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	12/16/2025

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 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** This citation pertains to 2677888. Based on interview and record review, the facility failed to report an incident of injury of unknown source to the State Agency in a timely manner for one resident (R105), out of six residents reviewed for abuse, resulting in the potential for unresolved resident concerns. Findings include:The facility self-reported incident (FRI) was received on 11/11/25. The incident was discovered on 11/7/25. A review of the facility's 5-Day investigation documented in part the following: On 11/7/25 at approximately 9:15 AM, R105 went to the nurses station and showed the nurse her left arm. There was a bruise on her left arm. It was purplish in color and was 3 1/2 inches by 2 inches on the forearm above the elbow. R105 told the nurse that she woke up with the bruise. R105 could not give an explanation of how she received the bruise. Staff that worked on the days before 11/6/25 and 11/7/25 did not see a bruise on R105's arm. R105 did go out on a LOA (leave of absence) with her guardian. The guardian said that R105 went on the LOA to get her hair done. After the hair appointment, R105 was brought back to the facility. R105 did not report any pain due to the bruise. On 11/7/25, Nurse A notified the Director of Nursing (DON). The DON notified the Administrator via cell phone. The NHA was out of town when it was reported to him. A review of the clinical record for R105 documented an initial admission date of 12/1/23 and readmission date of 12/6/23. R105's diagnoses included encephalopathy and psychotic disorder with delusion. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. On 12/15/25 at 3:23 PM, the Nursing Home Administrator (NHA) said the facility called him on 11/7/25 and reported the incident but he was at the airport. The DON, who was the back-up Abuse Coordinator, could not get into the reporting system. The DON reportedly was not able to log into the reporting system even after reaching out for technical assistance. The NHA previously reported that the DON was unable to log into the reporting system in August 2025. It was acknowledged by the NHA that there was a lack of follow-up concerning the DON's reporting system access between August and November 2025. A facility policy titled, Abuse Prohibition Policy, dated 10/14/22, was reviewed and documented in part the following: The staff will report any allegations or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown sourced to the Administrator and DON immediately. The Administrator or designee will notify the State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours. During the exit conference on 12/16/25 at 5:20 PM, the NHA and Assistant 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 no new information was provided.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes 2628767 and 2674347. Based on interview and record review, the facility failed to timely submit documentation of completed investigations to the State Agency for alleged resident-to-resident sexual abuse for two residents (R101 and R102) and alleged resident-to-resident physical abuse for two residents (R102 and R103) out of six residents reviewed for abuse, resulting in the potential delay for opportunities to implement corrective measures and interventions. Findings include: R101, R102A facility self-reported incident (FRI) was received by the State Agency (SA) on 8/8/25. The FRI documented that on 8/8/25 at approximately 2:30 PM, it was witnessed that R102 was in his wheelchair rolling towards his room. R101 was in her wheelchair rolling in the direction of R102. When the two residents rolled past each other, R102 reached his arm over to move R101's head towards him and then R102 kissed R101 on the mouth. R102 then rolled to his room and R101 rolled to the dining room. R101 could not recall the event. R102 denied doing anything. R102 was moved to another floor. A review of the clinical record for R101 documented an initial admission date of 4/10/23 and readmission date of 5/2/24. R101's diagnoses included Alzheimer's Disease. A Minimum Data Set (MDS) assessment dated [DATE] documented severe cognitive impairment. A review of the clinical record for R102 documented an initial admission date of 1/11/23 and readmission date of 12/1/25. R102's diagnoses included convulsions. A MDS assessment dated [DATE] documented moderate cognitive impairment. On 12/15/25 at 3:17 PM, the Nursing Home Administrator (NHA) acknowledged that the five-day complete investigation was submitted to the SA on 8/19/25. The NHA said he was out of town and the Director of Nursing (DON), who was the back-up Abuse Coordinator, was unable to log into the reporting system to submit the investigation. The NHA was unable to provide documentation of communication with the SA regarding the inability to access the reporting system. R103, R104A FRI was received by the SA on 10/12/25. The FRI documented that on 10/12/25 at approximately 10:30 AM, a maintenance staff person observed R104 hitting R103 with a banana. When the maintenance staff walked over to the situation, R103 rolled away to his room and R102 rolled to the dining room. The maintenance staff reported the incident to the charge nurse. R103 showed no signs or symptoms of pain or discomfort. R104 was moved to another floor. A review of the clinical record for R103 documented an initial admission date of 2/14/25 and readmission date of 7/21/25. R103's diagnoses included hypertensive emergency and vascular dementia. A MDS assessment dated [DATE] documented severe cognitive impairment. A review of the clinical record for R104 documented an initial admission date of 9/13/17 and readmission date of 6/12/24. R104's diagnoses included atherosclerotic heart disease and unspecified dementia. A MDS assessment dated [DATE] documented moderate cognitive impairment. On 12/15/25 at 3:24 PM, the NHA indicated the five-day complete investigation was submitted to the SA on 10/21/25. The NHA said the delay in the 5-day submission of the completed investigation was an oversight on his behalf. The NHA added, I got it in late. A review of the facility policy titled, Abuse Prohibition Policy, dated 10/14/22, was reviewed and revealed in part the following: The Administrator or designee will notify the State or Federal agencies of allegations per state guidelines. At the conclusion of the investigation, and no later than five working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action. Federal Regulation S483.12(c)(4) documented the following: Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident . During the exit conference on 12/16/25 at 5:20 PM, the NHA and Assistant 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 no substantially new information was provided

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered properly and per physician's orders for one resident (R108) of three residents reviewed for medication administration, resulting in the potential for less than therapeutic effect of the prescribed medication when medications were not taken or administered properly. Findings include: In an observation and interview on 12/15/25 at 9:35 AM, R108 was awake and lying in bed. While grimacing and holding her stomach, R108 said her stomach hurts. R108 said she reported her stomach pain to Certified Nurse Aide (CNA) J. On 12/15/25 at 9:37 AM, CNA J indicated that she told Registered Nurse (RN) I that R108 was in pain. On 12/15/25 at 9:45 AM, RN I denied being informed that R108 was in pain. RN I and the State Surveyor went into R108's room. R108 again stated that she had pain in her stomach. While in R108's room, seven unidentified oral medications were observed on R108's overbed table; two tablets were loose on the overbed table and five were contained in a clear plastic medicine cup. RN I removed the pills from the overbed table and stated to R108, You didn't take all your pills. On 12/15/25 at 9:50 AM, RN I identified the pills left at R108's bedside as follows:Sucralfate, Metoprolol, Pantoprazole, Levothyroxine., Acetaminophen. Atorvastatin, and the last pill was not identified by RN I. When RN I noted that R108 had not taken the sucralfate and pantoprazole tablets (both medications were prescribed for gastrointestinal concerns), he stated, That's why her stomach hurts. RN I acknowledged that R108 did not have a physician's order for atorvastatin. On 12/15/25 at 10:20 AM, the pills obtained from R108's overbed table were compared with R108's Medication Administration Record (MAR) with RN/Unit Manager (RN/UM) D. The following was documented:The two loose pills on the overbed table were documented as:1. Sucralfate tablet. 1 gm. Give 1 tablet by mouth two times a day for gastric protection at 9:00 AM and 5:00 PM2. Metoprolol succinate extended-release tablet. Give one tablet by mouth one time a day for hypertension at 9:00 AM Per RN/UM D the sucralfate and metoprolol were documented as being administered on 12/15/25 at 9:09 AM.The five pills in the clear plastic medicine cup were documented as:1. Pantoprazole sodium 40 mcg oral tablet delayed release. Give 1 tablet by mouth two times a day for GERD (gastroesophageal reflux disease) at 6:00 AM and 9:00 PM.2. Levothyroxine sodium oral tablet 25 mcg. Give one tablet by mouth in the morning for hypothyroidism. Take on an empty stomach at 6:00 AM.3. Acetaminophen oral tablet 500 mg. Give one tablet every six hours as needed for pain.4. Atorvastatin. A review of physician orders for R108 revealed that atorvastatin had not been prescribed for R108.5. The pill in the cup not identified by RN I was oxycodone hydrochloride 5 mg. Give one tablet by mouth every four hours as needed for pain.RN/UM D said involved staff will receive education and discipline. The facility needs to put something in place to make sure this does not happen again. Medications are not to be left at bedside. Nurses are to make sure medications are swallowed by the residents. RN/UM D added that resident medications come pre-packaged from the pharmacy and was unable to explain why the atorvastatin was given to R108. RN/UM D said oxycodone was a controlled narcotic and not included in the pre-packaged medications. On 12/16/25 beginning at approximately 12:30 PM, the December 2025 MAR for R108, obtained on 12/15/25 at 10:19 AM, was reviewed with the Assistant Director of Nursing (ADON) and revealed the following:The 9AM dose of Sucralfate was documented administered by RN I.The 9AM dose of Metoprolol was documented administered by RN I.The 6AM dose of Pantoprazole was documented administered by nurse initialed mnbt. The 6AM dose of Levothyroxine was documented administered by nurse initialed mnbtThe ADON reported that RN I had documented an administration of oxycodone 5 mg tablet for 12/15/25 on the controlled substance narcotic sheet but not on the MAR. The ADON added that nurses were to follow the five Rs when administering medication: right person, right time, right drug, right route, and right dose. Nurses should remain with the residents until they are sure the medications have been completely swallowed. The ADON indicated that R108 had not been evaluated and approved to self-administer medications. A review of the clinical record for R108 documented an initial admission date of 4/19/23 and readmission date of 4/9/25. R108's diagnoses included peripheral vascular disease, hypertension, alcoholic cirrhosis of liver, hypothyroidism, and irritable bowel syndrome. A Minimum Data Set assessment dated [DATE] documented intact cognition. A review of the facility policy titled, Medication Administration, dated 10/17/23 was reviewed and documented in part the following:- Resident medications are administered in an accurate, safe, timely, and sanitary manner - Medications are administered in accordance with written orders of the attending