNA K assigned residents, however, was unsuccessful and ultimately had to split the residents among the six CNAs on duty. UMII O stated CNA K was scheduled to come in the next day on 4/21/24, however was a no call, no show. On 5/1/24 at 2:18 PM, CNA K was interviewed via telephone and asked why they walked off duty on 4/20/24 and why they were a no call & no show on 4/21/24, CNA K stated they came on duty and completed their rounds on their residents and was informed by the nurse that they were not on their regular set (regarding the front assignment on the North unit). CNA K stated the nurse informed them that they made the schedule and CNA K . didn't like to be talked like this . CNA K stated the supervisor came (UMII O) and CNA K told UMII O that they would rather go home. CNA K stated UMII O told them to stay, and CNA K stated they left. When asked who they passed their assignment/residents to, CNA K stated they didn't know who was taking over, they just left. CNA K asked why they were a no call & no show on 4/21/24 and they stated they had walked off the day before, so they didn't return. When asked who they spoke to from the facility, CNA K stated they received a call from HRD A on 4/23/24, asking them to come back to work, this was verified by CNA K timesheet. CNA K was asked if they were contacted by anyone else from the facility prior to being contacted by HRD A on 4/23/24 to investigate what transpired on 4/20/24 and 4/21/24, CNA K stated they had not spoke to anyone from the facility. Review of a facility policy titled Accepting an Assignment dated 8/8/22, documented in part . This procedure is to ensure that employee assignments are made with a consistent set of rules and expectations. Final delegation of assignments and settling of disputes will be at the discretion of the current supervisor . Any refusals to accept assignment will be considered abandonment of patients and will not be tolerated . Any refusal to accept assignment will be called in to the DON (Director Of Nursing) or designee immediately . On 5/1/24 at 2:46 PM, the DON was interviewed via telephone (the Administrator was out on Medical leave at the time of the survey) . when asked, the DON stated UMII O called them on 4/20/24 to inform them that CNA K walked out of the building and didn't want to do their assignment or take any of the other units offered. The DON stated they told UMII O to inform CNA K that if they left the building it would be considered job abandonment and CNA K clocked out and left the facility. UMII O stated the next day CNA K was a no call and no show. The DON stated a few days later the Administrator and HRD A stated because CNA K is a union member they could not give CNA K a disciplinary action and asked CNA K to return back to duty. It was identified that CNA K accepted an assignment on 4/20/24 evening shift, clocked in at 3:16 PM and clocked out at 4:10 PM and was a no call and no show on 4/21/24. The facility failed to hold CNA K accountable for their actions and failed to implement their facility policy and disciplinary actions. There was no documentation of this incident in CNA K personnel file. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235433	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/1/24 at 3:56 PM, the Administrator and HRD A was interviewed and asked if CNA K has any other written or verbal warnings besides the abuse allegation suspension and HRD A stated CNA K did not have any prior disciplinary actions. The Administrator and HRD A was then asked about CNA K walking off duty on 4/20/24 resulting in job abandonment and asked about CNA K to have been a no call and no show on 4/21/24 and the Administrator stated after they talked to their corporate HR (Human Resources) they were instructed that they had to bring CNA K back. When asked if the Administrator investigated the incident of CNA K job abandonment on 4/20/24 and why they were a no call no show on 4/21/24, the Administrator stated they had not. HRD A then stated CNA K wrote a letter and told them they didn't feel comfortable. When asked why CNA K had no expressed that to the manager on duty or contacted the DON or the Administration staff before making the decision to walk off duty and abandoning their job duty and residents, HRD A did not respond. When asked why the facility did not hold CNA K accountable for their actions and why there was no paper trail regarding their violations, the Administrator and HRD A did not have a response. No additional information or documentation was provided by the end of the survey.