STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235076	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWAYGO CO MEDICAL CARE FACILI	4465 W 48TH ST FREMONT, MI 49412

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 intakes MI 739 and MI 496 Based on interview and record review facility staff failed to prevent and recognize abuse and neglect for 2 out of 3 sampled residents (Residents #1 and #3) resulting in pain, emotional distress and the denial of needed goods and services, also resulting in the delay in investigating abuse and neglect allegations and the potential for additional abuse and neglect to occur. Findings include: Review of facility policy and procedure Abuse Program with a most recently revised date of 11/14/19 revealed: It is the policy of (facility) to maintain an environment free of abuse and neglect. Abuse is defined as The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish .Abuse includes verbal, physical, sexual or mental abuse, corporal punishment and involuntary seclusion. Physical abuse is defined as: Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment: any type of impermissible or unjustifiable physical contact with an Elder that has resulted in injury or harm to the Elder. Verbal abuse is defined as The use of oral, written or gestured language that willfully includes disparaging or derogatory terms to Elders or their families, within their hearing distance; regardless of their age or ability to comprehend . Neglect is defined as: The failure, either intentionally or accidentally, to provide goods and services that are necessary to avoid physical harm, mental anguish or mental illness; with resulting harm to the Elder. Per the Abuse Program policy Employee training is to include: orientation to and ongoing training on the following topics, at least annually: 1. Abuse and neglect definitions .3. What constitutes abuse, neglect, exploitation and misappropriation of Elder property 4. How to identify abuse, neglect, exploitation and misappropriation. 5. How to intervene when abuse is witnessed or suspected. 6. Proper steps in reporting allegation or suspicion of abuse, neglect exploitation or misappropriation . Prevention strategies include: Elder care and treatment shall be monitored by all staff, on an ongoing basis, to assure that Elders are free from abuse, neglect, exploitation or mistreatment. It is the responsibility of all staff to provide a safe environment for the Elders. Under the section Investigation, reveals: Investigation will begin immediately upon identifying the situation as either a potential abuse situation or an allegation of abuse. Under Reporting Allegations of Abuse: Any allegation of suspicion of abuse, neglect, exploitation, misappropriation or mistreatment will be immediately reported to the Director of Nursing or her designee. Resident #3 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #3 was a [AGE] year old female initially admitted to the facility on [DATE] and most recently admitted on [DATE] with [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS) score indicated Resident #3 had moderate cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #3's care plan there is a focus area with initiated date 11/18/2019: The resident has an ADL self-care performance deficit r/t (related to) [MEDICAL CONDITION]. Interventions include: LOCOMOTION: 1 assist with w/c (wheel chair) for long distances. Based on facility submitted Incident Summary an allegation of abuse perpetrated against Resident #3 by Certified Nursing Assistant (CNA) D occurred on 1/16/2020 at 8:00 AM and was discovered on 1/16/2020 at 8:25 AM. The finding of abuse was noted as inconclusive. The investigation summary revealed it is likely (CNA D) was rude and or disrespectful during the time she was providing care to (Resident #3). (CNA D) admitted that she did not follow the plan of care that was available to her on the Kardex, by assisting (Resident #3) in her wheelchair to the dining room. As defined in section 483.5 abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. (Resident #3) has no resulting harm, pain or mental anguish related to this incident. (Facility) has decided to separate employment with (CNA D) due to the likeliness that she was rude/disrespectful and her failure to follow the care plan. (Facility) cannot confirm nor deny that abuse and or neglect occurred. Per facility provided 5 Day Summary the incident details included: (Resident #3) reported to her daughter this am that the CNA who had taken care of her this morning, would not help her get to breakfast and told her that she could push her own chair to breakfast. (Resident #3) also reported to her daughter, that she felt like the CNA was yelling at her when the CNA told her she could push herself .(Resident #3) is care planned and has a kardex in her room with the intervention of one staff assist for mobility for long distances . Also per the 5 Day Summary report, during an Interview with (CNA I) on 1/16/2020 at 10:54 AM. (CNA I) stated that she went to go find (CNA D) and found her in (Resident #3's) bathroom assisting (Resident #3) with morning care. (CNA I) stated that (CNA D) said 'I am irritated with this one' .(CNA D) rolled her eyes and (CNA I) could tell the (sic) (CNA D) was frustrated. (CNA I) stated she stayed in the room until (CNA D) had (Resident #3) back in the wheelchair because she felt the elder was safe at that time. During a follow up interview with CNA I on 1/20/2020 at 1:15 PM she again stated (CNA D) said 'I can't stand this one' .When she left the room (CNA D) was still in the room cleaning up the bathroom. (CNA I) stated when she left the room she went to complete some other tasks including getting .(roommate of (Resident #3)) some coffee. (CNA I) states that after bring (sic) the coffee .she exited the room and reported .what had occurred. Per interview documented with (CNA D) on 1/20/2020 at 3:51 PM she placed herself in the room assisting (Resident #3) just before (7:15 AM) and call light times confirmed that Resident #3 turned on her call light at (6:55 AM) and the call light was turned off 2 minutes and 44 seconds later. Per facility provided interview transcript with CNA I completed by Registered Nurse (RN) G, RN G posed the question to CNA I: So am I right in saying that you left (Resident #3) in the room with (CNA D)? Then you went to do a 'few' things, and got (another resident name) her coffee from the dining room, took it back t her room, then helped her to sit up and drink the coffee? Then when you were leaving the room you saw (nurse) and then reported what you witnessed? Then when (former DON) came to the cart you did not say anything to her about what had happened? and CNA I responded: yes, that's right. During an interview with Resident #3 on 08/05/2020 at 10:15 AM in the Resident's room, she reported she could not recall the incident in question. During an interview with the Family Member G on 08/05/2020 at 1:40 PM, the incident with Resident #3 was discussed. Family Member G stated the day of the incident Resident #3 had informed her a staff member had been rough with her, yelled at her and made her feel unhappy. Per Family Member G, Resident #3 told her she had asked for help and the staff basically said you can do it yourself and refused to take her to breakfast. Per Family Member G, Resident #3 thought the staff member was disrespectful and she was reluctant and embarrassed to talk about it. Family Member G stated she immediately reported the incident to the charge nurse and the facility started an investigation. Per review of facility provided 5 day summary document and supported by facility provided Individual Timecard for CNA D, CNA D was suspended at 10:48 AM on 1/16/2020, at least 2.5 hours after another employee viewed CNA D display abusive behavior towards a resident at approximately 8:00 AM. The witnessed allegation was potentially earlier than the estimated time of 8:00 AM due to call light logs and CNA D reporting she completed the resident's morning cares prior to a 7:15 AM meeting. Per Facility provided disciplinary paperwork, CNA D employment was terminated because she failed to treat an elder with kindness, respect, dignity and courtesy during morning care .(CNA D)

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** - Few	(continued... from page 1) failed to follow the approved plan of care for an elder that resulted in the elder expressing that she felt 'disrespected.' During the investigation of the complaint it was identified that another staff member heard (CNA D) speaking in an unkind manner to the elder. Resident #1 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was a [AGE] year old female initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Staff Assessment for Mental Status for Resident #1 indicated she had severe cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #1's care plan, there is a focus area with a date initiated of 8/16/2017: I have pain secondary to h/o (history of) left hip fx (fracture), decreased mobility and a hx of RLS and [MEDICAL CONDITION]. Interventions include Monitor/record/report to nurse any s/sx (signs or symptoms) of non-verbal pain . On 8/05/2020 at 10:05 AM Resident #1 was observed sleeping in her room on a mattress of the floor. Per interview with LPN K, Resident #1 spends most of her time on the floor, either sleeping or scooting around. LPN K stated that Resident #1 is not very communicative and can get very agitated at times. Based on facility submitted Incident Summary an allegation of abuse perpetrated by CNA B against Resident #1 occurred on 5/20/2020 at 7:12 PM and was not discovered until 5/21/2020 at 3:50 PM. The Investigation Summary document notes that abuse was not substantiated by the facility and the section Incident Summary of the document revealed: Although (Resident #1) verbalized discomfort when (CNA B) moved her, (CNA B) did not willfully inflict pain . and that CNA B admitted she could have verbally responded differently to Resident #1. The facility provided 5 Day Summary for this incident further revealed that on 5/21/2020 Dietary Aide (DA) L reported hearing (Resident #1) say 'ouch' when moved out of the dining room doorway by CNA B on the evening of 5/20/2020. During a follow up interview on 5/28/2020 DA L stated that on 5/20/2020, (Resident #1) was in the doorway of the dining room and the CNA (whose name she didn't know) stepped over (Resident #1) and pulled her out of the way .(DA L) stated 'she reached over the elder and under her arms, sliding her backwards, out of the doorway to shut the door. When the CNA moved her, (Resident #1) said 'ouch' .began stuttering and basically said you don't know what you're doing to my body.' The CNA responded by saying, 'you don't know what you're doing to my body when I have to pull you.' Per the document, during an interview completed by the facility with CNA B on 5/29/2020, CNA B admitted that she moved Resident #1 and the resident stated my body hurts and CNA B stated she responded that my back hurts. An interview was completed with RN H on 8/5/2020 at 1:30 PM regarding the incident with Resident #1. RN H confirmed she had completed the investigation regarding the incident and she was the Director of Nursing for the facility from February 2020 through July 2020. RN H confirmed that DA L had not immediately reported the incident. RN H stated that DA L was a newer employee at the time and stated she was not aware of the process due to being new. RN H stated she immediately provided verbal education to DA L related to reporting allegations immediately and who to report to. RN H was not aware of or could not recall if re-education was provided to all staff after this incident. On 8/5/2020, the personnel file for DA L was reviewed and no documentation of re-education or discipline related to abuse reporting for the 5/20/2020 incident was observed. RN A was asked on 8/5/2020 at 2:15 PM if any education or discipline was completed, RN A looked into the matter and later stated on 8/5/2020 at 2:45 PM that DA L's supervisor had indicated they completed verbal re-education with her but did not document anything in her personnel file. Per review of facility provided Individual Timecard for CNA B, on 5/20/2020 CNA B worked from 6:42 PM to 5:08 AM on 5/21/2020. The alleged incident of abuse with Resident #1 occurred at 7:12 PM on 5/20/2020 and CNA B completed an additional 10 hours of her shift after a witnessed allegation. Per facility provided disciplinary paperwork, CNA B's employment was terminated on 5/29/2020 due to an interaction with elder- overheard by another staff member telling the elder 'she doesn't know what she does to her back' when repositioning her. Attitude: failure to treat all persons with kindness, respect, and dignity using the appropriate tone of voice, and body language. The disciplinary paperwork further revealed CNA B received a verbal warning on 12/9/19 for her interaction and attitude while in an elder's room. On 3/13/20 (CNA B) received a final written warning related to her attitude and demeanor while in a patient care area.
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** This citation pertains to intakes MI 739 and MI 496 Based on interview and record review the facility failed to implement their abuse policy for 2 out of 3 sampled residents (Residents #1 and #3) by failing to appropriately recognize and immediately report allegations of abuse and neglect resulting in the delay in investigating abuse and neglect allegations and the potential for additional abuse and neglect to occur. Findings include: Based on interview and record review facility staff failed to prevent and recognize abuse and neglect for 2 out of 3 sampled residents (Residents #1 and #3) resulting in pain, emotional distress and the denial of needed goods and services, also resulting in the delay in investigating abuse and neglect allegations and the potential for additional abuse and neglect to occur. Findings include: Review of facility policy and procedure Abuse Program with a most recently revised date of 11/14/19 revealed: It is the policy of (facility) to maintain an environment free of abuse and neglect. Abuse is defined as The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish .Abuse includes verbal, physical, sexual or mental abuse, corporal punishment and involuntary seclusion. Physical abuse is defined as: Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment: any type of impermissible or unjustifiable physical contact with an Elder that has resulted in injury or harm to the Elder. Verbal abuse is defined as The use of oral, written or gestured language that willfully includes disparaging or derogatory terms to Elders or their families, within their hearing distance; regardless of their age or ability to comprehend . Neglect is defined as: The failure, either intentionally or accidentally, to provide goods and services that are necessary to avoid physical harm, mental anguish or mental illness; with resulting harm to the Elder. Per the Abuse Program policy Employee training is to include: orientation to and ongoing training on the following topics, at least annually: 1. Abuse and neglect definitions .3. What constitutes abuse, neglect, exploitation and misappropriation of Elder property 4. How to identify abuse, neglect, exploitation and misappropriation. 5. How to intervene when abuse is witnessed or suspected. 6. Proper steps in reporting allegation or suspicion of abuse, neglect exploitation or misappropriation . Prevention strategies include: Elder care and treatment shall be monitored by all staff, on an ongoing basis, to assure that Elders are free from abuse, neglect, exploitation or mistreatment. It is the responsibility of all staff to provide a safe environment for the Elders. Under the section Investigation, reveals: Investigation will begin immediately upon identifying the situation as either a potential abuse situation or an allegation of abuse. Under Reporting Allegations of Abuse: Any allegation of suspicion of abuse, neglect, exploitation, misappropriation or mistreatment will be immediately reported to the Director of Nursing or her designee. Resident #3 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #3 was a [AGE] year old female initially admitted to the facility on [DATE] and most recently admitted on [DATE] with [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS) score indicated Resident #3 had moderate cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #3's care plan there is a focus area with initiated date 11/18/2019: The resident has an ADL self-care performance deficit r/t (related to) [MEDICAL CONDITION]. Interventions include: LOCOMOTION: 1 assist with w/c (wheel chair) for long distances. Based on facility submitted Incident Summary an allegation of abuse perpetrated against Resident #3 by Certified Nursing Assistant (CNA) D occurred on 1/16/2020 at 8:00 AM and was discovered on 1/16/2020 at 8:25 AM. The finding of abuse was noted as inconclusive. The investigation summary revealed it is likely (CNA D) was rude and or disrespectful during the time she was providing care to (Resident #3). (CNA D) admitted that she did not follow the plan of care that was available to her on the Kardex, by assisting (Resident #3) in her wheelchair to the dining room. As defined in section 483.5 abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. (Resident #3) has no resulting harm, pain or mental anguish related to this incident. (Facility) has decided to separate employment with (CNA D) due to the likeliness that she was rude/disrespectful and her failure to follow the care plan. (Facility) cannot confirm nor deny that abuse and or neglect occurred. Per facility provided 5 Day Summary the incident details included: (Resident #3) reported to her daughter this am that the CNA who had taken care of her this morning, would not help her get to breakfast and told her that she could push her own chair to breakfast. (Resident #3) also reported to her daughter, that she felt like the CNA was yelling at her when the CNA told her she could push herself .(Resident #3) is care planned and has a kardex in her room with the intervention of one staff assist for mobility for long distances . Also per the 5 Day Summary report, during an Interview with (CNA I) on 1/16/2020 at 10:54 AM. (CNA I) stated that she went to go find (CNA D) and found her in (Resident #3's) bathroom assisting (Resident #3) with morning care. (CNA I) stated that (CNA D) said 'I am irritated with this one' .(CNA D) rolled her eyes and (CNA I) could tell the (sic) (CNA D) was frustrated. (CNA I) stated she stayed in the room until (CNA D) had (Resident #3) back in the wheelchair because she felt the elder was safe at that time. During a follow up interview with CNA I on 1/20/2020 at 1:15

