STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235462	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAUMONT REHAB & CONTINUING CARE FARMINGTON HILLS	**21450 ARCHWOOD CIRCLE FARMINGTON HILLS, MI 48336**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 795 Based on interview and record review, the facility failed to follow-up on a complaint of reported missing items for one resident (R#702) of one resident reviewed for missing items, resulting in a complaint of missing items not returned after resident was transferred to the hospital. Findings Include: A complaint was filed with the State Agency (SA) on 12/26/2019 that alleged some of the resident's personal belongings were missing. On 8/4/20, review of the electronic clinical record revealed R#702 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) revealed R#702 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 indicating severe cognitive impairment and required extensive to total assistance with one to two-person physical assistance for activities of daily living. On 8/4/20 at 12:55 p.m., the Director of Nursing (DON) was asked if there were any concern or grievance forms in regard to R#702' missing items. The DON stated, I don't have any . On 8/5/20 at 10:45 a.m., when queried about the facility's process for complaints of residents' reported missing items and personal belongings when they are transferred to the hospital, The DON stated, Belongings are usually packed up and sent downstairs to the housekeeping and laundry department. The family is called to come pick them up. When asked if that process was used for R#702 personally belongings after they were transferred to the hospital, the DON was unaware that R#702 had any missing items and stated, We would have called the family because the guardian have given us permission to communicate with the daughter . On 8/5/20 at 11:15 a.m., an interview was conducted with Environmental Specialist (EVS) Director 'R'. When asked about the facility's procedure for missing items and if it was followed for R#702, EVS Director 'R' explained that rooms are held for 48 hours until admission. Sanitize and packed up things are disinfected in their boxes and stored in the EVS Department, and the family are notified. EVS Director 'R' further stated, We'll check to see what happened to (Name Redacted) R#702's belongings. On 8/5/20 at 1:35 p.m., EVS Director 'R' returned and stated, I don't have it documented, but my assistant (Name Redacted) Housekeeping/Laundry 'S' stated, 'the family came and picked up the residents stuff.' On 8/5/20 at 1:49 p.m., during a phone interview, when queried about R#702's belongings, Housekeeping/Laundry 'S' stated, The family picked up everything. It happened on the weekend. When we came back on Monday, everything was gone. There was nothing left up there. Nothing was ever reported missing. They (Family) called about some black pants and a top that we never located. When asked if R#702's missing items were labeled, Housekeeping/Laundry 'S' stated, Yes. Housekeeping/Laundry 'S' further explained (Name Redacted), 3rd Floor Supervisor 'T' had talked with the family, and asked if I would keep my eye out for them (missing items). During that interview it was confirmed that 3rd Floor Supervisor 'T' and Housekeeping/Laundry 'S' did not follow up with the Administrator regarding R#702's reported missing items. On 8/6/20 at 10:25 a.m., an interview was conducted with the facility's Administrator. When queried about the facility's practice for returning residents' belonging after discharge, the Administrator stated, (Name Redacted) 3rd Floor Supervisor 'T' should have reported it to me in an email or call if (Name Redacted) Housekeeping/Laundry 'S' didn't find it. Our process is to reimburse people or tell them to pick out something similar online, (Name Redacted) Online Distributor 'U', and either (Name Redacted) (DON) or I will order it. A review of the facility's policy titled Abuse Prohibition Program revised September 14, 2017 read in part: Policy Statement . (Facility Name Redacted) will maintain an environment free from abuse and neglect. The resident has the right to be free from abuse, neglect, mistreatment, misappropriation of resident property . Policy Interpretation and Implementation The purpose of the Abuse Prohibition Program (The Program) is to assure that the facility is doing all that is within its control to prevent occurrences. The Program provides procedures that include screening and training, prevention, identification, investigation, protection and reporting/response .
