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	05/15/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview, and record review the facility failed to ensure the resident's active Durable Power of Attorney (DPOA) wishes for their family member's code status was accurately followed for one (R34) out of five residents reviewed for advanced directive/code status. Findings include: On [DATE] at 8:35 AM, R34 was observed walking around in their room. The resident was alert, but not able to answer any questions asked. Review of R34's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Parkinsonism, vascular dementia and depressive disorder. A review of the resident's Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] (significantly impaired cognition). The face sheet noted that R34 was a FULL CODE. Continue review of the clinical record documented, the following: [DATE]: DPOA Paperwork: Indicated that R34 had nominated Family Member 1 as their DPOA for healthcare. [DATE]: (facility name) Advanced Directive: I (R34) have determined that these are my Advanced Directive for my care during my stay at (facility name) .directives will be followed by the facility .Cardiopulmonary Resuscitation & Respirator (CPR) - Answer: NO (Do-Not-Resuscitate) .IV's: Answer: NO . [DATE]: Documents noted that R34 was again deemed incompetent and not able to make their own decision. [DATE]: (facility name) Advanced Directive: I (R34) have determined that these are my Advanced Directive for my care during my stay at (facility name) .These directives will be followed by the facility unless revoked at later date: CPR- Answer: YES (FULL CODE) .IV's- Answer: YES . This document was signed by Family Member 2 on [DATE] and witnessed by Social Worker (SW)W. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at approximately 11:48 AM, an interview and record review were conducted with Social Worker (SW) J. SW J reported that they had been working intermittently for the facility for about one year. SW J asked if it was facility protocol to allow R34's, Family Member 2 to change the resident's code status and IV choices from NO (DNR) to YES (FULL CODE). SW J noted that only a resident's legal representative has the right to change a resident's code status. SW J reported that SW W no longer works at the facility and would contact Family Member 1 to discuss the advanced directive. Social Work Note ([DATE]) noted: .Writer (SW J) spoke with residents DPOA to discuss advanced directives as there was a conflicting document from 2022 signed by Family Member 2 stating resident is FULL CODE. DPOA (Family Member 1) confirmed that resident prior advanced directive DNR status is the corrected advanced directive . The facility policy titled, Advance Directives ([DATE]) was reviewed and documented, in part: .It is the policy of the facility that the resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advance directives related to code status are honored in accordance with state law and facility policy .Do Not Resuscitate (DNR) indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, durable power of attorney for health care decisions (DPOA) .legal representative to make health care decisions regarding the resident's code status has directed no CPR .if the resident/or their legal representative has chosen for the resident's code status to be Do-Not-Resuscitate : . the form is filled out and includes the resident signature or resident's legal representative signature, two witness signatures and physician signature .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake# MI00142649 Based on observation, interview and record review the facility failed to inform the resident's family/legal guardian of a room change, physician recommendations and enquire as to vaccination recommendations for one (R38) out of two residents reviewed for change in condition. Findings include: A complaint was filed with the State Agency (SA) that alleged that the facility was not informing them as to why the resident was changing rooms, not providing complete medical information and generally not answering and/or returning calls. On 5/13/24 at approximately 8:41 AM, R38 was observed lying in bed. The resident was alert but not able to answer many questions asked. A review of the resident's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Parkinsons Disease, Dementia and falls. Review of the resident's Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3/15 (severely impaired cognition). The resident was noted as having a court appointed legal guardian. Continued review of R38's record noted the resident changed rooms one time over the past year on 10/20/23. A review of the resident's note did not indicate the reason for the change and/or noted that the resident's legal guardian was informed. A nursing note dated 3/25/24 documented, Writer spoke with resident guardian who requested the resident see a neurologist for his Parkinson's disease .Appointment scheduler made aware. A nursing note dated 4/15/24 documented, Resident was seen by (name redacted) at (name redacted) Neurological Center .Resident returned with the following recommendations:follow-up appointment .Adjust Sinemet (medication for Parkinson's disease) .Encourage oral hydration .corrective physical therapy . suggest lumbar radiology . *There was no indication in R38's record that the resident's legal guardian was informed about the resident's appointment. Review of R38's Immunization record revealed Consent Refuse for the influenza vaccine. Review of R38's Influenza Vaccine Authorization dated 11/3/23 read in part, .Information provided to patient . Relationship to Resident: self . The resident will not receive the influenza vaccine due to refusal . *It should be noted that there was no indication in the resident's clinical record that R38's legal guardian was informed that the influenza vaccine was offered to the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at approximately 1:47 PM, an interview and record review were conducted in the Administrator office. New Administrator A was present along with Regional Nurse Consultant Z. When asked as to the facility protocol for informing residents legal representatives/guardians of notification on change in condition, change in room census, medical service recommendations and contacting them regarding vaccination opportunities, Nurse Z reported that legal representatives/guardians should be contacted. Nurse Z was able to review R38's clinical record and could not locate any documentation that the resident's guardian was informed of a room change, provided findings following a neurology appointment and informed that the facility was offering the influenza vaccine. The facility policy titled, Change in Condition Notification (8/9/23) was reviewed and documented, in part: .It is the policy of the facility to notify .the resident's designated representative of changes in the resident's medical/medical condition and/or status .The nurse will notify the .residents designated representative when there is: .a need to alter the resident's medical treatment .such as a new treatment .discontinuation of current treatment . a room or roommate change .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on interview and record review, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) for one resident (Resident #76) of three residents reviewed for Beneficiary Notices, resulting in the resident and/or the representative not being informed of the right to appeal and the potential for undue emotional and financial hardships. Findings include: Record review revealed R76 was admitted for skilled rehabilitation and nursing services after hospitalization on [DATE]. R76's admitting diagnoses included sepsis, acute respiratory failure, and muscle weakness. Based on the Minimum Data Set (MDS) assessment dated [DATE], R76 had a Brief Interview for Mental Status score of 8/15, indicative of moderate cognitive deficits. During an observation on 5/13/24, at approximately 9:30 AM, in their room R76 reported to the surveyor that they would like to get stronger and walk. Their therapy services ended last week due to their insurance. Review of R76's Electronic Medical Record (EMR) revealed that skilled services ended on 5/6/24. On 5/15/24, an e-mail was sent to the facility administrator requesting the Medicare beneficiary notices provided to the resident/legal representative regarding the ending of Medicare and their rights to appeal for R76. The completed worksheet revealed that R76/legal representative was not provided with Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) and notice of Medicare Non-coverage (NOMNC) prior to ending of Medicare Part A services. An interview was completed with the Business Office Manager DD on 5/15/24 at approximately 2:30 PM. BOM DD was queried on why R76/legal representative did not receive the appropriate beneficiary notices prior to ending of the Medicare Part A services and they reported that the facility missed the notices as they were in the transition with the social work department. They did not have a social worker onsite and they understood the concern. On 5/15/24, at approximately 2:40 PM, the Administrator was notified of the concern related to R76 not receiving the appropriate beneficiary notices. The Administrator reported that they were not aware that R76/legal representative did not receive the notices and they understood the concern.

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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** 47283 This citation pertains to Intake Number(s): MI00138288, MI00140123, and MI00144352. Based on observation, interview, and record review, the facility failed to protect three (R33, R35, and R21) residents' rights to be free from physical and verbal abuse by staff and other residents (R50 and R61). Findings include: R33 Record review revealed R33 was a long-term resident of the facility originally admitted to the facility on [DATE]. R33 had a hospitalization during their stay at the facility. Most recently they were readmitted to the facility on [DATE]. R33's diagnoses included polyneuropathy, liver failure, spinal stenosis, and osteoarthritis. Based on most the recent Minimum Data Set (MDS) assessment dated [DATE], R33 had a Brief Interview for Mental Status (BIMS) score of 10/15, indicative of moderate impairment with their cognition. A facility reported incident that was submitted to the state agency dated 10/5/23 revealed that R33 suffered physical and psycho-social harm inflicted by an LPN (Licensed Practical Nurse) approximately 6 months ago (between 3/23/23 and 3/28/23) that was witnessed by a CNA (Certified Nursing Assistant). The investigation summary also read (R33 name omitted) stated that she pulled and twisted (gender pronoun omitted) arm some time ago. When asked since (gender omitted) falls frequently if she was trying to help (gender pronoun omitted) up, (gender omitted) stated that it was more out of anger that she pulled (gender pronoun omitted) arm. When asked if anything happened when (gender omitted) was on the floor, (gender omitted) said that she yelled at (gender pronoun omitted) and kicked .did not claim to sustain physical injury from the incident. (gender omitted) cried profusely throughout the interview. The alleged perpetrator and the witness who failed to report the abuse continued to work at the facility after the incident (for approximately over 6 months) until their employment was terminated after investigation, that was initiated on 10/5/23. The investigation report also revealed that that witness had reported to the abuse coordinator that they were fearful of the perpetrator. Review of the report from the local Police Department (PD) revealed that the local PD was notified of the staff witnessed abuse that happened over 6 months ago (in March 2023) and was reported to the abuse coordinator/administrator on 10/5/23 at 3 PM, was reported to local PD on 10/6/23, at 11:30 AM. The report that was grouped under aggravated/felonious assault read in part, (R33 name omitted) continued that (perpetrator name omitted) is always mean to (gender pronoun omitted) and is very aggressive with her words. (R33 name omitted) advised that (perpetrator name omitted) has only assaulted (gender pronoun omitted) the one time which was a about five months ago, when (gender pronoun omitted) had fallen down in (gender pronoun omitted) room .It should be noted that (R33 name omitted) was still distraught from the incident and cried throughout our conversation . Further review of the local PD report revealed that the CNA had witnessed the entire incident and it read, (Witness name omitted) continued that she saw (perpetrator) kick (R33 name omitted) while (gender pronoun omitted) was on the floor, and then proceed to lift (gender pronoun omitted) up with (gender pronoun omitted) arm, while itwas behind (gender pronoun omitted) back . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An initial observation was completed on 5/13/24, at approximately 12:45 PM. An interview was completed during this observation. R33 was queried about their stay at the facility and how they were treated by the facility staff. R33 reported that they liked their stay at the facility and most of the staff were nice. When queried further, R33 reported that the staff member who were mean to them no longer worked at the facility. Multiple follow-up observations were completed throughout the survey between 5/13/24 and 5/15/24. R33 remembered the surveyor and they were able to recall and ask to follow up questions from the previous visit/conversations. Review of R33's Electronic Medical Record (EMR) revealed that R33 had a guardian (sister) and they were under hospice care. Review of the investigation report read, The guardian (name omitted) was interviewed on 10/6/2023. She stated that (relationship omitted) complained about 6 months ago that the nurse pulled his arm and kicked (pronoun omitted) (Guardian name omitted) stated that (relationship omitted) understands and knows what's going on cognitively but needs help with medical decisions. Further review of EMR revealed that R33 had a BIMS score of 15/15, based on MDS assessments dated 1/11/24 and 10/11/23. Review of a social work progress note dated 10/5/23 at 14:29, read Resident made an allegation of abuse that has been reported to the State of Michigan. At readmit resident was anxious, depressed, tearful, and resistant to care. Resident focus was on the incident. Resident was difficult to stay on task. Resident mood behavior should be monitored as needed .referred resident to psych. A progress note dated 10/6/23, at 14:26 read Conducted wellness visit secondary to an abuse allegation. Resident was emotional about (gender omitted) concern but content with the facility response to ensure safety. Recommended psych services follow-up and to continue to monitor (gender pronoun omitted) well-being. A social work progress note dated 10/6/23 at 15:37 read in part, Resident is a readmit to the facility. Resident is alert and orientedx3. Resident scored a 15 on the readmit BIMS assessment. Resident to sign on to (Provider name omitted) Choice hospice 10/7/23. Resident RX (prescribed) lorazepam for agitation. Resident presented with alteration in mood. Resident has periods of tearfulness since readmit. Referral sent to (provider name omitted) for medication management and supportive therapy. An interview was completed with Human Resource (HR) Director T on 5/14/24 at approximately 4:45 PM in the Administrator's office. HR Director T was queried about the incident and how they had narrowed down the dates as the incident was reported after approximately 6 months. HR Director T reported that the CNA who witnessed the incident was speaking with them about the alleged perpetrator (LPN) and they were upset about how the LPN was treating them (witness). When the director T queried further on why, the CNA reported that the LPN had been upset as they had witnessed the LPN being physically abusive to R33 several months ago. They added that when they heard this from the CNA they had followed up with the unit manager and the abuse coordinator (Administrator) at that time. The Administrator followed up with their investigation. Director T reported that both staff members were terminated upon completion of the investigation. HR Director T was queried how they had narrowed down the time frame for the incident. They reported that the CNA was able to recall the time frame as the incident happened prior to their scheduled vacation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview with the Administrator was completed on 5/14/24, at approximately 4:35 PM. The administrator who investigated and reported the incident was no longer working at the facility. The current reported that they were aware of the incident and harm. They also reported that the incident was not reported timely and confirmed that both the perpetrator and witness were terminated. Administrator was notified that the incident was not reported to the local PD timely and it was reported the next day (approximately after 21 hours) from time it was [NAME] to the attention of the abuse coordinator (previous administrator). Administrator reported that they understood the concern. An interview was completed with Assistant Director of Nursing (ADON) who was covering as the interim DON, on 5/15/24 at approximately 8:30 AM. ADON was queried about the abuse prevention and reporting process. ADON reported that if staff witnessed any abuse they should intervene and stop to ensure that resident were safe and report to the abuse coordinator (administrator) immediately. Abuse coordinator would initiate the investigation and notification. Notified of the staff to resident abuse to R33 and concern with not reporting timely. ADON reported that this was prior to their current role as ADON and they understood the concerns. 32568 R50 and R35 A review of a complaint submitted to the State Survey Agency revealed multiple allegations of resident to resident abuse, including an allegation that R50 physically assaulted R35 by hitting him 5 times in the head. On 5/13/24 at approximately 8:30 AM, R35 was observed seated on the side of his bed eating breakfast. When interviewed, R35 appeared confused, but did answer some questions. When queried about whether he was previously in another room with a different roommate, R35 reported he was. R35 began rubbing his arms and stated, I have these knots here on my arm. When queried about any issues or altercations that occurred with his previous roommate, R35 reported that was why his room was changed. R35 stated, He came after me, then he left, and I don't know. He was in and out. On 5/13/24 at approximately 8:45 AM, R50 was observed walking in the hallway pushing an empty wheelchair. When addressed R50 did not respond to any questions or greeting. A review of R35's clinical record revealed R35 was admitted into the facility on [DATE] with diagnoses that included: vascular dementia and a personal history of childhood abuse. A review of a MDS assessment dated [DATE] revealed R35 had severely impaired cognition and no behaviors. A review of an Incident Note dated 3/27/24 at 4:11 AM, written by Registered Nurse (RN) 'M', revealed, Resident involved in physical altercation at approximately 0325 (3:25 AM) with roommate .Room changed . A review of an incident report for R35 dated 3/27/24 at 3:30 AM, completed by RN 'M', revealed, CENA (Certified Nursing Assistant) heard a noise entered the room to investigate sound observed (R50) strike (R35) 4 times. It was documented that R35 stated, He just hit me. The incident report noted that R35 grabbed R50's footboard (on the bed) to propel forward in the wheelchair. It was noted that Certified Nursing Assistant (CNA) 'N' was a witness to the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 5/14/24 at 9:03 AM, an interview was conducted with RN 'M' via the telephone. When queried about the incident that occurred between R35 and R50 on 3/27/24, RN 'M' explained a CNA reported to her that R35 was trying to propel in the wheelchair out of the room, grabbed R50's bed to help move forward, and R50 assaulted (R35) in the head. RN 'M' explained R50 was known to have aggressive and threatening behaviors if anyone touched his stuff or even if staff were to bump up on his bed. RN 'M' reported R50 would have done better in a private room due to his aggressive and threatening behaviors toward others. RN 'M' further reported she moved R35 to another room, but R50 received another roommate and had a roommate currently. RN 'M' further reported the facility had a lot of resident to resident incidents. On 5/14/24 at 9:14 AM, a telephone interview was attempted with CNA 'N'. CNA 'N' was not available prior to the end of the survey. A review of R50's clinical record revealed R50 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Wernicke's encephalopathy (a neurological disorder) and adjustment disorder. A review of a MDS assessment dated [DATE] revealed R50 had intact cognition and no behaviors. However, there was witnessed resident to resident abuse that was perpetrated by R50 on 3/27/24, which was within the seven day look back period for the MDS assessment. A review of R50's progress notes revealed no documentation that he had hit R35 in the head on 3/27/24. A review of a care plan initiated on 3/27/24 revealed, The resident is/has potential to be physically aggressive r/t (related to) poor impulse control. A review of an Incident Report dated 3/27/24 at 3:52 AM written by RN 'M' revealed, CENA reported to writer that she observed resident physically struck roommate (R35) approximately 4 times .Resident refused to speak . On 5/14/24 at 3:04 PM, an interview was conducted with the Administrator who was the facility's Abuse Coordinator. The Administrator reported she was unaware that R50 hit R35 in the head on 3/27/24 and first heard about it that day (5/14/24). 34275 R21 and R61 On 5/13/24 at approximately 8:27 AM, R21 was observed sitting in their room in a wheelchair. The resident was alert and able to answer all questions asked. When asked if they felt safe in the facility, R21 stated that they do now, but not in the past. R21 reported that they lived in a different room with R61 who at many times was psychotic and verbally aggressive. They further reported that they finally had had enough of the roommate's verbal abuse after they started yelling antisemitic slurs at them. R21 stated about a week or so ago their roommate (R61) was snoring loudly, and they had to turn up their TV, after doing so, R61 yelled at them and stated, Turn off the TV you dirty [NAME] and then said, the only good [NAME], is a dead [NAME]. R21 stated that they reported the incident to the Administrator. R21 noted that that they were allowed to change rooms and hoped they never will run into R61 again. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of R21's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: end stage renal disease and pressure ulcers to the left heel. A review of the resident MDS noted the resident had a BIMS score of 13/15 (cognitively intact cognition). There were no behavior concerns noted in R21's MDS. The census section in the resident electronic medical record (EMR) noted the resident changed rooms on 5/7/24. There was no documentation in R21's record that noted why there was a room change. On 5/13/24 at approximately 2:19 PM, a request for any Investigation/Accident (IA) reports and/or grievances and/or Facility Reported Incidents (FRI) pertaining to R21 and R61. *No documents pertaining to incidents between R21 and R61 was provided by the end of the survey. On 5/14/24 at approximately 11:19 AM, an interview was conducted with the Administrator/Abuse Coordinator. When asked if R21's had ever reported an incident with their roommate (R61) they indicated that they did. When asked what the incident involved, the Administrator reported that it had something to do with the television and statements and worries about the resident (R21) being Jewish. When asked if there had been any investigation into the incident and whether they could provide any documentation pertaining to any incidents involving R21 and R61. They further noted that they moved R21 out of the room and they believed the resident felt safe after that. On 5/15/23 at approximately 8:53 AM, an interview was conducted with R61. R61 was asked about R21 moving out of their room. R61 noted that they did not get along and that they had a difference of opinion when it came to religion. R61 did not provide any further information. A review of R61's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that include end stage renal disease and depression. A review of the resident's MDS noted the resident had a BIMS of 15/15 (intact cognition). Continued review of R61's clinical record documented, in part, the following: 2/29/24: Alert Note: Behavior concerns have been noted by care staff . 2/27/24: Alert Note: Behavioral Concerns have been noted by staff. Resident will become angry and use inappropriate language towards staff . 12/26/23: Psychiatry: .seen as urgent consult .to assess mood. Refused to go to multiple dialysis sessions and has been agitated at dialysis .he is aware of the consequences of refusing dialysis .he does not like his roommate and wants the roommate out of the room. He has had 5 other roommates .he was seen in his room. He was irritable during the visit and admits to being frustrated .he does not want any psych meds . *It should be noted that at the time of the interview with psychiatry, R61 was roommates with R21. 12/15/23: Behavior Note: Resident came to SW (social worker) office cursing and yelling obstinacies <sic>about his roommate smell and want him out his room. SW advised that if he is unable to co-assist with his room and he is the one not happy then he is the one that has chosen to move. Resident continue to yell and state he is not moving. It should be noted that at the time of this interview with the SW, R61 was roommates with R21. Further the SW who authored this Note was no longer employed by the facility as such no interview was conducted. Again, no documentation was provided regarding incidents pertaining to R21 and R61. (continued on next page)

