STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235582	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health and Rehabilitation Center	19933 West Thirteen Mile Road Southfield, MI 48076

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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 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 intake: 2809647.Based on observation, interview and record review the facility failed to conduct a thorough investigation for a staff to resident abuse allegation and failed to protect the alleged victim (resident) while the investigation was conducted for one (R303) of three residents reviewed for abuse. Findings include:A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 3/17/26 at 12:46 AM, documented in part . Resident told a staff member that over the weekend they were abused by someone. Immediately the administrator was notified a statement was collected from which the resident identified a staff member that was immediately suspended pending investigation. Nursing Supervisor conducted a skin assessment on residence no concerns were noted. Increased supervision was instituted for the resident's assuring safety throughout the night. Resident stated they feel safe at center, and no psychosocial conditions noted.A review of the investigation summary submitted to the SA on 3/24/26 at 8:59 PM, documented in part . On 3/16/2025 at around 10 pm (R303 name) stated that on the midnight shift- around 11pm that a CNA (Certified Nursing Assistant) came into his room with 2 pillows hitting swinging them at him. He stated that the CNA also threw water at him. Administrator and <sic> collected a statement from the residents. CENA (Certified Nursing Assistant- CNA A name) was suspended till a full investigation was completed . All residents who were assigned to (CNA A name) on 3rd shift on 3/15/2026 were interviewed. No one reported any issues regarding care and or CENA behavior. No issues identified. On 3/20/26 at around 1 pm Administrator (name) and nurse manager (name) LPN (Licensed Practical Nurse) interviewed (R303 name). The resident was resting in bed. He was alert and able to answer questions. Based on investigation facility unsubstantiated mistreatment/abuse.A review of R303's medical record revealed they were admitted to the facility on [DATE], with diagnoses that included mild cognitive impairment, disorientation and required staff assistance for all Activities of Daily Living (ADLs).On 4/6/26 at 10:11 AM, an observation was made of R303 lying on their back in bed receiving care from an aide. Once care was completed an interview was conducted with R303. R303 denied any mistreatment or any staff to have ever hit them. When specifically asked about the incident, R303 denied that anything like that had ever occurred. The resident stated that they were currently in England and in the middle of a war. When asked, R303 stated they felt safe where they were because . I have big bullets and I will hit back and they know that.On 4/6/26 at 10:26 AM, a request was made to the Administrator and Director of Nursing (DON) to provide the complete investigation for the incident with R303 and CNA A and the time sheets for CNA A for the month of March 2026.A review of the investigation provided revealed the following:A statement completed by CNA C documented, . On Monday March 16, 2026 at approximately 7pm, I gave (R303's room mate name and room number) a bed bath. And at that time, he began recalling events he heard going on next door, that happened over the weekend. (R303's room mate name) explained to me that he heard a CNA beating up on his neighbor. Upon hearing this I asked him to describe who he was referring to. He said that he heard (R303 name) yelling for help, but no help came. After finishing his bed bath, I reported what I was told to the supervisor. This statement was not dated to reflect when it was obtained.A statement completed by the Administrator documented, . 3/17/2026- Administrator requested that (continued on next page)

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	Nursing Management question competent resident on the (unit name) if they recalled any concerns from distressed residents over the past few days. This was based off the statement from (R303 name) regarding that he could hear multiple residents and staff stating while the staff member was attacking him with pillows why are you doing that? . Ma'am why are you doing that to him? . Don't hit him! The administrator had to attend a conference that week and stated he would follow up upon his return. 