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) PM she again stated (CNA D) said 'I can't stand this one' .When she left the room (CNA D) was still in the room cleaning up the bathroom. (CNA I) stated when she left the room she went to complete some other tasks including getting .(roommate of (Resident #3)) some coffee. (CNA I) states that after bring (sic) the coffee .she exited the room and reported .what had occurred. Per interview documented with (CNA D) on 1/20/2020 at 3:51 PM she placed herself in the room assisting (Resident #3) just before (7:15 AM) and call light times confirmed that Resident #3 turned on her call light at (6:55 AM) and the call light was turned off 2 minutes and 44 seconds later. Per facility provided interview transcript with CNA I completed by Registered Nurse (RN) G, RN G posed the question to CNA I: So am I right in saying that you left (Resident #3) in the room with (CNA D)? Then you went to do a 'few' things, and got (another resident name) her coffee from the dining room, took it back t her room, then helped her to sit up and drink the coffee? Then when you were leaving the room you saw (nurse) and then reported what you witnessed? Then when (former DON) came to the cart you did not say anything to her about what had happened? and CNA I responded: yes, that's right. During an interview with Resident #3 on 08/05/2020 at 10:15 AM in the Resident's room, she reported she could not recall the incident in question. During an interview with the Family Member G on 08/05/2020 at 1:40 PM the incident with Resident #3 was discussed. Family Member G stated the day of the incident Resident #3 had informed her a staff member had been rough with her, yelled at her and made her feel unhappy. Per Family Member G, Resident #3 told her she had asked for help and the staff basically said you can do it yourself and refused to take her to breakfast. Per Family Member G, Resident #3 thought the staff member was disrespectful and she was reluctant and embarrassed to talk about it. Family Member G stated she immediately reported the incident to the charge nurse and the facility started an investigation. Per review of facility provided 5 day summary document and supported by facility provided Individual Timecard for CNA D, CNA D was suspended at 10:48 AM on 1/16/2020, at least 2.5 hours after another employee viewed CNA D display abusive behavior towards a resident at approximately 8:00 AM. The witnessed allegation was potentially earlier than the estimated time of 8:00 AM due to call light logs and CNA D reporting she completed the resident's morning cares prior to a 7:15 AM meeting. Per Facility provided disciplinary paperwork, CNA D employment was terminated because she failed to treat an elder with kindness, respect, dignity and courtesy during morning care .(CNA D) failed to follow the approved plan of care for an elder that resulted in the elder expressing that she felt 'disrespected.' During the investigation of the complaint it was identified that another staff member heard (CNA D) speaking in an unkind manner to the elder. Resident #1 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was a [AGE] year old female initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Staff Assessment for Mental Status for Resident #1 indicated she had severe cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #1's care plan, there is a focus area with a date initiated of 8/16/2017: I have pain secondary to h/o (history of) left hip fx (fracture), decreased mobility and a hx of RLS and [MEDICAL CONDITION]. Interventions include Monitor/record/report to nurse any s/sx (signs or symptoms) of non-verbal pain . On 8/05/2020 at 10:05 AM Resident #1 was observed sleeping in her room on a mattress of the floor. Per interview with LPN K, Resident #1 spends most of her time on the floor, either sleeping or scooting around. LPN K stated that Resident #1 is not very communicative and can get very agitated at times. Based on facility submitted Incident Summary an allegation of abuse perpetrated by CNA B against Resident #1 occurred on 5/20/2020 at 7:12 PM and was not discovered until 5/21/2020 at 3:50 PM. 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When the CNA moved her, (Resident #1) said 'ouch' .began stuttering and basically said you don't know what you're doing to my body.' The CNA responded by saying, 'you don't know what you're doing to my body when I have to pull you.' Per the document, during an interview completed by the facility with CNA B on 5/29/2020, CNA B admitted that she moved Resident #1 and the resident stated my body hurts and CNA B stated she responded that my back hurts. An interview was completed with RN H on 8/5/2020 at 1:30 PM regarding the incident with Resident #1. RN H confirmed she had completed the investigation regarding the incident and she was the Director of Nursing for the facility from February 2020 through July 2020. RN H confirmed that DA L had not immediately reported the incident. RN H stated that DA L was a newer employee at the time and stated she was not aware of the process due to being new. RN H stated she immediately provided verbal education to DA L related to reporting allegations immediately and who to report to. RN H was not aware of or could not recall if re-education was provided to all staff after this incident. On 8/5/2020, the personnel file for DA L was reviewed and no documentation of re-education or discipline related to abuse reporting for the 5/20/2020 incident was observed. RN A was asked on 8/5/2020 at 2:15 PM if any education or discipline was completed, RN A looked into the matter and later stated on 8/5/2020 at 2:45 PM that DA L's supervisor had indicated they completed verbal re-education with her but did not document anything in her personnel file. Per review of facility provided Individual Timecard for CNA B, on 5/20/2020 CNA B worked from 6:42 PM to 5:08 AM on 5/21/2020. The alleged incident of abuse with Resident #1 occurred at 7:12 PM on 5/20/2020 and CNA B completed an additional 10 hours of her shift after a witnessed allegation. Per facility provided disciplinary paperwork, CNA B's employment was terminated on 5/29/2020 due to an interaction with elder- overheard by another staff member telling the elder 'she doesn't know what she does to her back' when repositioning her. Attitude: failure to treat all persons with kindness, respect, and dignity using the appropriate tone of voice, and body language. The disciplinary paperwork further revealed CNA B received a verbal warning on 12/9/19 for her interaction and attitude while in an elder's room. On 3/13/20 (CNA B) received a final written warning related to her attitude and demeanor while in a patient care area.