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	235433	A. Building B. Wing	05/15/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	A review of a facility policy titled Abuse, updated 5/24/23, revealed, in part, the following: Residents have the right to be free from abuse .:

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 49083 Based on observation, interview, and record review, the facility failed to appropriately store resident property for two residents (R9, R67) of two reviewed for personal property, allowing for the potential loss and or theft of personal possessions. Findings include: On 5/15/24 at 8:35 AM, A medication storage observation was conducted with Licensed Practical Nurse (LPN) Y with the One South Back medication cart. Observation in the narcotic box identified a Ziplock baggie with black writing identified with R9's name and room number. A Ziplock bag was observed to have one ten-dollar bill on one side, and when turned over, a one-dollar bill. More bills were layered in between but the denominations were not observed. Placed next to the bag of cash, a small black cell phone encased in a black phone case was identified with a return address sticker identifying as a relative of R67. LPN Y acknowledged that resident's money and personal items should not be stored in the medication cart. LPN Y was unclear what the facility policy was for personal property storage, but indicated money was supposed to be in the business office. LPN Y placed the money and cell phone back into the narcotic drawer. On 5/14/24 at 4:42 PM, the Assistant Director of Nursing (ADON) was informed of the finding and confirmed that a resident's money should never be stored in a medication cart and should be placed with the business office. The ADON also confirmed any residents' property are never to be stored in a medication cart. The ADON was informed LPN Y placed the items back into the cart after the observation. A facility policy was requested for personal belonging storage and was not received 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00140123 and MI00144352. Based on interview and record review, the facility failed to report actual and alleged physical and verbal abuse to the Abuse Coordinator, law enforcement, and/or the State Agency within the required time frame for six (R7, R21, R33, R35, R50, and R61) of 11 residents reviewed for abuse, resulting in an approximately six month delay in investigating physical abuse of R33 by a staff member who continued to work in the facility during that time. Findings include: R50 and R35 A review of a complaint submitted to the State Survey Agency revealed multiple allegations of resident to resident abuse, including an allegation that R50 physically assaulted R35 by hitting him 5 times in the head. A review of an Incident Note dated 3/27/24 at 4:11 AM, written by Registered Nurse (RN) 'M', revealed, Resident involved in physical altercation at approximately 0325 (3:25 AM) with roommate .Room changed . A review of an incident report for R35 dated 3/27/24 at 3:30 AM, completed by RN 'M', revealed, CENA (Certified Nursing Assistant) heard a noise entered the room to investigate sound observed (R50) strike (R35) 4 times. It was documented that R35 stated, He just hit me. The incident report noted that R35 grabbed R50's footboard (on the bed) to propel forward in the wheelchair. It was noted that Certified Nursing Assistant (CNA) 'N' was a witness to the incident. A review of R35's clinical record revealed R35 was admitted into the facility on [DATE] with diagnoses that included: vascular dementia and a personal history of childhood abuse. A review of a MDS assessment dated [DATE] revealed R35 had severely impaired cognition and no behaviors. On 5/14/24 at 9:03 AM, an interview was conducted with RN 'M' via the telephone. When queried about the incident that occurred between R35 and R50 on 3/27/24, RN 'M' explained a CNA reported to her that R35 was trying to propel in the wheelchair out of the room, grabbed R50's bed to help move forward, and R50 assaulted (R35) in the head. RN 'M' further reported she contacted the Director of Nursing (DON), physician, and R35's family member. RN 'M' explained the Administrator was the facility's Abuse Coordinator and she asked the DON for her phone number and the DON refused to give it to her. On 5/14/24 at 9:14 AM, a telephone interview was attempted with CNA 'N'. CNA 'N' was not available prior to the end of the survey. A review of R50's clinical record revealed R50 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Wernicke's encephalopathy (a neurological disorder) and adjustment disorder. A review of a MDS assessment dated [DATE] revealed R50 had intact cognition and no behaviors. However, there was witnessed resident to resident abuse that was perpetrated by R50 on 3/27/24, which was within the seven day look back period for the MDS assessment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R50's progress notes revealed no documentation that he had hit R35 in the head on 3/27/24. A review of a care plan initiated on 3/27/24 revealed, The resident is/has potential to be physically aggressive r/t (related to) poor impulse control. A review of an Incident Report dated 3/27/24 at 3:52 AM written by RN 'M' revealed, CENA reported to writer that she observed resident physically struck roommate (R35) approximately 4 times .Resident refused to speak . On 5/14/24 at 3:04 PM, an interview was conducted with the Administrator who was the facility's Abuse Coordinator. When queried about when resident to resident abuse was reported to the State Agency, the Adminsitrator reported it depended on whether the resident was harmed or if there was injury and whether the perpetrator had intent. When queried about how it was determined if a resident was harmed when some residents, particularly residents with cognitive impairment may not show obvious signs of harm, the Administrator reported it depended on the resident. When queried about R50 being witnessed hitting R35 in the hit multiple times, the Administrator reported it was not reported to the State Agency. The Administrator reported she was unaware that R50 hit R35 in the head on 3/27/24 and first heard about it that day (5/14/24). The Administrator further explained if it had been reported to her immediately, she would have reported it to the State Agency. R7 On 5/14/24 at 7:41 AM, all incident reports and investigations pertaining to R7 were requested from the Administrator. A review of several typed and signed statements revealed the following: A typed statement signed by the Assistant Director of Nursing (ADON) dated 2/6/24 noted the following: Around 6:30pm writer went to speak with (R7) related to nurse coming to DON/ADON stating 'resident in (R7's room number) has some serious allegations and I need to report abuse she is really upset'. Writer asked nurse what was allegation? The nurse responded, 'she is really upset, and she is saying the 'N' word'. The writer then told the nurse any abuse allegation will need to be reported to the administrator as soon as possible. The nurse was unsure who (R7) had allegations against and could not tell writer and DON exactly what the resident said to her. The writer went down to speak to the resident. On arrival in the room, the resident was in bed sitting on the side asked the resident, can she tell me what happened during the shift. Resident stated, I was sitting here, and he wanted to move my wheelchair and shook his ass in my face and said he'll beat my son ass, my ass and his ass and smacked his ass and took my wheelchair' . On 5/14/24 at 3:04 PM, an interview was conducted with the Administrator. When queried about whether the allegations noted in the statement mentioned above, the Administrator reported they interviewed the CNAs and determined it was unfounded and therefore did not report the allegations. When queried about why there was no statement from the nurse who reported the allegation, the Administrator explained the ADON would have more information. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 3:25 PM, an interview was conducted with the ADON. When queried about the documented statement with allegations of abuse made by R7 on 2/6/24, the ADON reported a nurse who no longer worked at the facility (RN 'X') reported the allegation to her. The ADON explained RN 'X' said it was serious but did not give any specific information. The ADON further reported herself and the DON spoke with R7 who was really upset but that she did not say anything about abuse only about grits or food or something. When queried about why there was no statement from RN 'X', the ADON did not offer a response. The ADON explained that the allegation was reported to the Administrator and was unsure if it was reported to the State Agency. On 5/15/24 at 11:48 AM, an interview was conducted with Human Resources Director (HR) 'T'. When queried about what happened with R7 on 2/6/24, HR 'T' reported at the end of the shift, a nurse came into the HR office and said R7 told her that she was abused. At that time, HR 'T' called in the CNAs and reported it to the Adminsitrator. After talking to the CNAs (CNA 'I' and CNA 'S'), HR 'T' reported it appeared R7 was upset that they were caring for her roommate and moved R7's wheelchair, but HR 'T' still reported it to the Administrator because R7 alleged abuse. HR 'T' did not recall what the allegation was. A review of R7's clinical record revealed R7 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: schizophrenia and dementia. A review of a MDS assessment dated [DATE] revealed R7 had intact cognition and no behaviors. A review of a facility policy titled, Abuse, updated 5/24/23, revealed, in part, the following: .The facility will ensure that all allegations involving abuse .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 .and to other officials (including .law enforcement) . 34275 R21 and R61 On 5/13/24 at approximately 8:27 AM, R21 was observed sitting in their room in a wheelchair. The resident was alert and able to answer all questions asked. When asked if they felt safe in the facility, they stated that they do now, but not in the past. R21 reported that they lived in a different room with R61 who at many times was psychotic and verbally aggressive. They further reported that they finally had had enough of the roommate's verbal abuse after they started yelling antisemitic slurs at them. R21 stated about a week or so ago their roommate (R61) was snoring loudly, and they had to turn up their TV, after doing so, R61 yelled at them and stated, Turn off the TV you dirty [NAME] and then said, the only good [NAME], is a dead [NAME]. R21 stated that they reported the incident to the Administrator. R21 noted that that they were allowed to change rooms and hoped they never will run into R61 again. A review of R21's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: end stage renal disease and pressure ulcers to the left heel. A review of the resident MDS noted the resident had a BIMS score of 13/15 (cognitively intact cognition). There were no behavior concerns noted in R21's MDS. The census section in the resident electronic medical record (EMR) noted the resident changed rooms on 5/7/24. There was no documentation in R21's record that noted why there was a room change. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/24 at approximately 2:19 PM, a request for any Investigation/Accident (IA) reports and/or grievances and/or Facility Reported Incidents (FRI) pertaining to R21 and R61. *No documents pertaining to incidents between R21 and R61 was provided by the end of the survey. On 5/14/24 at approximately 11:19 AM, an interview was conducted with the Administrator/Abuse Coordinator. When asked as to R21's had every reported an incident with their roommate (R61) they indicated that they did. When asked what the incident involved, the Administrator reported that it had something to do with the television and statements from R61 about resident (R21) being Jewish. When asked if there had been any investigation into the incident and whether they could provide any documentation pertaining to any incidents involving R21 and R61, the Administrator noted that they did not have any documentation. When asked why they did not report the incident to the State Agency (SA) they stated that they felt the resident was felt safe after they transferred to a new room on a different hallway. On 5/15/23 at approximately 8:53 AM, an interview was conducted with R61. R61 was asked about R21 moving out of their room. R61 noted that they did not get along and that they had a difference of opinion when it came to religion. A review of R61's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that include end stage renal disease and depression. A review of the resident's MDS noted the resident had a BIMS of 15/15 (intact cognition). Continued review of R61's clinical record documented, in part, the following: 2/29/24: Alert Note: Behavior concerns have been noted by care staff . 2/27/24: Alert Note: Behavioral Concerns have been noted by staff. Resident will become angry and use inappropriate language towards staff . 12/26/23: Psychiatry: .seen as urgent consult .to assess mood. Refused to go to multiple dialysis sessions and has been agitated at dialysis .he is aware of the consequences of refusing dialysis .he does not like his roommate and wants the roommate out of the room. He has had 5 other roommates .he was seen in his room. He was irritable during the visit and admits to being frustrated .he does not want any psych meds . *It should be noted that at the time of the interview with psychiatry, R61 was roommates with R21. 12/15/23: Behavior Note: Resident came to SW (social worker) office cursing and yelling obstinacies <sic>about his roommate smell and want him out his room. SW advised that if he is unable to co-assist with his room and he is the one not happy then he is the one that has chosen to move. Resident continue to yell and state he is not moving. It should be noted that at the time of this interview with the SW, R61 was roommates with R21. Further the SW author of this Note was no longer employed by the facility. 47283 R33 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R33 was a long-term resident of the facility originally admitted to the facility on [DATE]. R33 had had hospitalization during their stay at the facility. Most recently they were readmitted to the facility on [DATE]. R33's diagnoses included polyneuropathy, liver failure, spinal stenosis, and osteoarthritis. Based on most recent Minimum Data Set (MDS) assessment dated [DATE], R33 had a Brief Interview for Mental Status (BIMS) score of 10/15, indicative of moderate impairment with their cognition. A facility reported incident that was submitted to state agency dated 10/5/223 revealed that R33 suffered physical and psycho-social harm inflicted by an LPN (Licensed Practical Nurse) approximately 6 months ago (between 3/23/23 and 3/28/23) that was witnessed by a CNA (Certified Nursing Assistant). The investigation summary also read (R33 name omitted) stated that she pulled and twisted (gender pronoun omitted) arm some time ago. When asked since (gender omitted) falls frequently if she was trying to help (gender pronoun omitted) up, (gender omitted) stated that it was more out of anger that she pulled (gender pronoun omitted) arm. When asked if anything happened when (gender omitted) was on the floor, (gender omitted) said that she yelled at (gender pronoun omitted) and kicked .did not claim to sustain physical injury from the incident. (gender omitted) cried profusely through the interview. The alleged perpetrator and the witness who failed to report the abuse continued to work at the facility after the incident (for approximately over 6 months) until their employment was terminated after investigation, that was initiated on 10/5/23. The investigation report also revealed that that witness had reported to the abuse coordinator that they were fearful of the perpetrator. Review of the report from the local Police Department (PD) revealed that the local PD was notified of the staff witnessed abuse that happened over 6 months ago (in March 2023) and was reported to the abuse coordinator/administrator on 10/5/23 at 3 PM, was reported to local PD on 10/6/23, at 11:30 AM. The incident that happened in March-2023 was reported to the abuse coordinator on 10/5/23 and abuse coordinator reported to the local PD approximately 20 hours after the witnessed abuse allegation was brought to their attention.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00144325 and MI00143575. Based on observation, interview, and record review the facility failed to investigate witnessed and alleged resident to resident physical and verbal abuse and failed to thoroughly investigate a bruised eye of unknown origin for five (R21, R35, R50, R61, R66) of 11 residents reviewed for abuse. Findings include: R50 and R35 A review of a complaint submitted to the State Survey Agency revealed multiple allegations of resident to resident abuse, including an allegation that R50 physically assaulted R35 by hitting him 5 times in the head. A review of an Incident Note dated 3/27/24 at 4:11 AM, written by Registered Nurse (RN) 'M', revealed, Resident involved in physical altercation at approximately 0325 (3:25 AM) with roommate .Room changed . A review of an incident report for R35 dated 3/27/24 at 3:30 AM, completed by RN 'M', revealed, CENA (Certified Nursing Assistant) heard a noise entered the room to investigate sound observed (R50) strike (R35) 4 times. It was documented that R35 stated, He just hit me. The incident report noted that R35 grabbed R50's footboard (on the bed) to propel forward in the wheelchair. It was noted that Certified Nursing Assistant (CNA) 'N' was a witness to the incident. A review of R35's clinical record revealed R35 was admitted into the facility on [DATE] with diagnoses that included: vascular dementia and a personal history of childhood abuse. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R35 had severely impaired cognition and no behaviors. On 5/14/24 at 9:03 AM, an interview was conducted with RN 'M' via the telephone. When queried about the incident that occurred between R35 and R50 on 3/27/24, RN 'M' explained a CNA reported to her that R35 was trying to propel in the wheelchair out of the room, grabbed R50's bed to help move forward, and R50 assaulted (R35) in the head. RN 'M' further reported she contacted the Director of Nursing (DON), physician, and R35's family member. RN 'M' explained the Administrator was the facility's Abuse Coordinator and she asked the DON for her phone number and the DON refused to give it to her. RN 'M' further explained that R50 had a history of threatening and aggressive behaviors and would get angry if anyone even brushed against or touched his things. RN 'M' reported she believed R50 On 5/14/24 at 9:14 AM, a telephone interview was attempted with CNA 'N'. CNA 'N' was not available prior to the end of the survey. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R50's clinical record revealed R50 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Wernicke's encephalopathy (a neurological disorder) and adjustment disorder. A review of a MDS assessment dated [DATE] revealed R50 had intact cognition and no behaviors. However, there was witnessed resident to resident abuse that was perpetrated by R50 on 3/27/24, which was within the seven day look back period for the MDS assessment. A review of R50's progress notes revealed no documentation that he had hit R35 in the head on 3/27/24. A review of a care plan initiated on 3/27/24 revealed, The resident is/has potential to be physically aggressive r/t (related to) poor impulse control. A review of an Incident Report dated 3/27/24 at 3:52 AM written by RN 'M' revealed, CENA reported to writer that she observed resident physically struck roommate (R35) approximately 4 times .Resident refused to speak . On 5/14/24 at 3:04 PM, an interview was conducted with the Administrator who was the facility's Abuse Coordinator. When queried about what was done to investigate the witnessed physical abuse by R50 toward R35 to determine the root cause and how to prevent future incidents, the Administrator reported she was unaware that R50 hit R35 in the head on 3/27/24 and first heard about it that day (5/14/24). The Administrator further explained if it had been reported to her she would have investigated it. 34275 R21 and R61 On 5/13/24 at approximately 8:27 AM, R21 was observed sitting in their room in a wheelchair. The resident was alert and able to answer all questions asked. When asked if they felt safe in the facility, they stated that they do now, but not in the past. R21 reported that they lived in a different room with R61 who at many times was psychotic and verbally aggressive. They further reported that they finally had had enough of the roommate's verbal abuse after they started yelling antisemitic slurs at them. R21 stated about a week or so ago their roommate (R61) was snoring loudly, and they had to turn up their TV, after doing so, R61 yelled at them and stated, Turn off the TV you dirty [NAME] and then said, the only good [NAME], is a dead [NAME]. R21 stated that they reported the incident to the Administrator. R21 noted that that they were allowed to change rooms and hoped they never will run into R61 again. A review of R21's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: end stage renal disease and pressure ulcers to the left heel. A review of the resident MDS noted the resident had a BIMS score of 13/15 (cognitively intact cognition). There were no behavior concerns noted in R21's MDS. The census section in the resident electronic medical record (EMR) noted the resident changed rooms on 5/7/24. There was no documentation in R21's record that noted why there was a room change. On 5/13/24 at approximately 2:19 PM, a request for any Investigation/Accident (IA) reports and/or grievances and/or Facility Reported Incidents (FRI) pertaining to R21 and R61. *No documents pertaining to incidents between R21 and R61 was provided by the end of the survey. (continued on next page)

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Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at approximately 11:19 AM, an interview was conducted with the Administrator/Abuse Coordinator. When asked as to R21's had every reported an incident with their roommate (R61) they indicated that they did. When asked what the incident involved, the Administrator reported that it had something to do with the television and statements from R61 about resident (R21) being Jewish. When asked if there had been any investigation into the incident and whether they could provide any documentation pertaining to any incidents involving R21 and R61, the Administrator noted that they did not have any documentation. When asked why they did not report the incident to the State Agency (SA) they stated that they felt the resident (R21) felt safe after they transferred them to a new room on a different hallway. When asked why the they did not conduct a full investigation to ensure the safety of residents in the facility, again the Administrator reported that they felt R21 was safe after they changed rooms. The Administrator did indicate that would reach out to the Assistant Director of Nursing (ADON) to see if they had any additional documentation as to the alleged incident(s). No documentation was provided by the end of the survey. On 5/15/23 at approximately 8:53 AM, an interview was conducted with R61. R61 was asked about R21 moving out of their room. R61 noted that they did not get along and that they had a difference of opinion when it came to religion. A review of R61's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that include end stage renal disease and depression. A review of the resident's MDS noted the resident had a BIMS of 15/15 (intact cognition). Continued review of R61's clinical record documented, in part, the following: 2/29/24: Alert Note: Behavior concerns have been noted by care staff . 2/27/24: Alert Note: Behavioral Concerns have been noted by staff. Resident will become angry and use inappropriate language towards staff . 12/26/23: Psychiatry: .seen as urgent consult .to assess mood. Refused to go to multiple dialysis sessions and has been agitated at dialysis .he is aware of the consequences of refusing dialysis .he does not like his roommate and wants the roommate out of the room. He has had 5 other roommates .he was seen in his room. He was irritable during the visit and admits to being frustrated .he does not want any psych meds . *It should be noted that at the time of the interview with psychiatry, R61 was roommates with R21. 12/15/23: Behavior Note: Resident came to SW (social worker) office cursing and yelling obstinacies <sic>about his roommate smell and want him out his room. SW advised that if he is unable to co-assist with his room and he is the one not happy then he is the one that has chosen to move. Resident continue to yell and state he is not moving. It should be noted that at the time of this interview with the SW, R61 was roommates with R21. Further the SW author of this Note was no longer employed by the facility. 