STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POMEROY LIVING ROCHESTER SKILLED REHABILITATION	3500 WEST SOUTH BLVD ROCHESTER HILLS, MI 48309

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 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 pertains to Intake Number: MI 204 Based on observation, interview and record review the facility failed to prevent Certified Nursing Assistant (CNA) K from using their personal cellphone to take pictures of a resident and sharing the picture of the resident's abdomen with their brief exposed to another staff person for one (R#819) of 16 residents reviewed for abuse, resulting in potential psychosocial harm such as feelings of mental anguish, humiliation, shame, dehumanization, anxiety and/or degradation per the reasonable person standard. Findings include: A review of a Disciplinary Action Record for Certified Nursing Assistant (CNA) K documented in part, .Date of Infraction: 1/13/2020 .Caregiver admitted to taking photographs of a resident's abdomen and brief which is against company policy .This is Termination . A facility Employee Interview form conducted by the facility's Human Resource (HR) department with CNA K dated 1/13/20 documented in part, .Did you have R#819 on your set today? Yes, did you take pictures of his room? No, I took a picture of the things I knew were wrong so I could show my unit manager. Did you show them to your unit manager? Yes., What were the pictures of? Medication left in the patient's room on the windowsill. What else? A brief that marked because is (sic) had never known anyone to mark a brief. Was the brief on the resident at the time? Yes, but I did not show the resident's face .Do you know it is a HIPAA violation to take pictures of a resident even if you do not show their face? I wasn't aware of that. Do you still have pictures on the phone? No. Are you sure? I though I deleted them. Can you check? (Employee checked phone) No, I deleted them. You took only two pictures, one of the meds and one of the brief? Yes, there was a third picture of the floor that was a mess . A facility Employee Interview form conduct by the facility's HR department with Unit Manager (UM) D dated 1/13/20 documented in part, .Did you work with CNA K today? Yes, did she show you some pictures? Yes, what were they? She showed me three pictures. On with medication in a cup, one a peg tube not clamped and a feeding line on the ground., Did the ped (sic) tube show a part of the body? Yes, the stomach .Was the resident's brief visible in the picture of the peg tube? I think she also showed me a picture of a marked brief. I forgot that .Would you consider these pictures a HIPAA violation? There was no face or room or resident identification on them. Based on her set I knew who they were . A review of R#819's clinical record revealed the following: R#819 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented moderately impaired cognition. R#819 was dependent on staff's assistance for activities of daily living. On 3/3/20 at 8:01 AM, R#819 was observed in their room, lying on their back in bed. When interviewed R#819 answered all questions appropriately. When asked Have staff ever taken pictures of you, your room mates or room? R#819 stated What? No, have staff actually done that to anybody? Like in compromising positions? No, no staff have taken pictures of me . On 3/3/20 at 11:58 AM, the Administrator was queried on CNA K photographing R#819 with their personal cellphone and why it wasn't reported to the State Agency? The Administrator acknowledged that the incident was not reported to the State Agency because my understanding is because it didn't have identifying information and staff took them to show their manager about another staff's performance. I reviewed the case and we terminated her for violating our company's policy. I don't believe it falls within the reporting guidelines. There was no willful intent . When asked why the resident wasn't informed that a staff member had taken a picture of them (without their knowledge) showing their briefs and had shown the pictures to someone else and the Administrator acknowledged that the resident was unaware and there is no potential harm to the resident . A facility policy titled Abuse and Neglect Policy (Revision Date: November 2017) documented in part, Each resident has the right to be free from abuse, mistreatment, neglect, exploitation, involuntary seclusion, misappropriation of property and mental abuse facilitated or enabled by the use of technology .The facility will train each employee regarding Abuse related policies, including the Elder Justice Act and prohibiting staff from using any type of equipment (e.g., cameras, smart phones and other electronic devices) to take, keep or distribute photographs and/or recordings of residents that are demeaning or humiliating .
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 pertains to intake(s): MI 179, MI 471 and MI 021 Based on observation, interview and record review the facility failed to ensure an enviroment free from abuse for five residents (#s 805, 807, 808, 811 and 814) of 16 residents reviewed for abuse, resulting in multiple resident to resident occurrences, aggressive behaviors when R#807 struck R#805 in the face, hit R#808 in the face and shoulder and R#814 having been struck in the face and hand by R#811. Findings include: R#805 and #807 A review of a facility Unusual Occurrence Report dated 11/12/19 at 8 PM documented in part, . (R#805) observed being struck in the face by another resident (R#807). Both resident (sic) were separated . On 3/3/20 at 8:19 AM, R#805 was observed in the dining room sitting alone at the table eating breakfast. When asked, R#805 didn't recall the incident with R#807. R#805 stated If someone hit's me, I'm hitting them back . A review of R#805's progress notes revealed the following: R#805 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. An MDS (Minimum Data Set) assessment dated [DATE] documented severely impaired cognition for R#805. A Nursing note dated 11/13/19 at 12:02 AM for R#805 documented in part, Resident observed by another staff member being struck in the face by a resident (R#807) . On 3/3/20 at 8:47 AM, R#807 was observed sitting in their wheelchair in the hallway. When asked questions R#807 did not respond appropriately. Review of R#807's clinical record reviewed the following: R#807 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. A MDS assessment dated [DATE] documented severely impaired cognition. A Nursing note dated 11/12/19 at 11:58 PM documented in part, Resident overserved (sic) by a staff member striking another resident (R#805). Resident was quickly separated and redirected to another area. Resident was unable to describe what upset her and remained agitated at staff . Further review revealed the facility's contracted behavioral provider was not notified of R#807 hitting R#805. R#808 and #807 On 3/3/20 at 8:23 AM, R#808 was observed in the dining room sitting in a geri-chair being fed by a staff member. R#808's eyes were closed and did not respond when interviewed. A review of R#808's clinical record revealed the following: R#808 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] documented indicated severely impaired cognition. A Nursing note dated 11/23/19 at 7:34 PM documented in part, .Resident was witnessed by activity assistant being hit by another resident in (room number redacted). R#807 hit resident (R#808) on shoulder and left side of face . A facility Unusual Occurrence Report dated 11/23/19 at 15:35 (3:35 PM) documented in part, .What was resident (R#808) doing before incident? Resting in chair .R#807 was witnessed by activity assistant hitting R#808 on her L (left) shoulder and inner face (left side) . A review of R#807's clinical record revealed the following: R#807 was admitted 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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] documented severely impaired cognition. A Nursing note dated 11/23/19 at 6:52 PM documented in part, .Resident was sleeping on the couch in the day room, woke up out her sleep and punched and slapped another resident in the head and shoulder. Both parties were separated. Resident was temporally 1:1 with second shift supervisor where she tried to attack her and other staff members. Resident was sent out to (hospital name redacted) for a psych evaluation . On 3/3/20 at 2:04 PM the Director of Nursing (DON) was queried on how the facility is able to protect other residents from R#807's impulsive behaviors and requested more time to look in to the residents record. At this time all documentation was requested from the DON for review of any physician consultations (involving the resident to resident abuse), care plans or any other reports that pertained to R#807's resident to resident behaviors and any documentation that informed the behavioral group (physician or nurse practitioner) of R#807 hitting R#805. No further documentation was provided by the end of survey. Resident #811 On 3/2/20 the medical record for R#811 was reviewed and revealed the following: R#811 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#811's MDS with an ARD (Assessment Reference Date) of 12/18/19 revealed R#811 needed extensive assistance from facility staff with most of their activities of daily living. R#811's BIMS score (brief interview of mental status) was zero indicating severely impaired cognition. A nursing note dated 1/20/20 revealed the following: Writer heard other resident (R#814) yelling at resident, other resident stated I'm going to kill you. Writer then begin (sic) to run in the hallway and observed other resident (R#814) punching resident in the face with a closed fist. Resident was trying to protect his face. Writer separated both residents and called the DON to assist with further investigation. DON then called administrator immediately after investigation. Resident #814 On 3/2/20 the medical record for R#814 was reviewed and revealed the following: R#814 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#814's MDS assessment with an ARD of 11/7/19 revealed R#814 had a BIMS score of 14 indicating intact cognition. A nursing note dated 1/20/20 revealed the following: After the writer has taken lunch break, around 2:25 PM the other nurse reported to me that (R#811) a resident was fighting with (R#814) also a resident. DON was around and doing an investigation and called the Police. Around 3:45 PM Police officer came and talked to the DON regarding the incident and did a follow up investigation. A DON progress note dated 1/20/20 revealed the following: Reported to this writer this afternoon resident verbally and physically aggressive. Administrator immediately notified of unusual occurrence . On 3/2/20 a facility investigation submitted to the state agency by the facility pertaining to the the altercation between R#811 and R#814 was reviewed and revealed the following: Incident Summary-Resident (R#811) reportedly bumped into resident (R#814) with his wheelchair. (R#814) became agitated by this and struck (R#811) in the face with his hand .Investigation Summary background and demographics: (R#814) is cognitively intact and evidenced by a BIMS score of 14 .Incident and investigation on 1/20/20 at approximately 2:20 PM (Nurse G) was working in the (name of unit) and overheard (R#814) yelling at (R#811). (Nurse G) immediately ran down the hallway towards them and witnessed (R#814) striking (R#811) about the face with a closed fist. (R#811) was noted trying to shield his face with his hands. The two residents were immediately separated and assessed. (R#811) .due to an affirmative response to questions of pain a facial x-ray was ordered . A witness statement dated 1/23/20 by staff member H pertaining to the altercation revealed the following: .1. What did you see: (R#814) was sitting in the middle of the hallway and (R#811) was trying to get past. I heard (R#814) say If you f*** with me I will kill you. Then (R#811) continued past (R#814) to the end of the hallway looking out the exit door. Then the next thing I knew (Nurse G) the nurse came running down the hallway stating (R#814) hit (R#811) in the face . On 3/3/20 at approximately 10:25 a.m., staff member H was queried regarding the altercation between R#811 and R#814. Staff member H indicated that they were cleaning rooms on the unit and they observed R#811 trying to get past R#814 in the hallway. Staff member H indicated that they observed R#811 and R#814's wheelchairs get tangled and they heard R#814 say I'm going to kill you to R#811. They then observed R#811 wheel past R#814 and head down to the end of the hallway. Staff member H indicated after cleaning another resident's room they came out and saw R#814 hit R#811 at the end of the hallway. On 3/3/20 at approximately 11:04 a.m., Nurse G was queried regarding the altercation between R#811 and R#814. Nurse G indicated that they were sitting at the nursing station when they heard R#814 cussing at R#811. Nurse G then indicated they ran down the hallway and observed R#814 punch R#811 on the left side of their face with a closed fist. Nurse G reported they separated the two resident and afterwards they asked R#814 why he punched R#811 and R#814 indicated they punched R#811 because R#811 had kicked them. On 3/3/20 at approximately 2:48 p.m., during a conversation with the facility Administrator (facility abuse coordinator), the Administrator was queried regarding the altercation between R#814 and R#811. The Administrator indicated after the incident had occurred they had spoken with R#814 about hitting R#811. The Administrator reported R#814 is in control of his own actions and that they had reinforced bringing their concerns to facility staff instead of acting out. The Administrator indicated R#814 told them they would try not to hit other residents. The Administrator was queried if was their expectation the facility maintain an environment free of abuse and they indicated it was. A facility policy titled Abuse and Neglect Policy (dated November 2017) documented in part Each resident has the right to be free from abuse, mistreatment, neglect .Abuse means the willfull infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Residents identified by staff as being self-injurious or exhibiting abusive behavior, which require professional services not provided in the facility, will be reviewed by the physician as soon as possible and treatment plans modified as appropriate . Resident #811 On 3/2/20 the medical record for R#811 was reviewed and revealed the following: R#811 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#811's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/18/19 revealed R#811 needed extensive assistance from facility staff with most of their activities of daily living. R#811's BIMS score (brief interview of mental status) was zero indicating severely impaired cognition. A nursing note dated 1/20/20 revealed the following: Writer heard other resident (R#814) yelling at resident, other resident stated I'm going to kill you. Writer then begin to run in the hallway and observed other resident (R#814) punching resident in the face with a closed fist. Resident was trying to protect his face. Writer separated both residents and called the DON (Director of Nursing) to assist with further investigation. DON then called administrator immediately after investigation. R#814 On 3/2/20 the medical record for R#814 was reviewed and revealed the following: R#814 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#814's MDS with an ARD of 11/7/19 revealed R#814 had a BIMS score of 14 indicating intact cognition. A nursing note dated 1/20/29 revealed the following: After the writer has taken lunch break, around 2:25 PM the other nurse reported to me that (R#811) a resident was fighting with (R#814) also a resident. DON was around and doing an investigation and called the Police. Around 3:45 PM Police officer came and talked to the DON regarding the incident and did a follow up investigation. A DON progress note dated 1/20/20 revealed the following: Reported to this writer this afternoon resident verbally and physically aggressive. Administrator immediately notified of unusual occurrence. Resident placed on one on one monitoring . On 3/2/20 a facility investigation submitted to the state agency by the facility pertaining to the the altercation between R#811 and R#814 was reviewed and revealed the following: Incident Summary-Resident (R#811) reportedly bumped into resident (R#814) with his wheelchair. (R#814) became agitated by this and struck (R#811) in the face with his hand Investigation Summary background and demographics: (R#814) is cognitively intact and evidenced by a BIMS score of 14 .Incident and investigation on 1/20/20 at approximately 2:20 PM (Nurse G) was working in the (name of unit) and overheard (R#814) yelling at (R#811). (Nurse G) immediately ran down the hallway towards them and witnessed (R#814) striking (R#811) about the face with a closed fist. (R#811) was noted trying to shield his face with his hands. The two residents were immediately separated and assessed. (R#811) .due to an affirmative response to questions of pain a facial x-ray was ordered and the results were negative . A witness statement dated 1/23/20 by staff member H pertaining to the altercation revealed the following: .1. What did you see: (R#814) was sitting in the middle of the hallway and (R#811) was trying to get past. I heard (R#814) say If you f*** with me I will kill you. Then (R#811) continued past (R#814) to the end of the hallway looking out the exit door. Then the next thing I knew (Nurse G) the nurse came running down the hallway stating (R#814) hit (R#811) in the face . On 3/3/20 at approximately 10:25 a.m., staff member H was queried regarding the altercation between R#811 and R#814. Staff member H indicated that they were cleaning rooms on the unit and they observed R#811 trying to get past R#814 in the hallway. Staff member H indicated that they observed R#811 and R#814's wheelchairs get tangled and they heard R#814 say I'm going to kill you to R#811. They then observed R#811 wheel past R#814 and head down to the end of the hallway. Staff member H then indicated that after cleaning another resident's room they came out and saw R#814 hit R#811 at the end of the hallway. On 3/3/20 at approximately 11:04 a.m., Nurse G was queried regarding the altercation between R#811 and R#814. Nurse G indicated that they were sitting at the nursing station when they heard R#814 cussing at R#811. Nurse G then indicated they ran down the hallway and observed R#814 punch R#811 on

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the left side of their face with a closed fist. Nurse G reported they separated the two resident and afterwards they asked R#814 why he punched R#811 and that R#814 indicated they punch R#811 because R#811 had kicked him. On 3/3/20 at approximately 2:48 p.m., during a conversation with the facility Administrator (facility abuse coordinator), the Administrator was queried regarding the altercation between R#814 and R#811. The Administrator indicated that after the incident had occurred they had spoken with R#814 about hitting R#811. The Administrator reported that R#814 is in control of his own actions and that they had reinforced bringing their concerns to facility staff instead of acting out. The Administrator indicated that R#814 told them they would try not to hit other residents. The Administrator was queried if was their expectation that the facility maintain an environment free of abuse and they indicated that it was. A facility policy titled Abuse and Neglect Policy (dated November 2017) documented in part Each resident has the right to be free from abuse, mistreatment, neglect . Abuse means the willfull infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Residents identified by staff as being self-injurious or exhibiting abusive behavior, which require professional services not provided in the facility, will be reviewed by the physician as soon as possible and treatment plans modified as appropriate .
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report allegations of abuse/neglect/mistreatment to the facility's Abuse Coordinator and State Agency in a timely manner for two (R#804 and R#812) of 16 residents reviewed for abuse, resulting in the potential for unidentified and/or continued abuse/neglect/mistreatment. Findings include: Resident #812 On 3/2/20 the medical record for R#812 was reviewed and revealed the following: R#812 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#812's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/4/19 revealed R#812 needed extensive assistance from facility staff with most of their activities of daily living. R#812's cognition was documented as severely impaired. On 3/3/20 at approximately 3:24 p.m., during a conversation with CNA A (Certified Nursing Assistant), CNA A reported on 2/22/20 they had been assisting another CNA (CNA B) with R#812 in R#812's room. CNA A indicated they observed CNA B pushing and pulling R#812's back very roughly multiple times to get them to lean forward while yelling at R#812 in an inappropriate manner. CNA A reported after they had finished assisting CNA B with R#812, they went to the afternoon supervisor (AS I) and told them that they had suspected abuse and AS I had directed them to write their statement on paper and give it to Nurse J. CNA A indicated they then wrote their statement down and gave it to nurse J. CNA A was queried if they had notified the facility Administrator (facility abuse coordinator) of their allegation and they indicated they did not and that it had slipped their mind. CNA A was queried if they felt their observation of CNA B was abusive and they indicated it was and that was why they decided to report it to AS I. CNA A then indicated on Monday [DATE], they had a meeting with the Administrator and the Director of Nursing regarding their allegation. CNA A reported that during the meeting, the Administrator had told them that the allegation was outside of the reporting window for the state and that it looked like CNA B had provided poor care but that it wasn't abuse. CNA A was queried when they were required to report allegations of abuse/neglect or mistreatment of [REDACTED]. On 3/3/20 at approximately 4:13 p.m., during a discussion with the facility Administrator, the Administrator indicated they were never made aware of CNA A's allegation until [DATE]. The Administrator indicated they did not report CNA A's allegations to the state agency and did not initiate an official investigation into the allegation. At that time a copy of the statement that CNA A had written on 2/22/20 was requested. On 3/3/20 at approximately 11:00 a.m., during a conversation with Nurse J, Nurse J was queried if CNA A had provided them with a written statement on 2/22/20 that contained CNA A's allegations and they indicated they had. Nurse J indicated that she was going to give the statement to AS I but they had already left for the day. Nurse J was queried if they had notified the facility's abuse coordinator regarding the allegations and they indicated they did not. Nurse J stated, Those things I don't want to deal with. That's for the management. There is no excuse, I failed in that area. Nurse J was queried what they did with the written statement from CNA A and they indicated that since AS I had already left for the day, they called AS I the next day and AS I told them to put it in the management office. On 3/3/20 at approximately 4:59 p.m., CNA A's statement dated 2/22/20 was reviewed and revealed the following: To whom it may concern, At aprox. (approximately) 6:00 PM on 2/22/2020, while putting (R#812) to bed, (CNA B) assisted in transferring the resident and I witnessed her pulling and being very rough as she pulled him forward various times and continued to be verbally aggressive and yelling. On 3/4/20 at approximately 4:30 p.m., The facility Administrator was queried if it was their expectation that facility staff report any allegations of abuse/neglect or mistreatment to them immediately and they indicated that it was. Resident #804 On 3/3/20 at 8:54 AM, R#804 was observed lying in bed on their back. A review of R#804's clinical record revealed R#804 was admitted into the facility on [DATE] with a readmission date of [DATE]. R#804 was admitted with [DIAGNOSES REDACTED]. On 3/3/20 at 3:16 PM, CNA A was interviewed and stated in part .CNA F (name redacted) told R#804, if you keep complaining about the water being cold. I'm gonna make it cold . I asked her if she was serious and she said No, I'm serious . When asked who they reported this incident to CNA A replied Unit Manager (UM) D name redacted. When asked when this incident occured CNA A stated about a week ago. On 3/4/20 at 10:34 AM, CNA F was queried on the incident involving R#804 and stated in part, .I said if it's cold were gonna make it cold . When asked if CNA A asked them if they were serious CNA F replied I told her absolutely . When asked if a supervisor, administration staff or anyone from the facility have talked to them about this incident CNA F replied No, no one has talked to me. On 3/4/20 at 3:25 PM, UM D was queried regarding the statement made by CNA F to R#804 and stated in part .I was not informed of this situation until after you guys got here .CNA A never informed me of that . On 3/4/20 at 3:48 PM, the Administrator (who serves as the facility's Abuse Coordinator) was queried on the above incident and stated in part . I debriefed CNA A and that's when I was informed of the statement CNA F made to R#804. I was not informed prior to debriefing CNA A. We are following up on it now . A facility policy titled Abuse and Neglect Policy (dated November 2017) documented in part Each resident has the right to be free from abuse, mistreatment, neglect, exploitation .Staff will report all allegations of abuse, neglect and misappropriation of property to the Administrator or designee immediately .The Administrator or designee is responsible for reporting to the State Agency all alleged violations involving abuse, neglect, exploitation or mistreatment .
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to thoroughly and timely investigate allegations of abuse/neglect/mistreatment and provide protection to the alleged victims from the alleged perpetrators for two (R#804 and R#812) of 16 residents reviewed for abuse, resulting in the potential for unidentified and/or continued abuse/neglect or mistreatment. Findings include: Resident #812 On 3/2/20 the medical record for R#812 was reviewed and revealed the following: R#812 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#812's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/4/19 revealed R#812 needed extensive assistance from facility staff with most of their activities of daily living. R#812's cognition was documented as severely impaired. On 3/3/20 at approximately 3:24 p.m., during a conversation with CNA A (Certified Nursing Assistant), CNA A reported on 2/22/20 they had been assisting another CNA (CNA B) with R#812 in R#812's room. CNA A indicated they observed CNA B pushing and pulling R#812 in the back very roughly multiple times to get them to lean forward while yelling at R#812 in an inappropriate manner. CNA A reported after they had finished assisting CNA B with R#812, they went to the afternoon supervisor (AS I) and told them that they had suspected abuse and AS I had directed them to write their statement on paper and give it to Nurse J. CNA A indicated they then wrote their statement down and gave it to nurse J. CNA A was queried if they had notified the facility Administrator (facility abuse coordinator) of their allegation and they indicated they did not and that it had slipped their mind. CNA A was queried if they felt their observation of CNA B was abusive and they indicated it was and that was why they decided to report it to AS I. CNA A then indicated that on Monday [DATE], they had a meeting with the Administrator and the Director of Nursing regarding their allegation. CNA A reported that during the meeting, the Administrator told had them that the allegation was outside of the reporting window for the state and that it looks like CNA B had provided poor care but that it wasn't abuse. CNA A was queried when they were required to report allegations of abuse/neglect or mistreatment of [REDACTED]. CNA A was queried if they had been contacted by the facility in

