STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235529	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MANOR OF NOVI	24500 MEADOWBROOK RD NOVI, MI 48375

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** - Few	**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 #MI 556 Based on interview and record review, the facility failed to ensure an environment free from abuse for two of three residents reviewed for abuse/neglect, resulting in R#909 being struck in the face by R#908. Findings include: R#908 On 7/30/20 the medical record for R#908 was reviewed and revealed the following: R#908 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#908's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/24/20 revealed R#908 needed extensive assistance from facility staff with most of their activities of daily living. R#908's BIMS score (brief interview of mental status) was three indicating severe cognitive impairment. A nursing progress note dated 10/21/19 revealed the following: Res (resident) received up in w/c (wheelchair) in hallway, res observed to be restless and anxious, scheduled [MEDICATION NAME] given as ordered. Res observed in dinning room still anxious attempting to leave dining room before meal was served. Writer able to redirect and calm res, Resident ate 70% of meal and upon returning from dining room res observed in hallway, writer at med cart and heard arguing between (R#908) and another res, as writer walking towards to separate them other res observed slapping (R#908) across her face knocking her glasses off. Res separated . An incident and accident report for R#908 dated 10/21/19 revealed the following: Describe the nature of the accident/incident and if injuries sustained, location of injuries: Writer observed resident being slapped across the face by another resident .Interventions Implemented-Residents separated . A review of R#908's careplan revealed the following: (R#908) has dx (diagnosis) major [MEDICAL CONDITION], adjustment disorder and dementia,. She receives anti-depressant, anti-anxiety and an anti-dementia med. She exhibits periods of verbal agitation, outbursts and irritability towards others . R#909 On 7/30/20 the medical record for R#909 was reviewed and revealed the following: R#909 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#909's MDS with an ARD of 6/9/20 revealed R#909 needed extensive assistance from facility staff with most of their activities of daily living. A nursing note dated 10/21/19 revealed the following: Resident up for meals and meds with no acute distress observed. Upon returning from dining room res observed coming out of her room into hallway. Writer at med cart and arguing between (R#909) and another res, writer attempting to walk to residents to separate them, as walking towards them (R#909) observed slapping resident across her face, knocking res glasses off. Res stated she spit on me, I am not taking that. Residents separated and redirected . An Incident and accident report dated 10/21/19 revealed the following: Describe the nature of the accident/incident and if injuries sustained, location of injuries: Writer heard a commotion between two residents. As writer walking towards residents. (R#909) was observed slapping other resident. Res stated, 'she spit on me, I'm not taking it anymore.' . On 7/30/20 a review of the facility investigation pertaining to the altercation between R#908 and R#909 on 10/21/19 was reviewed and revealed the following: On 10/21/19, at approximately 7:30 PM, Charge nurse heard a commotion between the two above mentioned residents. As the nurse began walking towards the residents, (R#908) was observed slapping the other resident (R#909) .Charge nurse interviewed (R#908) who is alert and oriented X3 (person, place and time) regarding the incident and the resident stated, 'she spit on me and I am not taking it.' .Unit Manager spoke with resident (R#908) regarding this incident. Resident (R#908) stated, 'I was going to get a gown and the lady, referring to (R#909), was coming towards me. I could not get by, she gave me a nasty look and spit on my arm so I hit her.' I do not just hit people for no reason, when she spit on me that did it. The resident also said, 'I should have overlooked the spit but that just did it for me. On 7/30/20 at approximately 1:09 PM, during a conversation with the facility Administrator, the Administrator was queried regarding the incident between R#908 and R#909 on 10/21/19. The Administrator indicated that R#908 did come down to their office to talk to them about it. The Administrator indicated that R#908 was worried about getting kicked out. The Administrator indicated that R#908 is alert and able to make her needs known and that they hit R#909 because they thought R#909 spit on them. On 7/30/20 a facility document titled Abuse Policy (07/2018) was reviewed and revealed the following: Each resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat the resident's medical symptoms .To assure residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the residents Staff members, volunteers, family members, and others should be encouraged to report incidents of abuse and suspected abuse, and should be assured that they will be protected against repercussions. Abuse can be resident-to-resident, staff-to-resident, family-to-resident, visitor-to- resident, etc .

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.