STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235381	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHIPPEWA COUNTY WAR MEM HOSP LTCU	**500 OSBORN BLVD SAULT SAINTE MARIE, MI 49783**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse prevention policy for one Resident (#101) of three residents reviewed for abuse/neglect. This deficient practice resulted in the potential for Resident #101 and other vulnerable residents to be at risk for abuse. Findings include: During an interview on 6/25/20 at 12:15 p.m., Physical Therapist (PT) A reported that Resident #101 had appeared sad when PT A came into Resident #101's room to provide therapy on 06/20/20. PT A asked Resident #101 what was wrong. Resident #101 told PT A someone was doing things to (Resident #101) they shouldn't be doing. PT A asked Resident #101who was doing things they shouldn't be doing, Resident #101 pointed at CNA B and said, everyone was there when it happened and nobody did anything. Resident #101 did not provide any additional information and did not not wish to discuss it further with PT A. PT A then reported the allegation to Registered Nurse (RN) C. PT A also filed a report via the state hotline. A review of Resident #101's face sheet showed an admission date of [DATE], with the following Diagnoses: [REDACTED]. On 06/25/20 at 11:50 a.m., the Director of Nursing (DON) reported further action was not taken regarding the abuse allegation made on 6/20/20 because Resident #101 had not offered any details or further information when RN A and the DON had asked Resident #101 about the allegations. The DON verified CNA B had not been removed from providing resident care and there had been no further investigation conducted by the facility. A review of Resident #101's Electronic Medical Record revealed no documentation pertaining to notification of Resident #101's provider or resident representative of the allegation. A review of the facility's Resident Abuse, Neglect or Mistreatment policy with the most recent review date of 5/06/2020, revealed the following information, .Suspected or substantiated cases of resident abuse .will be reported to the LTC (Long Term Care) administrator .The delegated person with thoroughly investigate and report to the appropriate state agencies, physician, families and/or representative . 1. The Administrator or designee will investigate all allegations .will contact state and law enforcement within .24 hours if no serious injury has occurred. 2. The Administrator or designee will notify resident's representative and any appropriate state or federal agencies within twenty four (24) hours of all allegations and will complete the investigation within 5 days .4. If the accused is an employee of the facility, he/she will be suspended until the investigation has been completed .7. The Administrator or designee shall notify the physician of the allegation, investigation, and resident's condition . On 6/25/20 at approximately 2:40 p.m. the Nursing Home Administrator (NHA) reported they did not think this was an allegation that needed further action because Resident #101 had been asked about the allegation and offered no further information. The NHA felt the incident had been investigated thoroughly enough and no action was warranted. The NHA reported both they and the DON were new to their roles and had asked the hospital administrative staff about any further action, and the NHA and DON had been advised no further action was needed.
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 interview, and record review, the facility failed to report an allegation of abuse to the State Agency for one Resident (#101) of three residents reviewed for abuse/neglect. This deficient practice resulted in the potential for undetected abuse. Findings include: A review of Resident #101's face sheet showed an admission date of [DATE], with the following Diagnoses: [REDACTED]. During an interview with Physical Therapist (PT) Aon 06/25/20 at 12:15 p.m., PT A reported Resident #101 had made allegations regarding abuse on 06/20/20. PT A notified the nurse in charge and reported it via the state hotline on 06/20/20. On 06/25/20 at 11:50 a.m., the Director of Nursing (DON) reported the abuse allegation had not been reported by the facility to the state agency because Resident #101 had not offered any details or further information when RN A and the DON had asked Resident #101 about the allegations. A review of the facility's Resident Abuse, Neglect or Mistreatment policy with the most recent review date of 05/06/2020, revealed the following information: .Suspected or substantiated cases of resident abuse .The delegated person will thoroughly investigate and report to the appropriate state agencies .1. The Administrator or designee will investigate all allegations .will contact state and law enforcement with in .24 hours if no serious injury has occurred. 2. The Administrator or designee will notify resident's representative and any appropriate state or federal agencies within twenty four (24) hours of all allegations . During an interview on 06/25/20 at approximately 2:40 p.m., the Nursing Home Administrator (NHA) reported they did not think the abuse allegation had to be reported to the State Agency because Resident #101 had been asked about the allegation and offered no further information. The NHA reported both they and the DON were new to their roles and had asked hospital administrative staff about any further action, the NHA and DON had been advised no further action was needed.

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.