STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235520	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROMEDICA MONROE SKILLED NURSING AND REHAB	700 STEWART RD MONROE, MI 48161

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 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: M 8852 Based on observation, interview and record review the facility failed to prevent verbal abuse of one resident (#901) of six residents reviewed for abuse from a total of 12 residents, resulting in the resident being verbally abused by a staff member. Findings include: On 3/4/2020 at 9:30 A.M. and 4:45 P.M. R#901 was observed well-groomed in the dining room, browsing through a magazine. Attempts were made to engage the resident in a conversation, but the resident was not able to verbalize details related to the alleged verbal abuse. At 9:40 A.M. review of the Clinical Record revealed R#901 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Per the Facility Incident Report received via online dated 12/18/2019, Timed 4:16 P.M. On 12/18/19 at 8:20 A.M. Nurse Aide F was verbally abusive towards R#901 and provided poor technique when positioning the resident back to bed. Nurse Aide F was suspended immediately pending an investigation. Family notified, Medical Doctor Notified, and Local authorities notified. A body/skin assessment was completed with no negative findings. R#901 was assessed with [REDACTED]. Facility to conduct wellness checks, assessments with vitals and body audits will be completed on day shift for next three days. Review of the Facility's Investigation Summary received via online dated 12/23/19, Timed 12:31 P.M. Upon review of all witness statements, facility has substantiated abuse towards R#901 by Employee (Nurse Aide) F remains on suspension and will ultimately be terminated. Staff to be in-service/educated on abuse, neglect and misappropriation policy. Resident has no visible injuries, no psycho-social changes, and remains comfortable in his daily routine. Follow-up monitoring noted no changes to resident's plan of care. The Michigan State Police was contacted on 12/18/19 at 12:20 P.M. and the officer arrived at the facility at 12:30 P.M. to interview resident, floor nurse and other witnesses identified during the verbal abuse incident. In addition, the facility informed the Local Ombudsman. On 12/19/19 R#901 a follow up visit was conducted by Senior Wellness, Interview's with staff and residents were completed and skin assessments on cognitively impaired residents completed. On 3/4/2020 at 2:30 P.M. during interview with the Administrator (Quality Assurance Coordinator) the Witness statements and Investigational file were reviewed. The Administrator reported R#901 was at his baseline and remained in the facility. This was confirmed through follow up interviews with the Social Worker and Nurse Practitioner on 3/5/2020. On 3/5/2020 at 3:00 P.M. review of the Employee's File revealed Nurse Aide F was terminated from employment at the facility on 12/23/19 for violation of work rule Type: CP #3.23 Under the Policy Title: Performance Improvement Group 2#6 Action or displayed attitudes detrimental to patient care. Group 2, #8 discourtesy to or improper treatment of [REDACTED]. The Employee Waring Notice stated on 12/18/19, the above employee was suspended pending investigation of abuse towards a resident in the facility. Upon investigation, the facility substantiated the abuse. Nurse Aide F signed and dated (12/23/18) the documented but refused Union Representation. Review of the Employee Inservice's and attendance on abuse/neglect and related subjects :(included but not limited to) Orientation In-Service by Social Services , other Inservice's dated 11/4/2019, Elder Justice Act 11/11/19, Behaviors, Dementia, 11/11/19 and Patient Bill of Rights dated 11/11/19 . In addition Computerized courses completed included: Annual Mandatory :2019 Care of the Cognitively Impaired completed 11/17/19 (35) minutes, Ensuring Effective Communication With person with . completed 11/12/19 (26) minutes, Dementia 101 completed [DATE] (6) minutes, Residents Rights 11/8/2019 (20) minute, Abuse, Neglect, Mistreatment and Misappropriation completed 10/23/19 (32) minutes. On 3/5/2020 at 3:30 P.M. a telephone interview was attempted for Nurse Aide E but was unsuccessful. On 3/5/2020 at 3:35 P.M. review of the facility's policy Titled Abuse, neglect, Exploitation, Mistreatment & Misappropriation Prevention, dated 11/2016 under Sub titled: Freedom From abuse, neglect and exploitation: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to update and add interventions to care plans for three sampled Residents (#907, #910 & #909) for a safety care plan and a fall care plan for three Residents reviewed for care plans, resulting in the likelihood of two Residents being harmed due to another altercation, and the likelihood of an injury due to a fall. Findings include: This citation pertains to intake #MI 479. On 3/4/20 at 10:45 a.m., a review of a facility reported incident date 6/28/19 documented the following: Date and Time of Incident: 6/27/19 at 5:40 P.M . Incident Summary: While in the dining room, Resident #910 was discussing his leg wraps with the staff. Resident #907 commented that the nurse should 'Wrap his ass as well as his legs. The Certified Nursing Assistance (CNA) U, redirected R#907 to the inappropriateness of his comment. R#907 then stated that he Promised to hit R#910 the next time he spoke. CNA, V then assisted R#910 out of the dining room and back to his room (208B). There was no physical contact or further altercations. Residents remained separated the rest of the night without further incident .Nurse followed up with R#910 about the incident. R#910 stated he feels safe and denies feeling threatened or in fear. Nurse followed up with DON, approximately 10:30 p.m., he was calm, pleasant and cooperative. Review of the facility's investigation report also revealed, Social Service follow-up notes documented, .Both Residents denied any distress, feeling unsafe or threatened at this time. No further incidents have been noted. Residents remain at separate tables for meals. Nurses Progress Notes dated 7/1/19 documented, R#910 stated he feels safe, does not feel threatened by the other resident and denies any further incidents. He does feel it is unfair that he is the one who had to move from the dining room table. Writer (Nurse) explained it is only for his best interest and the other resident is not agreeable to moving. Writer (Nurse) showed appreciation for his understanding and willingness to be the one to move to another table. On 3/4/20 at 11:25 a.m., R#910 was interviewed. R#910 was asked, has he had any other altercations with R#907. R#910 stated, No, I haven't been arguing with anyone since that day. On 3/4/20 at 12:34 p.m., R#907 was interviewed while sitting at the third-floor dining room table. R#907 was asked, has there been any other altercations with R#910. R#907 stated, No, He sits over there (Pointing at another table) at that table now. R#907 was asked, did R#910 sits over at the other table all the time. R#907 stated, Only sometimes he sits here, but he sits over at the other table now. Resident #907 On 3/4/20 at 11:57 a.m., review of the clinical record revealed R#907 was initially admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Facility's incident report documented, R#907 has a BIMS score of 15. R#907's care plan revealed no documented interventions of R#907 and R#910 are not to sit at the same table at mealtimes. Review of the CNA's Kardex (Information communication system used by the CNA's to care for the Residents) did not revealed any updated interventions. Resident #910 On 3/4/20 at 12:02 p.m., review of the clinical record revealed R#910 was initially admitted into the facility on [DATE] with [DIAGNOSES REDACTED].