49083 Resident #66 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Facility Reported Incident (FRI) investigation Intake #MI00143575 report submitted 3/18/24 at 12:55 PM, indicating bilateral orbital (eye) trauma of unknown origin for R66. On 5/20/24 at 9:00AM, a clinical record review of the MDS dated [DATE] revealed R66 was admitted to the facility on [DATE] with anoxic brain damage (brain damage that occurs when the brain has no oxygen), dysphagia (difficulty speaking, swallowing) cardiac arrhythmia, blood clots, long term anticoagulation (blood thinning medication). R66 psychiatric diagnosis included psychotic disorder with delusions, anxiety and depression. A Brief Interview for Mental Status (BIMS) score resulted 5/15 indicating R66 was severely cognitively impaired. The FRI submitted by the facility did not substantiate any form of abuse to R66 but identified the orbital trauma was a result of long-term use of Aspirin and Eliquis (a medication that thins the blood) and sleeping pattern of R66 places hand in a fist and holds into the eye. The FRI report included witness statements all identified observations of R66 not having any trauma to the eye/s and a physical trauma evaluation was not included in the report. On 5/14/24 at 12:05 PM, An interview was conducted with Registered Nurse (RN) Q that revealed she was the assigned RN for R66 on Friday 3/15/24 from 7:00 AM until 3:30 PM and no orbital trauma was present. RN Q was assigned Saturday 3/16/24 to R66 and was notified around 10:00 AM by Certified Nurse Assistant (CNA) AA that while delivering the breakfast tray to R66, obvious eye trauma was observed. RN Q described R66 right eye was red in color, and looked fresh. When asked why the statement included in the FRI only depicted the last time R66 was observed with no trauma, RN Q said the facility requested the statement to only include when R66 did not have trauma. On 5/14/24 at 1:13 PM, CNA AA was interviewed and confirmed when delivering the breakfast tray to R66 the right eye looked like a black eye and immediately notified RN Q. CNA AA also confirmed the statement taken by the facility was typed up and only wanted information of when R66 did not have trauma. On 5/14/24 at 4:51 PM, The Nursing Home Administrator (NHA) who is also the facilities Abuse Coordinator was interviewed and when asked why the witness statements included in the FRI did not identify an author, the NHA was unable to recall. When questioned why the statements primarily documented when R66 did not have trauma, the NHA stated they were trying to establish a timeline of when the trauma could have happened. The NHA was informed that RN Q was interviewed, and a timeline was established yet, this was not included in the investigation. The NHA then shrugged their shoulders and had no comment. Further clinical record review identified R66 was still taking Aspirin and Eliquis, and no orbital trauma was observed during the survey. When inquired how the use of chronic blood thinning medications was determined as the source of the trauma the NHA said the physician indicated bruising is a side effect of Aspirin and Eliquis. The NHA was informed that R66 continues to take Aspirin and Eliquis, probably has not changed their sleeping position, and has no trauma to the eyes. The NHA shrugged their shoulders and had no comment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Abuse, updated 5/24/23, revealed, in part, the following: .Any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator. The Administrator initiates investigating any allegations of abuse against a patient .Key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse. It is the Center's policy to investigate all alleged violations involving Abuse .including Injuries of Unknown Source to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident .The investigation process included: .Determining the purpose of the investigation and issue(s) to be investigated, whether or not the alleged violation has occurred, the extent, and cause .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations .Conducting observation of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other resident, and interactions/relationships between resident to other residents as applicable .Providing complete and thorough documentation of the investigation .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to ensure accurate assessments were completed for one (R50) of 32 residents reviewed for Minimum Data Set (MDS) assessments. Findings include: On 5/14/24 at 7:42 AM, a review of R50's clinical record revealed R50 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Wernicke's encephalopathy (a neurological disorder). A review of R50's most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R50 had no behaviors, including no rejection of care in the seven day look back period from 3/12/24 through 3/18/24. A review of R50's previous comprehensive annual MDS assessment dated [DATE] revealed R50 had no behaviors, including no rejection of care in the seven day look back period from 12/10/23 through 12/16/23. A review of R50's progress notes revealed the following: On 12/11/23, R50 refused medication x 3. On 12/25/23, R50 refused vitals .Resident noncompliant with medication intake and ADL (activities of daily living) assistance . On 3/12/24, R50 refused shower this afternoon. Further review of R50's progress notes revealed R50 refused care, medications, treatments, and services almost daily, including rehabilitation services, being weighed, and laboratory services. On 5/15/24 at 2:30 PM, an interview was conducted with MDS Coordinator 'U'. MDS Coordinator 'U' reported the social services department completed the behavior section of the MDS assessments and then she checked for accuracy and signed off on the assessment. When queried about R50's MDS assessments that documented he did not reject care, MDS Coordinator 'U' reported the MDS assessment should be accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to ensure a level I Preadmission Screening (PAS)/Annual Resident Review (ARR) Mental Illness/Intellectual Disability/Related Conditions Identification was completed on admission and/or annually and sent to local community mental health for a level II OBRA (Omnibus Budget Reconciliation Act of 1993) evaluation for two (R7 and R67) of three residents reviewed for PASARR. Findings include: A review of R7's clinical record revealed R7 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Schizophrenia, dementia with other behavioral disturbance. A review of R7's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed the following: Section A1500 for Preadmission Screening and Resident Review (PASRR) was marked No for the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? . It was documented in the MDS that R7 had diagnoses of schizophrenia. A review of R7's PASARR documentation revealed a PASARR, Level I screening was completed on 12/21/23 when R7 was in the hospital. It was documented that R7 had a current diagnoses and received treatment for mental illness and was prescribed an antipsychotic medications in the last 14 days. The Level II screening was completed by the hospital on 12/21/23 and indicated R7 had a hospital exempted discharge and was expected to require less than 30 days of nursing services (in the facility). R7 remained in the facility as of 5/15/24 and there was no evidence that a PASARR Level I or Level II screening were completed in the facility. A review of R67's clinical record revealed R67 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: anxiety disorder, major depressive disorder, psychotic disorder with hallucinations, and dementia. A review of R67's annual MDS assessment dated [DATE] revealed the following: Section A1500 for Preadmission Screening and Resident Review (PASRR) was marked No for the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? . It was documented in the MDS that R67 had diagnoses of anxiety disorder, depression, psychotic disorder, and dementia. A review of R67's PASARR documentation revealed a PASARR, Level I screening was completed on 9/2/22 when R67 was admitted into the facility. It was documented that R67 had a current diagnoses and received treatment for mental illness, was prescribed an antipsychotic or antidepressant medications within the last 14 days, and there was presenting evidence of mental illness or dementia which included significant disturbances in thought, conduct, emotions, or judgement. There was no Level II screening present in the electronic medical record for R67 and no Level I screening completed since 2022. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 9:28 AM, an interview was conducted with Director of Social Services 'J'. Director of Social Services 'J' reported R7 should have had a Level I and Level II Screening completed by the facility since she stayed longer than 30 days and R67 should have had a Level I and Level II Screening completed annually.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to consistently monitor blood pressure for one (R7) of one resident reviewed for a change in condition who was prescribed multiple medications to treat high blood pressure. Findings include: A review of R7's clinical record revealed R7 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: lupus (an autoimmune disorder) and hypertension. R7 was transferred to the hospital on 4/25/24. A review of a progress note dated 4/25/24 revealed the following regarding R7 on that date, Writer attempted to wake resident up for breakfast and noticed resident unable to respond to verbal commands. Once writer attempted to reposition resident, she was unable to sit upright in bed. Vitals obtained BP (blood pressure) 189/93 (mmHg - millimeters of mercury) (According to the guidelines of American Heart Association - AHA, a systolic blood pressure - top number - higher than 180 indicates a hypertensive crisis requiring emergent care) .New order to send resident to (hospital) for change in mental status . A review of R7's hospital records revealed a History and Physical Note that noted, .presents with altered MS (mental status), less aggressive toward staff and not eating and drinking well .Increased BP on admit 196/120 but appears may of missed meds . A review of R7's physician's orders prior to her transfer to the hospital on 4/25/24 revealed R7 was prescribed the following medications to treat high blood pressure: carvedilol 12.5 milligrams (mg) two times a day, hydralazine 100 mg every eight hours, and nifedipine extended release (ER) 30 mg two tablets one time a day. The orders for the blood pressure medications did not include any parameters for administration. A review of R7's care plans revealed a care plan that noted, Resident has altered cardiovascular status r/t (related to) HTN (hypertension), CHF (congestive heart failure) .obtain vital signs and notify physician as needed . A review of R7's blood pressure summary for April 2024 revealed prior to 4/25/24 when R7 was transferred emergently to the hospital due to an altered mental status and high blood pressure, the last documented blood pressure for R7 was on 4/15/24 (ten days prior to her change in condition). A review of R7's Medication Administration Record revealed no records of blood pressure readings between 4/15/24 and 4/25/24. On 5/15/24 at 9:25 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON reported nurses should follow physician ordered parameters for residents prescribed blood pressure medications. If there were no ordered parameters, the resident's vital signs should be taken each shift. At that time, any documented blood pressure monitoring for R7 between 4/15/24 and 4/25/24 was requested from the ADON. No additional information was provided prior to the end of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39592 This citation pertains to Intake MI00137192 and MI00140349 Based on observation, interview and record review, the facility failed to implement preventative interventions and timely assess and identify formation of pressure ulcers for one (R75) of five residents reviewed for pressure ulcers resulting in R75 acquiring one Stage 2 (partial-thickness loss of skin with exposed dermis) and two Stage 3 (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer) pressure ulcers. Findings include: On 5/13/24 at 10:35 AM, R75 was observed lying in bed with dressing on both of their ears. R75 did not respond in any way to questions asked. Review of the clinical record revealed R75 was admitted into the facility 2/18/24 with diagnoses that included: metabolic encephalopathy, altered mental status and diffuse traumatic brain injury. According to the Minimum Data Set (MDS) assessment, dated 3/29/24, R75 had severely impaired cognition and was dependent on staff for all activities of daily living (ADL's). Review of R75's progress notes revealed: A Skin/Wound Note by Wound Care Manager, Registered Nurse (RN) L, dated 3/4/24 at 2:11 PM that read in part, During weekly skin assessment writer noted resident to have new stage 3 pressure ulcer to left ear . A Wound Rounds Note by Nurse Practitioner (NP) K dated 3/5/24 at 10:46 AM that read in part, .Wound #4 Right shoulder stage 