STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235492	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Manor Nursing & Rehabilitation Center	15311 Schaefer Rd Detroit, MI 48227

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2792770. Based on observation, interview and record review, the facility failed to protect the resident's right to be free from psychosocial harm for one resident (R102) of three residents reviewed for abuse by Social Worker B. Findings include:On 02/16/2026, an alleged resident-to-resident abuse allegation was reported to the State Agency. The alleged incident occurred on 02/15/2026. Record review revealed on 02/15/2026 at approximately 01:30 P.M., it was alleged that R102 was hit in the face by R101. Incident summary revealed: R102 was sitting in the hall when R101 rolled past in a wheelchair, stopped and hit R102 in the face. R102 screamed, the staff immediately responded. R102 and R101 were separated. Record review of progress note dated 02/15/2026 by Nurse A revealed, . R102 sitting in hallway peacefully, R101 rolling by punched this resident in the face unprovoked, on the left side. On 05/06/26 at 12:20 P.M., Nurse A was interviewed and stated, I was sitting at my desk and heard (R102) yell out He hit me. I assessed (R102) with no harm and ensured (R101) was no longer within reach. Nurse A said she reported this incident to the Nursing Home Administrator (NHA). Nurse A stated, The staff tries to keep the males and females separated on the floor for safety. On 05/06/2026 at 1:00 P.M., R102 was interviewed in her room during lunch time. R102 was well groomed and was able to recall the alleged incident. R102 stated, (R101) hit me. R102 also stated, (R101) hit me before too. Queried as to previous physical interactions with R101, R102 said this isn't the first time R101 has hit her. R102 said that R101 tries to come into R102's room. R102 stated, I scream and pushing the call light when (R101) tries to come into my room. R102 stated, I'm afraid (R101) will hit me again. Queried as to the most recent incident and feelings of safety, R102 stated, (R101) socked me in the face and No. I don't feel safe because he keeps hitting me! Queried as to the response of staff after the incident, R102 stated, The nurse checked on me after (R101) hit me. Queried as to a follow-up visit with a Social Worker (SW) after the incident, R102 reported the SW did not assess safety after the incidents. Queried as to how these incidents make R102 feel, R102 stated, I don't feel safe. R102 stated, I eat in my room so I can stay away from him. R102 reports plans to talk to her guardian about a transfer due to lack of safety. When asked, how R102 felt today, R102 stated, I feel safe today as long as (R101) isn't anywhere around me. On 05/06/2026 at 12:40 P.M., Social Worker (SW) B was interviewed and said SW B was made aware of the alleged incident between R101 and R102 shortly after it occurred. SW B stated, I followed up with R102 to ensure R102 felt safe afterwards. At this time, a request for documentation of the SW follow-up after the incident due to feelings of lack of safety was made. Record review revealed no documentation in the Electronic Health Record (EHR) regarding a follow up or an assessment after the alleged resident to resident abuse allegation. Queried SW B about expectations of a safety assessment after an allegation of abuse, SW B stated, The Social Services Department is supposed to do a safety assessment after an allegation, we did and we should have documented that this was done. I just forgot to document it. Queried as to whether SW B was aware of R102's reports of fearfulness of R101. SW B said he was not aware of R102's safety concerns. On 05/06/2026 at 1:50 P.M., the Director of Nursing (DON) was interviewed to discuss expectations of a psychosocial (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	assessment after an allegation of abuse has been reported. The DON stated, Social Service is supposed to complete a safety assessment of the resident when abuse is reported. SW B said he did it but didn't document it. When queried about previous reports of abuse between R101 and R102, the DON discussed a previously reported incident dated 08/05/2025 where R101 physically assaulted R102. Queried as to documentation of a Social Services Assessment following the previously reported incident, the DON was unable to locate Social Services documentation of an assessment to rule out psychosocial harm. Record review determined no documentation of a Social Work follow up visit and/or assessment completed after the current or previously reported resident to resident abuse allegation. At this time, queried the DON regarding R102 not feeling safe within the facility due to fear of R101. The DON stated, I didn't know (R102) felt that way. She recants her feelings based on who she is talking to. During this interview, the DON was informed of the concern of the lack of a safety assessment for R102 by the Social Services Department on multiple occasions after allegations of abuse are reported and R102's report of not feeling safe due to R101 hitting R101 on multiple occasions. Record review revealed R102 has a Brief Interview of Mental Health Status score of 15 (Cognitively Intact) according to the Minimum Data Set, dated [DATE]. Review of the facility policy, last revised on 09/09/2022 and entitled, Abuse Prohibition Policy, read in part: Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Social Services will provide follow -up counseling with the resident if abuse occurred.