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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235498	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulevard Temple Care Center, LLC	2567 West Grand Boulevard Detroit, MI 48208

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 - Minimal harm or potential for 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** 34901 This citation pertains to intakes MI00146539 and MI00146638. Based on interview and record review, the facility failed to ensure staff to resident verbal abuse did not occur for one resident (R102) and physical abuse did not occur for two residents (R103 and R106) out of four residents reviewed for abuse. Findings include: R102 - A review of the facility's investigation documentation submitted to the State Agency documented in part that on 8/8/24 at around 8:15 AM, Certified Nurse Aide (CNA) G was passing out juice to residents in the main dining room on the 2nd floor. CNA G asked R102 if she wanted a juice, and she said yes. CNA G proceeded to give her juice. Once CNA G turned around to serve another resident, R102 hit CNA G in the neck two times. After CNA G was hit, she immediately reacted by shouting profanity at the resident. CNA H was able to hold the hand of R102 from hitting CNA G (again). CNA G did walk away and the nurse on duty walked CNA G to the nurse manager's office. R106 and R102 - A review of R106's progress note as clarified by the Nursing Home Administrator (NHA) included in part, on 8/12/24 at 12:18 PM, (R102) was observed in the dining room hitting another resident (R106). Writer separated residents. (R102) stated that (R106) rolled next to her. (R102) stated she didn't like (R106) and began hitting (R106). Writer asked (R106) was she hurt, and resident stated no. R103 and R102 A review of the facility's investigation documentation submitted to the State Agency documented in part that on 8/22/24 at 8:00 AM, R102 and R103 were both sitting in the dining room at the same table on the 2nd floor. Registered Nurse (RN) J was sitting at the nursing station when she heard the sound of a slap. RN J saw R103 holding his face. R103 was very upset and stated that I'm going to kill that b***ch. The nurse immediately separated the two residents. (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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of R102's clinical record revealed an initial admitted [DATE] and readmitted [DATE]. R102's diagnoses included schizophrenia and vascular dementia, severe, with psychotic disturbance. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment.

A review of R103's clinical record revealed an admitted [DATE]. R103's diagnoses included hemiplegia and hemiparesis following cerebral infarction and heart failure. A MDS dated [DATE] documented moderate cognitive impairment.

A review of R106's clinical record revealed an initial admitted [DATE] and readmitted [DATE]. R106's diagnoses included cardiomyopathy, orthostatic hypotension, and neuropathy. A MDS dated [DATE] documented moderate cognitive impairment.

On 10/8/24 at 2:10 PM, the NHA was interviewed and documents reviewed about these three incidents.

1. Regarding the 8/8/24 incident, the NHA indicated that CNA G received a disciplinary action. A document titled, Disciplinary Action Record - Work Rules, signed 8/9/24, documented that CNA G received the disciplinary action because, Employee may not use profane or abusive language to any employed person or resident in the facility. Employee had a verbal outburst toward a resident. CNA G received education on abuse. The NHA reported that R102 was seen by behavioral health services on 8/9/24 and received an adjustment in her antipsychotic medication, Dispersal.

2. Regarding the 8/12/24 resident-to-resident physical abuse, the NHA said the incident of R102 hitting R106 was not reported to the State Agency because he felt it was not a willful or targeted act by R102 due to the agitated behaviors R102 was exhibiting at that time.

Prior to the 8/12/24 incident, R102 exhibited the following aggressive behaviors:

- On 8/8/24 at around 8:15 AM, Certified Nurse Aide (CNA) G was passing out juice to residents in the main dining room on the 2nd floor. CNA G asked R102 if she wanted a juice, and she said yes. CNA G proceeded to give her juice. Once she turned around to serve another resident, R102 hit CNA G in the neck 2 times.

- Review of R102's behavioral care note dated 8/9/24 documented in part the following:

Complaint: aggressive behaviors. History of present illness: Discussed case with nurse reports increased aggressive behaviors, attempts to fight others, attempting to elope via elevator and increased impulsive behaviors over the last 1-2 weeks. Discussed behaviors with husband via phone; husband agreed to increase Dispersal 3 mg every 12 hours due to behaviors. Assessment & Plan: Undifferentiated schizophrenia deteriorated. Plan: Increased Dispersal 3 mg every 12 hours due to behaviors, Depakote, continue to monitor mood and behaviors.

