STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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 Incident 2984504.Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff, affecting one resident (R701) of three reviewed for abuse.Findings include: An allegation of staff to resident abuse was submitted to the state agency on 3/27/26 documenting; On the afternoon of 3/27/26, a hospice representative told the Administrator that [R701] had concerns regarding the midnight shift and was afraid of the two ladies that cared for her. Licensed Practical Nurse (LPN) B and Certified Nurse Assistant (CNA) C were assigned to [R701] from 11 p.m. on 3/26/26 until 7 a.m. on 3/27/2026. An investigation revealed that around 11:30 p.m. on 3/26/26, [R701] began calling out for help. LPN B and CNA C entered the room. LPN B told [R701] to stop yelling and they are not the only patient on this floor. [R701] began calling out for help again that they could not reach they're call cord. When LPN B and CNA C entered the resident's room, [R701] explained they needed to be turned/repositioned. The nurse and aide told the resident that it had not been two hours. [R701] expressed they was in pain and the nurse replied, I gave you your pain medication. Goodnight.On 4/15/26 at 1:00 PM, R701 was observed laying in their bed. R701 appeared anxious and had just received assistance from the nurse on the floor. When R701 was asked about the incident on 3/26/26 during the midnight shift, they said about the staff, They were mean to me and wouldn't help me. I kept yelling for help.On 4/15/26 at 1:30 PM, a phone was placed to Licensed Practical Nurse (LPN) B, there was no answer and a voicemail message was left. There was no return call prior to end of survey.On 4/15/26 at 1:40 PM, a phone call was placed to Certified Nursing Assistant (CNA) C, there was no answer and a voicemail message was left. There was no return call prior to end of survey.On 4/15/26 at 2:30 PM, the Nursing Home Administrator (NHA) was interviewed in their office. The NHA stated there was video footage and audio of the hallway outside of resident's room from the date of the incident. A review of the video footage revealed the following: R701 can be heard yelling for help while the LBN B is outside of room for several minutes before LPN B and CNA C enter the room. LPN B is heard telling R701 to stop yelling and told her she is not the only patient on this floor. Both staff are seen leaving the room, and R701 is heard yelling again saying she could not reach her call light. Both LPN B and CNA C were observed responding to R701's room after several minutes. R701 was heard telling the two staff members that they needed to be turned due to being in pain. LPN B was heard telling R701 that it had not been two hours. When R701 stated they were in pain, LPN B replied, I gave you pain medication. Goodnight. Both staff members exited the room and ignored R701's calls for help and request to be turned. CNA C entered the room sometime later and then exited the room and stated Goodnight. If you get messed up (soil on self), that's on you to R701.The NHA was asked what their expectation regarding residents and abuse. The NHA replied, All residents should be free from abuse and neglect.R701's medical record was reviewed and revealed the resident was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the brain and Radiculopathy thoracic region. Further review revealed R701's Brief Interview for Mental status (BIMS) assessment dated [DATE] was 12/15 indicating intact cognition and they required staff's (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 - Minimal harm or potential for actual harm Residents Affected - Few	assistance with activities of daily living (ADLs). A review of the Abuse, Neglect and Exploitation Policy dated 1/30/23 revealed, 'It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included interviews, skin, and pain assessments on all residents, all staff abuse education, weekly abuse audits. The facility was able to demonstrate monitoring of the corrective action and maintained compliance. Date of Compliance was 4/10/26.A review of the plan of correction revealed the following actions:Immediately suspended employees upon notification from resident.Resident was assessed, no injuries noted, and no pain was reported. Physician and family were notified of alleged incident.Resident's roommates were interviewed.Staff statements were taken.Facility Social Work completed 3 days well check visits for Resident.Behavioral Health Psychiatric Services offered to Resident.Police were called, and a report was filed, Detective was assigned, and the case was closed.Both staff were given disciplinary action related to abuse and resident rights resulted in termination. Interview able residents within the assignment set were queried.Facility policy on Resident Rights and Abuse was reviewed and deemed appropriate.Facility staff were reeducated on Resident Rights and Abuse Policies. The Administrator or designee will conduct audits of random interviewable residents to ensure they have not received rough treatment or inappropriate verbal conversation from staff.The Administrator is responsible for overall compliance by 4/10/26.