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) regards to any investigations into their allegation and they indicated they weren't contacted until the meeting on Monday [DATE]. On 3/3/20 at approximately 4:13 p.m., during a discussion with the facility Administrator, the Administrator indicated they were never made aware of CNA A's allegation until Monday [DATE]. The Administrator indicated that they did not report CNA A's allegation to the state agency and did not initiate an official investigation into the allegation. The Administrator was queried if any other residents had been interviewed regarding the care that they have received from CNA B and they indicated that none had been interviewed. The Administrator reported the only thing they did pertaining to any form of investigation into CNA A's allegation was that they had talked to the nurse management. On 3/3/20 at approximately 4:59 p.m., CNA A's statement dated 2/22/20 was reviewed and revealed the following: To whom it may concern, At aprox. (approximately) 6:00 PM on 2/22/2020, while putting (R#812) to bed, (CNA B) assisted in transferring the resident and I witnessed her pulling and being very rough as she pulled him forward various times and continued to be verbally aggressive and yelling. On 3/4/20 at approximately 3:07 p.m., CNA B was Interviewed regarding the allegation that they had yelled at and mistreated R#812. During the interview, CNA B was queried if the facility had spoken with them at all regarding any investigation pertaining to the allegation and they indicated the facility had called them that day (3/4/20) and informed them they had been suspended. CNA B was queried if they had worked in the facility at all after the allegation date of 2/22/20 and they reported that they had worked the next day. A review of the facility staffing assignments for 2/23/20 was completed and revealed CNA B was assigned to care for R#812 the day after the alleged allegation. Resident #804 A review of R#804's clinical record revealed R#804 was admitted into the facility on [DATE] with a readmission date of [DATE]. R#804 was admitted with [DIAGNOSES REDACTED]. On 3/3/20 at 8:54 AM, R#804 was observed lying in bed on their back. On 3/3/20 at 3:16 PM, CNA A was interviewed and stated in part .CNA F (name redacted) told R#804, if you keep complaining about the water being cold. I'm gonna make it cold .I asked her if she was serious and she said No, I'm serious . When asked who they reported this incident to, CNA A replied Unit Manager (UM) D name redacted. When asked when this incident occurred, CNA A stated about a week ago. On 3/4/20 at 10:34 AM, CNA F was queried on the allegation involving R#804 and stated in part, .I said if it's cold were gonna make it cold . When asked if CNA A asked them if they were serious CNA F replied I told her absolutely. When asked if a supervisor, administration staff or anyone from the facility talked to them about this incident CNA F replied No, no one has talked to me. On 3/4/20 at 3:25 PM, UM D was queried regarding the statement made by CNA F to R#804 and stated in part .I was not informed of this situation until after you guys got here .CNA A never informed me of that . When asked UM D stated the facility was currently looking into the incident. On 3/4/20 at 3:48 PM, the Administrator (who serves as the facility's Abuse Coordinator) was queried on the above allegation and stated in part .I debriefed CNA A and that's when I was informed of the statement CNA F made to R#804. I was not informed prior to debriefing CNA A. We are following up on it now . A facility policy titled Abuse and Neglect Policy (dated November 2017) documented in part Each resident has the right to be free from abuse, mistreatment, neglect, exploitation .The facility will train each employee regarding Abuse related policies .Facility supervisors will immediately correct and intervene in reported or identified situations .The facility Administrator or designee will oversee the investigation of an alleged abuse/neglect or misappropriation of resident property in accordance with state law .The facility will protect residents from harm during the investigation .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI 204 and MI 304 This citation has two deficient practice statements (DPS). DPS#1 Based on interview and record review the facility failed to ensure a safe environment and adequate supervision for one resident with hot liquids (R#806) of four residents reviewed for accidents, resulting in redness to the resident's left leg that required a topical antibiotic ointment treatment. Findings include: A review of R#806's clinical record revealed the following: R#806 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and required one-person assistance when eating. A facility Hot Beverage Assessment created on 10/7/19 and noted completed on 12/5/19 documented in part, .Dietary Department informed to provide hot beverages with supervision only . was checked off on the assessment. A Nursing progress note dated 12/8/19 at 11:35 PM documented in part, Resident in the dining room at dinner time. Staff was passing out food trays when resident spill (sic) her luke room (sic) coffee on herself, when the aid sat the tray in-front of her. Staff immediately pour (sic) ice water and removed resident clothing . An Unusual Occurrence Report dated 12/8/19 at 17:35 (5:35 PM) documented in part .Staff was placing food in front of resident who her (sic) lukewarm coffee spill (sic) on her .Intervention: Remove clothes pour ice water on them (sic) . A care plan titled Red Napkin (effective 12/9/19) documented in part, .Obtain thermal backing clothing protectors .Interventions- I will be identified at risk for spilling hot liquids with a red napkin on my tray or dining seat . A Hot Beverage - Red Napkin Protocol (dated July 10, 2019) documented in part, Purpose: To establish an internal process to identify residents at risk for potential burns/injuries related to hot beverage .Dietary - A red napkin will be provided to the resident for all meals and the meal ticket will indicate the red napkin program. The resident will be given hot beverage with staff supervision . A Hot Beverage Assessment created on 12/8/19 and completed on 12/9/19 documented in part, .Risk Factors - Part 1 .Impaired Cognition/Confusion/Dementia . Risk Factors Part 2: Question 1- Does the resident have any of the conditions listed above? Yes, Risk Factors - Part 2: Question 2- 2. If Yes, Does the condition put them at risk for accidents or injuries with the use of hot beverage? Yes, PROVIDE HOT BEVERAGES AND RED NAPKIN TO RESIDENT ONLY WITH SUPERVISION .Nursing Staff informed to provide supervision with hot beverages . A Nursing note dated 12/10/19 at 2:21 PM documented in part, .Pt. (patient) was sitting at dining room table and spilled soup on Lt. (left) mid leg and on floor Pt. stated oh no that's hot. Pt. assessed lt. leg has slight redness . A Unusual Occurrence Report dated 12/10/19 at 11:55 AM documented in part, .Oh no, that was hot. Pt. was sitting at dining room table and spilled soup on mid Lt leg and floor. Lt leg slightly reddened .Resident outcome: Burn (is circled) slight redness . A Nursing - Weekly Skin assessment dated [DATE] documented a circle on the medial part of left leg and documented slightly reddened . A DON (Director of Nursing) note dated 12/11/19 at 1:50 PM documented in part, . Small area noted on top of left thigh, measures 1.5cm x 1.5 cm circular, skin is intact, color is light pink edges with normal skin tone in the center. There is no redness, no blistering, no s/sx (signs and symptoms) pain, no inflammation or swelling, and no dry peeling skin present. There is no redness to resident's abdomen, right thigh and right and left hip . A Nursing - Weekly Skin Assessment created on 12/11/19 and completed on 12/12/19 documented a 1 on the left lateral side of chest/abdomen area and a 2 on the left lower thigh with a description as 1- slight redness and 2- redness. A Nursing note dated 12/12/19 at 6:17 AM documented in part, .resident has slightly reddened area on left lower thigh . A Nursing note dated 12/13/19 at 7:01 AM documented in part, .resident has slightly reddened area on left lower thigh . R#806's Treatment Administration Record (TAR) for December of 2019 was reviewed and revealed the following: Start Date: 12/11/19 at 2:21 PM, Silver [MEDICATION NAME] 1% topical cream, apply by topical route once daily thin layer, Cleanse left medial thigh with n/s (normal saline), and pat dry and apply thin layer of Silver [MEDICATION NAME] cream. The cream was started three days later on 12/14/19. The cream was also documented as given on the following dates: December 15, 16, 17, 18, 19, 20, 24, 25, 26, and 12/30/19. On 3/4/20 at 11:16 AM, the DON was queried on the facility's Red Napkin program and the lack of supervision provided to R#806 when handling hot liquids. The DON explained that the staff in the dining room had added knowledge to keep residents with a red napkin in sight. The DON was then asked about R#806's red napkin care plan intervention that noted PROVIDE HOT BEVERAGES AND RED NAPKIN TO RESIDENT ONLY WITH SUPERVISION .Nursing Staff informed to provide supervision with hot beverages and why additional supervision wasn't provided to R#806 to prevent their hot soup from spilling on them? The DON explained that the staff got to the resident immediately after it spilled. The DON was then asked what was the goal of the facility's Red Napkin program if not to prevent or add additional supervision to resident's with impaired cognition, confusion or Dementia/Alzheimer's from spilling hot liquids on themselves? The DON acknowledged that the Red Napkin program was going into review with the facility's Quality Assurance and Performance Improvement (QAPI) program. The DON was asked to provide a facility policy for non-pressure skin changes/conditions and provided a Skin Management Facility Guidelines policy. A Policy titled Skin Management Facility Guidelines (Revision Date: December 2017) was reviewed and contained no relevant information to the above deficient practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) DPS #2 Based on observation, interview and record review the facility failed to ensure a resident was safely repositioned in their bed while providing care for one resident (R#802) of four residents reviewed for accidents, resulting in R#802 sustaining pain in their left thumb. Findings include: On 3/2/20 at approximately 3:53 p.m., R#802 was observed in their room up in their wheelchair. R#802 was queried if they had any concerns about care in the facility regarding their left thumb. R#802 indicated they had an incident in which they had been changed by someone (they didn't know who) and while they were being rolled over, they had smashed their thumb on the side rail. R#802 stated, I think they did it too fast. it was a long time ago. On 3/2/20, the