STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235224	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LENAWEE MEDICAL CARE FACILITY	200 SAND CREEK HWY ADRIAN, MI 49221

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 refers to intake # MI 380 and MI 489. Based on interview and record review, the facility failed to prevent the neglect of 3 residents (#s 10, 11, 12) out of three residents reviewed for neglect who did not receive their supper trays on 2/26/20 resulting in the likelihood that residents would experience unnecessary hunger and mistrust that staff would meet their needs. Findings include: Resident #10 (R10) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. According to the documentation on the CENA Kardex, R10 was on a No added salt diet, regular textures and thin liquids for all meals and snacks. Resident #11 (R11) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Documentation in the electronic medical record (EMR) indicated R11, when eating in the dining room, would require supervision when eating a regular diet. When eating in her room, would require a mechanical soft diet. R11 did not recall not eating supper on 2/26/20. Resident #12 (R12) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R12's EMR indicated that R12 could feed himself after setup and may occasionally need more assistance due to vision problems. R12 may benefit from being fed or using clock to describe the position of food on his plate. On 3/3/20 at 10:00 AM, in confidential interview #1, a facility staff member #1 stated on 2/26/20 three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). Facility staff member #1 stated that, on the morning of 2/27/20, a dietary aide discovered 3 untouched trays in a hot box storage unit which was used to keep food warm before serving the food to residents. On 3/3/20 at 11:00 AM, in confidential interview #2, a facility staff member #2 stated that, on 2/26/20, three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). Their untouched trays were discovered the morning after (2/27/20) by kitchen staff. On 3/3/20 at 11:40 AM, in confidential interview #3, a facility staff member #3 stated, on 2/26/20, three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). This was not discovered until the next morning. Facility staff member #3 stated Administrator A was not planning to report the event to the state as it was an accident. On 3/3/20 at 2:46 PM, Dietary Manager (DM) E was interviewed. When asked if she was aware that 3 residents were not served dinner on 2/26/20, DM E stated she was notified the morning of 2/27/20 that, the previous day at supper time, three trays were placed in the hot box, which is a storage container for keeping trays warm. The three trays were discovered on the morning of 2/27/20 still in the hot box and appeared to be untouched. DM E was asked if any of the 3 residents had anything to eat that evening and DM E said the residents possible had an evening snack but she wasn't sure. On 3/4/20 at 10:00 AM, Administrator A was interviewed. When asked about the incident where three residents did not receive a supper tray she stated I was informed the following day (after the incident). I tried to resolve the issue and did not report it to the state. In hindsight, I should have reported it as neglect. I was so focused on the issue, I did not follow through. On 3/4/20 at 10:20 AM, Assistant Administrator (AA) D was interviewed. AA D stated she was aware of the incident. AA D said the 3 certified nursing assistants (CENAs) were disciplined for falsification of documentation as they charted that 2 of the residents refused their dinner and one resident ate 75% of his meal. On 3/4/20 at 10:40 AM, Human Resource Assistant (HR) F was interviewed. She stated she investigated the situation. HR F interviewed the 3 CENAs involved and they were unable to clarify what had happened. CENA H told HR F she assumed Resident #12 (R12) had eaten and charted the amount he normally ate even though she did not ask R12 if he had received his tray or asked R12 how much he had eaten for supper. CENA H told HR F that she asked Resident #11 (R11) if she ate. When R11 stated she did not have anything to eat, CENA H asked her if she wanted something to eat. According to CENA H, R11 refused a snack. When HR F was asked if this incident was reported to the State agency, she stated there must be intent in order to call this incident neglect. On 3/4/20, a record review of the (name of facility) Abuse Prevention and Intervention Program, reviewed/revised: 5/2/19, revealed the following definition: Neglect is the failure of the facility, its employees or service providers to provide goods and services to an elder that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. On 3/4/20 at 3:24 PM, an interview with certified nursing assistant (CENA) G was done. She stated on 2/26/20, she was assigned to work on the unit where residents #10, 11, 12 lived. CENA G assigned CENA I to pass trays to the residents who were eating in their rooms. CENA G placed the supper trays for R10, R11 and R12 in a warming container called a Hot Box to keep the trays and the food in them warm prior to distribution. Although CENA G did not check to see if the three residents received their trays or asked any of the three residents what they ate, CENA G charted what R11 and R12 normally ate. CENA G admitted to falsifying the documentation but stated this was the first time she had done so. On 3/5/20 at 2:05 PM, CENA I was interviewed regarding the three residents who did not receive their supper trays on 2/26/20. CENA I stated she was asked to pass out the room trays that evening. CENA I asked someone in dietary (unknown dietary person) where the room trays were located and was told the trays were already distributed. CENA I said that no one turned their call light on. CENA I stated she thought the three residents were fed. CENA I admitted , although she knew which residents were eating in their rooms, he did not check to see if they received their trays. On 3/5/20 at 2:25 PM, CENA H was interviewed. CENA H stated she worked closely with CENA G during dinner. CENA H said she passed water and put residents to bed during that time. After dinner, when she did bed checks, she saw R11 had coffee sitting on her table and charted R11 refused to eat.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 380 and MI 489 Based on interview and record review the facility failed to ensure allegations of abuse were immediately reported to the abuse coordinator and or State Agency for four out of twelve residents (Resident #2, 10, 11, and 12) resulting in the potential for further abuse to occur. Findings include: Resident 2 According to the clinical record including the Minimum Data Set ((MDS) dated [DATE], Resident 2 (R2) was an [AGE] year old female, admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Further review of the clinical record reflected Administrator A was the daughter and Durable Power of Attorney of R2. Review of R2's nurses notes dated 2/17/2019 reflected Elder was very confused and irritable during writers shift. Elder went into two other elders rooms yelling at them to be quiet and get out of her house, elder told one of the elders family members she was going to get her gun and shoot them. Redirected elder back to her room and gave her warm towels. Elder was difficult to redirect all shift. (Name redacted) Assistant Director of Nursing (ADON) N and (name redacted) Administrator A notified. Review of R2's nurses notes dated 3/11/2019 reflected RSA (certified nursing assistant) reports that during dinner another resident was propelling wheelchair

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 -** Some	(continued... from page 1) toward this elder. This elder then raised hand and said to other elder 'you better get away'. Other elder was redirected away from this elder. No signs of distress from either elder was reported. Will continue to monitor. DON (Director of Nursing B) and administrator notified. Review of R2's nurses notes dated 3/15/2019 reflected Elder overheard a conversation between another elder and an RSA. The other elder was concerned that she might accidentally bump her with her foot at the dining room table. This elder then stated, sometimes I'd like to smack the s**t out of you. The other elder did not hear this comment and did not respond. RSA encouraged elder to eat her dinner. She did not make any further negative comments during the meal. Review of nurses notes dated 4/12/2019 reflected RSA stated that elder opened her gate to her room and hit another elder on the hand with her gate as elder was passing her room in the hallway. Both elders assessed, both elders denied pain. DON and administrative director notified. Will continue to monitor. Review of nurses notes dated 4/29/2019 reflected RSA reported to writer few hours after incident happened on first shift that elder grabbed another elder around the neck of her shirt and said she needs to stop talking to me before I hit her. RSA went to move elder away and elder got her fist up and was was ready to swing at other elder. RSA moved elder to her room to cool down while she check on other resident. Review of nurses notes dated 5/05/2019 reflected Stop and watch filled out by RSA stating that Elder was being rude to other elders and their family members. Will continue to monitor for behaviors during AM shift. Review of the nurses notes dated 6/16/2019 reflected Elder was verbal abusive about another elder. Elder was talked to and redirected easily and stated she wouldn't do anything to harm anyone. Will continue to monitor. ADON notified. Review of the nurses notes dated 8/05/2019 reflected RSA reports that this elder told another elders family to shut their mouths then told that elder to watch out b/c she was going to break her nose. Other elder and family went to community room to visit and that elder and family shows no signs of distress. (Name redacted) Administrator A notified and suggested elder eat in room tonight. Review of the nurses notes dated 8/09/2019 reflected RSA reports that when they were walking another resident, this elder wheeled past and said f**k you, and kept going. Review of the nurses notes dated 9/28/2019 reflected RSA reported seeing this elder reach out and grab at another elder's hair while they were conversing in the hall. Staff separated the two of them. DON notified and SW followed up with elders. Neither seem distressed or otherwise agitated following incident. A follow up nurses note to 9/28/2019 incident, dated 11/14/2019 reflected video footage was reviewed, and the conclusion was R2 was not aggressive. Review of the nurses notes dated 10/04/2019 reflected At 1500, elder was sitting at nurse's station, another elder reached for a paper sign, then reached over to (name redacted) (R2) . (name redacted) (R2) swatted other elder in the right arm. Elders were immediately separated, PCP, POA notified. Review of nurses notes dated 12/08/2019 Around 1800, RSA took elder to her room, then reported to writer that she had made a comment towards another elder, stating I will shoot you. during dinner. Elder immediately taken from dinning room. Writer called DON. DON said to chart on it, and to not let those elders sit together at meals anymore. Information passed onto RSAs, and will continue to be passed onto the oncoming shift. Elder has been in room, relaxing peacefully. Staff will continue to monitor. On 03/03/2020 at 11:50 AM, during an interview with Director of Nursing B and Corporate Compliance Director C, DON B stated she served as the facility's abuse coordinator. A review of R2's abusive behaviors from the nursing notes was completed, at that time and a request was made to review the facility reported incidents. DON B stated the only incident from the above list that was reported to the State Agency was the 10/04/2019 occurrence. When queried why the remaining incidents were not reported to the State Agency DON B stated she does not have the authority, access or the password to submit abuse investigations to the State Agency. Corporate Compliance Director C stated Administrator A, Assistant Administrator D and herself were the only people that had the password to submit facility reported incidents to the State Agency. When queried why the abuse coordinator did not have access or a password to report occurrences of abuse to the State Agency, there was no response given. When queried why the 3 employees that did have a password and access to the State Agency did not report the incidents to the State Agency, DON B stated all abuse reporting to the State Agency is strictly at Administrators A discretion. On 03/04/2020 at 10:00 am, during an interview with Administrator A she stated she was R2's daughter and Durable Power of Attorney. Administrator A further reported she was aware of R2's verbal and physical abuse directed at other residents, as she is at the facility daily, her staff keep her informed as she is also the daughter and durable power of attorney. When queried why DON B/Abuse coordinator was not provided access to report the episodes of abuse to the State Agency, Administrator A stated all investigations were done jointly between her and DON B, but reporting to the State Agency was at her discretion. When queried why there were no investigations related R2's multiple episodes of abusive behaviors towards other residents Administrator A stated it was a conflict of interest for her to conduct and abuse investigation about R2 as it was her mother and she instructed Assistant Administrator D to handle all investigation and reporting to the State Agency as it relates to R2. When queried if she followed up with the DONB/ abuse coordinator or Assistant Administrator D, Administrator A to ensure the allegations were investigated, reported or corrective measures implemented, Administrator A stated no, it was a conflict of interest. On 03/04/2020 at 10:30 AM, during an interview with Assistant Administrator D she stated she had been asked by Administrator A one time to investigate and allegation of abuse related to R2. Assistant Administrator A further stated the one incident she was asked to investigate, was the incident on 10/04/2019 which she then reported to the State Agency. According to the facility policy titled Abuse Prevention and Intervention Program Reviewed/Revised 5/02/19 reflected Verbal Abuse defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to elders or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Physical Abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. On page 4. under the heading Procedure reflected 2.The Director of Nursing, Administrator or designee shall thoroughly investigate all allegations. 3. The Director of Nursing, Administrator or designee will notify the elder's representative, and any state or federal agencies of allegations immediately and investigation within 5 days. 4. Residents 10, 11 and 12 Resident #10 (R10) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. According to the documentation on the CENA Kardex, R10 was on a No added salt diet, regular textures and thin liquids for all meals and snacks. Resident #11 (R11) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Documentation in the electronic medical record (EMR) indicated R11, when eating in the dining room, would require supervision when eating a regular diet. When eating in her room, would require a mechanical soft diet. R11 did not recall not eating supper on 2/26/20. Resident #12 (R12) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R12's EMR indicated that R12 could feed himself after setup and may occasionally need more assistance due to vision problems. R12 may benefit from being fed or using clock to describe the position of food on his plate. On 3/4/20 at 10:00 AM, Administrator A was interviewed. When asked about the incident where three residents did not receive a supper tray she stated I was informed the following day (after the incident). I tried to resolve the issue and did not report it to the state. In hindsight, I should have reported it as neglect. I was so focused on the issue, I did not follow through. On 3/4/20 at 10:20 AM, Assistant Administrator (AA) D was interviewed. AA D stated she was aware of the incident. AA D said the 3 certified nursing assistants (CENAs) were disciplined for falsification of documentation as they charted that 2 of the residents refused their dinner and one resident ate 75% of his meal. On 3/4/20 at 10:40 AM, Human Resource Assistant (HR) F was interviewed. She stated she investigated the situation. HR F interviewed the 3 CENAs involved and they were unable to clarify what had happened. CENA H told HR F she assumed Resident #12 (R12) had eaten and charted the amount he normally ate even though she did not ask R12 if he had received his tray or asked R12 how much he had eaten for supper. CENA H told HR F that she asked Resident #11 (R11) if she ate. When R11 stated she did not have anything to eat, CENA H asked her if she wanted something to eat. According to CENA H, R11 refused a snack. When HR F was asked if this incident was reported to the State agency, she became very upset and stated there must be intent in order to call this incident neglect.
F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #MI 380 and MI 489 Based on interview and record review, the facility failed to identify, thoroughly investigate, and implement corrective action for alleged and/or actual abuse for five out of twelve residents (#1, 2, 10, 11 and 12), resulting in Immediate Jeopardy when the facility failed to ensure abuse investigations were investigated thoroughly, ensure prevention of further verbal and physical abuse of residents, and put corrective action into place to prevent further incidents of abuse placing all 101 residents who reside at the facility at risk for serious harm, injury, impairment and or death. Findings include: Resident 2 According to the clinical record including the Minimum

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F 0610 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) Data Set ((MDS) dated [DATE], Resident 2 (R2) was an [AGE] year old female, admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Further review of the clinical record reflected Administrator A was the daughter and Durable Power of Attorney of R2. Review of R2's nurses notes dated 2/17/2019 reflected Elder was very confused and irritable during writers shift. Elder went into two other elders rooms yelling at them to be quiet and get out of her house, elder told one of the elders family members she was going to get her gun and shoot them. Redirected elder back to her room and gave her warm towels. Elder was difficult to redirect all shift. (Name redacted) (Assistant Director of Nursing (ADON) N) and (name redacted) (Administrator A notified.) Review of R2's nurses notes dated 3/11/2019 reflected RSA (certified nursing assistant) reports that during dinner another resident was propelling wheelchair toward this elder. This elder then raised hand and said to other elder 'you better get away'. Other elder was redirected away from this elder. No signs of distress from either elder was reported. Will continue to monitor. DON (Director of Nursing B) and administrator notified. Review of R2's nurses notes dated 3/15/2019 reflected Elder overheard a conversation between another elder and an RSA. The other elder was concerned that she might accidentally bump her with her foot at the dining room table. This elder then stated, sometimes I'd like to smack the s**t out of you. The other elder did not hear this comment and did not respond. RSA encouraged elder to eat her dinner. She did not make any further negative comments during the meal. Review of nurses notes dated 4/12/2019 reflected RSA stated that elder opened her gate to her room and hit another elder on the hand with her gate as elder was passing her room in the hallway. Both elders assessed, both elders denied pain. DON and administrative director notified. Will continue to monitor. Review of nurses notes dated 4/29/2019 reflected RSA reported to writer few hours after incident happened on first shift that elder grabbed another elder around the neck of her shirt and said she needs to stop talking to me before I hit her. RSA went to move elder away and elder got her fist up and was was ready to swing at other elder. RSA moved elder to her room to cool down while she check on other resident. Review of nurses notes dated 5/05/2019 reflected Stop and watch filled out by RSA stating that Elder was being rude to other elders and their family members. Will continue to monitor for behaviors during AM shift. Review of the nurses notes dated 6/16/2019 reflected Elder was verbal abusive about