STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235555	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANTERBURY ON THE LAKE	**5601 HATCHERY RD WATERFORD, MI 48329**

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** Based on observation, interview and record review, the facility failed to ensure a resident was free from verbal abuse by a facility employee for one (R704) of eleven residents reviewed for abuse, resulting in the resident being told to shut up by a facility employee. Findings include: The facility reported the following to the State Agency: .Date/Time Incident Discovered: 3/4/2020 11:15 AM .Incident Summary: Resident, (R704), was in an activity and stated to an Activity staff that she did not like the CNA (Certified Nursing Assistant) staff member that walked by because she was mean to her. When questioned, resident (R704) stated it was because had (sic) told her to shut up . Investigation Summary/Actions Taken: .The investigation into the allegation of abuse was inconclusive however due to the cognitive status of resident (R704), the employee was terminated. Resident (R704) was able to pick this CNA out of a line up of pictures and her story never changed. This particular CNA also had a previous corrective action for inappropriate behavior. It was due to that corrective action, resident (R704) positive identification of the CNA, and this CNA's behavior during the investigation that this employee was terminated . On 7/21/20 - 7/23/20, an unannounced, onsite investigation was conducted. On 7/22/20 at 10:38 AM, R704 was observed in their room, lying in bed. When questioned about the incident with CNA 'B', R704 remembered the incident and explained they had not seen CNA 'B' since it happened and did not think CNA 'B' worked at the facility any more. Review of the clinical record revealed R704 was admitted into the facility 9/11/19 with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R704 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) exam, indicating intact cognition. The MDS assessment also indicated R704 required the assistance of staff for all Activities of Daily Living (ADL's). Review of the facility's investigation revealed, .An interview with the alleged perpetrator, (CNA 'B') was completed. She denied all allegations and stated adamantly that she has never cared for resident (R704). This was verified reviewing assignment sheets and staffing sheets however she was assigned to the same floor and because of the dining room staffing overlap and coverage for breaks, contact with resident (R704) cannot be ruled out. The resident, (R704) was also interviewed and was also adamant that this particular CNA, did tell her to shut up . Review of a Corrective Action Notice dated 11/27/19 revealed CNA 'B' received a 'Verbal Warning' for, Being disruptive on the floor in the presence of staff and residents . Review of a Personnel Action Form dated 3/10/20 revealed CNA 'B' was suspended from 3/4/20 - 3/10/20 and was terminated 3/10/20 for Resident complaint of poor care & hospitality. On 7/22/20 at 2:42 PM, an interview was conducted and the Administrator was queried about CNA 'B'. The Administrator explained CNA 'B' had received discipline previous to the incident with R704 and CNA 'B' had a difficult attitude. The Administrator was asked why CNA 'B' had been terminated. The Administrator explained they felt there was smoke (referencing the phrase, Where there's smoke, there's fire) and they concluded CNA 'B' did tell R704 to shut up. Review of an undated Abuse Policy provided by the facility read in part, .Verbal Abuse: defined as use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families or within their hearing distance to describe residents regardless of their age, ability to comprehend, or disability . For substantiated cases of abuse, neglect, mistreatment, or misappropriation, corrective action shall be taken and documented. Any employee shall be subject to immediate termination if the employee is the perpetrator .
