STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235488	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Bloomfield Health and Rehabilitation Center	6445 W Maple West Bloomfield, MI 48322

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to intake #'s MI00147219 and MI00149909 Based on observation, interview and record review, the facility failed to ensure multiple allegations of verbal and physical employee to resident abuse were reported to the State Agency (SA) for two (R404 and R401) of three residents reviewed for abuse. Findings include: R404 A complaint was filed with the SA that read in part, .on 1/27/25, (R404) got into a fight with a nurse's aide possibly named (Certified Nursing Assistant - CNA D) . (R404) was hit with a fist on the top of the head, shoulder, and in (their) chest area during the incident . the nurse's aide got scratched while (R404) was trying to defend (themselves) . other staff were made aware of this incident . On 2/11/25 at 9:30 AM, R404 was observed lying in their bed. R404 was asked if there had been an incident between themselves and an employee at the facility. R404 explained when they were first admitted into the facility and did not know how things were done there, they had asked their aid for a shower on Sunday . the aid told them they did not do showers on Sundays . then a supervisor told the aid to give them a shower . three aides came and called them Bitch because they had told the supervisor and now they had to give them a shower on Sunday . the next evening the aide wanted them to go to bed early and pushed their wheelchair into the bathroom where there was another aide in the bathroom . the aid in the bathroom then hit them on the head, shoulder and chest area . they were in a wheelchair and could only defend themselves by grabbing the aids arm and scratching her . the nurse came and said they all needed to listen to each other . they did not know how they could listen to someone when they were hitting them . later two supervisors came and talked to them about what happened . Review of the clinical record revealed R404 was admitted into the facility on [DATE] with diagnoses that included: arthritis, diabetes and kidney disease. According to the Minimum Data Set (MDS) assessment dated [DATE], R404 scored 15/15, indicating intact cognition, and required the assistance of staff for activities of daily living (ADL's). Review of R404's progress notes revealed: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Health Status Note dated 1/26/25 at 10:02 PM by Licensed Practical Nurse (LPN) B read in part, .Resident was very anxious and combative towards staff while providing ADL this evening . A Health Status Note dated 1/27/25 at 10:11 AM by the Director of Nursing (DON) read in part, .the patient requested a shower which was arranged by the nurse supervisor so (they were) given shower [sic] Sunday. Plus, Sunday evening the patient was being taken by 2 CNAs and a supervisor to the toilet. Patient accused one CNA hitting (them) to (their) forehead (their) chest, so (they) scratched CNA's face, hand and pulled her necklace. The writer and UM (Unit Manager) visited the patient to address issues . On 2/11/25 at 12:25 PM, LPN B was interviewed by phone and asked about the incident between R404 and CNA D. LPN B explained two CNA's were taking R404 to the bathroom . CNA C flagged her down, when she got closer could hear R404 could be heard loudly talking . R404 said CNA D had hit them three or four times . R404 had CNA D's necklace in their hand and CNA D had scratches up her arm . asked CNA D to leave and helped CNA C with the rest of R404's care . tried to calm R404 down, but R404 was upset and also told her about a CNA on the day shift who called them a Bitch . told her Supervisor, LPN F, about what happened . LPN B was asked if she had notified the Abuse Coordinator about R404's allegations of abuse. LPN B explained they were supposed to report all allegations to their Supervisors. When asked if she had ever made a written statement about the incident, LPN B explained she had actually written two statements, because she had forgotten to mention certain details in the first one. On 2/11/25 at 1:48 PM, LPN F , who was the Nursing Supervisor on 1/27/25, was interviewed by phone and asked about the incident involving R404. LPN F explained LPN B told her R404 had said CNA D had hit them . went and talked to R404 who also alleged a day shift CNA had called them a Bitch . called the DON and let her know what had happened. LPN F was asked who was the facility Abuse Coordinator. LPN F explained it was the Administrator. When asked if she had called the Administrator, LPN F explained she did not, she called the DON. Review of a facility provided OCCURRENCE INVESTIGATION for R404 read in part, .Occurrence Date: 01/26/2025 - Afternoon shift . OCCURRENCE: .resident stated to Nurse Supervisor (LPN F) on the afternoon shift (01/26/2025) that CENA - (CNA D) hit (them) during a toileting transfer . Occurrence Date: 01/26/2025 - Dayshift Reported by resident the evening of the afternoon shift . OCCURRENCE: Resident stated to nurse supervisor (LPN F) on the evening of 01/26/2025 that CENA - (CNA E) had called (them) a bitch regarding (them) taking a shower that morning . On 2/11/25 at 3:06 PM, the DON was interviewed and asked why the incidents between R404 and CNA E and CNA D were not reported to the Administrator and the SA. The DON explained it had been reported to her that CNA C was in the room at the time of the incident, and did not find out until later that CNA C had not been in the room at the time R404 alleged CNA D hit them. On 2/11/25 at 3:30 PM, the Administrator was interviewed and asked why R404 ' s verbal and physical abuse allegations had not been reported to the SA. The Administrator agreed the allegations should have been reported. 38271 R401 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 a concern submitted to the State Agency was reviewed and alleged R401 was slapped at the Nursing station multiple times by a staff member. A review of the MIFRI (Michigan-facility reported incidents) reporting system for Nursing facilities did not reveal any allegation or investigations pertaining to R401 allegedly being slapped by facility staff. On 2/11/25 the medical record for R401 was reviewed and revealed the following: R401 was initially admitted to the facility on [DATE] and had diagnoses including Muscle weakness and Fracture of Lumbar Vertebra and was discharged from the facility on 9/25/24 to the hospital. On 2/11/25 at approximately 9:32 a.m., family member G (FM G) was contacted regarding the allegation and indicated that one of the facility staff had called them at around 3:00 AM (because their mother was agitated) to assist in helping to calm them down. FM G indicated that during that time, R401 informed them that someone had slapped them at the Nursing station and that they had multiple conversations with the Administrator regarding to the allegation. On 2/11/25 at approximately 10:50 a.m., during a conversation with the Administrator, the Administrator was queried pertaining to the allegation of R401 being slapped and they reported they could not remember the incident, but that they would check for documentation of the allegation investigation. On 2/11/25 at approximately 3:08 p.m., the Administrator provided a facility investigation pertaining to the allegation that R401 had been slapped. A review of the investigation revealed the following: Occurrence Investigation .Occurrence Date: 9/24/24-afternoon shift .Family called stating resident informed them that staff hit her arm during the time of her fall. Resident had fall on 09/24/24 and was sent to hospital . On 2/11/25 at approximately 3:14 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the investigation and their conclusion. The DON indicated the resident could not provide any information pertaining to the allegation including any potential perpetrators. The DON indicated that the staff were interviewed and nobody witnessed anything and a skin assessment was done without any new identification of bruising indicating they were slapped. On 2/11/25 at approximately 3:29 p.m., during a follow-up conversation with the Administrator, the Administrator was queried why the allegation and investigation had not been reported to the State Agency and they indicated that it it should have been and would look to report unsubstantiated allegations in the future. On 2/11/25 a facility document titled Abuse Program was reviewed and revealed the following: Policy: It is our policy to maintain an environment free of abuse and neglect. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, clinicians, volunteers, staff or other agencies servicing the resident, family members or legal guardians, friends or other individuals. The focus on the resident and supporting the resident in making their own choices and having control of their daily lives is the approach of person-centered care Component 7: Reporting/Response 7. The facility shall: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. In accordance with CFR 483.12 (c) the facility shall ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident's property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury