STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235234	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE MANOR NURSING AND REHAB CENTER	9500 GRAND RIVER AVE DETROIT, MI 48204

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 4, MI 5, and MI 6. Based on observation, interview, and record review, the facility failed to operationalize an abuse policy in a timely manner regarding reporting of resident abuse for two (#701, #702) residents reviewed for abuse, resulting in the potential for further delays in abuse reporting to occur. Findings include: It was alleged to the State Agency that resident to resident sexual abuse occurred. On 3/12/2020 at 10:32 AM, Resident #702 (R702) was observed awake and in his room. When R702 was queried about how things were going in the facility, he said, I got accused of touching some girl. R702 stated that he was on parole and didn't want to talk about what happened because he didn't want to go back to prison. R702 added, I was near her, but I didn't touch her. I put a bottle of Pepsi in my pants. The girl looked at it and smiled. R702 then demonstrated the following: R702 took a 20-ounce bottle of Pepsi, stretched open his sweatpants, and laid the bottle of Pepsi on top of his penis. The bottle of Pepsi obscured the view of R702's penis. When queried if he wore underwear R702 said, No, none of us do. When queried if he can propel himself in his wheelchair, he said, Yes. On 3/12/2020 at 11:00 AM, Resident #703 (R703) was observed awake and in her room. When R703 was queried about the alleged resident to resident sexual contact, she said, I saw (R702) pulling his sweatpants out. He was adjusting himself. He scooted in front of (Resident #701) and put his hand inside his pants. He was moving his hand. He put his hand between her legs. I yelled for him to stop. A nurse had him removed. On 3/12/2020 at 11:09 AM, Resident #701 (R701) was observed awake and sitting in a dayroom. R701 smiled when greeted. A review of the clinical record for R701 documented an admission date of [DATE]. R701's [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented severe cognitive impairment and one-person extensive physical assistance for movement about her room and the floor where she resided. A review of the clinical record for R702 documented an admission date of [DATE]. R702's [DIAGNOSES REDACTED]. A MDS dated [DATE] documented moderate cognitive impairment, and he required only supervision for movement about his room and the floor where he resided. A review of the clinical record for R703 documented an initial admission into the facility on [DATE] and readmission on 12/22/19. A MDS dated [DATE] documented intact cognition. A review of R701's clinical record documented in part the following progress notes dated 3/1/2020: --1:40 PM: Approached while sitting at nurses' desk by (R703). She reported that she observed (R702) in front of nurses' desk inappropriately (touching) (R701) on her lap. Nurse quickly intervened and separated residents. --2:00 PM: Residents were separated far apart; taken back to their rooms .Writer immediately called DON (Director of Nursing); was instructed to move (R702) to all male floor . A review of the incident and accident investigation for the alleged event revealed the following: --Alleged incident date: 3/1/2020 at approximately 2:30 PM. --Date incident reported: 3/2/2020 On 3/12/2020 at 2:50 PM, when the DON was queried about the incident report date of 3/2/2020 when the nurse's note of 3/1/2020 clearly indicated an allegation of inappropriate touching by R702, she said, (Nurse A) reported that (R702) was acting suspiciously. (Nurse A) did not provide details. The DON added, That is why (Nurse A) received an 'Educational Opportunity Form' (a counseling memo). A review of the Educational Opportunity Form issued on 3/3/2020 to Nurse A documented the following: --Reason for education: Reporting of Abuse --Describe issue: Reporting any type of suspected abuse in detail to Supervisor/Administrator, Abuse Coordinator. On 3/12/2020 at 3:06 PM, the facility Administrator said, (Nurse A) did not follow the reporting protocol. That is why she received a 1 on 1 counseling. The Administrator added that her expectations for staff reporting suspected sexual abuse are that they notify us immediately when they are aware of any allegations of abuse. We were not aware of the details of the event until Adult Protective Services came into the building (on 3/2/2020). The facility document titled, Resident Abuse/Neglect, dated 1/30/19, was reviewed and revealed the following: --The facility will not condone any form of resident abuse of neglect. To aid in abuse prevention, all personnel are to report any signs and symptoms of abuse/neglect to the Administrator or to the Director of Nursing Services immediately. --Abuse prevention program (includes): timely and thorough investigations of all reports and allegations of abuse. --Reporting observed, suspected or alleged abuse: 1. All personnel, residents, family members, visitors, etc., are encouraged to report observed incidents, suspicions, or allegations of resident abuse; 2. Employees, facility consultants and/or Attending Physicians must immediately report any suspected abuse or incidents of abuse to the Administrator. In the absence of the Administrator, such reports may be made to the Director of Nursing, or the Nurse in charge; 3. Any individual observing an incident of resident abuse, suspecting resident abuse, or receiving an allegation of resident abuse must immediately report such incident to the Administrator or Director of Nursing Services; 4. Incidents involving alleged, suspected or actual abuse ., shall be reported to the state immediately, but not more than 2 hours after forming the suspicion; 8. Any staff member or person affiliated with the facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect or any other criminal offense shall immediately report, or cause of report to be made of the mistreatment or offense; 9. Staff members and person affiliated with this facility shall not knowingly fail to report an incident of mistreatment or other offense.

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.