STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAND OAKS NURSING CENTER	600 DENMARK ST BALDWIN, MI 49304

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake Number: MI 920 Based on interview and record review, the facility failed to ensure staff spoke to residents in a dignified manner for one Resident (#58) of three residents reviewed for dignity and respect. This deficient practice resulted in the potential for feelings of embarrassment and humiliation, based on the reasonable person standard. Findings include: Review of Resident #58's medical record indicated he was admitted to the facility on [DATE] with readmission on 7/27/20 and [DIAGNOSES REDACTED]. Review of the 7/6/20 Minimum Data Set (MDS) assessment revealed he scored a 1/15 on the Brief Interview for Mental Status (BIMS) score, indicating severe cognitive impairment. Resident #58 required extensive two person assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. Review of the Facility Investigation with MI-FRI ID: 5903 dated 7/29/20 stated, Certified Nurse Aid (CNA O) observed (CNA Q) use inappropriate redirection with Resident (#58) while he was experiencing a catastrophic reaction to an unknown stimulus, as is his baseline. A phone call was placed to CNA Q on 8/26/20 at 12:11pm with a message left requesting a return phone call. CNA Q was terminated on 8/5/20 from the facility. Review of CNA Q's Resident Rights training revealed she last completed the training on 7/25/19. A phone call was placed to CNA O on 8/27/20 at 10:28 a.m. CNA O described the incident on 7/29/20 and stated, (Resident #58) was having a bad day. I was providing one-to-one supervision to him when (CNA Q) came into the room to see what was going on. (Resident #58) began cussing at (CNA Q) and (CNA Q) replied back to him, I'll sit your a** down. When asked if there was any further verbal conversations between Resident #58 and CNA Q, CNA O stated, He (Resident #58) kept calling her derogatory words, and she (CNA Q) would reply back with sarcastic remarks, like 'at least I'm getting some.' Review of the witness statement provided by CNA Q on 7/29/20 read, .We had to push him (Resident #58) back in the bed because he is unsafe to stand. He has been so combative he is hurting himself .(Resident #58) was calling her a s*** and a w****. Said that I was using humor with him and said, 'At least I'm getting some' . Review of Resident #58's Care Plan dated 2/5/19 read, .has angry outbursts with loud verbalization which include swearing .interventions: .(Resident #58) also enjoys playful and joking yet appropriate banter with staff and his visitors. date initiated 2/28/20 revision on 3/10/20 . Review of the Rights of Residents in (Name of State) Nursing Facilities pamphlet, undated read, in part: Respect and Dignity: You have the right to be treated with respect and dignity .
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Linked Intakes: MI 021, MI 118, MI 399, MI 756 Based on interview and record review, the facility failed to protect residents from misappropriation of resident property and money for four Residents (#53, #55, #56, & #57) of six residents reviewed for misappropriation. This deficient practice resulted in feelings of frustration, loss and anguish from missing money and property. Findings include: Resident #53 A review of the face sheet for Resident #53 revealed a [AGE] year old resident, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/25/20 at 3:00 p.m., an interview with Resident #53 revealed the following: When asked if anything came up missing back on April 13th, 2020, Resident #53 acknowledged $25.00 came up missing without being prompted about a specific sum. Resident #53 stated he did not know who would have taken it. Resident #53 stated he received money for his birthday this year in July from (Family Member (FM) E), and stated he gave the money to .(Activities Director F) to be placed in the resident trust .so it wouldn't get taken again. A review of a Minimum Data Set (MDS) assessment dated [DATE] for Resident #53 revealed a Brief Interview of Mental Status (BIMS) of 15, indicating intact cognition. On 8/25/20 at 3:15 p.m., an interview with FM E revealed Resident #53 was mailed a sum of money for his birthday in July this year. FM E stated he was informed by Resident #53 he had money taken earlier in the year and expressed sympathy for Resident #53. A request for receipts for withdrawals and deposits made by Resident #53 was requested for the month of April 2020, around the time of the alleged incident on 4/13/20. A review of the facility incident summary dated 4/13/20 revealed Resident #53 stated he took $25 out of his resident trust fund so a CNA could assist him in purchasing pop from the grocery store. Due to COVID-19 restrictions, resident was advised that this was not essential and the pop could not be purchased from the store at this time, so he still had the money on him. A review of a withdrawal receipt dated 4/8/20 revealed Resident #53 had withdrawn $25.00 from the resident trust. On 8/25/20 at 3:30 p.m., an interview with Certified Nurse Aide (CNA)/Activities Aide S revealed the following: I have not shopped at all for the residents in 2020. The guardians were made responsible for outside purchases in 2019. On 8/25/20 at 3:40 p.m., an interview with Activities Director Frevealed the following: When asked if she