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 investigate two allegations, one allegation of attempted rape and another regarding multiple bruising of unknown origin for two (R#'s 708 and 711) of eleven residents reviewed for abuse, resulting in a thorough investigation to not have been done and the potential for further unidentified physical and sexual abuse to occur, Findings Include: R# 708 On 7/22/20 at 1:27 PM, an observation was made of R# 708 sitting up in bed and watching television. A review of the facility's Event Report form dated 3/13/20 at 9:50 PM, documented in part . Nurse went into resident's room to give her 9:00 PM medication, the call light was on, I asked whether she needs help, she said a young guy wanted to rape her . A Nursing Note dated 3/14/20 at 8:05 am, documented in part . when writer got to resident's room at 5:50 PM for her medications her call light was on, writer asked resident whether she needs some help, and she said Yes, she put <sic> light because a young guy came to her room to rape her, writer asked the resident to repeat herself, she said a young guy came to her room to rape her and he was holding some tissue in his hand and he wanted to touch her she screamed and held the guys hands and asked him to leave her so the guy stock the tissue in her private area . a skin assessment was done and some paper napkin were inside in front of her private area with the brief on, she also had a skin tear at the right elbow . she also has some reddish area at the inner groin . A review of the clinical record revealed R# 708 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12 out of 15 (indicating intact cognition) and was dependent on staff for all Activities of Daily Living (ADL's). The Event Report form dated 3/13/20 at 9:50 PM, documented in part . Root Cause Determination by Charge Nurse at the time of the event: Investigation pending. Resident was sleeping. Resident was confused as staff member came up to her while she was sleeping, Normally goes to bed at 7 PM, resident was wet and needed changed . 3/13/2020 . Investigation Summary: Resident normally goes to bed at 7 PM, per family resident <sic> private person & would not understand a male coming into change her. Staff member did not try to rape her trying to clean her up prior to bed. Care plan updated to no male caregivers. Lay her down around 7 PM and education given to staff . (signed by the Director of Nursing- DON) 3/23/2020 . A statement taken from the nurse (that had R# 708 on the night of the allegation 3/13/20) documented in part . writer asked her about the call light whether she needs something, she said No, she said a young guy came into her room and wanted to rape her, he tried to take off her cloth <sic>. I asked her to repeat herself and she said, yes he wanted to rape her, and he took her clothes and put them in a plastic bag. She asked me, who was the young guy who work the day shift said I don't' know, then she said you don't know your workers. So, I'm reporting because I don't want to conclude that she is confused. She look okay. (no date or time was documented on the statement provided by the facility.) A statement taken from Certified Nursing Assistant (CNA) A (the staff member that was accused of attempted rape) dated 3/13/20 (no time) documented in part . and told her she is soiled and I'm going to change her into a new clean one. I unfastned <sic> the brief and she said, your trying to rape me. I told her that is disgusting and she can stay in her old brief that is soiled. She said no she'll change. I asked her to roll to the wall cleaned her backside then asked her to roll towards me and finished. Gave her the call light and overbed table, asked her if she needed anything; she replied no and I left . A facility Inservice Topic form (no date or time) documented in part . if at anytime a resident voice any concerns with care, stop care immediately and report to charge nurse . the form was signed by CNA A. A police report dated 3/13/20 at 23:54 (11:54 PM) documented in part, . (Nurse name redacted)

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) then conducted a skin assessment which she does on all of the residents to check if there are any injuries or other problems with the skin. (Nurse name redacted) said that R# 708 had a bowel movement and had urinated in her underwear. (Nurse name redacted) said she cleaned R# 708 and changed her underwear. While doing this (Nurse name redacted) found the paper towel that was in R# 708's underwear. She placed the urine-soaked towel inside a latex glove to save for evidence. (Nurse name redacted) said that R# 708 was very confused during their conversation (which contradicted the nurse statement given to the facility upon their investigation). (Nurse name redacted) saw a small skin tear on the right elbow of R# 708 that appeared to be fresh . A care plan titled R# 708 voiced negative outcome in regard to male care giver behavior (no start date) documented in part . will feel comfortable with staff providing care . Explain all care to (R# 708) to her level of understanding . Two staff in (R# 708's) room while providing care . Female caregivers only . On 7/22/20 at 2:30 PM, the Administrator and DON were both queried on why the allegation was concluded as unsubstantiated when there was no thorough follow up on the paper towel/napkin left in the residents brief and the reddish area found by the groin area on the night of the incident and neither the Administrator or DON could provide an explanation. Both were then asked if cleaning a resident with a paper towel