3 measurements: 1.06cm (centimeters) x0.86cmx0.3cm min amount of serous drainage, slough (non-viable yellow, tan, gray, green or brown tissue) scattered to base, edges intact. Wound #3 Front left ear stage 3 measurements: 1.8cmx0.65cmx0.3cm pale pink granular base, small amount slough to base. Min (minimum) amount of serous drainage . A Skin/Wound Note by RN L dated 3/6/24 at 1:40 PM read in part, During walking rounds, writer was made aware by nursing staff that resident has open area that has developed on right shoulder . Writer educated staff . on the importance of keeping resident skin clean and dry, frequent repositioning, and offloading pressure sites . A Skin/Wound Note by RN L dated 3/6/24 at 4:26 PM read in part, During walking rounds, writer was made aware by nursing staff that resident has open area that has developed on right shoulder, and blanchable redness to right ear . A Wounds Rounds Note by NP K dated 3/19/24 at 4:09 PM read in part, .Right shoulder stage 3 . Front left ear stage 3 . Right ear stage 2 pressure injury . Review of R75's pressure ulcer care plan initiated 2/18/24 revealed an intervention that read, Administer treatment per physician orders. On 2/26/24, two interventions were initiated that read, Low Air Loss Mattress to promote wound healing . Use pillows and/or positioning devices as needed. No other interventions were initiated prior to R75 developing two Stage 3 pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Skin & Wound Evaluation for R75's front left ear dated 3/4/24 read in part, .Type: Pressure . Stage 3: Full-thickness skin loss . In-House Acquired . Exact Date: 3/4/24 .Healable . Review of Skin & Wound Evaluations for R75's right shoulder revealed: 3/6/24 .Pressure . Stage 3 . In-House Acquired . Exact Date: 3/6/24 . Healable 4/9/24 .Resolved . Review of Skin & Wound Evaluations for R75's right ear revealed: 3/19/24 .Pressure . Stage 2: Partial-thickness skin loss with exposed dermis . In-House Acquired . Exact Date: 3/19/24 . Healable . 3/25/24 .Resolved . On 5/14/24 at 10:20 AM, NP K and RN L were interviewed and asked about R75's pressure ulcers. RN L explained R75 only had a wound on their left ear, but kept a dressing on the right ear for prevention. NP K was asked to confirm R75 had acquired wounds to their left ear, right ear and right shoulder. NP K agreed R75 had acquired three pressure ulcers while at the facility. On 5/14/24 at 10:33 AM, R75's wound care was observed with NP K and RN L. R75's right ear appeared to have an approximately 1.5 cm x 0.5-1 cm open area with a pink base containing a small hole-like spot. On 5/15/24 at 10:34 AM, the Assistant Director of Nursing (ADON), who was serving as the Acting Director of Nursing, was interviewed and asked about R75's left ear and right shoulder only being identified as concerns when they were at a Stage 3 pressure ulcer. The ADON explained the staff should be identifying skin concerns before they were a Stage 3. The ADON was asked if a pressure ulcer was truly unavoidable if it was deemed healable and did heal, or was close to healing. The ADON agreed if pressure ulcers healed, they were probably not unavoidable. Review of a facility policy titled, Skin and Wound Guidelines revised 3/20/24 read in part, .Body Audits are completed: By the licensed nurse routinely and documented in the resident's electronic medical record. By the nursing assistant during scheduled baths/showers, and if indicated during routine daily care. The nursing assistant will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review, the facility failed to follow the recommendations and physician orders for assistive devices to maintain range of motion and positioning for two (R12 and R30) of three residents reviewed for positioning resulting in the potential for decline in range of motion and worsening of contractures. Findings include: R12 R12 was a long-term resident of the facility. R12 was originally admitted to the facility on [DATE]. R12's admitting diagnoses included hemiplegia (paralysis of one side of the body) due to stroke, contracture of joints, dementia, and anxiety. Based on the Minimum Data Set (MDS) assessment dated [DATE], R12 had a brief Interview for Mental Status (BIMS) score of 00/15, indicative of severe cognitive deficits. An initial observation was completed on 5/13/24 at approximately at 10:50 AM, R 12 was observed sitting in their wheelchair watching TV. R12's left elbow was bent, wrist bent, and fingers bent in the closed fist position with their fingertips touching the palm. R12 did not have any brace or splint on. A follow-up observation was completed later that day at approximately 2:10 PM. R12 was observed sitting on their wheelchair. R12 did not have any brace or splint on their left elbow hand. On 5/14/24, at approximately 8:35 AM, a follow-up observation was completed. R12 was observed in their bed, eyes closed. R12 had their left hand (elbow and wrist) in the same position and did not have any brace on. A follow up observation was completed later at approximately 10:45 AM. R12 did not have their brace on the left hand. Review of R12's Electronic Medical Record (EMR) revealed a physician order dated 2/9/24 that read, orthosis/splint to be applied to: restorative team to apply left elbow brace and left palm protector x5 weeks as tolerated. Every day and evening shift. On in the morning and off in the evening. Review of R12's care plan included interventions that included, active assisted range of motion to both lower extremities 3 times/wk (week)., restorative therapy as ordered, and apply contracture management devices as ordered - left elbow brace and left palm protector. Review of a therapy progress note titled quarterly therapy screen dated 5/6/24 revealed that R12 was at high risk for worsening contractures or loss of passive range of motion. Review of R12's Kardex (electronic care plan information for Certified Nursing Assistants-CNAs) did not reveal any information on left elbow splint and left palm protector on 5/13 and 5/14. The information was added to the Kardex after the concern was brought to the attention of the facility. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with CNA BB was completed on 5/15/24 at approximately 8:55AM. CNA 'BB was queried about their routine for R12 and reported that they knew the residents on the unit well and they had primarily worked on that unit. When queried on where they had obtained information to care for residents from their care plan on their electronic documentation system, they provided R12's preferred daily routine with their getting out of bed, eating etc. When queried if R12 used any brace, CNA BB reported that they used a brace for their left hand and showed the brace on top drawer of R12's nightstand. R30 R30 was a long-term resident of the facility, originally admitted to the facility on [DATE]. R30 was recently hospitalized and readmitted on [DATE]. R30's admitting diagnoses included hemiplegia on the left side due to stroke, depression, and Chronic Obstructive Pulmonary Disease (COPD). Based on the Minimum Data Set (MDS) assessment dated [DATE], R30 had a Brief interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. R30 needed extensive assistance from staff for their mobility and Activities of Daily Living (ADLs such dressing, bathing etc.). An initial observation was completed on 5/13/24, at approximately 10:35 AM. R30 was observed in their bed with eyes closed and they were receiving oxygen. R30's left wrist was in bent position with fingers clenched in a closed fist position with fingers tips almost touching the palm of the hand. R30 reported that they were not able open and they used a brace on their hand and they were not sure where it was. A follow up observation was completed later that day at approximately 1:30 PM. R130 was in their bed and they did have any brace on. There was a nightstand at the foot of the bed and there were no braces observed in the room. On 5/14/24, at approximately 8:15 AM, R30 was in their bed, eyes closed. They did not have any brace on and the left wrist/hand were in a clenched position. At approximately 9:35 AM, R30 was in their bed and did not have any brace on. Later that day, at approximately 10:20 AM staff were assisting resident with their care. The surveyor went in the room after the care was completed and R30 was in their bed. R30 did not have any brace on. At approximately 11:45 AM, R30 was observed in their bed and did not have any brace. They reported they had breakfast and would like to go home. When queried about the brace they reported that did not know. Review of R30's care plan for restorative nursing included the following: Left palm protector on x 5 week as tolerated initiated on 02/09/2024 and active assisted range of motion to both upper extremities 3 times/week. Review of R30's Kardex (electronic CNA care plan) under dressing/splint care had one note that read 1 person assist. There was no information on R30's use of palm protector for their left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24, at approximately 1:15 PM and interview with Restorative Aide (RA) C was completed. During their interview, this surveyor queried on what their daily tasks were. RA C reported that they covered the restorative care for all the residents in the facility. They were also in charge of all the admission weights, weekly weights, and monthly weights for all residents. They reported they assisted with residents who needed assistance with eating for breakfast and lunch. They were also in charge of providing wheelchairs for residents. When queried how many total residents they had, RA C reported that they had over 20 residents for restorative care. When queried who was providing the oversight for the program, they reported that the Director of Nursing (DON) was providing oversight and since they were on leave they did not have anyone at this time. RA CC was queried about the splints or braces for the residents and if they were able to complete everything that was ordered. RA C reported they prioritized and tried their best to do everything and there were times they were not able to do restorative as they had other priorities that were time sensitive. When queried further about splinting, they reported that they were applying splints/braces and palm protectors were applied by the CNAs who were assigned to care for the residents. They also added that they applied splints/braces during the day and they removed them before the end of their shift at 3:30 PM. When queried about the observations for R12 and R30 on 5/13/24 and 5/14/24 they reported that were trying their best and they knew it had to be on as ordered. An interview with Assistant Director of Nursing (ADON) was completed on 5/14/24 at approximately 1 PM. ADON was covering as the interim DON. ADON was queried on their expectations for splints/braces and where the CNAs obtained their information on how to care for their residents. The ADON reported that most of the splints/braces were applied by the restorative aide as per physician's order. The CNAs were able to get the information from the nurses as well as their care plan from their electronic charting system. The ADON was reported on all the observations for R12 and R30 and there was information on the Kardex for the floor staff. The ADON reported that they understood the concern and they would follow up with the team. A facility provided document titled Restorative Nursing Program dated 1/11/23, read in part, It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. 1.Cognitive and physical functioning of all residents will be assessed in accordance with the facilities assessment protocols. 2. Play interdisciplinary team with the support and guidance from the physician will assure the ongoing review, evaluation, and decision making regarding the services needed to maintain or improve resident's abilities in accordance with the resident's comprehensive assessment, goals and preferences. 3. Nursing personnel are trained on basic or maintenance nursing care the does not require the use of a qualified therapist or licensed nurse oversight. The training may include, but is not limited to: a. maintaining proper positioning and body alignment encouraging b. encouraging and assisting residents, as needed in turning and position changes. (continued on next page)