another elder. Elder was talked to and redirected easily and stated she wouldn't do anything to harm anyone. Will continue to monitor. ADON notified. Review of the nurses notes dated 8/05/2019 reflected RSA reports that this elder told another elders family to shut their mouths then told that elder to watch out b/c she was going to break her nose. Other elder and family went to community room to visit and that elder and family shows no signs of distress. (Name redacted) Administrator A notified and suggested elder eat in room tonight. Review of the nurses notes dated 8/09/2019 reflected RSA reports that when they were walking another resident, this elder wheeled past and said f**k you, and kept going. Review of the nurses notes dated 9/28/2019 reflected RSA reported seeing this elder reach out and grab at another elder's hair while they were conversing in the hall. Staff separated the two of them. DON notified and SW followed up with elders. Neither seem distressed or otherwise agitated following incident. A follow up nurses note to the 9/28/2019 incident, dated 11/14/2019 reflected video footage was reviewed, and the conclusion was R2 was not aggressive. Review of the nurses notes dated 10/04/2019 reflected At 1500, elder was sitting at nurse's station, another elder reached for a paper sign, then reached over to (name redacted) (R2) . (name redacted) (R2) swatted other elder in the right arm. Elders were immediately separated, PCP, POA notified. Review of nurses notes dated 12/08/2019 Around 1800, RSA took elder to her room, then reported to writer that she had made a comment towards another elder, stating I will shoot you. during dinner. Elder immediately taken from dinning room. Writer called DON. DON said to chart on it, and to not let those elders sit together at meals anymore. Information passed onto RSAs, and will continue to be passed onto the oncoming shift. Elder has been in room, relaxing peacefully. Staff will continue to monitor. On 03/03/2020 at 11:50 AM, during an interview with Director of Nursing B, Assistant Director of Nursing N and Corporate Compliance Director C, DON B stated she served as the facility's abuse coordinator. A review of R2's abusive behaviors from the nursing notes was completed, at that time and a request was made to review the each of the above listed incidents entire investigations, including but not limited to witness statements and corrective measures. DON B stated the only incident from the above list that was investigated was the facility reported incident that was submitted to the State Agency on 10/04/2019 . When queried why the remaining incidents were not investigated or corrective measures implemented DON B offered no explanation. When DON B, ADON N and Corporate Compliance Director C were queried if they were aware of R2's verbal and physical abuse towards other residents. All three reported R2's behavior was well known throughout the facility. Review of R2's behavior care plan, dated 11/02/2018 reflected R2 was verbally and physically aggressive at times, with a goal of maintaining behavioral stability without showing an increase in behavioral symptoms from the previous assessment. An intervention dated 01/08/2019 was to encourage R2 to use a sewing box of materials in her room if she becomes anxious and provide a 1:1 if becomes anxiety increases and use [MEDICATION NAME] lotion Intervention dated 2/18/2019 was to be agreeable with R2 and not to rationalize, and if delusional go along with it if R2 was safe. Intervention dated 2/18/2020 was to provide her with meaningful activities, and provide reassurance. Review of the facility care guide, utilized by the certified nursing assistants reflected Behavior: My visual hallucinations often times are distressful to me. Please reassure me. On 3/04/2020 at 11:20 am, during an interview with Director of Nursing (DON) B she reported there was no special behavior program, or intervention used when R2 becomes physically and verbally aggressive. DON B stated they just try to separate from other residents. On 3/04/2020 at 1:20 PM, during an interview with Certified Nursing Assistant (CNA) M, she reported the CNA's use the care guide to learn what each residents needs were. CNA M reported she has never been given instruction or specialized training on how to handle R2's abusive behaviors or how to protect the other residents. I just have to figure it out by trial and error. On 3/05/2020 at 2:30 PM, during an interview with CNA H she reported she also used the facility's care guide for instruction on how to care for residents, not the care plan. On 03/04/2020 at 10:00 am, during an interview with Administrator A she stated she was R2's daughter and Durable Power of Attorney. Administrator A further reported she was aware of R2's verbal and physical abuse directed at other residents, as she is at the facility daily, her staff keep her informed as she is also the daughter and durable power of attorney. Review of the events from the nurses notes were reviewed with Administrator A, she acknowledge again that she was aware of all of the events though could not recall specific details. When Administrator A was queried why there was no evidence that