or napkin was normal procedure at the facility and stated No. The Administrator confirmed that CNA A was terminated two weeks after this allegation for an incident of improper care regarding another resident. R# 711 On 7/22/20 at 1:38 PM, an observation was made of R# 711 sitting in a high built up wheelchair at a table in the common area with a lunch plate in front of them. The resident was observed with their eyes closed; verbal stimuli was attempted however did not awake the resident. A bump (dime size) noted above the right eyebrow, with a quarter size discoloration of dark purple (in the center) and green and yellow (outer discoloration) from the right corner of the eye, temple and extending to the hairline. At that time CNA L was queried on how the resident obtained the facial bruising and stated, I don't know. A Investigation Summary submitted to the State Agency by the Administrator documented in part . found to have bruise on her eye and later another bruise was discovered on her chest . Therapy was asked to re-evaluate her transfer status and determined that the bruises may have been caused by transfer equipment due to her [DIAGNOSES REDACTED]. At this time, the investigation found the bruising to be related to a decline in (R# 711) physical abilities which impacted her ability to transfer. Her transfer status has been changed to a hoyer lift and a discontinuation of her aspirin. Her Broda chair has been reinstated for safety and comfort . A review of the clinical records revealed the following: R# 711 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE] revealed the resident was unable to complete the interview to determine the cognition level and was dependent on staff for all ADL's. A facility Event Report form dated 7/13/20 at 8 PM, documented in part CNA observed bruise to resident's right eye during toilet . Bruise greenish/purple/blue 1.5 x 2.5 and breast 5 x 6.5 . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Investigate . Meds that could cause bruising/bleed: ASA (aspirin) . Root ?Cause Determination by Charge Nurse at the time of the event: Resident has history of fidgeting around in chair and leaning to her side and pressing against the wall, table, or the upper part of the w/c (wheelchair) head rest, when she's agitated and uncomfortable. By during <sic> so pt's (patients) bruises very easily. She's on ASA (aspirin) and [MEDICATION NAME] which also makes her prone to bruising. Along with a dx's (diagnoses) of abnormal involuntary movements . date 7/13/20 . Resident was not in her normal chair . was out for repair which decreases injuries resident becomes fidgety & bruises easily, between the transfers, different chair & behaviors bruises are the result of her behaviors & increased risk of bruising due to aspirin use. Transfer status changed new (wheelchair) given to resident & medication discontinued . date 7/20/20. A Nursing Note dated 7/14/20 at 8:31 am, documented in part . CENA (Certified Nursing Assistant) toilet resident and observed a bruise to the right upper eyelid . brought resident to the table and asked if anyone had told this writer about it. There was no notation of it written or spoken to this here writer . Resident is day 1 for greenish, purple blue color bruise to the right upper eyelid and left breast . It is the size of a silver dollar . A Nursing Note dated 7/14/20 at 20:27 (8:27 PM) documented in part, .Bruise has spread from right outer eye to her brow and temple, bruise left breast . A Nursing Note dated 7/19/20 at 4:30 am documented in part, . Resident day <sic> for bruise to right eyelid that has spread and the outer side is a deep purple now . Right breast bruise fading. The facility's weekly skin assessments were reviewed and revealed the following: A Visual Skin Evaluation form dated 7/8/20 at 22:28 (10:28 PM) documented a bruise to the lower and upper Left Right extremities and a reddened area to the medial sacrum. The comment section documented Ongoing discoloration/pupura's (red or purple discolored spots on the skin) from pt fidgeting around in chair. Pillow to be applied when sitting at table at nursing station . This weekly assessment was completed five days prior to the identification of the reported 7/13/20 bruising. Staff Interview Statements provided by the Administrator were reviewed and revealed interviews from one staff member who worked on 7/8/20, one staff member who worked on 7/9 and 7/10/20, one staff member who worked on 7/12/20 and the remaining staff members who had worked on 7/13/20 and 7/14/20. This revealed that not all staff members involved in R# 711's care from 7/8/20 until 7/13/20 were interviewed. A staff statement from CNA J dated 7/14/20 (no time) documented in part, On Monday July 13, 2020 I was on my lunch break and CENA (name redacted) along with (infection control nurse) were testing the resident on 3rd floor. (Infection control nurse name redacted) notice (R# 711) has a bruise above her right eye. I had (R# 711) on July 9, 10th no bruises were there. A staff statement from CNA I dated 7/14/20 (no time) documented in part, On Monday July 13th, 2020 R#711 in (room number redacted) was observed with a new bruise on her right temple by her eye. I was asked by (staff member name redacted) if I had seen it before. I had not. A staff statement from CNA H dated 7/14/20 (no time) documented in part, On 7/13/20 while toileting and changing (R# 711) I observed a small bruise above the right eye. I immediately informed the nurse (name redacted). When I previously took care of (R# 711) on Friday July 10th there had been no bruise there . A staff statement from CNA K dated 7/14/20 (no time) documented in part, On 7-13 I was assisting (infection control nurse name redacted) with testing the residents for COVID when (infection control nurse) notice the resident (R# 711) had <sic> bruise over her right eye. (infection control nurse name redacted) asked me if I knew what happened to her eye. I told her no. A staff statement from Licensed Practical Nurse (LPN) G documented in part, . last day of work last week was Thursday night 7p-7a shift on 7/9/2020. (R# 711 room number and name redacted) has a shower on that Wednesday 7/8/2020 which is noted and shower sheet completed. Yesterday on July 13, 2020 was my first day back and I end up doing an incident report on a bruise that was observed hours before my shift started. On 7/22/20 at 2:15 PM, the Administrator and DON was queried on the actual date and by whom R# 711's bruises were discovered and why it wasn't initially reported when it was found, the DON stated in part . myself and (infection control nurse name redacted) noted a bruise and they (staff) said it was old, so we thought it was reported. A nurse then reported it later in the day . The Administrator and DON was then queried how the facial bruising and bump cause was concluded as being caused by a transfer and abnormal body movements if no staff member had ever reported an issue, fall or the resident hitting their head while transferring the resident. The Administrator stated in part . No one can tell me . No CNA ever stated that she hit her head . The DON then stated in part . She is fidgety on transfers . A facility policy titled Incidents & Accidents- Investigating and Reporting (dated: 8/1/19) documented in part . All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator . The Charge Nurse or supervisor shall promptly initiate and document investigation of the accident or incident . A facility Abuse policy (no date) documented in part . The facility will identify, correct, and intervene in situations in which abuse, neglect, mistreatment . is more likely to occur. The facility will conduct an analysis of suspicious bruising, injuries . and shall investigate all occurrences for patterns and trends that may constitute abuse. This will determine the direction of the investigation . The facility will identify and investigate all situations or incidents in which a resident may have suffered abuse including physical or other harm for reasons which are unknown, unclear, or not adequately explained. The facility shall use the investigation guide and algorithm provided by Licensing and Regulatory Affairs . Interview and/or obtain a statement(s) from potential witnesses as determined by the scope of the investigation . Conduct a root cause analysis .
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to consistently investigate the root cause analysis of falls and implement/modify interventions to prevent further falls for two (R#'s 702 and 705) of three residents reviewed for falls, resulting in unknown causes of repetitive falls, care plan interventions not modified to prevent further falls and R# 705 to have sustain a left femoral neck fracture requiring hospitalization and left hip hemiarthroplasty (a

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) surgical procedure that replaces one half of the hip joint with a prosthetic). Findings include: R# 702 A facility reported incident dated 2/18/20 at 10:38 am, documented in part . found to have a bruise on face, sacrum and right leg. Investigation initiated . A review of the clinical record revealed R# 702 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6 out of 15 (indicating severely impaired cognition) and was dependent on staff for all Activities of Daily Living (ADL's). A facility Event Report form dated 2/17/20 at 8:05 am documented in part, . CNA (Certified Nursing Assistant) notice pt (patient) had a bruise to her left lower cheek as she was sitting at the dining room table. When pt was asked about how she got the bruise resident stated, I don't know. When asked if it hurted <sic> when touched/pressed pt stated, no. When asked by unit manager pt stated, I fell and crawled to the chair. . bruise greenish purple around purple/red area size of a quarter 2 x 2 cm (centimeters) . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Resident is no <sic> compliance with asking for assistance and does everything for herself. Door is always open when resident is in room . Root Cause Determination by Charge Nurse at the time of the event: It's possible she could have caused irritation and bruising by picking and pulling out her facial hairs. Pt also taking ASA (aspirin), which makes her prone for bruising . The Investigation Summary was not completed and left blank on this form. A fall risk assessment dated [DATE] at 13:21 (1:21 pm) documented a total fall risk score of 80, indicating High Risk which then directs the staff to Implement High Risk Fall Prevention Intervention. A Radiology Report dated 2/17/20 at 2:47 pm, documented in part . Reason for Exam: swelling bruising on right side of face . Conclusion: Unremarkable facial bones . A facility Even Report form dated 2/17/20 at 16:00 (4 pm) documented in part, . Resident said she fell but doesn't know when. CNA showered the resident and additional bruises were observed 2 dark purple bruises- 6cm x 6cm on her R (right) left and one same description on the sacrum . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Son encouraged his mother to not ambulate without supervision . Root Cause Determination by Charge Nurse at the time of the event: See original incident report . The Investigation Summary was not completed and left blank on this form. On 7/22/20 at 9:55 am, R# 702's reports on falls were requested from the Administrator for review. The Administrator provided the following: On 11/23/19 at 4:25 pm, an Event Report form documented in part . Resident was ambulating in hallway pushing w/c (wheelchair) resident was standing in front of patio window stepped to the side + lost her balance fell to her knees then over onto her right side resting on her right arm . c/o (complaints of) mild discomfort (R) (right) thigh . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Referred to therapy, staff to continue to redirect resident to use her walker for ambulation around and not push w/c . Root Cause Determination by Charge Nurse at the time of the event: Resident has poor safety awareness has a hx (history) of noncompliance with using walker and w/c . The Investigation Summary was not completed and left blank on this form. On 12/22/19 at 2:30 pm, an Event Report form documented in part . Resident stated she fell in her room when CENA (Certified Nursing Assistant) asked her why she was breathing to <sic> hard, Resident reported to this writer she was walking in her room and lost her footing and fell next to the bed . Resident stated she was having some discomfort in her (L) (left) hip . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Door of room (room number redacted) was left open while resident was in room. Refer to therapy . . Root Cause Determination by Charge Nurse at the time of the event: Resident has poor safety awareness, has a hx of noncompliance with use of w/c and walker. Resident is non-compliant with using call light/ or asking for assistance . The Investigation Summary was not completed and left blank on this form. On 1/17/20 at 11:30 pm, an Event Report form documented in part . Resident was cleaning/organizing her closet and states she fell on her bottom out of her w/c . Res (resident) was observed sitting on the floor in her room, on her buttocks with feet/legs in front of her, and w/c directly behind her . small ping pong sized <sic> red blanchable area on the back of the upper L (left) thigh . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Put resident's items back where she wanted them, assisted her to the toilet, and back to bed. Door left open . Root Cause Determination by Charge Nurse at the time of the event: Poor safety awareness. Non-compliant with safety interventions that are in place . The Investigation Summary was not completed and left blank on this form. On 2/23/20 at 10:50 pm, an Event Report form documented in part . Resident states she was trying to go to the bathroom with her w/c & fell off of the bed . observed resident sitting on the floor with bedside, on buttocks, back against the bed with w/c out in front of her . Red/pink blanchable area to L shoulder blade area where resident was leaning against bed . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Assisted resident to bed, placed w/c next to bed, locked, positioned call light where resident requested- asked resident to demonstrate call light use & asked her to please use it. Room door left open . Root Cause Determination by Charge Nurse at the time of the event: Resident has poor safety awareness & continues to use her w/c as a walker regardless of frequent reminders & instructions . The Investigation Summary was not completed and left blank on this form. On 2/25/20 at 10:20 am, an Event Report form documented in part . Resident observed by staff sitting on the floor resting against restroom door frame, bathroom door was closed, w/c facing resident . resident bruised from previous falls . Restorative exchanged w/c for a lower and shorter w/c seating, dyson applied to cushion, current cushion changed to wedge cushion. Bathroom alarm, and N.O. (new orders) received for labs . resident is not to be in room by herself unless in bed . Root Cause Determination by Charge Nurse at the time of the event: Resident has a hx (history) of poor safety awareness and not alerting staff for assistance. Resident also has a hx of sitting on the edge of her w/c despite staff cues and redirection . The Investigation Summary was not completed and left blank on this form. On 4/3/20 at 7:00 pm, an Event Report form documented in part . Resident said <sic> was trying to open her dresser, but lost balance and fell to the floor . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Safety measures taken and explained resident's CNA to keep residents room always open to prevent new incidents . Root Cause Determination by Charge Nurse at the time of the event: Resident was in her room with the door closed and when she got up from her w/c to try to open the dresser, lost her balance and fell to the floor . Investigation Summary: Resident was trying to open dresser & lost balance IDT (Interdisciplinary team) believes w/c moved, antiroll backs ordered for wheelchair . A care plan titled (R# 702's name) is at risk a <sic> self-care deficit: bed mobility, transfers, hygiene, dressing, grooming, feeding, toileting, locomotion on/off unit (no date) documented in part, . Often refuses showers on shower days or help from staff. Will not lock wheelchair. Gets mad and defensive if help is offered. Wants door to room closed. Heightened Supervision every 30 minutes for safety . A care plan titled (R# 702's name) is at risk for falls as r/t (related to) decreased mobility and dementia . Refer to therapy for evaluation and treatment as needed, refer to therapy for evaluation and treatment