STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235354	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRACE HEALTHCARE OF THREE RIVERS	55378 WILBUR RD THREE RIVERS, MI 49093

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 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 MI 025, MI 381 and MI 387. Based on observation, interview and record review, the facility failed to immediately report allegations of abuse for five (Resident #1, #2, #3, #4, #5) of 13 residents reviewed for abuse, resulting in allegations of abuse that were not reported to the State Agency timely and the potential for further allegations of abuse to go unreported and without thorough investigation. Findings include: Review of the medical record reflected that Resident #1 (R1) was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/3/2020 reflected that R1 scored seven out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 7/23/2020 at 12:23 PM, R1 was observed awake in bed with a lunch tray on the over-bed table, in front of her. R1 reported she was doing good and everyone was treating her fine. R1 denied any problems or concerns with how she had been treated by others. Review of the medical record reflected that Resident #2 (R2) was admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. R2's medical record reflected they passed away on 4/13/2020. Review of a facility investigation reflected that on 1/24/2020 at 8:40 AM, R2 was overheard asking R1 for a hug. When the Certified Nurse Aide (CNA) (CNA H) got up from their chair and turned around, they observed R2 with their left arm placed on R1's upper back and R2's right hand on R1's left breast. The residents were immediately separated. R1 returned to their room for an assessment, and R2 was placed on one to one supervision. The facility investigation reflected that Nursing Home Administrator (NHA) A was notified of the event on 1/24/2020 at approximately 8:45 AM. Further review of the facility investigation file reflected that NHA A reported the allegation to the State Agency on 1/24/2020 at 11:32 AM, which was more than two hours after the alleged event occurred. During a phone interview on 7/29/2020 at 1:21 PM, NHA A was asked when he reported (abuse allegations) to the State Agency. NHA A stated that he reported within two hours. When asked if he could identify what time he reported the allegation for R1 and R2 to the State Agency, NHA A reported that his confirmation reflected 11:32 AM. He stated he did not know why it wasn't completed (reported) within the two hours. Review of the medical record reflected that Resident #3 (R3) was admitted to the facility on [DATE] and was readmitted [DATE], with [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 5/13/2020 reflected that R3 had short-term and long-term memory impairments. R3's medical record reflected they passed away on 6/25/2020. Review of the medical record reflected that Resident #4 (R4) was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 6/5/2020 reflected that R4 scored one out of 15 (severe cognitive impairment) on the BIMS. On 7/28/2020 at 1:49 PM, R4 was observed lying in bed with their eyes closed. R4 did not open their eyes or respond when spoken to and was heard intermittently snoring. Review of a facility investigation reflected that on 2/1/2020 at 3:10 PM, R4 was walking in the hallway, and while passing R3's room, R3 came to the doorway. R4 was startled and raised their hand in a defensive manner. R3 slapped R4 twice, then there was an exchange of slaps, resulting in R3 pushing R4. R4 fell to the floor and struck their head and shoulder on a doorway. R4 sustained injuries of a laceration to the back of the head and a fracture involving the distal clavicle, without displacement. The facility investigation file reflected that the incident was witnessed by Registered Nurse (RN) I. The facility investigation file reflected that the incident occurred on 2/1/2020 at 3:10 PM and was discovered on 2/1/2020 at 3:35 PM. The facility investigation file reflected that the incident was submitted to the State Agency on 2/1/2020 at 5:40 PM, which was more than two hours after the incident occurred. During a phone interview on 7/29/2020 at 1:21 PM, NHA A was asked when he reported (abuse allegations) to the State Agency. NHA A stated that he reported within two hours. When asked when he was notified of the incident between R3 and R4, NHA A stated that he always used the time he was informed as the discover time, which was 3:35 PM, according to NHA A. NHA A stated that he reported the incident to the State Agency at 5:40 PM on 2/1/2020. Review of the medical record reflected that Resident #5 (R5) was admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 12/5/19 reflected that R5 had short-term and long-term memory impairments. The medical record reflected that R5 passed away on 2/29/2020. Review of a facility investigation reflected that on 2/13/2020 at approximately 7:45 AM, the CNA woke R5 and observed dried blood on R5's lips and a bruise on R5's chin. The nurse assessed R5 and noted a 2 centimeter square bruise to the front of R5's chin and a split to the inside center of R5's lower lip. The investigation reflected that the incident was discovered on 2/13/2020 at 8:30 AM and was reported to the State Agency on 2/13/2020 at 10:42 AM, which was more than two hours after R5's injuries of unknown origin were noted. During a phone interview on 7/29/2020 at 1:21 PM, NHA A was asked when he reported (abuse allegations) to the State Agency. NHA A stated that he reported within two hours. NHA A stated that he was not sure where the time of 8:30 AM came from for the discovery of the incident. NHA A stated the time on the incident report reflected 7:10 AM, but the CNA statement reflected they woke R5 at 7:45 AM (when the injuries were observed). NHA A confirmed that he reported to the State Agency at 10:42 AM on 2/13/2020. Review of the facility policy titled, Abuse Prevention Policy & Procedure, with a revision date of 1/23/17, reflected, .Report all allegations of abuse immediately to the Director of Nursing and the Administrator .Any allegation of abuse is reported immediately to the state agency and to all other agencies as required, per state and federal guidelines .Immediately means as soon as possible, but should not exceed 24 hours after the discovery of the incident, in absence of a shorter state timeframe requirement. Refer to State, Federal and Elder Justice Act guidelines. Reporting must occur within 2 hours for incidents resulting in an injury and no longer than 24 hours for non-injury incidents .

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.