STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235287	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROVINCIAL HOUSE OF ADRIAN	**700 LAKESHIRE TR ADRIAN, MI 49221**

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	**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 327. Based on interview and record review, the facility failed to prevent a fall for one (Resident #7) of two reviewed for falls, resulting in R7 being rolled away from the Certified Nursing Assistant (CNA) during care, falling from their bed onto the floor and sustaining a contusion, laceration and transfer to the hospital. Findings include: Review of the medical record reflected that Resident #7 (R7) was admitted to the facility on [DATE] and was readmitted on [DATE], with [DIAGNOSES REDACTED]. The Significant Change in Status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/29/2020, reflected that R7 had short-term and long-term memory problems, was non-ambulatory (did not walk) and required total assistance of one to two or more people for Activities of Daily Living (ADL's). R7 was discharged from the facility on 8/4/2020. According to a facility investigation, on 6/28/2020 at 4:50 AM, R7 slid out of bed while receiving incontinence care from CNA M. A Concern Form, dated 6/28/2020, reflected that R7's mother was worried about R7 due to her falling out of bed. According to the Concern Form, R7's mother stated they felt it was neglectful. A Progress Note for 6/28/2020 at 6:08 PM reflected that at 4:40 AM, CNA M notified the nurse that R7 slid out of the bed while she was attempting to roll her onto her side to change her brief. R7 had minimal bleeding on her lip from where her tooth had hit when she fell . The note further reflected that R7 appeared frightened but was showing no visible or audible signs of pain. A Progress Note for 6/28/2020 at 8:40 AM reflected that during 7:30 AM neurological checks, it was discovered that R7 was developing a hematoma to the right side of her forehead, measuring five centimeters by three centimeters. The areas was maroon in color and slightly raised. The on-call provider was notified, and R7 was sent to the emergency room . Hospital documentation reflected that R7 had ecchymosis and evidence of a contusion to the right forehead as well as a superficial laceration to upper lip and mucosa, with scab formation. R7's medical record reflected that they returned to the facility on [DATE]. According to the facility investigation file, CNA M's statement on 6/28/2020 at 10:15 AM, reflected that CNA M was changing R7's brief, and she was still wet. CNA M was wiping R7 off with a towel. CNA M tucked the brief under R7, and R7 was facing away from CNA M. CNA M had just tucked the brief under R7 and was holding onto R7 with her left hand, while tucking the brief with her right hand. R7 moved her left leg over her right leg. CNA M's glove was wet, and R7's hip was wet. R7 slipped out from underneath CNA M's hand. She turned right over on her stomach and slid off the bed. I've always turned (R7's First Name) away from me to change her. She doesn't normally move. I have turned other patients away from me as well, (sic) but will never do it again. The statement reflected that CNA M was educated that it was not safe to turn patients away from her when changing them, as it was a safety risk where they could roll out of bed. CNA M was notified to always have another staff member present on the other side of the bed when turning patients away from her. According to the statement, CNA M agreed she should have waited for help. CNA M was contacted via phone on 9/2/2020 at 3:15 PM. The surveyor provided their first name, title and purpose of call being for a survey at (Facility Name). When asked if they were still employed by the facility, CNA M stated they were not. When asked how long it had been since their employment with the facility had ended, CNA M stated she could not do this right now. She requested to be called the next day, as she was busy. CNA M hung up the phone before the surveyor could respond. CNA M was contacted via phone on 9/3/2020 at 9:47 AM. The surveyor provided their first name and title. CNA M reported that she did not have time and was getting ready to go to work. CNA M hung up the phone before the surveyor could respond. During a phone interview on 9/3/2020 at 1:22 PM, Director of Nursing (DON) B reported that R7 was totally dependent for care and required two people to assist with care, such as incontinence care. DON B reported that CNA M turned R7 away from her during perineal care, which was against facility guidelines, according to DON B. DON B reported that R7's hip was wet and slid out from under her, resulting in R7 falling off the other side of the bed. DON B reported that CNA M received education regarding not rolling residents away from her in the bed. CNA M was suspended pending investigation but did not return to work, according to DON B. CNA M had given her (resignation) notice and no longer worked for the facility, according to DON B. A ONE-ON-ONE INSERVICE RECORD, dated for 7/1/2020, reflected that CNA M was educated on a topic of patient care, patient protection practice guide forms of abuse. The description of the education reflected, Ensure that you do not roll residents away from you without another staff member present x2 if the bed isn't against the wall.

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.