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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** 39592 Based on observation, interview and record review, the facility failed to provide appropriate supervision and/or positioning during showers and therapy for cognitively impaired residents for two (R436 and R11) of four residents reviewed for falls, resulting in R436 sustaining a compression fracture to the thoracic vertebrae and R11 hitting their head. Findings include: R436 On 5/13/24 at 8:38 AM, R436 was observed lying in their bed. A back brace was observed hanging on the headboard. R436 was asked about the back brace. R436 indicated they had fallen in the shower and needed the back brace now. Review of the clinical record revealed R436 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: stroke, fracture of first thoracic vertebra and wedge compression fracture of T11-T12 vertebra. According to the Minimum Data Set (MDS) assessment dated [DATE], R436 had severely impaired cognition and required the supervision of staff for showers and/or bathing. Review of R436's ADL (activities of daily living) care plan revealed an intervention initiated 4/23/24 that read, Assist to bathe/shower as needed. Review of R436's progress notes revealed: A Nursing note by Registered Nurse (RN) D dated 4/28/24 at 10:15 PM read in part, Resident reported falling in the shower room this afternoon [NAME] [sic] taking a shower. Resident stated that he did not hit head on the floor, rather hit his back on the floor. Complained of pain to the back . A Physician Team note by Nurse Practitioner (NP) E dated 4/30/24 at 1:10 PM read in part, .Writer alerted that pt (patient) fell yesterday in the shower room and hit his back. He states tylenol is not helping and the pain is moderate to severe . cooperative with exam, Other findings: mild emotional distress due to back pain . pain is concentrated to lower thoracic and upper lumbar area of spine, tender on palpation . Pt. has had two falls in the last week. Reinforced to pt. and staff to ensure pt. is transferring and mobilizing safely. Fall and safety precautions in place . A Nursing note by Licensed Practical Nurse (LPN) C dated 5/1/24 at 11:28 AM read in part, Resident c/o (complaining of) severe back pain. Resident was given prescribed pain medication with no relief. Resident was seen by physician NP and writer was given a verbal order to send resident out (to the hospital) . A Physician Team note by NP E dated 5/13/24 at 5:24 PM read in part, .(R436) was sent to (local hospital) emergency department on 5/1/24 with acute thoracic and lumbar spinal pain status post fall. He was found to have T1, T11, T12 acute vertebral compression fractures . management with pain, control, andback [sic] brace as needed for pain. He was restricted to no heavy lifting, bending, or twisting . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/24 at 8:56 AM, RN D was interviewed by phone and asked about R436's fall in the shower room. RN D explained he was walking past the shower room and saw R436 standing in the shower, he went in and made R436 sit down on a shower chair, then he went out of the room to get a Certified Nursing Assistant (CNA) and told them to watch R436. R11 On 5/13/24 at 8:47 AM, R11 was observed lying in bed with the covers over their face. R11 explained they did not want to be disturbed. Review of the clinical record revealed R11 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: dementia, diabetes and ataxia (impaired coordination). According to the MDS assessment dated [DATE], R11 had severely impaired cognition and required the assistance of staff for all ADL's. Review of R11's progress notes revealed an Incident Note dated 4/29/24 at 2:45 PM that read in part, Physical therapy team was providing ROM (range of motion) exercises and stretching the resident in the gym. During stretching resident rocked back and forth in the wheelchair and lost balance and fell .Resident was noted to have mild redness to back of the head during skin assessment . Review of R11's Physical Therapy (PT) Treatment Encounter Notes signed by Physical Therapy Assistant (PTA) H 4/23/24 at 5:24 PM read in part, Wrtier [sic] was providing ROM ex (exercises) and stretching to resident (R11) in the gym, During stretching resident rocked back and forth in the wheelchair, and lost balance and hit back of his head at the wall. wheelchair then rolled backwards as residents weight shifted back and fell . On 5/15/24 at 9:26 AM, the Therapy Director was interviewed and asked about R11's fall while getting therapy. The Therapy Director explained PTA H, who did not work at the facility anymore, had been doing stretching exercises on R11's leg when R11 started rocking in the wheelchair and flipped the whole chair backwards. When asked if he had ever seen someone flip their chair backwards while getting therapy, the Therapy Director explained he had not seen this happen before. On 5/15/24 at 9:51 AM, PTA H was interviewed by phone and asked about R11's fall. PTA H explained they were in the gym doing stretching on R11's leg when they began to rock back and forth in the wheelchair, R11 had a lot of upper body strength and hit their head on the drywall, then the chair flipped over, he was able to minimize the fall so R11's head did not hit the ground hard. PTA H was asked, due to R11's cognition, should the stretching of R11's leg have been done on a matt table instead of a wheelchair. PTA H did not answer.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to implement recommendations made by the contracted behavioral health provider for one (R67) resident reviewed for behavioral health services. Findings include: On 5/13/24 at approximately 8:30 AM, R67 was observed in her room. R67 was pleasant and participated in an interview. R67 talked about her love for playing bingo and spoke about the recent prizes she won. A review of R67's clinical record revealed R67 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia with psychotic disturbance, anxiety disorder, adjustment disorder, psychotic disorder with hallucinations, and major depressive disorder. A review of R67's Minimum Data Set (MDS) assessment dated [DATE] revealed R67 had intact cognition with no behaviors, hallucinations, or delusions. A review of a Psychiatric Evaluation & Consultation reported dated 3/25/24 revealed the following documentation: Chief Complaint: 'I'm scared and upset'. Pt (patient) seen for urgent visit at staff request .Pt anxious, paranoid, under stress due to roommate who is delirious today .anxious and irritable .some confusion. Paranoia directed at sisters .Anxiety, Psychosis, Memory Impairment .Collaboration: DON (Director of Nursing) - Pt increasingly anxious, agitated and paranoid, esp. (especially) with decompensation of roommate .Current Assessment/Plan .Pt's paranoia and agitation despite 150 mg (milligrams) of Seroquel (an antipsychotic medication) daily argues for switch to alternative antipsychotic .1. Taper Seroquel as follows: 50 mg PO (by mouth) bid (two times a day), then 25 mg po bid x 5 days, the d/c (discontinue). 2. Start Risperdal (an antipsychotic medication) 0.25 mg po bid x 5 days, then 0.5 mg po bid. 3. Increase Remeron (an antidepressant medication) to 15 mg po qhs (at bedtime) .5. Consider room change given instability of roommate . A review of R67's Physician's Orders revealed since 3/25/24, R67's Seroquel dose was not tapered according to the Psychiatrist's recommendations and Risperdal was not started. Remeron (mirtazapine) was not increased according to the psychiatrist's recommendations. A room change was not done until 4/8/24, 14 days after the recommendation was made. On 5/15/24 at approximately 9:00 AM, the following active orders were in place for R7: Seroquel 50 mg three times a day for psychosis with a start date of 4/20/24. This order was changed from 50 mg every 8 hours (which is the same as three times a day) which had a start date of 11/14/23. Mirtazapine 7.5 mg at bedtime with a start date of 8/10/23. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/15/24 at 9:28 AM, an interview was conducted with Director of Social Services (SW) 'J'. SW 'J' reported he began working at the facility approximately 10 days prior to the interview. When queried about how it was ensured recommendations made by the contracted psychiatrist/behavioral health agency were implemented, SW 'J' reported the contracted psychiatrists entered their own orders for medications and social services would fax the recommended orders to the attending physician. When queried about why the recommendations for R67 made by the contracted psychiatrist (Psychiatrist 'V') on 3/25/24 were not implemented, SW 'J' reviewed R67's electronic medical record and confirmed they were not implemented. SW 'J' explained there should have been some kind of follow up to ensure the orders were implemented. On 5/15/24 at 11:33 AM, a telephone interview was attempted with Psychiatrist 'V'. Psychiatrist 'V' was not available for an interview prior to the end of the survey. On 5/15/24 at 12:00 PM, an interview was conducted with the Assistant Director of Nursing (ADON) who was covering for the Director of Nursing (DON) in her absence. When queried about who was responsible to ensure recommendations made by the contracted psychiatrist were implemented, the DON reported the psychiatrist was responsible to enter their own orders and the DON and social services department were responsible to follow up to ensure they were implemented.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to evaluate the competency and obtain guardianship for a resident with severely impaired cognition who did not have a resident representative for one (R35) residents reviewed for social services. Findings include: On 5/13/24 at approximately 9:00 AM, R35 was observed seated on the side of his bed eating breakfast. R35 appeared disheveled, wearing stained clothing and with a scruffy beard. R35 was interviewed and when asked questions, R35 did not always answer in a way that was relevant to the question asked. R35 appeared confused. A review of R35's clinical record revealed R35 was admitted into the facility on [DATE] with diagnoses that included: vascular dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R35 had severely impaired cognition. Further review of R35's clinical record revealed no paperwork that indicated R35 had a legal guardian or advance directive that named a decision maker in the event R35 was unable to make his own decisions. There was no evidence that R35 had been evaluated for competency to make medical decisions. On 5/15/24 at 11:39 AM, an interview was conducted with Director of Social Services (SW) 'J'. SW 'J' reported he began working in the facility 10 days prior to the interview. When queried about who made decisions for R35, SW 'J' reviewed R35's clinical record and reported R35 was his own decision maker. When queried about how the facility determined which residents needed a resident representative to make medical decisions for them, SW 'J' reported if a resident was cognitively impaired or had a change in cognition, a competency evaluation was completed by a physician and a psychologist. If a resident was deemed to be incompetent to make decisions, family would be contacted about any decision making paperwork (Durable Power of Attorney) that they had or a discussion about obtaining legal guardianship would be started. If the family was not interested in guardianship, the facility petitioned the court to obtain a guardian for the resident. SW 'J' reported R35 required a competency evaluation due to his cognitive status and potentially a guardian. A review of a facility policy titled, Advance Directives - Code Status, revised 10/5/23, revealed, in part, the following: .During the admission process, the interdisciplinary team assessed the resident's decision-making capacity and identifies the primary decision-maker of the resident if it is determined that the resident does not have decision-making capacity .In cases where the resident has not appointed a Durable Power of Attorney for Health Care or a Patient Advocate with power regarding Life-Sustaining Treatment: The resident's decision-making capacity should be determined and documented in the resident's medical record by the attending physician and other interdisciplinary team members. The social worker will initiate the process to obtain a formal capacity and seek direction from the probate court, including the appointment of a guardian .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49083 Based on observation, interview, and record review, the facility failed to accurately document and reconcile two controlled medications observed in a random surveillance of the narcotic drawer for one resident (R9) of one reviewed during medication storage and labeling observation. Findings include: On 5/15/24 at 8:35 AM, a medication storage observation was conducted with Licensed Practical Nurse (LPN) Y with the One South Back medication cart. A random selection from the controlled substance drawer identified R9 with Gabapentin (an anticonvulsant medication to treat seizures and neuropathic pain) 100 milligram (mg) capsules. The blister pack was observed and contained 11 capsules. The narcotic binder documented Gabapentin 100 mg remained with 12 capsules. A second controlled blister pack medication was pulled for R9 and identified as Clonazepam (a medication to treat seizures, panic disorders, bi-polar, and anxiety) 0.5 mg. The blister pack was observed with 12 tablets. The narcotic binder documented Clonazepam with 13 tablets remaining. LPN Y acknowledged that both medications were given to R9 prior to the medication cart observation and admitted that the medications were not signed off in the narcotic binder. Review of the facilities policy for Medication Administration Issued 8/7/2023 .Medications are administered in accordance with the following rights of medication administration: Right Documentation . On 5/14/24 at 4:42 PM, the Assistant Director of Nursing (ADON) was interviewed and confirmed that medications are to be documented in the narcotic binder as soon as administered.