had been interviewed by administration following the allegation of missing money on April 13th 2020, stated No. Activities Director F acknowledged the receipt for April 8th, 2020 with a withdrawal of 25.00 for Resident #53 with her signature on it. Activities Director F stated she did not do any shopping for Resident #53. Activities Director F stated the facility was not allowing outside purchases deemed non-essential during the time frame the withdrawal occurred on 4/8/20 until the money was reported missing on 4/13/20. Activities Aide F was asked for any deposits into Resident #53's trust account from the time of the withdrawal of $25.00 on 4/8/20 until the report of missing money on 4/13/20. On 8/25/20 at 3:50 p.m., an interview with Human Resources (HR) G revealed there were no deposits between the 4/8/20 $25 withdrawal, and the 4/13/20 missing money allegation. A review of the Resident Inventory lists provided by the facility for Resident #53 revealed the most recent inventory sheet was dated 3/1/20 and no documentation was seen showing Resident #53 had any money in his posession. Resident #55 A review of the face sheet for Resident #55 revealed an [AGE] year old resident, admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/26/20 at 11:20 a.m., an interview with Resident #55 revealed he had a phone come up missing as described in the facility reported incident dated 8/4/20. Resident #55 stated had no idea what happened to his phone, and was unable to give any further detail on what might have happened to his phone. Resident #55 Denies and further items missing since incident occurred on 8/4/20 per facility incident summary. A review of the MDS assessment dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. A review of the Physician Determination of Decision Making Capacity dated 7/14/20 revealed the physician indicated Resident #55 was .capable of understanding the bill of rights and participate in medical treatment decisions. On 8/25/20 at 11:34 a.m., an interview with Registered Nurse (RN) B regarding the missing phone for Resident #55 revealed the following: I was here when she (wife) asked about it, but I am not sure if I was the first person to hear about it. It all started when the wife called and said she was calling and calling (Resident #55), but it was going to voice mail. RN B stated multiple areas of the building were searched in an attempt to locate the phone. When asked if the phone was ever found, RN B stated, No, his wife brought him a new phone. A review of the facility incident summary dated 8/4/20 revealed the following: After it was confirmed there was a cell phone missing resident was assisted by CNA T and the Director of Health Care Services (DHCS) in looking in his room and through his things. The cell phone was unable to be located . A review of a Resident Inventory (cont'd) sheet dated 6/30/20 revealed a Black LG flip phone was logged into

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 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) his personal effects. A review of a Resident Inventory (cont'd) sheet dated 8/7/20 revealed a replacement phone flip phone lg black was logged into his list of personal effects. Resident #56 A review of the face sheet for Resident #56 revealed a [AGE] year old resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/26/20 at 11:30 a.m., an interview with Resident #56 revealed the following: When asked if anything has come up missing, Resident #56 was able to state without verbal cuing $20.00 which I had in a change purse, and the reason I noticed it was the zipper to the change purse was open, and I never leave it open. Resident #53 stated she had her suspicions, but was unwilling to share those suspicions of who took it. Resident #56 stated, I don't want to get anyone in trouble. Resident #56 was informed sharing this information would help to protect her as well as other residents from further incident. Resident #53 declined to reveal further information on a suspect. Resident #56 also stated she told all of her family not to send her money any more because she doesn't want to have any more stolen. Resident #56 expressed frustration with having money taken, and also frustrated with having to tell her family not to send any more money. A review of the MDS assessment for Resident #56 dated 6/16/20 revealed a BIMS assessment of 12 indicating moderate cognitive impairment. A review of the Physician Determination of Decision Making Capacity dated 6/5/19 revealed the physician indicated Resident #55 was .capable of understanding the bill of rights and participate in medical treatment decisions. A review of the facility provided copies of multiple sheets of resident inventory dated 6/29/15, 5/30/16, 6/26/16, and 8/31/18 revealed no entries regarding money on any of the documents provided. A review of facility investigation summary dated 5/10/20 revealed the following: A statement from CNA U: States that she had heard there has been some theft in the facility. Interviewed by (local law enforcement agency) and asked if she had heard or seen anything. Asked if coworker is asking for money. States she has not seen or heard anything. States that she has worked here for three weeks. Deputy asked staff to be their eyes and ears. A statement from CNA V: States that she is aware that there are residents who are getting things stolen. States yesterday or the day before she heard that (Resident #56) was missing $20.00. States that when she started working here she knew there was an employee who was missing money. States she does not know of any staff who would have taken anything. A statement from Licensed Practical Nurse (LPN) W: .states she has been off for about a week so has not heard of any additional money missing. States she is not aware of anything happening but will let me know if she does. She states this has not been an issue until more recently, so I feel like it has to be someone who started working here recently. The investigation Summary stated .