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** This citation pertains to intakes MI 739 and MI 496 Based on interview and record review facility staff failed to immediately report allegations of abuse and neglect for 2 out of 3 sampled residents (Residents #1 and #3) resulting in the delay in investigating abuse and neglect allegations and the potential for additional abuse and neglect to occur. Findings include: Based on interview and record review facility staff failed to prevent and recognize abuse and neglect for 2 out of 3 sampled residents (Residents #1 and #3) resulting in pain, emotional distress and the denial of needed goods and services, also resulting in the delay in investigating abuse and neglect allegations and the potential for additional abuse and neglect to occur. Findings include: Review of facility policy and procedure Abuse Program with a most recently revised date of 11/14/19 revealed: It is the policy of (facility) to maintain an environment free of abuse and neglect. Abuse is defined as The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish .Abuse includes verbal, physical, sexual or mental abuse, corporal punishment and involuntary seclusion. Physical abuse is defined as: Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment: any type of impermissible or unjustifiable physical contact with an Elder that has resulted in injury or harm to the Elder. Verbal abuse is defined as The use of oral, written or gestured language that willfully includes disparaging or derogatory terms to Elders or their families, within their hearing distance; regardless of their age or ability to comprehend . Neglect is defined as: The failure, either intentionally or accidentally, to provide goods and services that are necessary to avoid physical harm, mental anguish or mental illness; with resulting harm to the Elder. Per the Abuse Program policy Employee training is to include: orientation to and ongoing training on the following topics, at least annually: 1. Abuse and neglect definitions .3. What constitutes abuse, neglect, exploitation and misappropriation of Elder property 4. How to identify abuse, neglect, exploitation and misappropriation. 5. How to intervene when abuse is witnessed or suspected. 6. Proper steps in reporting allegation or suspicion of abuse, neglect exploitation or misappropriation . Prevention strategies include: Elder care and treatment shall be monitored by all staff, on an ongoing basis, to assure that Elders are free from abuse, neglect, exploitation or mistreatment. It is the responsibility of all staff to provide a safe environment for the Elders. Under the section Investigation, reveals: Investigation will begin immediately upon identifying the situation as either a potential abuse situation or an allegation

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) of abuse. Under Reporting Allegations of Abuse: Any allegation of suspicion of abuse, neglect, exploitation, misappropriation or mistreatment will be immediately reported to the Director of Nursing or her designee. Resident #3 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #3 was a [AGE] year old female initially admitted to the facility on [DATE] and most recently admitted on [DATE] with [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS) score indicated Resident #3 had moderate cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #3's care plan there is a focus area with initiated date 11/18/2019: The resident has an ADL self-care performance deficit r/t (related to) [MEDICAL CONDITION]. Interventions include: LOCOMOTION: 1 assist with w/c (wheel chair) for long distances. Based on facility submitted Incident Summary an allegation of abuse perpetrated against Resident #3 by Certified Nursing Assistant (CNA) D occurred on 1/16/2020 at 8:00 AM and was discovered on 1/16/2020 at 8:25 AM. The finding of abuse was noted as inconclusive. The investigation summary revealed it is likely (CNA D) was rude and or disrespectful during the time she was providing care to (Resident #3). (CNA D) admitted that she did not follow the plan of care that was available to her on the Kardex, by assisting (Resident #3) in her wheelchair to the dining room. As defined in section 483.5 abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. (Resident #3) has no resulting harm, pain or mental anguish related to this incident. (Facility) has decided to separate employment with (CNA D) due to the likeliness that she was rude/disrespectful and her failure to follow the care plan. (Facility) cannot confirm nor deny that abuse and or neglect occurred. Per facility provided 5 Day Summary the incident details included: (Resident #3) reported to her daughter this am that the CNA who had taken care of her this morning, would not help her get to breakfast and told her that she could push her own chair to breakfast. (Resident #3) also reported to her daughter, that she felt like the CNA was yelling at her when the CNA told her she could push herself .(Resident #3) is care planned and has a kardex in her room with the intervention of one staff assist for mobility for long distances . Also per the 5 Day Summary report, during an Interview with (CNA I) on 1/16/2020 at 10:54 AM. (CNA I) stated that she went to go find (CNA D) and found her in (Resident #3's) bathroom assisting (Resident #3) with morning care. (CNA I) stated that (CNA D) said 'I am irritated with this one' .(CNA D) rolled her eyes and (CNA I) could tell the (sic) (CNA D) was frustrated. (CNA I) stated she stayed in the room until (CNA D) had (Resident #3) back in the wheelchair because she felt the elder was safe at that time. During a follow up interview with CNA I on 1/20/2020 at 1:15 PM she again stated (CNA D) said 'I can't stand this one' .When she left the room (CNA D) was still in the room cleaning up the bathroom. (CNA I) stated when she left the room she went to complete some other tasks including getting .