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	10/23/2024

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 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** 34208 This citation pertains to intake #MI00147465 Based on observation, interview, and record review the facility failed to ensure freedom from staff neglect for one resident, (R903) of three residents reviewed for abuse, resulting in a significant delay of administration of an anti-anxiety medication and feelings of sadness, frustration, anger, anxiety, fear, and disappointment with care. Findings include: An abbreviated survey was conducted at [NAME] Nursing and Rehab on 10/23/24 to address the facility reported incident. A review of a facility provided policy titled, Abuse updated 5/24/23 was reviewed and read, Residents have the right to be free from abuse, neglect, exploitation, mistreatment .Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .Neglect: Failure of the facility, it's employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . On 10/22/24 at 10:08 AM, a review of R903's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: mouth cancer, protein calorie malnutrition, adult failure to thrive, dysphagia (difficulty swallowing), presence of a feeding tube, and anxiety disorder. R903's Minimum Data Set assessment dated [DATE] revealed they were cognitively intact and ranged from independent to set-up assist and supervision for various activities of daily living. A review of a progress note entered into the record by Regional Nurse Consultant 'F' dated 10/1/24 at approximately 5:45 PM revealed R903 had received a new order from Dr. 'E' for Ativan (anti-anxiety medication) 0.5mg (milligrams) by mouth every six hours, as needed. R903's orders were reviewed and revealed the order for the Ativan had been entered into the computer as an active order by Nurse Consultant 'F' on 10/1/24 at 5:47 PM. On 10/22/24 at 11:48 AM review of facility provided investigation documents for an incident between R903 and Licensed Practical Nurse (LPN) 'B' was conducted. The documents contained the following: (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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(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	An incident summary that read, .On 10/1/24 at approximately 9:30 pm, the Administrator was notified that a physical altercation occurred between the resident (R903) and LPN ('B'). When the Administrator asked the nurse what happened, (LPN 'B') stated, When I was giving him the medication, he stood up out of his wheelchair and punched me in the face 5 times. I pushed him back down into his wheelchair .In conclusion, it was identified that the nurse (LPN 'B') neglected to provide the resident with the PRN (as needed) Ativan that he was requesting for approximately 4 hours. A review of R903's physician's orders and medication administration record (MAR) revealed the following: A signed physician's order from Dr. 'E' dated 10/1/24 at 5:47 PM for Ativan 0.5 mg every 6 hours, as needed for anxiety. A MAR for October 2024 that indicated LPN 'B' administered R903's Ativan at 9:25 PM, approximately four hours after the medication had been ordered. Continued review of the facility's investigation revealed the following witness statements: A statement by the facility's Administrator dated 10/2/24 that read, I was approached by (R903) in the 1 north <sic> hallway on 10/1/2024. It was probably between 5 and 5:30 p.m. He said 'I want my Ativan. The nurse said I have medication in the cart, but it's not in the computer. I don't know what that means. Can you help me?' I approached the nurse (LPN 'B') who was standing at the med cart and asked her what he meant as she was standing with an <sic> ear shot of me and the resident. She said 'he <sic> has a sleeve of medication in the cart with his name on it, but I don't have an order for it.' I asked if I could see something on her computer real quick. I clicked on the order tab in (eMAR program) to view the completed/struck out/discontinued orders and found a PRN order for Ativan that looked to have ended due to the 14 day stop day. She seemed to be irritated already so I told her I would get one of the nurse managers to see if they could get an updated order. I called (Regional Nurse Consultant 'F') .and asked her if she could assist with getting the order quickly, and she said yes. Before I left for the evening, around 7:15 p.m., I walked down the 1 north hallway up to (LPN 'B') and told her that the order was in and to make sure she gives (R903) his medication . Around 9:15 p.m. my cell phone rang at home. The call ended before I could get my phone. I saw it was (LPN 'B') and I called her back 8 times in a row before I got a hold of her. When she answered she said she was busy being a nurse and a CNA (certified nurse aide) and she's tired .She continued 'So I'm down here working hard and I'm