3/20/2026- (~12:45pm-1:15pm) meeting with (unit manager name- later identified as UM D- and unit name). Spoke with (unit manager name and unit name). The administrator asked her how her morning rounds went. Unit Manager (name) stated that no concern were noted from residents on (unit name) regarding (R303 name) situation during her rounds throughout the week. (Unit manager name) went on to explain that competent residents (four residents listed) did not mention anything regarding them witnessing or hearing a resident calling out in distress over the past few days during her .morning rounds. Unit Manager (name) and Administrator (name) then went to check in on (R303) together. I explained the reason for his visit was to check in on how he has been being treated during his stay at the center. (R303 name) stated '.staff treat him well and she <sic> has no concern/complaints of care'. The administrator and Unit Manager continued to chat with residents that if he had any issues with quality or care or wrongful doing/treatment that he could tell us. (R303 name) acknowledged stating if anything come to mind Ill make sure to tell you or (unit manager name). Signed by the Administrator and dated 3/20/2026.The investigation did not contain resident statements, nor did it contain interviews and/or assessments from the residents that was assigned to CNA A on the shift that the allegation was made.Further review of the documentation provided revealed CNA A worked in the facility on the following dates and times:3/15/26 - 11:16 to 7AM3/16/26- 3:00 PM to 11:20 PM and there is also a punch for 11:21 PM to 7AM3/17/26- 3:00 PM to 11:00 PM3/19/26- 3:00 PM to 7:00 AM3/21/26- 3:16 PM to 10:54 PMShortly after being provided the documentation- the dates and times were reviewed with the Administrator who stated although CNA A timesheet revealed they were on duty during the investigation, they were not. The Administrator explained that the facility modified the timesheet to pay CNA A during the investigation due to the findings to have been unsubstantiated. The Administrator was asked to provide the time correction sheets or documentation from the responsible department to verify the reason, dates & times that the time punches were modified. No additional documentation was provided to confirm the Administrator explanation regarding CNA A timesheet by the end of the survey. A review of the progress notes revealed the following:On 3/16/26 at 6:02 AM, a Nursing note documented in part . Resident is combative this morning. Resident stating that staff was trying to hurt him. Writer tried to de-escalate resident, but resident picked up TV remote and swung on writer. Resident felt more comfortable with other nurse and allowed her to clean him up.On 3/17/26 at 5:19 AM, a Nursing note documented in part . spoke with Medical Director. regarding res (resident) c/o (complaints of) tenderness to right inner aspect of right eye.On 3/17/26 at 12:47 PM, a Nurse Practitioner (NP) note documented in part . seen for evaluation of change in behavior, pt (patient) agitated, confused, accusing staff of harming him. R (right) eye pain; pt c/o (complained of) pain to the R eye, Xray negative.On 3/18/26 at 3:12 PM, a Social Work (SW) note documented in part . Resident stated he has not been sleeping well because he does not feel safe. Resident stated he thought he saw the person last night come into his room. SW did explain to resident that the person is not in the building so he will not see that person. Resident stated that makes me feel better, hopefully my sleep will improve, he stated. SW asked if he would like to speak with the psychologist, resident stated yes. SW will arrange. Resident thanked SW for speaking with him and making him feel a little better.On 3/21/26 at 3:08 PM, a Psychologist note documented in part . There is a history of dementia. When he did not mention the alleged incident, he was asked about it. He said he remembered 'a woman in a white uniform hitting me with a pillow' on the right side of his face. He said he yelled, 'Stop hitting me'- and 'other people also yelled' for her to stop. He said he 'tried to push the wheelchair to stop her', noting, 'There was a crowd that came to my rescue', He said he had not seen the individual since the alleged attack.On 4/7/26 at 12:06 PM, a (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	telephone interview was conducted with CNA A. CNA A stated they were trying to change R303 and the resident attempted to hit them with a remote. CNA A stated they went to get the nurse and remembered another nurse having to step in. CNA A denied any previous incidents or any further incidents to have occurred between them and R303 since that day. CNA A stated they were informed the next day that they were suspended from the Administrator and a Unit Manager. CNA A explained the day after they were suspended they came to the facility to talk to the DON (Director of Nursing). CNA A stated she was provided an education and was told the investigation is over and they could return back to work.On 4/7/26 at 11:30 AM, the Administrator was interviewed and