as needed, Encourage or remind to use assistive devices daily: walker when ambulating, transfer bars in bathroom and handrails in hallways, continue to maintain observation by keeping her door open while she is in the room, shave resident facial hair on shower days if needed, monitor for facial bruising and notify physician of any changes, medication review, assist with activities as needed, bed in lowest position, check on resident at least every 2-3 hours to identify and meet needs as well as note location and safety status. Keep in view as much as possible as indicated . Risk Committee to review all falls per policy and provide appropriate interventions as indicated . On 7/22/20 at 11:02 am, the Administrator provided education and training on Incident reminder check off list, post fall investigation, event report, 72-hour neuro-check sheet and CNA post incident reporting. On 7/22/20 at 11:03 am, the Administrator acknowledged the concerns and stated that they identified I & A (Incident and Accident) report's not being completed and the facility is currently trying to rectify this. The Administrator stated the team is discussing it in QA (Quality Assurance). On 7/22/20 at 2:07 pm the Administrator and Director of Nursing (DON) were queried on the multiple documented falls, the IDT findings on root cause analysis of falls, the repetitive implemented interventions, the lack of Investigation Summary documentation and the documented heightened supervision for the resident and stated in part . no follow up investigation or interventions were implemented in the past. We are meeting as a team and doing post falls constantly, discussing it at QA. We are still trying to tighten that process and making sure their following the resident's interventions. A lot of this wasn't done before with the prior Administration . R# 705 A facility reported incident was reported to the State Agency on 3/9/20 at 4:41 pm, which documented in part . sent to the ER (emergency room) on 3/7 due to increased complaints of pain <sic> her left hip. Reports from the hospital were just received and it has been determined that she has an acute impacted fx (fracture) of left femoral neck . On 7/22/20 at 1:30 pm, R# 705 was observed lying in bed on their back, their eyes was closed and their mouth was observed open. The resident did not respond to verbal stimuli. A review of the clinical record revealed R# 705 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6 out of 15 (indicating severely impaired cognition). R# 705 was dependent on staff for all ADL's. A facility Event Report dated 2/23/20 at 5:10 pm, documented in part . describe what happened: unable to say what happened . in middle

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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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) of hallway . small superficial abrasion on L (left) forehead . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Resident opted to eat in her room, then brought out by Nurse's station . The Root Cause Determination by Charge Nurse at the time of the event and the Investigation Summary portion of this form was left blank and not completed. A facility Event Report dated 2/27/20 at 7:40 pm, documented in part . Resident said she bent over to check on her shoes . No injury sustained . What Action Nurse initiated immediately in response to this Event to prevent a reoccurrence: Re-educated resident regarding staying safe while on the w/c (wheelchair). Resident reminded not to bend over to pick up anything from the floor. Always to ask for help . The Root Cause Determination by Charge Nurse at the time of the event and the Investigation Summary portion of this form was left blank and not completed. A facility Event Report dated 2/29/20 at 6:40 pm, documented in part . Resident was observed on her bottom on the floor between the wheelchair and her bed. She is unable to describe what happened . Typically resident is within eyesight of nurse's station . Resident put in bed. Will keep resident within eyesight of nurse's station whenever possible . Root Cause Determination by Charge Nurse at the time of the event: resident wanted to go to bed . Investigation Summary: Resident wanted to go to bed . A review of the Event Report's and clincial record revealed the facility failed to consistently determine the root cause analysis of the resident falls, complete a thorough investigation for all of the falls and consistently implement new and/or modify interventions to prevent further falls. A Nursing Note dated 3/7/20 at 10:41 am, documented in part . At the start of this shift 7p-7a, this nurse witnessed this resident ambulating in her room pushing her w/c. This nurse approached the resident and assisted the resident to sit down in her w/c . The resident c/o (complaints of) pain to her left hip at this time. The resident was given PRN (as needed) Tylenol . Approx. 