tired and I want to take a break, but the resident (R903) is starting to call me names and follow me around.' I asked if she had given him the Ativan yet. She said No, and that she told the resident she wanted to take her break and that he needs to give her a minute .I told her at this point he has been waiting for the Ativan for 4 hours and to give it to him. I explained that he had a rough day and she knew that, and all of this could be avoided if she had just given him the medication that he has been asking for. She kept going back and forth with me essentially giving reasons why she should take a break instead of giving him his medication .I told her no less that 5 times to 'just give him the medication'. She finally said Ok <sic> and we hung up the phone . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	About 10-15 minutes later, my phone rang again. It was (LPN 'B'). I answered .and she screamed 'YOUR PATIENT JUST PUNCHED ME IN THE FACE!' .I asked her what happened exactly? she said 'He was talking all this stuff to me and called me a (expletive) .I just started to pop his pills and when I was giving him the medication he stood up out of the wheelchair and punched me in the face 5 times and I pushed him back down into his wheelchair and called 911'. I asked her if she was okay and if she needed to go to urgent care and she said 'I'm pressing charges and I'm probably not coming back!' .A few minutes later I texted (LPN 'B') with (DON, Director of Nursing) included on the message to let (LPN 'B') know she was suspended .(The DON) informed me that (LPN 'B') threatened to bring her husband to the facility to beat the resident up . A statement from the facility's DON dated 10/2/24 was reviewed and read, I missed a call from (LPN 'B') at 9:08 p.m. I called her back at 9:21 p.m. I spoke to her about the resident (R903). She stated that she didn't have an Ativan order for him .I texted (Dr. 'E') for Ativan and I told (LPN 'B') that per (Dr. 'E') it was okay to enter the order and give the medication. I spoke to her again around 10 p.m. when she stated she was punched by the resident and she was going to call her husband to come into the facility because the resident was harassing her .I said to her that she cannot call her husband to come to the building .you cannot fight the patient, you cannot do anything to the patient .She said 'What am I supposed to do if the patient is hitting and punching me?' I said 'Get away from the patient, that's a patient!' I also told her that (Registered Nurse, RN 'A') is going to take care of that patient . It was noted, R903 had an order obtained by Regional Nurse Consultant 'F' for Ativan dated 10/1/24 at 5:47 PM, prior to LPN 'B' calling the facility's DON and them calling Dr. 'E'. Continued review of the witness statements revealed a statement dated 10/2/24 from RN 'A' that read, . Yesterday I was coming from one south <sic> and the resident (R903) approached me and stated that the nurse was not giving him his medication and while we were talking, the nurse (LPN 'B') came from outside. I told her that the resident wants his medication and the nurse stated 'I have to take my break because I am entitled to one' and she left to go on her break. The resident then stated 'you see how she is treating me'. It was about 9pm <sic>. The don (Director of Nursing) called me asked me to tell the nurse (LPN 'B') that she could not call her husband to come to the building . A statement from LPN 'B' dated 10/2/24 was reviewed and read, When I came onto the shift, (R903) was getting into it with (LPN 'G') .He was being petty .He said he wanted Ativan. I told him I saw a sleeve of Ativan in the drawer but you don't have an order for it. I told him to let me call the doctor, and just give me a minute. He asked who he can talk to about this .Then the Administrator was coming around the hall. We had addressed it with her because she was on the hall. She was going to call the nurse practitioner or somebody to see if she could get an order. I was still working .Sometimes my blood sugar drops. I don't feel like I need to explain to the patient that I'm lightheaded. I told him to give me a minute. He was saying I was waiting all day, now I got to wait for you to take a break. I went out the door to call the Administrator .She told me that in the meantime that I called her I could have given him his medication. I come <sic> back in the building and (RN 'A') is standing there. RN 'A' said he (R903) needs his meds. I told them I'm going to get them .I called (the DON) and (the DON) said not to panic and to give him his meds . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A statement from R903 dated 10/2/24 was reviewed and read, I was attacked by one of the nurses .What happened to me should not have happened to me or any other resident in the facility .She didn't give me the Ativan. I was asking for it. She pushed me in the chair. I swung at her .She pushed me down. I stood back up because I didn't want her to trap me in the chair .The police came but it took a while .The girl (LPN 'B') told me in front of everybody she was going to get her husband to come up here and beat me up. I guess I was harassing her .or non-stop asking for my Ativan and my pain medicine. My anxiety was running high because I had not had my anxiety pill all day. She put a road block in so I went around to talked <sic> to the Administrator and she said she was going to work on it and see if she could get the medicine quicker. Every time I went to the nurse she kept saying it's got to get in the computer. You don't have to keep coming to me. When it gets into the computer I will come to you .The lady said I'm tired from doing all that work to get your medicine and I want to take a break. (RN 'A') said why don't you give him the medicine first. She snapped at (RN 'A') and said I want to take a break. She turned around and disappeared at the nurse's station. I sat in my doorway and watched for her and she eventually came out. I asked her if she felt better now? She said No <sic> My <sic> contract tells me I can take a break whenever I want and if you keep talking you're going to have to get this medicine from someone else. I told her the contract says she has to take care of patients and she's holding me up from getting my medicine. I asked her why she is still talking about what your contract says instead of giving me my medicine- that's time you could be giving me the medicine. She said, 'Look I'm done. Someone will be here in a couple of hours to give you your medicine'. She went over to the computer and started typing and was giving the guy next to me his medicine .She kept treating it like the medicine order wasn't in the computer. (RN 'A') ended up giving me the medicine . A witness statement from a resident dated 10/2/24 was reviewed and read, .The nurse (LPN 'B') called 911. I saw her do that. Then she said she was going to call her husband also insinuating that he was going to come and beat the resident (R903) up. It started over his medication. All day she was having altercations with people. She got really funny with me. I asked her (LPN 'B') what her name was. She looked at me really funny and said how many times do you have to ask me what my name is? You've asked me 7 times. I told her I've had a stroke so I don't remember some of the names sometimes. Then she got really funny with me. She was hard to get along with. She has a major attitude. She has a great big chip on her shoulder. She said an awful lot of the F word. It was very loud. She was very loud and trying to throw her weight around .I heard her using the F word at times. That I know for a fact because that's what brought me out into the hall. A review of another resident witness statement dated 10/2/24 was conducted and read, .The nurse warned him a few times to stop bothering her because she's busy and has all these people to take care of. Then there must have been a fight. I heard her say she was going to call her husband . On 10/23/24 at 9:24 AM, a telephone interview was conducted with RN 'A' regarding their recollection of the incident between R903 and LPN 'B'. RN 'A' said they went downstairs for something and while down there R903 approached them and said the nurse (LPN 'B') did not give him his medicine. RN 'A' said while they were talking with R903, LPN 'B' came into the building from outside and he told her to give R903 his medication. They continued to say LPN 'B' told them they were, Entitled to a break. RN 'A' said they thought LPN 'B' had returned from their break since they had come in from outside and they were going to give R903 his medication. RN 'A' said they went back upstairs and shortly after received a call from the facility's DON who told them not to let LPN 'B's husband into the building as LPN 'B' had threatened to have their husband come to the facility to, beat up R903. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/23/24 at 10:38 AM, a telephone interview was conducted with LPN 'B' regarding the incident with R903. LPN 'B' said R903 got, aggressive with them around 9:00 in the evening on 10/1/24, and punched them in the face. They continued to say R903 wanted his Ativan at about 5:30 PM but they didn't have an order for it. They said R903 went to the Administrator and the Administrator was going to get the order. They were asked why they didn't administer the medication around 9 PM after the Administrator obtained the order earlier in the evening and they said, I didn't know if the order was in. They were asked about their phone call to the Administrator just prior to the incident and said the Administrator told them they obtained the order and to give R903 the medication. They further said RN 'A' also came downstairs and told them to administer R903's medication. They were again asked why they delayed checking for