- Review of progress note of 8/11/24 at 2:14 PM documented in part the following:

Resident observed going after male resident in (dining room). Resident threatening and attempting to hit residents. Staff intervened and separated residents. Resident refused meds times three .(Urinalysis) results pending.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Review of progress note of 8/12/24 at 12:09 PM documented in part the following: Resident observed in dining room cussing at staff and residents in dining room. Resident attempted to strike staff. Resident redirected and placed into a quiet area. When writer asked resident what is wrong, she stated that she didn't like the lady and that the lady called her a b***h. Writer asked resident who was the lady and resident just said they are in the dining room. Notified (nurse practitioner) of resident's aggressive behaviors. On 10/9/24 at 11:10 AM when R102's August 2024 Medication Administration Record was reviewed with the Director of Nursing (DON), the following was noted: the AM dose of Risperdal (prescribed for schizophrenia) was increased from 2 mg to 3 mg on 8/10/24. R102 also received Depakote twice daily for schizophrenia disorder. As indicated in the referenced progress notes, R102 continued to exhibit aggressive behaviors after the medication change of 8/10/24. 3. Regarding the 8/22/24 resident-to-resident physical abuse, R102 was transferred to another floor. A review of the facility policy titled, Abuse Prohibition, dated 10/14/22, documented in part the following: - Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposed of discipline or convenience that are not required to treat the guest's/resident's medical symptoms. -Verbal abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the guest/resident to experience humiliation, intimidation, fear, shame, agitation, or degradation regardless of their age, ability to comprehend or disability. - Physical abuse include hitting, slapping, pinching, and kicking. On 10/9/24 at 11:40 AM during the exit conference, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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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** 34901 Based on interview and record review, the facility failed to submit an incident of resident-to-resident abuse and the 5-day investigation to the State Agency involving two residents (R102 and R106). Findings include: Review of R102's progress note of 8/12/24 at 12:35 PM documented in part the following: Resident observed hitting another resident (R106) while sitting in wheelchair in dining room. Writer separated residents. Writer asked resident what happened. Resident (R102) stated that she didn't like (R106) and that (R106) had called her a b***h. Writer asked resident (R106) what happened and (R106) stated that resident rolled her wheelchair beside hers and started hitting her. Writer asked resident (R106) was she hurt, and resident stated no. Resident (R102) removed from dining room area and into hallway with nurse aide present. Writer notified unit manager and administrator. Writer called and left message with resident's husband. Review of R106's progress note as clarified by the Nursing Home Administrator (NHA) included in part, on 8/12/24 at 12:18 PM, Resident (R102) observed in dining room hitting another resident (R106). Writer separated residents. (R102) stated that (R106) rolled next to her and stated she didn't like her and began hitting resident. Writer asked (R106) was she hurt, and resident stated no. A review of R102's clinical record revealed an initial admitted [DATE] and readmitted [DATE]. R102's diagnoses included schizophrenia and vascular dementia, severe, with psychotic disturbance. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment. A review of 106's clinical record revealed an initial admitted [DATE] and readmitted [DATE]. R106's diagnoses included cardiomyopathy, orthostatic hypotension and neuropathy. A MDS dated [DATE] documented moderate cognitive impairment. On 10/8/24 at 2:10 PM, the NHA said the incident of R102 hitting R106 was not reported to the State Agency because it was not a willful or targeted act by R102 due to the agitated behaviors R102 was exhibiting at that time. R102 had a history of getting upset and hitting. We got in touch with psych for intervention. The NHA indicated there was not a file available that included an investigation into this matter. A review of the facility policy titled, Abuse Prohibition, dated 10/14/22, documented in part the following: - Allegation of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and/or representative. - Physical abuse includes hitting, slapping, pinching, and kicking. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The Administrator, Director of Nursing or designee will compile a final summary of all investigations and report the finding at the Quality Assurance Performance Improvement Committee Meeting. - The administrator or designee will notify the guest's/resident's representative. Also, any State or Federal agencies of allegation per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective actions. On 10/9/24 at 11:40 AM during the exit conference, the NHA and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34901

This citation pertains to intake MI00145800.

Based on interview and record review, the facility failed to ensure proper care was provided as indicated on the resident care guide for one resident (R101) dependent on staff for performance of activities of daily living (ADL).

Findings include:

On 5/20/24 at 2:36 PM, the facility filed a Facility Reported Incident that alleged on 5/19/24, R101 stated Certified Nurse Aide (CNA) C was rough while providing her care.