any investigations excluding the 10/04/2019 incident had been investigated thoroughly or corrective action to prevent further abuse were in place. Administrator A stated all investigations surrounding her mother (R2) and abuse were a conflict of interest and she instructed Assistant Administrator D to handle all R2's abuse investigations and reporting to the State Agency. When Administrator A was queried if she followed up with the DONB/ abuse coordinator or Assistant Administrator D as to the results and corrective measures to be implemented from the investigations Administrator A stated no, it was a conflict of interest. When queried what had the facility implemented to prevent R2 from verbally and physically abusing other residents, Administrator A reported they started her on medication. Record review revealed R2 had been prescribed [MEDICAL CONDITION] medication since 11/02/2018. On 03/04/2020 at 10:30 AM, during an interview with Assistant Administrator D she stated she had been asked by Administrator A one time to investigate an allegation of abuse related to R2. Assistant Administrator A further stated the one incident she was asked to investigate, was the incident on 10/04/2019 which was then reported to the State Agency. According to the facility policy titled Abuse Prevention and Intervention Program Reviewed/Revised 5/02/19 reflected Verbal Abuse defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to elders or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Physical Abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. On page 4. under the heading Procedure reflected 2.The Director of Nursing, Administrator or designee shall thoroughly investigate all allegations. 3. The Director of Nursing, Administrator or designee will notify the elder's representative, and any state or federal agencies of allegations immediately and investigation within 5 days. 4. The Director of Nursing, Administrator or designee will take steps to ensure and prevent further potential abuse while the investigation is in process. On page 6. under the heading Elder to Elder reflected 11. All incidents are to be documented in each elder's medical record with intense monitoring to continue for at least 24 hours. On 03/06/2020 this surveyor verified that the facility implemented the following to remove the Immediate Jeopardy that began on 2/17/2019, and was identified on 03/04/2020: Beginning 3/4/2020, The Abuse Coordinator and/or Designee will review progress notes daily of all Elders to determine if there have been allegations of Abuse that were not reported to the Abuse Coordinator or Administrator. On 3/4/2020 at 3:45 p.m. the Abuse Coordinator, Administrator, Assistant Administrator & Corporate Compliance were educated via telephone regarding the requirements of Abuse reporting under Regulation F610 by (name

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F 0610 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) redacted) RN, LNHA (Registered Nurse and Licensed Nursing Home Administrator) with (name redacted) Consulting. The Abuse Coordinator and/or designee will thoroughly investigate all allegations of abuse after they have first been reported through the MI-Login online portal by the Administrator or designee. The Facility will also register the Abuse Coordinator through the MI-Login allowing her access to reporting. A comprehensive [MEDICAL CONDITION] medication review including all mood and behavioral symptoms and interventions for Resident #2 is being completed. Resident #2 will be discussed at the Facility's IDT meeting today 3/5/2020 with the Administrator & Assistant Administrator also in attendance and care plan updated to prevent future occurrences of verbal or physical abuse. Administrator has implemented and will maintain a log at all times (24 hours a day) of phone calls & notifications received regarding allegations of Abuse and the action taken. Log will begin today 3/5/2020. Beginning 3/5/2020 the Administrator and Assistant Administrator will attend all IDT meetings at the Facility to ensure that any allegations of Abuse have been reported. On 3/5/2020 the Facility will place posters at all nursing stations within the building outlining the forms of abuse and who to notify for any potential incidents of abuse. The Facility began re-educating staff on 3/4/2020 at 4:00 p.m. regarding the Facility's Abuse policy and Abuse reporting guidelines as well as immediately protecting other residents from potentially abusive peers. This education will be completed by 3/5/2020 at 5:00 p.m. Any employees who are on leaves of absence or are scheduled on a casual basis will be reeducated via telephone prior to them returning to work. The Administrator, Assistant Administrator, Abuse Coordinator & Corporate Officer reviewed the Abuse Policy on 3/4/2020 & 3/5/2020. The result of the review is that our current policy lacks specific language as described in Regulations 609 & 610. The Facility will revise its policy by 3/6/2020. Although the Immediate Jeopardy was removed on 3-6-2020 non compliance continued at no actual harm with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance could not be verified by the state agency.