asked what day CNA A was suspended. The Administrator reviewed the time sheet and replied that CNA A was suspended on the 16th. The Administrator stated CNA A came in on Tuesday to meet with the DON. When asked how long CNA A was suspended and what day they returned, the Administrator stated that CNA A returned on 3/21/26. The Administrator again explained how although the time sheet revealed that CNA A was in the building working during the investigation, they were not. The Administrator was again asked to provide documentation to confirm.On 4/7/26 at 12:03 PM, the Administrator was asked about the statement obtained from the reporting CNA that documented what R303's roommate overheard and asked if they took that statement into consideration and interviewed the room mate due to no statement from the roommate found in the investigation provided. The Administrator was also asked again for any statements/assessments obtained from the residents that was assigned to CNA A during the shift of the alleged allegation. The Administrator stated they believed they had something and would follow back up.On 4/7/26 at 12:45 PM, an observation of R303's roommate was made. R303's roommate was observed lying on their back in bed listening to their mobile device. When specifically asked about the alleged incident between their roommate and CNA A, they stated . I can't remember. I kind of forgot. I can't really recall. An interview was conducted further and before leaving the resident room, the roommate was asked one more time about the incident and stated . I really don't remember what I said.On 4/7/26 at 1:35 PM, an interview was conducted with UM D. UM D was asked their involvement in the alleged abuse investigation that involved R303 and CNA A. UM D explained they were notified by a CNA of the incident when they were home. UM D explained they came back to the facility and conducted a head to toe assessment on R303 and left. UM D explained that the Administrator was in the building when they returned to complete the assessment. UM D could not recall the date they returned to the facility. UM D was asked to look at their phone log and identify the date the CNA had called them to inform them of the incident and UM D explained they had just purchased a new phone. UM D stated that while on duty the next day they followed up with R303 and asked him what happened. UM D stated R303 gave them the description of the CNA and they knew immediately who the CNA was based on the description. UM D then went on to say . he (R303) has never made an allegation against staff that I know of before. Combative with care but he had never made an allegation against staff.On 4/7/26 at 3:46 PM, an interview was conducted with the Administrator and DON (with the Regional Clinical Service Director - RCSD B in attendance. All were asked who conducted the investigation for the alleged abuse and the Administrator responded that they completed the investigation. The Administrator was asked why there was no statement obtained from R303's roommate and asked about statements and/or assessments of the other residents' assigned to CNA A on the shift of the alleged incident. The Administrator stated . I actually was about to email you about a couple of statements. The Administrator was asked why the statements were not provided when the initial request for the full investigation was made on 4/6/26 and thereafter with the additional requests. The Administrator stated they thought it was included in the file. When reminded that additional requests was also made earlier in the day (4/7/26) to provide the documentation for review, they had not. The Administrator was then asked when the investigation was completed and stated it was actually completed when the five day was (five day submission to the SA). The Administrator was asked how CNA A was allowed to return to work the next day after being suspended, while the investigation was ongoing and no (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	explanation was provided. The Administrator left the room to provide the additional statements that they had on their computer.During the exit conference of the survey on 4/7/26 at 4:31 PM, two additional statements were provided. One was the Administrator statement, which was reviewed during the survey and noted above and the other was a statement obtained from R303 on 3/16/26 at 10:10 PM through 11:00 PM.A review of a facility policy titled Abuse updated 5/24/23, documented in part . Residents have the right to be free from abuse. mistreatment. The facility supports and protects patients. from harm during an investigation of alleged abuse including retribution and retaliation. If a staff member is the alleged perpetrator, that staff member should be immediately removed from the facility and the schedule pending the outcome of the investigation. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse.Identifying and interviewing all involved persons, including the alleged victim. witnesses. Conducting observations of the alleged victim interactions and relationships between staff and the alleged victim and/or other residents. Providing complete and thorough documentation of the investigation. After completion of the investigation, the evidence should be analyzed, and the Administrator. will make a determination regarding whether the allegation is substantiated or unsubstantiated.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake(s): 2966229 & 2803135.Based on interview and record reviews the facility failed to complete Braden assessments per the facility policy, failed to accurately/timely implement wound orders and failed to ensure timely reporting of abnormal changes to wounds for two (R's 304 & 305) of three residents reviewed for pressure wounds. Findings include:R304A review of a complaint submitted to the SA documented a concern of a wound to have developed while inpatient at the facility.A review of the medical record revealed that R304 was admitted to the facility on [DATE] with diagnoses that included: a closed fracture and repeated falls. R304 was dependent on staff assistance for all activity of daily living (ADL). The resident was discharged from the facility on 6/26/25.A review of an admission Evaluation dated 5/20/25 at 3:39 PM, documented in part . Clinical Evaluation Integumentary (Skin). Left hip- Pressure- Stage II (partial-thickness loss of skin with exposed dermis). Coccyx- suspected DTI (Deep Tissue Injury- Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue).A review of an admission Braden assessment dated [DATE] at 3:39 PM, documented a Score of 17.0 At Risk. This was the only Braden assessment completed in the medical record.A review of a facility policy titled Skin and Wound Guidelines revised 2/4/26, documented in part . upon admission or readmission to the facility with a head-to-toe skin evaluation and completion of the Braden Scale for Predicting Pressure Sore Risk. Using the Braden Scale For Predicting Pressure Sore Risk., weekly X 3 after admission for a total of 4 weekly evaluations, then quarterly.Review of the progress notes revealed the following:A wound consultation note dated 6/1/25 at 11:55 AM, documented in part . Date of Service: 2025-05-27. Referred by medical team to consult regarding shoulder hip leg heel and facial coccyx wounds. left hip unstageable ulcer (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar) 5.0 x 3.1 by UTD (unable to determine) minimal amount of serosanguineous drainage no clinical evidence infection surrounding tissue is intact base is covered with tight nonviable tissue. coccyx DTPI (deep tissue pressure injury) 6.4 x 3. 9 cm (centimeters) area of dark nonblanching tissue that is beginning to surface scant amount of serosanguineous drainage (watery, clear, or slightly yellow/tan/pink fluid) no clinical evidence of infection open areas are granular. Assessments/Plans. Pressure ulcer of left hip, unstageable. Recommend treatment: Apply Medihoney cover with foam dressing change 3 time a week. Pressure-induced deep tissue damage of sacral region. Recommend treatment: Apply thin layer of Triad to entire area daily.On 5/28/25 at 11:46 PM, a Nursing note documented in part . Resident has an open area to coccyx. Ordered Triad paste and wound consult. Logged for dr. (doctor).Further review of the progress notes revealed a Medical Doctor (MD) examined R304 on 5/29/25 at 9:57 AM and noted . SKIN: heels soft, coccyx area not examined today. A Physician Assistant (PA) examined the resident on 5/30/25 at 9:22 AM and noted . Skin care: Continue decubitus ulcer precautions. Defer to IM (internal medicine) as well as wound care team. A D.O. (Doctor of Osteopathic Medicine) examine the resident on 6/2/25 at 2:13 PM and noted . Skin care: Continue decubitus ulcer precautions. Defer to IM as well as wound care team.A review of a wound consultation note dated 6/3/25 at 10:22 AM, documented in part . left hip unstageable ulcer. coccyx previous DTPI has now surfaced to a stage III (full-thickness loss of skin, in which subcutaneous fat my be visible in the ulcer and granulation tissue and rolled wound edges are often present) ulcer measuring 2.7 x 1.8 x 0.1 cm scant amount of serosanguineous drainage. Assessments/Plans. Pressure ulcer of left hip, unstageable. Recommend treatment: Apply Medihoney cover with foam dressing change 3 time a week. Pressure ulcer of sacral region, stage 3. Recommend treatment: Apply Medihoney cover with dry dressing change daily.A review of the June 2025 MAR (Medication Administration Record)/TAR (Treatment Administration Record) and Physician orders documented the Medihoney to be applied to the left hip and coccyx every day, despite the wound (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinician order to have the medihoney applied to the left hip three times a week.A review of the record revealed no documentation on why the wound clinician recommendation was not implemented.A review of a Wound consult dated 6/22/25 at 8:51 PM, noted a Date of Service: 2025-06-17 documented in part . Chief Complaint: Seeing patient regarding left hip and coccyx wounds. Pressure ulcer of left hip, unstageable. Recommend treatment: Apply Medihoney cover with foam dressing change 3 time a week. Pressure ulcer of the sacral region. Recommend treatment: Apply Medihoney cover with dry dressing change daily.A review of a Physician Team note completed by a NP dated 6/17/25 at 10:08 AM, documented in part . CHIEF COMPLAINT: Follow up pain. Pressure Ulcer to Coccyx, buttocks: Pt c/o (complaint of) pain to coccyx/buttocks. Has three areas to the coccyx and buttocks, coccyx has slough(non-viable yellow, tan, gray, green or brown tissue) covering the wound bed. Areas are sore with lying on back. Pt positioned off coccyx in bed, spoke to NM (Nurse Manager) about getting LALM (Low Air Loss Mattress).A review of the Physician orders revealed the low air loss mattress was implemented don 6/17/25. There was no documentation in the medical record on why this intervention was not implemented previously. R305A review of a complaint submitted to the State Agency (SA) documented concerns of R305's wound to have worsened while inpatient at the facility due to the lack of poor care.A review of the medical record revealed R305 admitted to the facility on [DATE] with diagnoses that included: chronic kidney disease and chronic systolic heart failure. R305 depended on staff assistance for all Activities of Daily Living (ADLs). R305 was discharged from the facility on 3/13/26.A review of an Admission assessment dated [DATE] at 10:37 PM, documented in part . Clinical Evaluation Integumentary (Skin). Left buttock. skin tear. Length-n/a (not applicable) . Width- n/a. Depth-n/a. Stage-N/A.A review of the only Braden assessment completed, dated 3/2/26 (four days after admission) documented a score of 18.0 At Risk.A review of the progress notes revealed the following:A Nursing note dated 2/26/26 at 10:19 PM, documented in part . A small open area was noted to the left buttock. Resident stated she was unaware of the open area. Wound care team has been consulted for further evaluation and management.A Physician note dated 2/27/26 at 12:22 AM, documented in part . Pressure sores L (left) buttock and coccyx, Stage 2-3, No signs of infection, Continue local care, offload. wound care.A Skin Issues note dated 3/3/26 at 3:29 PM, documented in part . Coccyx. Unstageable pressure ulcer/ injury. Unstageable ulcer due to slough and / or eschar (dead or devitalized tissue that is hard or soft in texture).A wound consult dated 3/4/26 at 3:29 PM, documented in part . Date of Service: 2026-03-03. Referred by medical team to consult regarding coccyx/left buttock wound. Skin: Extending from coccyx down left buttock unstageable ulcer 5.2 x 3.7 x 0.1 at the distal end UTD at the proximal end minimal amount serosanguineous drainage. necrotic proximal 50% . Assessments/Plans: Pressure ulcer of sacral region, unstageable. Recommend treatment: Apply thin layer of Triad to entire area daily.A review of a Wound consult dated 3/10/25 at 11:49 AM, documented in part . Assessments/Plans: Pressure ulcer of sacral region, stage 3. Recommend treatment: Apply Medihoney cover with dry dressing change daily.A review of the March 2026 MAR/TAR and Physician orders revealed the Medihoney treatment began three days later on 3/13/26.A review of the medical record revealed no documentation of the reason for the delay implementation of the wound treatment. Further review of the medical record revealed no documentation of identification of changes to the wound by the facility front line staff (nurses or aides), which were identified by the Wound clinician during their weekly consultations/examinations.On 4/6/26 at 3:01 PM, the facility's Wound Nurse (WN) E was interviewed and asked about their responsibilities in the facility. Included in the duties verbalized was the task of completing a second skin check for new admissions. WN E stated they also rounded with the Wound Clinician every Tuesday. WN E stated after rounding with the Wound Clinician they put all new and/or modified orders in the resident charts. WN E explained that the Wound Clinician makes the recommendations and they call the primary physician to confirm the orders and start them. When asked if any of the primary physicians have ever not followed the recommendations of the Wound Clinician, WN E responded . they never said no to the recommendations. WN E was asked about the (continued on next page)

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