A review of R101's clinical record documented an initial admitted [DATE] and readmitted [DATE]. R101's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), unspecified dementia, major depressive disorder, conductive hearing loss, and morbid obesity. A Minimum Data Set, dated dated dated [DATE] documented severe cognitive impairment, frequent incontinence of bowel and bladder, and dependence upon staff for toileting hygiene.

Review of R101's care plans documented in part the following:

Focus: (R101) has a functional ability deficit and requires dependent assistance with self-care and mobility related to fatigue/weakness. Diagnoses of CHF, COPD, obesity. Revised 8/14/24.

Interventions: Two staff members to assist with ADL (activities of daily living) care. Personal hygiene requires substantial/maximal assistance. Toilet hygiene: resident is dependent with two helpers. Revised 5/10/24.

Nursing progress note dated 5/19/24 documented in part that at approximately 9:20 AM, patient (R101) reported to the day shift CENA, whom reported this information to the day shift nurse, that the nursing assistant from the midnight shift handled her rough. (R101) said she informed the midnight CENA (CNA C) that she was wet and needed to be changed. (R101) said (CNA C) bullied and harassed her.

The witness statement by CNA C, dated 5/20/24, documented, I went in and asked if I can change her (R101), she said yea. (R101) said I was being very rough with her. I asked what I can do differently .didn't say anything. I was trying to turn her, and she said I was being rough.

During an interview on 10/8/24 at 4:30 PM, the Director of Nursing (DON) said R101 had not always been truthful. The DON added that part of the rationale R101 was a two-person assist for ADL care was because of past false allegations made by R101, to ensure a collaborative witness of the care rendered, for the resident's and staff's safety, and resident's physical size. The DON said when R101 told CNA C that she was being rough with her, CNA C should have stopped and went and got the nurse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/8/24 at 4:42 PM, CNA C said that after R101 told her she was being rough with her, she did not inform the nurse because R101 let her finish changing her. When queried why she proceeded to change R101 by herself, CNA C stated, I don't know. That was a bad mistake on my part. On 10/9/24 at 11:40 AM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to intake MI00146939. Based on interview and record review, the facility failed to ensure the proper medications were provided to a resident (R104) discharged from the facility. Findings include: It was reported to the State Agency that R104 was sent home from the facility with another resident's medications. A review of the clinical record for R104 documented an admitted [DATE] and discharged date of 9/9/24. R104's diagnoses included hypertension and Down's syndrome. On 10/8/24 at 10:48 AM, Home Care Nurse (HCN) D was interviewed and said R104 was sent home from the facility with medications that were labeled with someone else's name. HCN D said there were about six different medications that were labeled with R105's name. On 10/8/24 at 10:55 AM, the Resident Representative (RR) for R104 was interviewed and listed the following medications that were sent home with R104 but labeled with R105's name: amlodipine 10mg, atorvastatin calcium, esomeprazole magnesium, donepezil 10mg, levetiracetam 750 mg, baclofen 10mg, and divalproex 500 mg. A review of the clinical record for R105 documented an admitted [DATE]. R105's diagnoses included seizure disorder, dementia, and hypertension. A review of physician orders documented the following prescriptions for R105: amlodipine 10mg for hypertension, atorvastatin calcium 20mg tablet for hyperlipidemia, esomeprazole magnesium for reflux disease, donepezil 10mg for dementia, levetiracetam tablet 750 for seizures, baclofen 10mg for muscle spasm, and depakote (divalproex sodium) tablet 500mg for seizures. On 10/8/24 at 12:15 PM, Licensed Practical Nurse (LPN) F was interviewed and said that prior to discharging a resident, you are to compare the current medications with current prescriptions and the discharge orders. Complete patient teaching on the medications. Obtain a printout that informs the residents on the side effects and the last time they took the medications. The medications are bagged up and given to the resident or the transport person if the resident is confused. LPN F said when R104 was discharged , medications got mixed up and she gave R105's medications to the transport person when R104 was discharged . LPN F said this was a big medication error. On 10/8/24 at 4:18 PM, the Director of Nursing (DON) said that R105's medications were bagged up because R105 was moved to another nursing unit. LPN F gave the transport driver R105's medications. The DON said LPN F should not have sent the wrong medications with R104, and additionally this was a HIPPA (Health Insurance Portability and Accountability Act) violation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 11:40 AM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.