(roommate of (Resident #3)) some coffee. (CNA I) states that after bring (sic) the coffee .she exited the room and reported .what had occurred. Per interview documented with (CNA D) on 1/20/2020 at 3:51 PM she placed herself in the room assisting (Resident #3) just before (7:15 AM) and call light times confirmed that Resident #3 turned on her call light at (6:55 AM) and the call light was turned off 2 minutes and 44 seconds later. Per facility provided interview transcript with CNA I completed by Registered Nurse (RN) G, RN G posed the question to CNA I: So am I right in saying that you left (Resident #3) in the room with (CNA D)? Then you went to do a 'few' things, and got (another resident name) her coffee from the dining room, took it back t her room, then helped her to sit up and drink the coffee? Then when you were leaving the room you saw (nurse) and then reported what you witnessed? Then when (former DON) came to the cart you did not say anything to her about what had happened? and CNA I responded: yes, that's right. During an interview with Resident #3 on 08/05/2020 at 10:15 AM in the Resident's room, she reported she could not recall the incident in question. During an interview with the Family Member G on 08/05/2020 at 1:40 PM the incident with Resident #3 was discussed. Family Member G stated the day of the incident Resident #3 had informed her a staff member had been rough with her, yelled at her and made her feel unhappy. Per Family Member G, Resident #3 told her she had asked for help and the staff basically said you can do it yourself and refused to take her to breakfast. Per Family Member G, Resident #3 thought the staff member was disrespectful and she was reluctant and embarrassed to talk about it. Family Member G stated she immediately reported the incident to the charge nurse and the facility started an investigation. Per review of facility provided 5 day summary document and supported by facility provided Individual Timecard for CNA D, CNA D was suspended at 10:48 AM on 1/16/2020, at least 2.5 hours after another employee viewed CNA D display abusive behavior towards a resident at approximately 8:00 AM. The witnessed allegation was potentially earlier than the estimated time of 8:00 AM due to call light logs and CNA D reporting she completed the resident's morning cares prior to a 7:15 AM meeting. Per Facility provided disciplinary paperwork, CNA D employment was terminated because she failed to treat an elder with kindness, respect, dignity and courtesy during morning care .(CNA D) failed to follow the approved plan of care for an elder that resulted in the elder expressing that she felt 'disrespected.' During the investigation of the complaint it was identified that another staff member heard (CNA D) speaking in an unkind manner to the elder. Resident #1 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was a [AGE] year old female initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Staff Assessment for Mental Status for Resident #1 indicated she had severe cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #1's care plan, there is a focus area with a date initiated of 8/16/2017: I have pain secondary to h/o (history of) left hip fx (fracture), decreased mobility and a hx of RLS and [MEDICAL CONDITION]. Interventions include Monitor/record/report to nurse any s/sx (signs or symptoms) of non-verbal pain . On 8/05/2020 at 10:05 AM Resident #1 was observed sleeping in her room on a mattress of the floor. Per interview with LPN K, Resident #1 spends most of her time on the floor, either sleeping or scooting around. LPN K stated that Resident #1 is not very communicative and can get very agitated at times. Based on facility submitted Incident Summary an allegation of abuse perpetrated by CNA B against Resident #1 occurred on 5/20/2020 at 7:12 PM and was not discovered until 5/21/2020 at 3:50 PM. The Investigation Summary document notes that abuse was not substantiated by the facility and the section Incident Summary of the document revealed: Although (Resident #1) verbalized discomfort when (CNA B) moved her, (CNA B) did not willfully inflict pain . and that CNA B admitted she could have verbally responded differently to Resident #1. The facility provided 5 Day Summary for this incident further revealed that on 5/21/2020 Dietary Aide (DA) L reported hearing (Resident #1) say 'ouch' when moved out of the dining room doorway by CNA B on the evening of 5/20/2020. During a follow up interview on 5/28/2020 DA L stated that on 5/20/2020, (Resident #1) was in the doorway of the dining room and the CNA (whose name she didn't know) stepped over (Resident #1) and pulled her out of the way .(DA L) stated 'she reached over the elder and under her arms, sliding her backwards, out of the doorway to shut the door. When the CNA moved her, (Resident #1) said 'ouch' .began stuttering and basically said you don't know what you're doing to my body.' The CNA responded by saying, 'you don't know what you're doing to my body when I have to pull you.' Per the document, during an interview completed by the facility with CNA B on 5/29/2020, CNA B admitted that she moved Resident #1 and the resident stated my body hurts and CNA B stated she responded that my back hurts. An interview was completed with RN H on 8/5/2020 at 1:30 PM regarding the incident with Resident #1. RN H confirmed she had completed the investigation regarding the incident and she was the Director of Nursing for the facility from February 2020 through July 2020. RN H confirmed that DA L had not immediately reported the incident. RN H stated that DA L was a newer employee at the time and stated she was not aware of the process due to being new. RN H stated she immediately provided verbal education to DA L related to reporting allegations immediately and who to report to. RN H was not aware of or could not recall if re-education was provided to all staff after this incident. On 8/5/2020, the personnel file for DA L was reviewed and no documentation of re-education or discipline related to abuse reporting for the 5/20/2020 incident was observed. RN A was asked on 8/5/2020 at 2:15 PM if any education or discipline was completed, RN A looked into the matter and later stated on 8/5/2020 at 2:45 PM that DA L's supervisor had indicated they completed verbal re-education with her but did not document anything in her personnel file. Per review of facility provided Individual Timecard for CNA B, on 5/20/2020 CNA B worked from 6:42 PM to 5:08 AM on 5/21/2020. The alleged incident of abuse with Resident #1 occurred at 7:12 PM on 5/20/2020 and CNA B completed an additional 10 hours of her shift after a witnessed allegation. Per facility provided disciplinary paperwork, CNA B's employment was terminated on 5/29/2020 due to an interaction with elder- overheard by another staff member telling the elder 'she doesn't know what she does to her back' when repositioning her. Attitude: failure to treat all persons with kindness, respect, and dignity using the appropriate tone of voice, and body language. The disciplinary paperwork further revealed CNA B received a verbal warning on 12/9/19 for her interaction and attitude while in an elder's room. On 3/13/20 (CNA B) received a final written warning related to her attitude and demeanor while in a patient care area.