45 minuets after the med was given, the resident admitted relief from the prn pain med (medication) . The CNA (Certified Nursing Assistant) care giver explained to this nurse that the resident stood and transferred into bed with c/o left leg pain but only c/o pain momentarily . This nurse was doing skin tx's (treatments) per the doctor's orders. The resident c/o pain to the left hip area. The resident was given Tylenol per the prn order at 0539 (5:39 am). The resident admitted relief from the Tylenol . The therapist . came to the nurses during report and explained that the resident is having pain to the left hip that is keeping the resident from doing her exercises, which is new . The nurse assessed the resident's left hip. The resident continues to have slight [MEDICAL CONDITION] to the left hip . This nursed ordered a STAT (immediate) left hip xray . No fall noted . During the whole 7p-7am shift after the resident went to bed at approx 2030 (8:30 pm), the resident did not get OOB (out of bed) for the rest of the noc (night shift) . A Radiology Report dated 3/7/20 at 2:39 pm, documented in part . Reason for exam: pain in left hip . Conclusion: Acute left femoral neck fracture . Documented on that report (by staff) noted in part NP (Nurse Practitioner) notified asked to send resident out . (out to the hospital). A hospital physician consultation report dated 3/7/20 at 21:18 (9:18 pm), documented in part . Chief complaint: left hip pain . Per nursing home report, patient started complaining of left hip pain early this AM while trying to get out of bed. No witnessed falls. Patient normally ambulates independently at baseline with a walker . She has a history of right [MEDICAL CONDITION] s/p (status [REDACTED]. Radiographs demonstrated left subcapital displaced femoral neck fracture . Patient admitted to (unit name redacted) with orthopedic surgery consult . A hospital Radiology report dated 3/7/20 at 19:20 (7:20 pm) documented in part, . Impression: Acute impacted fracture left femoral neck the superior/cranial displacement of distal fracture component by 2.5 cm (centimeters) . A hospital physician consultation report dated 3/11/20 at 1602 (4:02 pm) documented in part, . Patient was taken to the OR (Operating Room) on 3/10/2020 for a left hip [MEDICAL CONDITION] hemiarthroplasty . On 7/22/20 at 11:03 am, the Administrator acknowledged the concerns and stated that they identified I & A (Incident and Accident) report's not being completed and the facility is currently trying to rectify this. The Administrator stated the team is discussing it in QA (Quality Assurance). On 7/22/20 at 2:07 pm the Administrator and Director of Nursing (DON) was queried on the multiple documented falls, the IDT findings on root cause analysis of falls, the repetitive implemented interventions, the lack of Investigation Summary documentation and stated in part . no follow up investigation or interventions implemented in the past. We are meeting as a team and doing post falls constantly, discussing it at QA. We are still trying to tighten that process and making sure their following the resident's interventions. A lot of this wasn't done before with the prior Administration . The fall risk assessment, falls, Incident and Accident policies were requested at this time. A facility policy titled Fall Prevention (7/14/20) was provided and documented in part . The goal of this policy/ procedure is to promote a safe environment and reduce the number of falls and severity of injuries related to fall and other incidents . Necessary fall precautions will be implemented: Place call light within resident's reach at all times, Encourage resident to request assistance before attempting to transfer/ ambulate, Orient/ reorient resident to new surroundings, Staff to assist with toileting and transfers when appropriate, staff to assess gait and balance . With the occurrence of a fall . an Incident/ Accident report will be completed by the nurse on duty . These reports will be reviewed at an interdisciplinary team meeting for further intervention of safety needs . The Interdisciplinary team includes the Director of Nursing, the Patient Care Coordinator, the Director of Staff Development, as well as representatives from Physical Therapy, Social Services, MDS, Dietary, and the Activities Department. It will meet to review all falls/ incidents and amend the resident's care plan and resident's summary as needed . The Charge nurse will initiate the Post Fall Investigation. Then Nurse Manager to review for completion . Care plans for those residents at risk for falls will be initiated upon admission and updated as needed . The Nurse Manager will pick up the incident reports from the units prior to morning meeting. The incidents will be discussed at the morning meeting with the Interdisciplinary Team. The report will be completed by the Unit Manager and reviewed by the DON, the Administrator, and the Medical Director .Any injury of unknown cause will also be documented on an Incident/ Accident report. The report will be initiated by the nurse on duty. If further investigation is necessary, an Abuse Investigation Report will be initiated by the nurse and then given to the Administrator who is the Canterbury Abuse Coordinator. An incident/ accident summary report will be completed by the nurse manager. Appropriate in-services and interventions will be implemented according to the summary's findings of any trends, patterns, or safety issues. These results and interventions will also be included in the facility's QAPI process. A facility policy titled Incidents & Accidents- Investigating and Reporting (dated: 8/1/19) was provided and documented in part . All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator . The Charge Nurse or supervisor shall promptly initiate and document investigation of the accident or incident . The Charge Nurse or supervisor shall complete a Report of Incident/ Accident form and submit the original to the Nurse Supervisor/Director of Nursing within 24 hours of the incident or accident. All Incident and Accident reports are reviewed in the morning meeting . the Director of Nursing will be notified immediately. All incident and accident reports and investigations shall be completed in 5 working days .