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) According to the facility's incident report, R#910 has a BIMS score of 13. R#910 care plans was reviewed with no interventions of R#907 and R#910 not to sit at the same table at mealtimes. The CNA's Kardex was reviewed with no updated interventions documented. On 3/4/20 at 1:56 p.m., The Administrator was interviewed. The Administrator was asked, what were the interventions for residents (R#907, R#910) keeping them from having another altercation in the dining room? The administrator stated, They are to sit at different tables. The Administrator was asked to review the care plans and the Kardex with the surveyors to ensure there was no interventions documented. The Administrator stated, I will have to go speak with (The DON) because like I said, I wasn't here at that time. It was brought to the Administrator attention that the interventions were not documented on the care plans nor the CNA's Kardex. The administrator was asked, how are the staff to know, to seat the two residents at different tables when there is no documentation on the care plans nor the CNA's Kardex. The Administrator stated, I will go check with the DON, but I see your point. The Administrator was asked to present a copy of the two residents (R#907 R#910) care plans and a copy of the CNA's Kardex prior to him leaving the conference room. On 3/4/20 at 2:45 p.m., the Administrator and The Human Resource Director C walked into the Conference room and presented a Copy of R#907's ADLs care plan and Kardex updated date of 3/4/20 documented, Resident is not to sit with resident R.B. who resides in room [ROOM NUMBER]-B at meals in the dining room. Did not receive a copy of R#910's care plans and Kardex. R#909 On 3/4/2020 at 11:00 A.M. R#909 was observed well groomed sitting in a wheelchair at the elevator. The resident was overheard informing staff he would be leaving the facility for an appointment. At 12:30 P.M. the resident's Medical record was reviewed. The resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per the Nurses Notes R#909 had a fall on 2/26/2020 (#1) at 1:45 A.M. in the resident's room and second fall on [DATE].Review of the Facility's Report dated 2/26/20; R#909 was found laying on the floor next to his bed at 1:45 A.M. on 2/26/20 by Nurse Aide. Resident stated: he was trying to get up to sit in a chair. Resident had no footwear on . Bed was in low position; call light was within reach of the resident's bed was not activated. Supra pubic catheter in place, brief void of bowel movement. Resident was assessed and found to have a skin tear to his left elbow, right elbow and R hand middle knuckle. No bruises or reddened area noted to resident. Resident denied pain/discomfort. Resident assisted back to bed. New treatment orders in place for skin tears. Call light left within reach; neuro checks initiated Review of the Care Plan titled: At risk for falls due to unsteady gait, initiated 1/10/20, documented under the intervention section of the care plan a low bed was put in place to minimize the risk for injury related to falls. Further review of the nurses notes revealed R#902 sustained a second fall which was witnessed on 3/2/20 at 5:40 P.M. R#909 tried to get out of bed to wheelchair, unassisted, while staff was in room. Staff was unable to place in wheelchair safely so lowered to the floor. Assessment no injury, denied pain or picked up . Staff reeducated, encourage patient to ensure wheelchair, brakes are locked prior to attempting to stand. Encouraged not to stand. On 3/4/2020 at 12:50 P.M. Review of the Falls Care Plan initiated 1/10/2020, indicated there was no revision of the interventions until 3/5/20, after inquiries were made related to the residents fall in the facility.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 778 and MI 600. Based on observation, interview and record review the facility failed to provide adequate nursing staff to supervise the residents during dining, resulting in the likelihood of a medical emergency occurring without properly trained staff and to ensure adequate staffing was available to provide care for the residents without utilizing management consistently. Findings include. On 3/4/20 at 8:20 a.m., during the initial entrance in the facility's conference room, the DON and the Administrator entered the conference room to assist the surveyors. On 3/4/20 at 8:40 a.m., during an initial tour on the third floor, observed Floor Nurse M standing at the medication cart at the Nurse's station and the DON and a Certified Nursing Assistance (CENA L) passing food trays to the residents on the hallway. Observed some residents on the hallway with no breakfast trays. Observed CENA (L) entering Resident 308's room to answer the call light and then proceeded to pass the residents breakfast trays. Third-floor Nurse M was asked to present a copy of the morning shift assignment. The morning shift assignment revealed, one nurse, one CENA and the Resident's Census of 18. On 3/4/20 at 8:45 a.m., the third-floor