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** This citation pertains to intakes MI 739 and MI 496 Based on interview and record review the facility failed to protect 2

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	235076	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWAYGO CO MEDICAL CARE FACILI	4465 W 48TH ST FREMONT, MI 49412

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) out of 3 sampled residents (Residents #1 and #3) from further abuse due to the staff delay in reporting allegations of abuse and neglect resulting in the potential for additional abuse and neglect to occur. Findings include: Based on interview and record review facility staff failed to prevent and recognize abuse and neglect for 2 out of 3 sampled residents (Residents #1 and #3) resulting in pain, emotional distress and the denial of needed goods and services, also resulting in the delay in investigating abuse and neglect allegations and the potential for additional abuse and neglect to occur. Findings include: Review of facility policy and procedure Abuse Program with a most recently revised date of 11/14/19 revealed: It is the policy of (facility) to maintain an environment free of abuse and neglect. Abuse is defined as The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish .Abuse includes verbal, physical, sexual or mental abuse, corporal punishment and involuntary seclusion. Physical abuse is defined as: Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment: any type of impermissible or unjustifiable physical contact with an Elder that has resulted in injury or harm to the Elder. Verbal abuse is defined as The use of oral, written or gestured language that willfully includes disparaging or derogatory terms to Elders or their families, within their hearing distance; regardless of their age or ability to comprehend . Neglect is defined as: The failure, either intentionally or accidentally, to provide goods and services that are necessary to avoid physical harm, mental anguish or mental illness; with resulting harm to the Elder. Per the Abuse Program policy Employee training is to include: orientation to and ongoing training on the following topics, at least annually: 1. Abuse and neglect definitions .3. What constitutes abuse, neglect, exploitation and misappropriation of Elder property 4. How to identify abuse, neglect, exploitation and misappropriation. 5. How to intervene when abuse is witnessed or suspected. 6. Proper steps in reporting allegation or suspicion of abuse, neglect exploitation or misappropriation . Prevention strategies include: Elder care and treatment shall be monitored by all staff, on an ongoing basis, to assure that Elders are free from abuse, neglect, exploitation or mistreatment. It is the responsibility of all staff to provide a safe environment for the Elders. Under the section Investigation, reveals: Investigation will begin immediately upon identifying the situation as either a potential abuse situation or an allegation of abuse. Under Reporting Allegations of Abuse: Any allegation of suspicion of abuse, neglect, exploitation, misappropriation or mistreatment will be immediately reported to the Director of Nursing or her designee. Resident #3 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #3 was a [AGE] year old female initially admitted to the facility on [DATE] and most recently admitted on [DATE] with [DIAGNOSES REDACTED]. The Brief Interview for Mental Status (BIMS) score indicated Resident #3 had moderate cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #3's care plan there is a focus area with initiated date 11/18/2019: The resident has an ADL self-care performance deficit r/t (related to) [MEDICAL CONDITION]. Interventions include: LOCOMOTION: 1 assist with w/c (wheel chair) for long distances. Based on facility submitted Incident Summary an allegation of abuse perpetrated against Resident #3 by Certified Nursing Assistant (CNA) D occurred on 1/16/2020 at 8:00 AM and was discovered on 1/16/2020 at 8:25 AM. The finding of abuse was noted as inconclusive. The investigation summary revealed it is likely (CNA D) was rude and or disrespectful during the time she was providing care to (Resident #3). (CNA D) admitted that she did not follow the plan of care that was available to her on the Kardex, by assisting (Resident #3) in her wheelchair to the dining room. As defined in section 483.5 abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish. (Resident #3) has no resulting harm, pain or mental anguish related to this incident. (Facility) has decided to separate employment with (CNA D) due to the likeliness that she was rude/disrespectful and her failure to follow the care plan. (Facility) cannot confirm nor deny that abuse and or neglect occurred. Per facility provided 5 Day Summary the incident details included: (Resident #3) reported to her daughter this am that the CNA who had taken care of her this morning, would not help her get to breakfast and told her that she could push her own chair to breakfast. (Resident #3) also reported to her daughter, that she felt like the CNA was yelling at her when the CNA told her she could push herself .(Resident #3) is care planned and has a kardex in her room with the intervention of one staff assist for mobility for long distances . Also per the 5 Day Summary report, during an Interview with (CNA I) on 1/16/2020 at 10:54 AM. (CNA I) stated that she went to go find (CNA D) and found her in (Resident #3's) bathroom assisting (Resident #3) with morning care. (CNA I) stated that (CNA D) said 'I am irritated with this one' .(CNA D) rolled her eyes and (CNA I) could tell the (sic) (CNA D) was frustrated. (CNA I) stated she stayed in the room until (CNA D) had (Resident #3) back in the wheelchair because she felt the elder was safe at that time. During a follow up interview with CNA I on 1/20/2020 at 1:15 PM she again stated (CNA D) said 'I can't stand this one' .When she left the room (CNA D) was still in the room cleaning up the bathroom. (CNA I) stated when she left the room she went to complete some other tasks including getting .