F 0712 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely physician visits for one (Resident #10) of four reviewed for physician visits, resulting in physician visits not completed timely. Findings include: Review of the medical record revealed Resident #10 (R10) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of R10's physician visits revealed there was an 80 day period between the visits of 10/10/19 and 12/29/19. In an interview on 3/5/20 at 1:40 PM, Compliance Staff C reported in the past, Social Work tracked the timeliness of physician's visits, but now R10's physician had a Medical Assistant that scheduled visits. Compliance Staff C reported the physician has had times where he was overdue for visits, but she was not aware of any that were outside of the 10 day grace period. On 3/5/20 at 2:05 PM, Compliance Staff C reported she did not have any other physician visits for R10 between 10/10/19 and 12/29/19.
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #MI 380 and MI 489 Based on interview and record review, the facility failed to administer it's policies, practices and procedures in a manner that displayed effective and efficient used of its resources to ensure the highest practicable physical, mental and psychosocial well-being for sampled residents (#2, 10, 11 and 12) and potentially affecting all 101 residents that reside in the facility resulting in not identifying allegations of abuse and neglect, not thoroughly investigating allegations of abuse and neglect and not implementing corrective action to prevent further incidents of abuse. Findings include: Resident 2 According to the clinical record including the Minimum Data Set ((MDS) dated [DATE], Resident 2 (R2) was an [AGE] year old female, admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Further review of the clinical record reflected Administrator A was the daughter and Durable Power of Attorney of R2. Resident #2 Nurses notes dated 2/17/19, 3/11/19, 3/15/19, 6/16/19, 8/05/19, 8/9/19, revealed R2 was verbally abusive and/ or threatened other residents with physical violence. Resident #2's nurses notes dated 4/12/19, 4/29/19, 9/28/19 and 10/04/19 reflected allegations that R2 was physically abusive toward other residents. The 10/04/2019 was the only physical abuse incident the facility investigated and reported to the State Agency. The facility did not prevent further potential abuse. The facility has not recognized allegations of abuse and neglect, thoroughly investigated the allegations of abuse and neglect and did not implement effective measures to protect residents. On 03/04/2020 at 10:00 am, during an interview with Administrator A she stated she was R2's daughter and Durable Power of Attorney. Administrator A further reported she was aware of R2's verbal and physical abuse directed at other residents, as she is at the facility daily, her staff keep her informed as she is also the daughter and durable power of attorney. When queried why DON B/Abuse coordinator was not provided access to report the episodes of abuse to the State Agency, Administrator A stated all investigations were done jointly between her and DON B, but reporting to the State Agency was at her discretion. When queried why there were no investigations related R2's multiple episodes of abusive behaviors towards other residents Administrator A stated it was a conflict of interest for her to conduct and abuse investigation about R2 as it was her mother and she instructed Assistant Administrator D to handle all investigation and reporting to the State Agency as it relates to R2. When queried if she followed up with the DONB/ abuse coordinator or Assistant Administrator D, Administrator A to ensure the allegations were investigated, reported or corrective measures implemented, Administrator A stated no, it was a conflict of interest. On 03/04/2020 at 10:30 AM, during an interview with Assistant Administrator D she stated she had been asked by Administrator A one time to investigate and allegation of abuse related to R2. Assistant Administrator A further stated the one incident she was asked to investigate, was the incident on 10/04/2019 which she then reported to the State Agency. Residents #10, 11, 12 On 3/3/20 at 10:00 AM, in confidential interview #1, a facility staff member #1 stated on 2/26/20 three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). Facility staff member #1 stated that, on the morning of 2/27/20, a dietary aide discovered 3 untouched trays in a hot box storage unit which was used to keep food warm before serving the food to residents. On 3/3/20 at 11:00 AM, in