dining room was observed with Residents eating breakfast, with Dietary Aid (J) standing behind the steam table and a staff member Occupational Therapist (K) sitting with a resident at the table. Observed some of the resident 's propelling themselves out of the dining room into the hallway. The staff standing behind the steam table (Dietary Aid J) was asked, what was her title and the title of the person sitting beside the resident. Dietary Aid J Stated, I am a Dietary Aid and she is a Therapist. On 3/4/20 8:50 a.m., Observed third-floor Nurse M passing medications on the hallway. Third-floor Nurse M was interviewed once she returned to the medication cart. Third floor Nurse M was asked, should there be someone from nursing in the dining room at mealtimes. Nurse M stated yes, but it's kind of hard if you have only one Cena. She can't be in the dining room the whole time and pass trays on the hallway too. Nurse M said, it was okay for a CENA to be in the dining room, but they have to be in there from the beginning to the end until the residents are finished. Nurse M was asked, what time did the breakfast trays came up on the unit. Nurse M said, about seven forty-five or somewhere around that time. On 3/4/20 at 9:05 a.m. the DON was in the conference room assisting the surveyors with requested documents. On 3/4/20 at 9:32 a.m., observed eight residents remaining in the third-floor dining room eating breakfast with no nursing staff. Only three of the residents (room [ROOM NUMBER]-A, 336-A, and room [ROOM NUMBER]-B) was able to identify themselves with a meal ticket beside their trays. There was no meal ticket beside the remaining five residents for identification. Observed Dietary Aid J standing behind the steam table. The dietary Aid J was asked, what was her duties while serving the food in the dining room. Dietary Aid J stated, I put the resident's food on their plates, and the Cena's (Certified Nurses Assistance) usually passes out the resident's food to them. This morning I served just one of the resident's plate after Cena L left the dining room. The Dietary Aid J was asked, what time does she usually finish serving breakfast. Dietary Aid J stated, I wait until all the residents come in the dining room, usually I am done by nine o'clock. Then I come back after everybody Is finished to bust tables. The Dietary Aid J was asked, has a nurse or a Cena been in the dining room to assist the residents for breakfast. The Dietary Aid Stated, CENA L was in here earlier, but she (Cena L) had to leave and start passing the trays on the hallway. The manager was helping giving out drinks when I got here, and there is a therapist sitting with a resident over there. On 3/4/20 at 9:55 a.m., occupational Therapist K was interviewed. Occupational Therapist K was asked, what was her reason for being in the dining room at that time. Occupational Therapist K stated, I am observing this resident for not able to feed herself and some chewing issues. Occupational Therapist K was asked, while she is observing a resident in the dining room, does she assist other residents with their meals. Occupational Therapist K stated, OH no, I might hand them a sugar pack or something if they asked me, but that's only if they are sitting next to me and it doesn't affect my patient at the time. Occupational Therapist K was asked, what time did she get in the dining room. Occupational Therapist stated, About 8:15ish. Occupational Therapist was asked, who was in the dining room at that time. Occupational therapist stated, One Cena was in the dining, but she left after most of the residents was done to pass trays on the hallway, and (The DON) came in to asked did anyone needed help and left back out. Occupational Therapist K and Dietary Aid J was asked, are they trained to assist the residents if an emergency occurs. Occupation Therapist stated, No, No and Dietary Aid J did not respond. On 3/5/20 at 1:32 p.m., a dining room policy was requested, but was presented a Meal Service policy instead. Review of the facility's Meal Service policy dated 2/2020 documented, Congregate Dining Location: 1) Perform hand hygiene, 5) .Check items on tray against tray card ensuring patient's special dietary requirements (allergies [REDACTED].Assist when necessary with meal set-up (e.g., Open milk, Condiments, Jelly, Syrup, Butter bread, Cut meat) .If patient requires assistance with eating, do not serve tray until able to stay and provide assistance. This citation pertains to intakes (M 9748, M 0567,M 9797,M 8512) On 3/4/2020 at 8:20 A.M. the Administrator was asked for a list of all job vacancies for Nursing, Housekeeping and the Dietary Department. The Nurses heading indicated there were: 1 full time nurse supervisor LPN/RN, 3 Part time Nurse Supervisor LPN/RN, 7 Full time Nurse Aides, and 8 Part Time Nurse Aide vacancies. At 8:50 A.M. during a breakfast observation on the second floor three staff members identified as (Management Staff) were observed serving breakfast to residents in the Dining Room and residents who ate meals in their rooms. One Dietary Aide serving food from the steam table directed the Management staff how to interpret the resident's meal tickets