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 intake #MI 528. Based on interview and record review, the facility failed to identify and report and allegation of abuse to the State Agency for one (R707) of seven residents reviewed for abuse, resulting in the abuse incident not being identified as a potential abuse incident and reported in the required timeframe, and the potential for undetected and/or continued abuse. Findings include: A review of a facility reported resident to resident incident which involved R707 on [DATE] at 5:40 PM was conducted. During a review of the clinical record, other instances of resident to resident incidents were identified with R707 that were not reported to the State Agency. Review of the interdisciplinary progress notes included: On [DATE] at 7:11 PM, a nursing progress note read, Resident has been agitating another resident. Resident had another resident upset at dinner time. Resident complaining about how the other resident eats, how much she eats and how she's chewing. Resident stated, I'm tired of her picking at me. Both resident was in a yelling match in dinning <sic> room. Writer had to separate residents. notified manager, notified spouse. will continue to monitor behavior. On [DATE] at 4:57 PM, a nursing progress note read, Resident up in w/c (wheelchair) kicking at another resident, while sitting in dinning <sic> room. Writer asked resident to stop, Resident stated, NO . A review of the clinical record revealed R707 was admitted into the facility on [DATE], readmitted on [DATE], and had expired in the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R707 was moderately cognitively impaired (scored ,[DATE] on mental status exam), exhibited behavioral symptoms which significantly interfered with the resident's participation in activities or social interactions, and that these behaviors had worsened since the previous MDS assessment dated [DATE]. On [DATE] at 1:45 PM, the Director of Nursing (DON) was queried about R707's behaviors and documented incidents involving other unidentified residents in the progress notes and why that was not reported to the State Agency as a resident to resident incident. The DON reviewed the documentation and reported there was no contact. When asked if there had to be physical contact to report, and whether the facility had identified R707's behaviors towards other residents that were berating, demeaning or degrading, the DON offered no further response. When asked what should occur when behaviors such as these resident to resident incidents occurred, the DON reported there should be an incident and accident report completed. At that time, the DON was reported that the incident and accident reports provided by the facility did not include any behaviors other than the incident that had been reported to the State Agency on [DATE]. The DON was asked to provide any further documentation that the facility had investigated these other incidents which involved R707, however there was no further documentation provided by the end of the survey. On [DATE] at 5:00 PM, an interview was conducted with the Administrator who also acted as the facility's Abuse Coordinator. When queried about the lack of identification and reporting of the incidents which involved R707, the Administrator was unable to offer any further

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.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) explanation. A review of the facility's Abuse Prohibition Program policy dated [DATE] documented, in part: .The resident has the right to be free from abuse .mistreatment .and exploitation .Residents will not be subjected to abuse by .other residents .The individual must have acted deliberately. The individual intended the action itself that he/she knew or should have known could cause .mental anguish. Also note, that even though a resident may have a cognitive impairment, he/she could still commit a willful act .Mental Abuse: includes, but is not limited to humiliation, harassment .The facility will identify, correct, and intervene in situations in which abuse, in any form, is likely to occur .Inappropriate behavior such as using derogatory language .The facility will identify and investigate all suspicions or allegations of abuse .and investigate .All alleged violations involving any form of abuse are reported immediately in accordance with State law .to the administrator of the facility .to other officials (including to the State Survey Agency .) A review of the facility's Abuse: Resident to Resident policy dated February 1, 2018 documented, in part: .If a resident-to-resident incident occurs, staff should immediately intervene .Notify the Administrator and the Director of Nursing immediately .Complete all necessary documentation for reporting the incident .The investigation protocol must be implemented and a report given to the appropriate agencies as specified by law and regulations .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 547 Based on interview and record review, the facility failed to ensure proper transfer per plan of care for one (R#701) of one residents reviewed for accidents and transfer status, resulting in the potential for falls/injuries during a transfer with a gait belt instead of plan of care for mechanical lift with two-person physical assist. Findings Include: A complaint was filed with the State Agency (SA) on 12/13/2019 that alleged the facility failed to properly transfer resident per plan of care with mechanical lift. On 8/4/20, review of the electronic clinical record revealed R#701 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] and 7/7/20 revealed R#701 had a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitively impaired and required total assistance with one to two-person physical assist for activities of daily living. The MDS revealed R#701 