confidential interview #2, a facility staff member #2 stated that, on 2/26/20, three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). Their untouched trays were discovered the morning after (2/27/20) by kitchen staff. On 3/3/20 at 11:40 AM, in confidential interview #3, a facility staff member #3 stated, on 2/26/20, three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). This was not discovered until the next morning. Facility staff member #3 stated Administrator A was not planning to report the event to the state as it was an accident. On 3/3/20 at 2:46 PM, Dietary Manager (DM) E was interviewed. When asked if she was aware that 3 residents were not served dinner on 2/26/20, DM E stated she was notified the morning of 2/27/20 that, the previous day at supper time, three trays were placed in the hot box, which is a storage container for keeping trays warm. The three trays were discovered on the morning of 2/27/20 still in the hot box and appeared to be untouched. DM E was asked if any of the 3 residents had anything to eat that evening and DM E said the residents possible had an evening snack but she wasn't sure. On 3/4/20 at 10:00 AM, Administrator A was interviewed. When asked about the incident where three residents did not receive a supper tray she stated I was informed the following day (after the incident). I tried to resolve the issue and did not report it to the state. In hindsight, I should have reported it as neglect. I was so focused on the issue, I did not follow through. On 3/4/20 at 10:20 AM, Assistant Administrator (AA) D was interviewed. AA D stated she was aware of the incident. AA D said the 3 certified nursing assistants (CENAs) were disciplined for falsification of documentation as they charted that 2 of the residents refused their dinner and one resident ate 75% of his meal.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** This citation refers to intake # MI 380 and MI 489. Based on interview and record review, the facility failed to prevent the falsification of information when three residents (#s 10, 11, 12) did not receive their dinner trays on 2/26/20 but charting in the electronic medical record indicated the residents were assessed as if they trays were delivered and the amount of food eaten/not eaten by the residents was documented resulting in mistrust in the care rendered by the certified nursing assistants working on the unit. Findings include: On 3/3/20 at 10:00 AM, in confidential interview #1, a facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235224	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LENAWEE MEDICAL CARE FACILITY	**200 SAND CREEK HWY ADRIAN, MI 49221**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) staff member #1 stated on 2/26/20 three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). Facility staff member #1 stated that, on the morning of 2/27/20, a dietary aide discovered 3 untouched trays in a hot box storage unit which was used to keep food warm before serving the food to residents. On 3/3/20 at 11:00 AM, in confidential interview #2, a facility staff member #2 stated that, on 2/26/20, three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). Their untouched trays were discovered the morning after (2/27/20) by kitchen staff. On 3/3/20 at 11:40 AM, in confidential interview #3, a facility staff member #3 stated, on 2/26/20, three residents did not receive a supper tray. The three residents were identified as Resident #10 (R10), Resident #11 (R11), and Resident #12 (R12). This was not discovered until the next morning. Facility staff member #3 stated Administrator A was not planning to report the event to the state as it was an accident. On 3/4/20 at 10:40 AM, Human Resource Assistant (HR) F was interviewed. She stated she investigated the situation. HR F interviewed the 3 CENAs involved and they were unable to clarify what had happened. CENA H told HR F she assumed Resident #12 (R12) had eaten and charted the amount he normally ate even though she did not ask R12 if he had received his tray or asked R12 how much he had eaten for supper. CENA H told HR F that she asked Resident #11 (R11) if she ate. When R11 stated she did not have anything to eat, CENA H asked her if she wanted something to eat. According to CENA H, R11 refused a snack. According to HR F, all three CENAs involved received a disciplinary write-up for falsifying documentation about the amount of food R10, R11 and R12 ate the night of 2/26/20. When HR F was asked if this incident was reported to the State agency, she stated there must be intent in order to call this incident neglect.