STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235632	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - SAMARITAN	5555 CONNER AVENUE, SUITE 4000 DETROIT, MI 48213

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 0604 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 459. Based on interview and record review, the facility failed to ensure a resident was free from physical restraint for one (#601) resident reviewed for abuse, resulting in a complete anterior dislocation of the shoulder and the potential for further mistreatment and injuries to occur. Findings include: The facility reported an injury of unknown origin. The facility further reported that on [DATE] at approximately 10:30 PM, CNA A, CNA B, and CNA C provided care in R601's room. While providing care, R601 became combative. CNA C held her legs. CNA A held her arms. CNA B cleaned her. The Director of Nursing (DON) heard the resident screaming and went into the room attempting to assist in calming the resident down related to the catastrophic reaction she was having. CNA A again entered R601's room at 2:15 AM and noticed that R601's shoulder appeared to look different than the other and immediately reported this to the nurse. According to the clinical record, Resident #601 (R601) had an original admission date of [DATE] and readmission date of [DATE]. Her [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented severe cognitive impairment, physical behaviors occurred ,[DATE] days, verbal behaviors occurred ,[DATE] days, and rejection of care occurred ,[DATE] days. R601 died at the facility on [DATE]. Further review of R601's clinical record documented in part the following progress notes: --[DATE] at 2:31 AM: CNA (Certified Nurse Aide) states resident complains of right shoulder pain. Writer assessed resident. Resident has limited ROM (range of motion) in right shoulder. Resident grimaces when arm is lifted. No trauma associated nor post fall. Dr. notified. Will continue to monitor --[DATE] at 4:21 AM: X-ray of right shoulder requested. --[DATE] at 8:37 AM: X-ray to right shoulder results: Complete anterior dislocation of the glenohumeral (shoulder) joint. Bony irregularity along the inferior rim of the glenoid (part of the shoulder). Acromioclavicular (top of the shoulder) joint is intact. Soft tissue swelling noted. Physician was called; received new order to send the resident to hospital. --[DATE] at 5:23 PM: Resident back from the hospital, right arm put on sling. A review of R601's care plans documented the following: Focus: I have a behavior problem, at times I may wander into peers' rooms and get into their beds or go into their night stands and bother their personal belongings. I am combative with staff when they try to help me with my daily care. Initiated: [DATE] Interventions included: Approach me and speak in a calm manner. Divert my attention and remove me from a situation as needed. Initiated: [DATE] Explain procedures to me before starting and allow me to adjust to changes. Initiated: [DATE] If reasonable, discuss my behavior with me and why it is inappropriate and/or unacceptable. Initiated: [DATE] On [DATE] beginning at 12:35 PM, when the DON was queried about what happened to R601 on the evening of [DATE], she said, The Resident was restrained. The CNAs should not have done that. They have been taught to walk away. Get someone else to come in. That's why CNA A was suspended and received a disciplinary. The DON added, If they (the residents) are combative you have to let them go. On [DATE] at 1:20 PM, when a telephone interview was conducted with CNA B regarding the [DATE] incident, she said, I am very familiar with (R601). I assisted two other CNAs to put (R601) to bed. After we put her in the bed and undressed her, I went to gather soap and towels. I performed the care. CNA B stated R601's backside was facing her. The other two CNA's were on the opposite side of the bed keeping her to one side. It takes three people to assist (in R601's care). CNA B said, (R601) would yank away. She can snatch away hard. We were trying to hold on to her, so she doesn't hurt herself. She was throwing punches. We try our best to clean her. We should have probably walked away because of what they told us happened after the fact. When CNA B was queried if she was familiar with a catastrophic reaction, she said, Somewhat. It's something big. I heard of that in school. It's been a while. On [DATE] at 1:56 PM, when a telephone interview was conducted with CNA A regarding the [DATE] incident, she said, We were getting her out of the wheelchair and into the bed. I was holding the wheelchair from behind. The wheelchair was lifting up because (R601) was grabbing the (wheelchair) armrest. She will wrestle with you. Once R601 was in the bed, CNA A added, She was fighting so bad. I was holding her wrist. The other CNA was holding her legs. The other CNA was getting towels and soap to wash her up. When queried what happened while you were holding R601's wrist and the other CNA was holding her legs, CNA A said, She was wrestling and wiggling. She was screaming really loud. When queried if R601 is very strong, CNA A said, Very, very, very. CNA A added, That last time she snatched away from me, I just let her (go) to give her some time. The DON walked in and said, You can't be holding her like that; you don't have to do it like that. When CNA A was queried if she was familiar with a catastrophic reaction, she said, I would have to look through my book. On [DATE] at 2:10 PM, when Staff Development Coordinator, Nurse D was queried about a catastrophic reaction, she said, It's an abnormal reaction to a normal stimuli. When queried if CNAs should know what a catastrophic reaction is, Nurse D said, They should because residents can have a catastrophic reaction and they need to know what it is and how to deal with it. When queried if when R601 becomes combative during care, is that a catastrophic reaction, Nurse D said, Not necessarily; for her, it's a behavior. We care plan it because she can be combative with care. R601's care plan related to combativeness during care was reviewed with Nurse D. The related intervention stated to Explain procedures to me before starting and allow me to adjust to changes. Nurse D was queried, When is holding someone down with your hands a form of restraint? Nurse D said, When they can't move, and they want to. That is restraining them. On [DATE] at 3:20 PM, when the facility Administrator was queried, What is a physical restraint?, he said, Something that restricts someone's movement. The Administrator added, I believe they (the three CNAs) were trying to take care of her. That's (R601's) normal behavior. When queried if they followed the care plan, the Administrator said, Yes. When queried about the purpose of allowing someone time to adjust, the Administrator said, So they don't have anxiety about what's going to happen. So as not to startle them. When queried if the three CNAs gave R601 time to adjust once she became combative, the Administrator said, No. There should have been non-chemical interventions for her behavior. The facility document titled, Abuse and Neglect Prohibition Policy, dated [DATE], was reviewed and documented the following: --Each resident has the right to be free from abuse, mistreatment, neglect, exploitation, involuntary seclusion, misappropriation of property and mental abuse facilitated or enabled through the use of technology. Each resident will be free from chemical or physical restraints imposed for purposes of discipline or convenience that are not required to treat resident symptoms. --Mistreatment is defined as inappropriate treatment or exploitation of a resident. The facility document titled, Physical Restraint Management, undated, was reviewed and document the following: --Physical restraints are not for purpose of discipline or convenience, but only as required to treat the resident's medical symptom. --A care plan will be developed and implemented addressing the restraint, medical symptom, least restrictive alternatives attempted, as well as intervention to promote restraint reduction or elimination. --Emergency Use: Restraints may be used with a physician order [REDACTED]. nursing notes. An intervention will need to be implemented to monitor/check at/on frequent intervals.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.