required total assistance with two-person physical assist for transfer. The facility's Injury of Unknow Origin - Investigation Report was reviewed and revealed the following: Date Injury Discovered: 10/30 (2019) Time: 2154 (9:54 pm). Description of Injury: Blood coming from coccyx area - noticed after transfer from wheelchair to shower chair . Staff Interviewed: (Evenings) - Licensed Practical Nurse (LPN) 'V', Former Certified Nurse Assistant (CNA) 'P', and CNA 'W'. Preliminary Investigation (Findings): Two person lift into chair-noticed bleeding at that time - encourage to sift weight while in chair . Follow-Up: Wound Care Consult. Conclusions & Recommendations: Resident tends to slide self-down in chair during day - ensure when repositioning - two-person assist. Reviewed by Director of Nursing (DON): Signed and Dated 11/1/19. Comments: No further investigation necessary . Incident/Accident Witness Statement Dated 10/30/19 - A. Witness Information: Former CNA 'P'. B. Witness Description of Accident/Incident: I (Name Redacted) CNA 'P' and (Named Redacted) CNA 'W' was transferring (Name Redacted) R#701 and we saw that she was bleeding, so we called the nurse in. We two person lift into chair and noticed bleeding. Review of a physician's orders [REDACTED]. Care Plan History Dated 7/17/2019: I require assistance with ADL's. I require assistance with washing my body . I transfer using a mechanical lift . Care Plan Updated 7/20/2020: I require assistance with ADL's (bed mobility, transfers, dressing, bathing, and toileting) r/t dementia, anxiety, ckd (sic) and depression. I require assistance with washing my body . I transfer using a mechanical lift . On 8/5/20 at 11:21 a.m., during a phone interview, when queried about the incident on 10/30/19, CNA 'P' explained that both she and ((Name Redacted) CNA 'W' used a gait belt under R#701's arms. CNA 'P' further explained that both CNAs were each on the side of R#701, and they lifted R#701 and transferred them onto the shower chair, and as soon as they sat R#701 down, blood was dripping a little on the chair. When asked if they reviewed R#701's plan of care for transfer before they transferred R#701, CNA 'P' stated, R#701 was a two-person assist, and they didn't remember if R#701 was a Hoyer lift. On 8/5/20 at 12:14 p.m., during a phone interview, CNA 'W' stated, We both transferred her (R#701). She is a Hoyer lift, but she is a two person assist as well. We used a gait belt because they (facility) didn't have no sling (use to put her in the Hoyer lift) . CNA 'W' further stated, When we transferred, we saw a little blood. I think it was probably a wound and had reopened. CNA 'W' further stated, I undressed (R#701) and transferred them to the shower chair in their room and took them to the shower in their room. CNA 'W' said, That's when I noticed all the blood. When asked if it was a lot of blood, CNA 'W' stated, Yes, but not dripping . On 8/5/20 at 4:10 p.m., an interview was conducted with the DON. When asked if R#701 used a Hoyer lift for transfers and should the Hoyer lift be used at all times. The DON stated, They should have used the same (mechanical lift). On 8/6/20, a review of the facility's policy titled Transfer Technique effective June 23, 2017 and reviewed May 28, 2020 revealed in part the following: Policy: All Nursing personnel will be instructed on the safe transfer techniques of non-weight bearing and weight-bearing resident not requiring use of a lift . Purpose: To safely transfer the non-weight bearing and/or weight bearing resident to a wheelchair or chair, using proper body mechanics . Safe techniques include: .4. Use correct body mechanics for all transfers . 6. Never place your hands under a resident's armpits.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 528. Based on interview and record review, the facility failed to provide medically related social services regarding instances of abuse and resident to resident altercations for two (R706 and R707) of seven residents reviewed for abuse, including other unidentifiable residents, resulting in insufficient/ineffective mood and behavior monitoring and implementation of changes to behavioral interventions, and the increased potential for unaddressed physical, mental and psychosocial needs of the residents. Findings include: A review of a facility reported resident to resident incident which involved R706 and R707 on 3/18/20 at 5:40 PM was conducted. A review of the closed clinical record for R706 revealed an admission into the facility on [DATE], readmission on 3/27/19, and discharge to the hospital on [DATE]. [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R706 had intact cognition (scored 15/15 on the BIMS-Brief Interview for Mental Status exam) and exhibited no behavior concerns. A review of the closed clinical record for R707 revealed an admission into the facility on [DATE], readmission on 6/26/19, and death in the facility on 4/13/20. [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R707 was moderately cognitively impaired (scored 8/15 on the BIMS exam), exhibited behavioral symptoms which significantly interfered with the resident's participation in activities or social interactions, and that these behaviors had worsened since the previous MDS assessment dated [DATE]. Review of R707's care plan for mood/behavior documented, .I have been determined to be competent to make my own medical decisions I can be easily agitated . Interventions identified only resolved dates and did not identify dates they were implemented. There were no resident specific interventions to address the behaviors exhibited by R707, nor were there revisions to the resident's decline in cognition. Review of the social services documentation for R707 available in the clinical record since December 2019 revealed only two entries: A late entry on 12/20/19 at 3:01 PM for 12/4/19 