STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE LIGHTHOUSE AT HANCOCK HEALTH AND REHAB	1400 POPLAR ST HANCOCK, MI 49930

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 -** Minimal harm or potential for 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** This citation pertains to intake #MI 328. Based on interview and record review, the facility failed to provide adequate supervision to prevent a resident to resident altercation for two Residents (#3 & #4) of eight residents reviewed for safety/supervision. This deficient practice resulted in painful physical contact for Resident #3, and minor injury (a scratch) to Resident #4's nose. Findings include: Review of Resident #3's Minimum Data Set (MDS) assessment, dated 10/29/2019, revealed the following diagnoses, in part: Non-Alzheimer's dementia, [MEDICAL CONDITION], anxiety, depression, and [MEDICAL CONDITION]. Resident #3 was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Resident #3 used a wheelchair for locomotion. Review of Resident #4's MDS assessment, dated 9/6/2019, revealed the following diagnoses, in part: Non-Alzheimer's dementia, delusional disorder, mood disorder, alcohol dependence with alcohol-induced dementia, [MEDICAL CONDITION], and [MEDICAL CONDITION]. Resident #4 scored 10 of 15 on the BIMS, reflective of moderately impaired cognition. Review of the facility undated, unsigned Investigative Summary revealed three residents, including Resident #3 and Resident #4, and one staff member (Laundry Aid (Staff) D) went out for the last smoke break (08:00 p.m.) on 10/15/2019. Resident #4 locked the brakes on his wheelchair, stood up, and told Resident #3 Let's go (fight). Resident #4 approached Resident #3 swinging. Resident #3 attempted to block the blows, but contact was made with the top of Resident #3's head and left cheek. Resident #3 removed Resident #4 from his immediate area and scratched the left side of Resident #4's nose causing a minor abrasion (bleeding scratch). During an interview on 3/3/2020 at 1:30 p.m., when asked about the 10/15/19 altercation with Resident #4, Resident #3 stated, He (Resident #4) was always telling us out there he was going to kill us and send us to jail .Oh yeah it hurt when he hit me. He (Resident #4) hit me in the head a couple of times . Resident #3 touched and pointed to his right cheek and his left cheek. Review of Resident #4's Progress Notes included the following entries: 9/26/19 - . (Resident #4) continues to go out on scheduled smoke breaks, with reported behavioral issues toward staff. Staff have reported (Resident #4) being confrontational with them outside. (Resident #4) has hallucinations and delusions . 10/5/19 - . Yelling at all staff today, very suspicious of staff and other residents. Resident (#4) is accompanied outside with activities to smoke his nicotine, cussing and being rude to other residents outside as reported by other residents. 10/13/19 - . laundry aid took out the smokers and relayed to me that (Resident #4) was yelling and swearing at (Resident #3). 10/15/19 - This Resident (#4) was noted to have a small spot of blood on the right side of his nose .Other resident (#3) and staff witnesses stated the resident (#4) became verbally abusive with other resident and stood up from his wheelchair and swung at another Resident (#3) and said Resident (#3) pushed this Resident (#4) by the face forcing him back into his wheelchair . Review of Staff D's Witness Statement regarding the above 10/15/19 altercation revealed the following: Staff D - (Resident #4) was mumbling . All of a sudden, he put his breaks (sic) on and got up and started yelling lets go and swinging at (Resident #3). (Resident #3) pushed his head. (Resident #4) sat back down in his chair and continued to yell. As soon as I saw him (Resident #4) stand up, I used my walkie talkie and asked for help (from staff inside the facility) . Resident #3 - . (Resident #4) pushed his chair back, stood up and started to swing at me and punched the top of my head. Then he hit me in the cheek (left) and then I shoved him (by his face) back into his chair. During an interview on 3/3/2020 at 4:10 p.m., when asked to describe the altercation that occurred on 10/15/2019 between Resident #3 and Resident #4, Staff D stated, .I held the door open for them, and I was six months pregnant. I could not push the residents out (outside), hold the smoke box (large rolling chest with resident smoking supplies) and hold the door. I had to go back in (into the facility doors) and get the smoke box and (Resident #4) was standing up over (Resident #3), and he was yelling, 'Let's fight - Let's go.' I don't know if anyone was hit, cause I was standing back because I didn't want to get hit because I was six months pregnant. I walkie talkied (sic) someone to come out and help me . Additional staff did not arrive until the altercation was over. Review of the facility Abuse Program policy revealed the following, in part: .Prevention .The facility identifies, corrects, and intervenes in situations in which abuse .is more likely to occur . The deployment of staff on each shift in sufficient numbers to meet the needs of the residents and assure that the staff assigned has knowledge of the individual resident's needs . During an interview on 3/3/2020 at 4:50 p.m., when asked what the expectation would be for staff present as a resident to resident altercation was occurring, the Nursing Home Administrator (NHA) stated, My expectation would be for them (staff) to intervene and keep the resident safe. During an interview on 3/4/2020 at 12:28 p.m., when asked about identified behavioral issues, Director of Social Services (Staff) L said Resident #4 was having behavioral issues outside with smoke breaks prior to the 10/15/19 resident to resident altercation. When asked how Staff L would handle a resident to resident altercation, Staff L stated, I would get between him and the other resident, first and foremost Absolutely that should be our instinct - to keep them apart .

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.