(roommate of (Resident #3)) some coffee. (CNA I) states that after bring (sic) the coffee .she exited the room and reported .what had occurred. Per interview documented with (CNA D) on 1/20/2020 at 3:51 PM she placed herself in the room assisting (Resident #3) just before (7:15 AM) and call light times confirmed that Resident #3 turned on her call light at (6:55 AM) and the call light was turned off 2 minutes and 44 seconds later. Per facility provided interview transcript with CNA I completed by Registered Nurse (RN) G, RN G posed the question to CNA I: So am I right in saying that you left (Resident #3) in the room with (CNA D)? Then you went to do a 'few' things, and got (another resident name) her coffee from the dining room, took it back t her room, then helped her to sit up and drink the coffee? Then when you were leaving the room you saw (nurse) and then reported what you witnessed? Then when (former DON) came to the cart you did not say anything to her about what had happened? and CNA I responded: yes, that's right. During an interview with Resident #3 on 08/05/2020 at 10:15 AM in the Resident's room, she reported she could not recall the incident in question. During an interview with the Family Member G on 08/05/2020 at 1:40 PM the incident with Resident #3 was discussed. Family Member G stated the day of the incident Resident #3 had informed her a staff member had been rough with her, yelled at her and made her feel unhappy. Per Family Member G, Resident #3 told her she had asked for help and the staff basically said you can do it yourself and refused to take her to breakfast. Per Family Member G, Resident #3 thought the staff member was disrespectful and she was reluctant and embarrassed to talk about it. Family Member G stated she immediately reported the incident to the charge nurse and the facility started an investigation. Per review of facility provided 5 day summary document and supported by facility provided Individual Timecard for CNA D, CNA D was suspended at 10:48 AM on 1/16/2020, at least 2.5 hours after another employee viewed CNA D display abusive behavior towards a resident at approximately 8:00 AM. The witnessed allegation was potentially earlier than the estimated time of 8:00 AM due to call light logs and CNA D reporting she completed the resident's morning cares prior to a 7:15 AM meeting. Per Facility provided disciplinary paperwork, CNA D employment was terminated because she failed to treat an elder with kindness, respect, dignity and courtesy during morning care .(CNA D) failed to follow the approved plan of care for an elder that resulted in the elder expressing that she felt 'disrespected.' During the investigation of the complaint it was identified that another staff member heard (CNA D) speaking in an unkind manner to the elder. Resident #1 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 was a [AGE] year old female initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Staff Assessment for Mental Status for Resident #1 indicated she had severe cognitive impairment and required extensive assistance for most activities of daily life (ADLs). Per review of Resident #1's care plan, there is a focus area with a date initiated of 8/16/2017: I have pain secondary to h/o (history of) left hip fx (fracture), decreased mobility and a hx of RLS and [MEDICAL CONDITION]. Interventions include Monitor/record/report to nurse any s/sx (signs or symptoms) of non-verbal pain . On 8/05/2020 at 10:05 AM Resident #1 was observed sleeping in her room on a mattress of the floor. Per interview with LPN K, Resident #1 spends most of her time on the floor, either sleeping or scooting around. LPN K stated that Resident #1 is not very communicative and can get very agitated at times. Based on facility submitted Incident Summary an allegation of abuse perpetrated by CNA B against Resident #1 occurred on 5/20/2020 at 7:12 PM and was not discovered until 5/21/2020 at 3:50 PM. 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When the CNA moved her, (Resident #1) said 'ouch' .began stuttering and basically said you don't know what you're doing to my body.' The CNA responded by saying, 'you don't know what you're doing to my body when I have to pull you.' Per the document, during an

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	235076	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) interview completed by the facility with CNA B on 5/29/2020, CNA B admitted that she moved Resident #1 and the resident stated my body hurts and CNA B stated she responded that my back hurts. An interview was completed with RN H on 8/5/2020 at 1:30 PM regarding the incident with Resident #1. RN H confirmed she had completed the investigation regarding the incident and she was the Director of Nursing for the facility from February 2020 through July 2020. RN H confirmed that DA L had not immediately reported the incident. RN H stated that DA L was a newer employee at the time and stated she was not aware of the process due to being new. RN H stated she immediately provided verbal education to DA L related to reporting allegations immediately and who to report to. RN H was not aware of or could not recall if re-education was provided to all staff after this incident. On 8/5/2020, the personnel file for DA L was reviewed and no documentation of re-education or discipline related to abuse reporting for the 5/20/2020 incident was observed. RN A was asked on 8/5/2020 at 2:15 PM if any education or discipline was completed, RN A looked into the matter and later stated on 8/5/2020 at 2:45 PM that DA L's supervisor had indicated they completed verbal re-education with her but did not document anything in her personnel file. Per review of facility provided Individual Timecard for CNA B, on 5/20/2020 CNA B worked from 6:42 PM to 5:08 AM on 5/21/2020. The alleged incident of abuse with Resident #1 occurred at 7:12 PM on 5/20/2020 and CNA B completed an additional 10 hours of her shift after a witnessed allegation. Per facility provided disciplinary paperwork, CNA B's employment was terminated on 5/29/2020 due to an interaction with elder- overheard by another staff member telling the elder 'she doesn't know what she does to her back' when repositioning her. Attitude: failure to treat all persons with kindness, respect, and dignity using the appropriate tone of voice, and body language. The disciplinary paperwork further revealed CNA B received a verbal warning on 12/9/19 for her interaction and attitude while in an elder's room. On 3/13/20 (CNA B) received a final written warning related to her attitude and demeanor while in a patient care area.