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) and special food preferences. The Director of Nursing (D.O.N.) was asked about the number of residents on the unit (37residents) and whether there were call-ins for the facility? The D.O.N. reported there was one nurse that had called in for the second floor and three nurse aides that she was aware of for the day shift on different floors. On 3/4/2020 at 4:50 P.M. during a dinner meal observation on the second floor Management and Nursing staff were observed passing hallway trays, responding to call lights and obtaining requested food items. There was one Dietary Aide present, serving food from the steam table. At 6:05 P.M. nurse O entered the dining room and was approached concerning the meal service. Nurses are expected to assist. We have been directed to answer the call lights and provide nursing and dietary tasks. The department Heads have always assisted but not to this degree, now we are consistently being used, There is no replacement. During the observation Nurse Aide R reported working 16 hours the previous night on 3/3/20 and was back for the afternoon shift. Upon leaving the second floor at 6:05 P.M. dinner was still being served to the residents. The management team was observed serving resident's meals (breakfast, lunch, and dinner) on 3/4/and 3/5/2020 of the survey. 3/4/2020 at 11:30 A.M. a visitor (who requested anonymity) reported over the week end her love one had sat in bowel movement (BM) over 25 minutes while she went looking for a staff person to assist her in repositioning and cleaning the resident up. Finally, an unidentifiable nurse came and informed the visitor I do not have anyone to help you. The visitor admitted she became upset and told the nurse she was going to help her reposition and clean up the resident. The visitor reported there were prior incidents, so it was reported. On 3/5/2020 at 11:00 A.M. the Administrator was interviewed concerning the Management staff being utilized instead of Dietary staff. The Administrator reported each department head had been assigned Monitoring for the dining room. A request was made to review the policy, which was provided. According to the document dated [DATE], Titled: Department Head Monitoring for Dining Room . The form documented all departments were assigned coverage or the Dining room for each meal for seven for days. Documentation on the memo stated: Daily this is an All Hands-on Deck process, if you need assistance on your scheduled time, you need to contact other department personnel to assist Customer Service and Leading by example starts with us! On 3/5/2020 at 5:30 P.M. during the exit interview with the Administrator and D.O.N. concerning residents being unsupervised during meal service and the utilization of management staff consistently for meal service was discussed. Both indicated adequate staffing was a challenge and the facilty was in an ongoing process of utilizing other resources to obtain adequate staffing.
F 0802 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** This citation pertains to (M 0567) Based on observation, interview and record review the facility failed to employee sufficient supportive personnel to carry out the functions of the department, resulting in delayed meal service. This deficient practice had a potential to affect 74 of 80 residents that received meals and services from the kitchen. Findings include: On 3/4/2020 at 8:20 A.M., the Administrator was asked for a list of all vacancies for Nursing, Housekeeping and Dietary Department. The list provided by Human Resource stated: open vacancies for Dietary :1 Full time cook, 1 part time Cook, 2 part time Dietary Aides. At 8:50 A.M. during a breakfast observation on the second floor, three staff members identified as (Management personnel) were observed serving breakfast to residents in the dining room and hallway. At 9:10 A.M. in the kitchen one employee T reported she was the A.M. cook and the Dietary Manager would be in later during the day. Posted on the outside of the door of the Dietary Office was a sign indicating the following vacancies: 1-40 hours-Dietary Aide 1-40 hour- Dietary Aide 1-40 hour-Cook 1-Full time Dietary Aide On 3/5/20 at 8:20 A.M. the Dietary Manager was interviewed concerning the staff shortage in the Dietary Department. The Manager was asked to explain the discrepancy in the number of positions and hours posted on the Dietary door and the list provided from Human Resources. The Manager stated he was hired to work as a manager from a Food Service Company and the employees were hired by the facility. The manager reported, candidates were interviewed to fill the positions, and potential hires may be cleared within two or three more weeks. At 5:30 P.M., upon exiting the, the facility, no additional evidence was provided indicating staff had been hired to carry out the functions of the kitchen.