clinical record for R#802 was reviewed and revealed the following: R#802 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#802's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/5/19 revealed R#802 needed extensive assistance from facility staff with most of their activities of daily living including bed mobility. R#802's BIMS score (brief interview of mental status) was 15 indicating intact cognition. A review of R#802's careplan revealed the following: I'm a (R#802 demographics) readmitted to (name of nursing facility) following a hospital stay for which I was admitted for Gastroparesis,[MEDICAL CONDITION](stroke), weakness. My PMH (previous medical history) includes: obesity, HLD ([MEDICAL CONDITION]), hypertensive [MEDICAL CONDITION], DM (Diabetes), NSTEMI ([MEDICAL CONDITION]). I'm alert and oriented and able to make my needs known. I have a chest incision d/t (due/to) recent loop recorder insertion. I'm here to receive PT/OT (Physical Therapy/Occupational Therapy). I currently require ext (extensive) to total assist x2p (times two people) assist for most adls (activities of daily living). I'm non-ambulatory status and transfer via hoyer lift w/2 staff assist. Extensive to total assist and a wheelchair for locomotion pushed by staff as needed. Episodes of bowel and bladder incontinence .Goals-Measures will be implemented to help promote my participation with ADL and therapy .Interventions-Assist me with turning and repositioning as I am able to tolerate .Provide me with physical assistance for toileting upon rising, . during bed check and as needed. Assist me with my Peri (genital area) care after incontinence and as needed .Provide me assistance for ADL, bathing, toileting, dressing, transferring, grooming, hygiene as needed . A nursing note dated 10/13/19 revealed the following: Resident informed writer of left radiating hand pain. Resident also stated that her hand was smashed while receiving care from night shift nurse assistant. Writer notified MD (Medical Doctor), Administrator and DON (Director of Nursing) .Ice applied to affected area. Tylenol given and was ordered PRN (as needed) . A nursing note dated 10/14/19 revealed the following: Spoke with client in regards to accident/incident. She claims that her hand was pushed against the guard rail during her cleaning/change, and that it was non intentional . An IDT note (interdisciplinary team) dated 10/15/19 revealed the following: IDT reviewed .Staff re-educated on safe extremity positioning when turning resident. An Unusual Occurrence Report for R#802 with an incident date of 10/13/19 revealed the following: Describe the incident based in resident's own words or what the first responder observed: Resident stated her thumb (L) (left) hurt and she believes it happen <sic> during the night shift (10/12/19) when she was being changed her hand was smashed .Intervention-Tylenol given .ice to area .Physician statement-Stat X-ray, Tylenol PRN Q (every) six hours. Ice to affected .Continue to monitor .What did you do to try to prevent the incident from happening again?-Remove assigned caregiver. Continue to follow care plan. Resident requires two person assist at all time. Educated caregivers on following care plan. Re-educate staff on safe repositioning resident and bed mobility, proper placement of extremities during repositioning .IDT: Resident [MEDICAL CONDITION](stroke) left side weakness, Lt (left) hand was not positioned correctly and was bumped into handrail. Staff re-educated on safe repositioning and bed mobility of resident . On 3/3/20 at 11:14 a.m., during a conversation with the Assistant Director of Nursing (ADON), the ADON was queried regarding the Facility Reported Incident including the Unusual Occurrence Report for 10/13/19 for R#802. The ADON indicated that Certified Nursing Assistant (CNA L) did not position R#802 correctly in the bed when providing care. They indicated that CNA L was not cognizant of R#802's left side weakness due to their stroke when they rolled them during care and as a result R#802 got their thumb caught in between the bed and the enabler bar. The ADON indicated that CNA L should have had R#802's arms crossed up over their chest instead of down next to them in the bed when rolling. The ADON further indicated that CNA L had to be re-educated on safe positioning when providing care. A copy of CNA L 's education was requested but not received by the end of the survey. A facility documented titled Turning a Dependent Resident Towards You (last reviewed 8/2011) revealed the following: Purpose-To reposition a resident for comfort or optimal skin care while maintaining good body alignment .Procedure l. Wash your hands. 2. Identify the resident, provide privacy, and explain the procedure. 3. Raise the bed to a comfortable height for working. 4. Be sure the bed is flat and the wheels are locked. 5. Cross the resident's arms over the chest. Cross the leg farthest from you over the leg nearest to you, unless contraindicated. Use abduction pillow as necessary. 6. Reach over the resident, supporting the resident behind the shoulder with one hand and behind the hip with the other. Using good body mechanics roll the resident gently and smoothly toward you. 7. Bend the resident's upper knee and hip forward slightly to a position of comfort. Place a pillow against the resident's back for support, if the position will be maintained. Pillows may also be placed under the top leg and under the top hand and arm. 8. Readjust the pillow under the resident's head. 9. Check for proper body alignment and comfort. If further adjustment is needed, raise the side rail, go to the opposite side of the bed, and place your hands under the resident's shoulders or hips. Adjust as needed to maintain a side-Lying position comfortably .