the order and administering the medications when the order was entered at 5:47 PM and they said, Every time I tried, he rolled up on me and I couldn't check. They were then asked if they could have asked for assistance from another nurse in the building to check for the order and administer the medication and said they could have. They were also asked if they threatened to call their husband to come to the facility and they denied the threat. On 10/23/24 at 1:00 PM, an interview was conducted with the facility's Administrator, DON, and Regional Nurse Consultant 'F' regarding the incident. They reported Nurse Consultant 'F' obtained the order for R903's Ativan at 5:47 PM. The Administrator said they told LPN 'B' the order was in and to give R903 his medication prior to them leaving the building at approximately 7:30 PM. The Administrator said LPN 'B' called them at approximately 9:15 and they sounded, aggravated. The Administrator said they asked LPN 'B' if they gave R903 their Ativan and LPN 'B' said they had not. The Administrator then said they told LPN 'B' several times over the phone to give them their medication. The Administrator said the whole incident could have been avoided if LPN 'B' did not neglect giving R903 their medication several hours after the order was obtained. They further indicated they terminated LPN 'B's employment and reported the incident of neglect to the appropriate licensing agencies. On 10/23/24 at 1:30 PM, R903 was observed in their room. An interview was conducted with R903 regarding the incident with LPN 'B'. They were hesitant to speak of the incident, but eventually said, She attacked me and knocked me into my chair. They were asked if they knew what provoked the incident and said, they were having a bad day and they wanted their anxiety medication. They admitted ly said, I was bugging her for it, but she wouldn't give it to me. He further explained earlier in the evening the Administrator told him the order had been obtained and he asked for it several times but LPN 'B', denied to give it to him. At that time in the interview, it was observed tears were [NAME] up in R903's eyes and began running down their cheeks. R903 then went on to say the nurse was, purposely withholding my medications. Through tears R903 then said, She is a horrible nurse, I cannot believe she could be that mean on purpose. She was so aggravated with me, but all she had to do was give me my medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 34275 This citation pertains to Intake(s): MI00147253 and MI00147444 Based on observation, interview and record review, the facility staff failed to timely report allegations of sexual abuse to the Administrator/Abuse coordinator to ensure timely reporting to the State Agency for one (R901) out of three residents reviewed for abuse. Findings include: A complaint and FRI (facility reported incident) were reported to the State Agency (SA) that alleged on or about 9/25/24 an outside male visitor entered R901's room and allegedly engaged in oral sex with the resident. R901 was noted as suffering from dementia, memory deficit and had a court appointed guardian. On 10/22/24 at approximately 12:44 PM, R901 was observed sitting in their wheelchair. The resident was alert but not able to answer regarding the allegation noted above. A review of R901's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: dementia, psychotic disorder with delusions and memory deficit. A review of the residents Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 5/15 (severely cognitively impaired cognition). The (name redacted) police case report was reviewed and documented, in part, the following: .Report Date/Time: 9/28/24 at 4:49 PM .were dispatched to Facility for a possible CSC (criminal sexual conduct) .dispatch advised that the possible CSC occurred on 9/24/25. The victim is [R901] who has a physician statement stating that she cannot make her own decisions. Upon arrival I (hereinafter officer J) spoke with the Administrator who stated that staff member (herein after Certified Nursing Assistant/CNA H) saw the incident. Officer spoke with [CNA H] who stated she walked into the room and the suspect (herein after suspect/visitor I) was standing behind the door zipping his pants up. [R901] was seen in her wheelchair in front of him as if she was giving him oral sex. [CNA H] stated that there was also another incident where suspect/visitor I was found in [R901's] room when he should not have been but nothing sexual occurred. [CNA H] stated that [R901's] room door is never closed and is always open and she said that it was odd when the incident occurred .Officer spoke with [R901] who could not seem to recall the incident. [R901] has dementia and seemed to talk about topics that were unrelated to the incident .Officer spoke with resident who stated she knows suspect/visitor I .and stated that suspect/visitor I comes in and gives [R901] candy or soda. On the day of the incident the resident stated she spoke with [R901] after the issue. [R901] stated suspect/visitor I kissed her on the cheek and hugged her and told her that she has a new boyfriend . On 10/1/24, I (Detective K) was assigned these suspicious circumstances investigation .Administrator was advised that there is no evidence of a crime at this point .I (Detective K) offered to contact suspect/visitor I for the Administrator to advise him not to return to the facility . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility investigation summary noted, in part, the following: .Resident: R901 .Alleged Perpetrator(s): suspect/visitor I .Facility report received online submission: 9/28/24 .Investigation summary: . 9/25/24 around 4 PM suspect/visitor I signed in .On 9/28/24 around 2:30 PM, Administrator was notified that there was an allegation made by CNA staff that earlier in the week, a visitor engaged in oral sex with [R901] . On CNA (hereinafter CNA H) stated she approached the residents room and the door was closed. She walked into the resident's room, and the male visitor was standing right behind the door and close to the wall where the door hinges are. The CNA stated that [R901] was sitting in her wheelchair very close to the visitor facing his waist and the male visitor appeared to be zipping up his pants. The CNA states that she did not observe any genitals. The CNA further stated that she saw him in [R901's] room a few weeks ago and thought it was odd .(other resident) endorsed the male visitor as suspect/visitor I .(other resident) states that when suspect/visitor I brings her something .he will bring it for [R901] .(other resident) states that on 9/25/24, suspect/visitor I stepped out the room while staff were changing her roommate, and shortly after, staff told (other resident) to get him out of [R901's] room .the other resident explained that there was another time previously that she found out suspect/visitor I went in [R901's] room .(other resident) also states that there was a time .that her and suspect/visitor I got into a fight on the phone and she told him she never wanted to see him again. However, he came into the facility, signed in to see (other resident) and actually went to another female resident's room .and brought her some treats or candy .The CNAs involved were issued corrective action related to abuse reporting . On 10/22/24 at approximately 2:46 PM, a phone interview was conducted with CNA H . CNA H reported that they started working at the facility around July 2024. The CNA was asked about the incident that occurred involving R901 and suspect/visitor I. CNA H reported that on 9/25/24 they saw that R901's door was closed and they thought it was strange their door was closed. They opened the door and observed suspect/visitor I zipping up their pants and they were very shocked and told CNA C. CNA H further reported that they had seen suspect/visitor I in R901's room on another occasion. When asked if they reported either incident to the Administrator/Abuse coordinator according to facility policy, they stated that they did not. They indicated that due to their delay in reporting they received in-service training. CNA H did indicate that they reported the incident observed on 9/25/24 to CNA C. On 10/22/24 at approximately 3:30 PM, an interview was conducted with CNA C. The CNA was asked about the incident involving R901 and suspect/visitor I. They reported that CNA H told them about the incident and thought it occurred either on Tuesday (9/24/24) or Wednesday (9/25/24) but they also did not report the incident per facility policy. CNA C did note that they did report the incident to CNA L. On 10/22/24 at approximately 3:51 PM, an interview was conducted with CNA L. The CNA was asked about the allegation/incident involving R901 and suspect/visitor I and reported that CNA L told them about the incident on the phone and they had been busy with school and should have reported it to the Administrator/Abuse coordinator sooner. On 10/23/24 at approximately 12:44 PM an interview was conducted with the Administrator/Abuse coordinator. The Administrator was asked about the facility policy pertaining to reporting allegations of sexual abuse and the failure of staff to do so timely. The Administrator confirmed that staff failed to report the allegation timely and received in-service abuse training. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Abuse (updated 5/24/23) was reviewed and documented, in part, the following: Policy Overview: Residents have the right to be free from abuse .The facility will educate the staff in identifying abuse (.sexual abuse .) .Initial Reporting: The facility will ensure that all allegations involving abuse .are reported 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 .and to other officials (including adult protective services and/or law enforcement, when applicable .