(Resident #56) with the assistance of the staff member of her choice , searched her room but were unable to locate the bill .It is reasonable to conclude that the bill in question was either taken by a staff member or otherwise misplaced by (Resident #56) . Resident #57 A review of the electronic face sheet accessed on 8/27/20 for Resident #57 revealed a [AGE] year old resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/27/20 at 10:45 a.m., an interview with FM Xrevealed the following: She fell and bruised herself and had to have therapy at (the facility). So she had a total of $200 I gave her just outside because they wouldn't let me in before she admitted there ($150 spent on bills before comeing to the facility), and she told me she stashed the $50 dollar bill in her wallet in her purse. I also had a staff member (unknown) tell me when they released her , 'Unfortunately this (missing money issue) is not the first time it's happened.' My mom was devastated when it happened because she said it was you (FM X) who gave it to me. A lady at the facility called my mother about a week after she left, and asked her 'Are you sure you didn't have it out on your bed playing with it? You know you old people have a tendency to forget where you placed your stuff.' I remember my mother said she was really upset about that call and couldn't believe they would ask her that. I'm really upset with how that place handled this. My mother is actually going through heart surgery today. A review of facility investigation summary dated 4/7/20 revealed the following: Interview with Housekeeper Y: States she has not heard that money was missing from a resident. States she did complete the admission inventory on admission. Does not specifically recall inventorying the specifics of the wallet . Interview with Resident #57: (Resident $57) stated she discovered a $50 dollar bill missing from her wallet. When she noticed the missing bill she notified staff .She stated it was folded in fours and tucked behind her bank card. She stated she knew she had the bill Monday 4/6 in the evening because she physically looked at it and noted it being in her wallet. On Tuesday evening, around 4:30, she took out her wallet to get her bank card to pay a few bills. When she removed her bank card she then noticed the bill missing .(staff) were unable to locate the bill .(Resident #57) stated the only time she had been out of her room during the time frame given was for 10 minutes while she was working with therapy. Due to COVID-19 and isolation precautions (Resident #57) has not otherwise been out of her room . The facility also acknowledged in the Actions Taken section, the need for more through personal effects inventory process after this incident. However evidence shows two of the other three resident's personal effects inventories lacked documentation of the missing possession in question. All of missing items in question are also following this incident. A review of the MDS assessment dated [DATE] for Resident #57 revealed a BIMS of 15 indicating intact cognition. A review of the Physician Determination of Decision Making Capacity dated 4/2/19 revealed the physician indicated Resident #55 was .capable of understanding the bill of rights and participate in medical treatment decisions. A review of the Inventory of Personal Effects sheet dated 4/2/20 revealed no documentation of any money in the possession of Resident #57. On 8/27/20 at 1:00 p.m., an interview with the DHCS revealed the following: When asked, when a resident is admitted to the facility, what is the expectation of what to do with funds that they came in with? The DHCS stated, The expectation would be to offer the resident a trust account and if they say 'No', we encourage them to send the money back home or a place it in a black lock box provided by the facility. When asked, if the expectation of staff would be to write the amount of money being brought in on the inventory sheet, the DHCS stated, It should be, yes. A review of the Rights of Residents in (State) Nursing Facilities undated, revealed the following: .You have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in federal regulation . A review of the policy Identification of Abuse with a revised date of March 2019 revealed the following: Definitions: .Misappropriation: 'The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the residents' consent.' A review of the policy Inventory of Personal Effects with a revised date of November 2016 revealed the following: It is the policy of this facility to inventory resident's property upon admission and safeguard this property during the residents stay. There was no direction seen in this policy to omit money items from the inventory process.