which read, .NSG (Nursing) staff report that resident does not speak appropriately to the staff and sometimes other Residents. Resident requires redirection during these times. (Name of contracted psych services) provides psychiatric services and supportive psychotherapy. An entry on 3/16/20 at 2:58 PM which read, .Res current BIMS=8 (moderately impaired) is lower than prior BIMS=14 (intact cognition). Res has noted to be more confused and agitated. Res noted by nsg (nursing) to be verbally/physically abusive. Res noted to yell at another resident and the following day to hit a CNA (Certified Nursing Assistant). Res was redirected and minimized what she had done by stating that she only tapped her . There was no further documentation in the clinical record from social services following 3/16/20. Review of the physician progress notes [REDACTED].Nursing reports that patient (R707) had an altercation with another resident (R706). Patient (R707) was the aggressor and did put her hand into another resident's face (R706) at which time that resident (R706) reportedly grabbed (R707's) wrist to remove her hand from her face area. Neither resident suffered any injuries. Patient (R707) states that she is sorry for what she did. She does admit that she just gets angry at times .Patient (R707) with intermittent episodes of aggression toward other residents and behavioral issues. Will again ask psychiatry to see patient . R707 was not seen by

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F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) psych services until 4/13/20. Review of R707's nursing progress notes identified these similar behaviors had been ongoing since December 2019 and included: On 1/23/20 at 6:55 PM, Resident very upset at another resident for yelling and talking in the dinning <sic>. (R707) is yelling at resident . On 2/5/20 at 7:11 PM, Resident has been agitating another resident. Resident had another resident upset at dinner time. Resident complaining about how the other resident eats, how much she eats and how she's chewing. Resident stated, I'm tired of her picking at me. Both resident was in a yelling match in dinning <sic> room. Writer had to separate residents. notified manager, notified spouse. will continue to monitor behavior. On 2/5/20 at 4:57 PM, a nursing progress note read, Resident up in w/c (wheelchair) kicking at another resident, while sitting in dinning <sic> room. Writer asked resident to stop, Resident stated, NO . On 2/14/20 at 10:15 PM, Resident hollering at another resident at the dinner table. Stating he needs to shut the hell up .(R707) said I don't want him to talk to me. Resident she was speaking to had been watching the TV in dining room, not saying anything to (R707) . On 3/2/20 at 11:46 PM, Resident observed yelling at other residents. Writer heard object fall across the dining room floor. The TV remote was seen on the floor. Resident tried to throw remote at another resident but was unsuccessful. When asked did she throw the remote she stated, Yes I did. On 3/3/20 at 8:47 PM, Resident observed yelling at other residents . There was no social service documentation for R707 to reflect there had been any follow up by social services following these documented behavior incidents. On 8/5/20 at 12:55 PM, an interview was conducted with the Social Service Director (SSD C). When asked about who had been assigned to R707, SSD C reported Social Service (SS D) had been but was currently furloughed. When asked about the facility's process for having social services evaluate and monitor following behavioral incidents such as verbal aggression, abusive behavior towards others (yelling, demeaning, and berating other residents) SSD C reported social services should evaluate and document what had been implemented to address the behaviors. SSD C was informed of the concerns regarding the lack of evidence that social services had addressed these behavior episodes due to lack of documentation in the clinical record and care plan and was requested to provide any social service documentation, psych consults and behavior documentation for R707. On 8/5/20 at 1:45 PM, the Director of Nursing (DON) was queried about the facility's process for social services and resident behaviors. The DON reported that social services should evaluate the residents following behavior changes or incidents and should be reflected in the documentation. The DON was informed of the concern regarding lack of documentation that had occurred. When asked about the specific interventions following R707's behaviors towards other residents, the DON indicated there should be an incident and accident report completed as well as follow up from social services. On 8/5/20 at 3:05 PM, a phone interview was conducted with SS D. At that time, SS D reported being laid off since May 2020. When asked about R707's behaviors and what had been implemented, or reviewed, SS D directed to look at the progress notes and psych and was unable to offer any further explanation/clarification. On 8/5/20 at 5:00 PM, an interview was conducted with the Administrator who confirmed SS D had been laid off. When informed of the concerns regarding lack of social service follow up following multiple incidents of R707's behaviors, the Administrator acknowledged the concerns as well and was unable to offer any further explanation. A review of the facility's Social Worker job description documented, in part: The Social Service Worker provides and/or coordinates medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This activity is achieved through the use of appropriate assessment tools, development, completion and revision of resident care plans .The Social Service Worker ensures that all charted progress notes are informative and descriptive of the services provided, including the resident's response to the service .