

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Boulevard Temple Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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** This citation pertains to intake 3003803 and 3006486. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from verbal and physical abuse by staff. Findings include: On 7/14/2026 at approximately 12:10PM, R27 was interviewed in their room. R27 was observed to be alert and communicative, well groomed, and did not appear in any distress. R27 said that a few months ago, a nurse wrapped her hands around their neck, hit them, and threw them to the ground. R27 said that the incident occurred in the dining area where other residents and staff witnessed it. R27 said they reported the altercation to the facility receptionist that same day. R27 denied any injuries from the incident and said they felt safe in the facility but were still angry that the incident occurred. A review of R27's electronic health record revealed they originally admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, muscle wasting and atrophy, insomnia, paroxysmal atrial fibrillation, hypertension, congestive heart failure, hypothyroidism, type II diabetes, depression, and adjustment disorder with disturbance of conduct. Section C of the Minimum Data Set (MDS) with an Assessment Reference Date of 4/23/2026 indicated R27 scored 12/15 on the Brief Interview for Mental Status questionnaire - indicative of no cognitive impairment. Section GG of the same MDS indicated R27 needed supervision for most activities of daily living. R27's care plan was reviewed and revealed the following focus initiated on 5/21/2025 and revised on 5/1/2026: (R27) has actual fluctuations in mood R/T (regards to) DX (diagnosis): depression and adjustment d/o (disorder) with disturbance of conduct. (R27) has potential for feeling down regarding recent alleged abuse incident on 4/29/2026. An intervention on the care plan was initiated on 4/29/2026 which revealed, Staff, SW (social work), and Psych services to provide emotional support. A nursing progress note dated 4/26/2026 at 12:46PM written by Licensed Practical Nurse (LPN) K revealed the following: Resident is yelling in dining area to go on elevator while staff are tending to other residents, when trying to remove resident from area (R27) begin to yell and grab at wheelchair brakes and cause for wheelchair to lock, resident slid forward out of chair sliding throws [sic] the floor, staff was able to slow fall with chair, resident still yelling very hard to calm down once calmed down staff was able to safely place (R27) back into (R27) chair, bp:124/80 p:55, r:20, resident assisted down stairs to relax, resident stated has no pain, resident stated did not hit head. no new skin tears observed. A nursing progress note dated 4/26/2026 at 2:18PM revealed the following: Neuro checks has started, resident is calm, no pain reported. Dr. notified of fall no new orders given. A nursing progress note dated 4/26/2026 at 4:06PM revealed a late entry indicating R27 was transferred to the hospital on 4/26/2026. On 7/15/2026 at approximately 11:30AM, an interview with Certified Nursing Assistant (CNA) E and witness to the incident was conducted. CNA E said they came out of a resident room when they heard arguing in the (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	dining room. Upon entering the dining room, CNA E observed LPN K holding R27's hands over their head. CNA E then said to LPN K, what is going on? LPN K replied, I want (R27) out of my (expletive) dining room. CNA E then observed LPN K put her knee on the back of R27's wheelchair and tip the chair forward - resulting in R27 falling to the floor and hitting their head. On 7/15/2026 at approximately 11:45AM, an interview with CNA D was conducted via telephone. CNA D said they entered the dining area and observed LPN K trying to pull R27's wheelchair backwards. CNA D said that while pulling the wheelchair backwards, LPN K lifted the wheelchair off the ground and R27 fell forward, hitting his head on the floor. On 7/15/2026 at approximately 2:55PM, an interview was conducted with CNA F who also witnessed the incident. CNA F said they heard yelling and arguing around the nursing station/dining area. When CNA F entered the area, they observed LPN K and R27 going back and forth, with LPN K trying to move R27's wheelchair saying, I don't give a (expletive) if you fall out of the chair. On 7/15/2026 a voicemail was left on LPN K's telephone asking for a return call. There was no return call upon exit from the facility on 7/16/2026. On 7/15/2026 at approximately 10:40AM, an interview was conducted with facility Social Worker (SW) A regarding R27's recent incident. SW A said they were notified of the incident and that wellness visits were provided to R27 for three days afterward. SW A said they did not observe any negative psychosocial harm outcomes but that a trauma assessment was completed, a referral made to the facility mental health/behavioral health services provider, and the care plan revised and updated. The SW confirmed R27 continues to be at their baseline after the incident. On 7/16/2026 at approximately 11:30AM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA confirmed they were the designated facility Abuse Coordinator and completed the investigation into the incident between LPN K and R27. The NHA reported they were made aware of the incident on 4/26/2026 by the facility receptionist. The NHA suspended LPN K that day and initiated an investigation which included contacting the local police department and notification to the state agency. The NHA said that through gathering witness statements and the statement of R27, they substantiated that abuse had occurred. The NHA then confirmed that LPN K was terminated from employment with the facility on 4/30/2026. A policy titled, Abuse Prohibition last revised 9/9/2022 was provided by the facility and revealed 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 purposes of discipline or convenience that are not required to treat the guest's/resident's medical condition. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included a review of the Abuse Prohibition Policy, re-education of staff on the facility abuse policy with an emphasis on identifying the different types of abuse, reporting allegations of abuse to the Abuse Coordinator and in accordance with state and federal guidelines, initiation of investigations timely, and implementing interventions to prevent the reoccurrence of potential abuse and to protect other residents. The facility has conducted ongoing monitoring and auditing which included interviewing residents and staff on abuse. These audits are reviewed during the monthly Quality Assurance Performance Improvement meeting to identify any further concerns. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		