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review, the facility failed to schedule follow up dental services for one resident (R236) of two residents reviewed for dental services. Findings include: R236 was a long-term care resident, originally admitted to the facility on [DATE]. R236 was recently hospitalized and readmitted back to the facility on [DATE]. R236's admitting diagnoses included dementia, anxiety and mood disorder, and recent pneumonia due to flu. Based on the Minimum Data Set (MDS) assessment dated [DATE], R236 had a Brief Interview for Mental status score of 10/15 indicative of moderate cognitive impairment. An initial observation was completed on 5/13/24 at approximately 1:45 PM. R236 was observed in their bed and they were receiving oxygen. R236 had multiple fractured teeth. On 5/14/24, at approximately 10:15 AM during a follow-up observation, R236 was queried about their breakfast that morning and their teeth. R236 reported that I don't have all of them. Little blood comes out. R236 asked the surveyor, Are you the doctor? Can you help me?. Review of R236's Electronic Medical Records (EMR) revealed a dental consult from 9/7/21. Further review revealed a consult dated 2/14/23 that R236 refused dental visit. R236 had a public guardian. Review of R236's EMR revealed a social work progress note dated 1/16/23. The note revealed that legal guardian had expressed concerns regarding R236's dental follow-up and they were last seen on 2/19/21. Further review did not reveal any attempts to obtain a dental appointment for R236 and follow-up with guardian after 2/24/23. An interview was completed with the covering Social Worker J on 5/14/24, at approximately 2:15 PM. Social worker J was queried about their dental visits for their residents. They reported that the facility had dental providers who visited quarterly to do the routine dental visits. The consents for dental services were obtained on admission or as needed during the resident's stay at the facility. If a Resident needed any surgeries or a special procedure done, the facility staff were assisting with scheduling the appointment and setting up transportation. When queried about the concern for R236, social worker J reviewed the EMR and reported that they did not see any other follow up documentation and they understood the concern and that they would reach out to the dental provider and check if they had any additional documentation. On 5/15/24 at approximately 10:30 AM, social worker J reported there were no follow up visits and they did not have any additional documentation. An interview with Assistant Director of Nursing (ADON) was completed on 5/15/24, at approximately 8:35 AM. ADON was queried about their dental consults and follow up process. ADON reported they had in house dental services for routine dental procedures through a provider and if Residents needed any procedures or specialists the facility was assisting with the appointment and transportation. ADON was notified of the observation and concerns with R236's dental visit. ADON reported that understood the concern and they would follow-up with the social worker.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review, the facility failed to provide timely skilled rehabilitation (physical therapy) services as ordered for one (#33) of one sampled resident reviewed for rehab/restorative services resulting in the delay in evaluation for physical therapy services to address the change in mobility and feelings of frustration. Findings include: A record review revealed R33 was a long-term resident of the facility originally admitted on [DATE]. R33 had had hospitalization during their stay at the facility and was most recently readmitted to the facility on [DATE]. R33's diagnoses included polyneuropathy, liver failure, spinal stenosis, and osteoarthritis. Based on the most recent Minimum Data Set (MDS) assessment dated [DATE], R33 had a Brief Interview for Mental Status (BIMS) score of 10/15, indicative of moderate impairment with their cognition. An initial observation was completed on 5/13/24, at approximately 12:45 PM. An interview was completed during this observation. During this observation, R33 reported that they need physical therapy and they had been waiting for a long time. Multiple follow-up observations were completed throughout the survey between 5/13/24 and 5/15/24. R33 remembered the surveyor and they were able to recall and asked follow up questions from the previous visit/conversations. R33 asked the surveyor if they had any information on their physical therapy and had enquired three times during the observations between 5/13/24 and 5/15/24. Review of R33's Electronic Medical Record (EMR) revealed that R33 had a guardian (sister) and they were under hospice care. Review of the investigation report read, The guardian (name omitted) was interviewed on 10/6/2023. She stated that (relationship omitted) complained about 6 months ago that the nurse pulled his arm and kicked (pronoun omitted) (Guardian name omitted) stated that (relationship omitted) understands and knows what's going on cognitively but needs help with medical decisions. Further review of the EMR revealed that R33 had a BIMS score of 15/15, based on MDS assessments dated 1/11/24 and 10/11/23. Review of R33's hospice progress notes dated 2/13/24, read in part MSW (Master of Social Work) will speak with facility social worker about when physical therapy will begin for the patient. Another progress note dated 2/8/24, read, Physical therapy has not started yet. Further review of hospice records revealed another social work note dated 1/24/24 and 1/15/24 that read in part, patient has not yet started physical therapy. Further record review did not reveal that R33 received any recent physical therapy screening and or evaluation. An interview was completed with Director of Rehabilitation (DOR) G on 5/15/24, at approximately 11:20 AM. During the interview, the DOR G was queried about the screening and evaluation for R33. DOR G reviewed the records and reported that R33 was not screened or evaluated recently as they were receiving hospice services. When queried further if they were aware of the request from hospice and R33, they reported that they were aware and had followed up with the administration/business office and waiting for their approval and they understood the concern. (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	05/15/2024

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.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Business Office Manager (BOM) DD on 5/15/24 at approximately 12:20 PM. BOM DD was queried if they were aware of any requests for physical therapy for R33 from hospice. BOM DD reported that they had some communication between them and the hospice provider on who was going to cover for the services. They checked the e-mails and reported that their first e-mail communication was on 4/4/24 and then they did a follow up e-mail on 4/8/24. BOM DD also shared a copy of the handwritten physician order form the hospice provider dated 3/14/24, that read Physical Therapy to evaluate for strengthening, ambulation and transfers - may visit up to 8 sessions. This verbal order was not transcribed on R33's EMRs under orders. BOM DD was queried if they had any updates as R33 had been several months. They also reported that they did not have any updates and were trying to figure it out. BOM DD was notified of the concerns and reported that they understood. An interview with Assistant Director of Nursing (ADON) who was covering for the DON (Director of Nursing) was completed on 5/15/24 at approximately 11:45 PM. The ADON was notified of the concern about R33's requests and multiple hospice documentation since 1/15/24 for physical therapy services and queried on their process and why R33 had been waiting for months. The ADON reported that they should have followed up timely and understood the concern. They also added that they would check and provide any additional information they may find. No additional information was provided prior to survey exit. A facility provided document titled Therapy evaluation' dated 3/22 read in part, Policy: The Licensed Therapist will perform an initial evaluation upon physician referral and any re-evaluation where indicated. 1. The Rehabilitation Department will be notified when a physician order is written for therapy evaluation and treatment. 2. The Licensed Therapist will perform a chart review and initiate the evaluation. 3. The initial evaluation will include, but is not limited to, the following: a. Resident name, date of birth, and health insurance or ID number b. Diagnosis (treatment diagnosis and medical diagnosis) c. Past medical history d. Prior level of function e. Current functional level f. Rehabilitation potential/severity g. short- and long-term goals and time frames for completion h. Treatment plan of care to accomplish goals. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Initial evaluation will be completed within 2 days from the time the referral is written. 5. Evaluations will be documented, signed by licensed therapist, printed, and placed in the resident's chart. 6. Completed evaluation will be signed by the physician .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake MI00142547 Based on interview and record review, the facility failed to ensure vaccine consent/declination was signed by a resident's legal guardian, and ensure accurate tracking and administration of the pneumococcal vaccinations for residents residing in the facility for three (R38, R1 and R216) of five residents reviewed for influenza and pneumococcal vaccinations. Findings include: Review of a facility policy titled, Vaccination - Influenza dated 10/13/23 read in part, .Prior to the vaccination, the resident or the resident's legal representative will be provided information and education regarding the benefits and potential side effects of their influenza vaccine which will be documented in the resident's medical record . Individuals receiving the influenza vaccine, or their legal representative, will provide informed consent to the administration of the vaccine which will be documented in the resident's medical record . R38 Review of the clinical record revealed R38 was admitted into the facility on [DATE], and had a legal guardian. Review of R38's Immunization record revealed Consent Refuse for the influenza vaccine. Review of R38's Influenza Vaccine Authorization dated 11/3/23 read in part, .Information provided to: patient . Relationship to Resident: self . The resident will not receive the influenza vaccine due to refusal . Review of a facility policy titled, Vaccination - Pneumococcal Vaccine dated 10/13/23 read in part, .Residents will be offered a pneumococcal vaccine unless it is medically contraindicated, or the resident has already been immunized . The type of pneumococcal vaccine (PCV15, PCV20, or PPSV23/PPSV) offered will depend upon the recipient's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations . R1 Review of the clinical record revealed R1 was admitted into the facility on [DATE] and readmitted [DATE]. Review of R1's Immunization record revealed documentation of a Pneumovax 23 (PPSV23) had been given on 4/3/17. According to Centers for Disease Control and Prevention (CDC) guidelines, R1 was due for PCV15 or PCV20 immunization. R216 (continued on next page)

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	235433	A. Building B. Wing	05/15/2024

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record revealed R216 was admitted into the facility on [DATE] and readmitted [DATE]. Review of R216's Immunization record revealed PCV20 had Immunization Req. (required) listed for Consent Status. According to CDC guidelines, R216 was due for PCV15 or PCV20. On 5/15/24 at 1:06 PM, the Assistant Director of Nursing (ADON), who served as the Infection Control Nurse, was interviewed and asked about R1 signing their own declination for the influenza vaccine when they had a legal guardian. The ADON explained any consent should always be signed/declined by the legal guardian. The ADON was asked why R1 and R216 had not received the pneumococcal vaccines that were recommended. The ADON had no answer. When asked how it was determined when residents were due for a vaccine, the ADON explained they followed CDC guidance for vaccinations.