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** Based on observation, interview and record review, the facility failed to provide adequate supervision and assistance with safety devices to prevent a fall for one Resident (#66) of three residents reviewed for safety/supervision. This deficient practice resulted in Resident #66's wheelchair falling backwards while during a transport ride and the potential for other Residents inappropriately be secured in the transport van putting them at risk for harm/injury. Findings include: Review of Resident #66's medical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the 7/20/20 Minimum Data Set (MDS) assessment revealed he scored a 3/15 on the Brief Interview for Mental Status (BIMS) score, indicating severe cognitive impairment. Resident #66 required extensive one to two person assist for bed mobility, transfer, locomotion, dressing, toilet use, and personal hygiene. Resident #66 used a walker and wheelchair for mobility devices. According to the Facility Reported Incident (MI-FRI ID 796) submitted to the State Agency (SA) on 8/14/20, .It was reported by the transport driver CNA (Certified Nurse Aide) M that resident (#66) had tipped backwards, in his wheelchair, during transport to an orthopedic appointment .When CNA M and Resident #66 returned to the facility, the Administrator was made aware. The resident was immediately assessed for injury which was negative .The health care provider suggested resident be transported to the ED (Emergency Department) as a precaution to check for internal injury .at the hospital the nursing assessment was confirmed with no findings of injury and a CT (Cat Scan) was completed with no findings of hemorrhage .Further investigation suggests that the security straps were attached to the anti-rollback and wheel spoke portion of the chair, instead of the more secure frame of the wheelchair . An observation and interview was conducted with Resident #66 on 8/25/20 at approximately 12:06 p.m. Resident #66 was noted to be in his room watching television. When asked how his day was going, Resident #66 stated, I'm having a good day so far. How about you? When asked if Resident #66 recalled the incident on 8/14/20, Resident #66 stated, No. An interview was conducted with CNA M on 8/26/20 at 12:13 p.m. CNA M demonstrated how the wheelchair tipped back and landed while in the transport van, with the back of the wheelchair being placed on the floor. When asked to further describe the incident on 8/14/20, CNA M stated, I was at a stop sign and started to turn around the corner. I heard a noise and saw that (Resident #66) was tipped backwards while still being in

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) his wheelchair. I pulled off to the side, but realized that I wasn't able to lift him by myself. A construction worker nearby helped me tip him back upright and I took him to his appointment. When asked if she notified the facility at the time what occurred, CNA M stated, No. I didn't tell them until we came back from the appointment. When asked if CNA M notified the physician they were going to see of the incident that occurred, CNA M stated, No, I was too scared. Review of CNA M's personnel file indicated she had the proper chauffeur license which expires on 10/01/2021. Review of the Return Demonstration for Securing Wheelchair in Transport Van for CNA M was last completed on 8/8/18. CNA M received further education on 8/17/20 after the incident with Resident #66 on 8/14/20.