STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235164	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PINE RIDGE - A REHABILITATION AND NURSING CENTER	4368 CLEVELAND AVE STEVENSVILLE, MI 49127

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** This citation pertains to intake #MI 125 Based on interview and record review, the facility failed to implement the abuse policy for reporting and response to allegations of abuse, and prevent the potential for further allegations of abuse to be unreported in 1 of 3 residents (Resident #101) reviewed for abuse, resulting in a delay in the reporting of an allegation of abuse to the State Agency and other required entities and the potential for tampering of evidence for an allegation of physical abuse and continued abuse to occur. Findings include: Review of a facility policy last revised 7/2019 revealed It is the policy of (facility name) to maintain an environment free of abuse and neglect. Staff are to report all allegations of abuse/neglect/exploitation or miss treatment, including injuries of unknown sources and misappropriation of resident property to the administrator of the facility and to other appropriate agencies in accordance with the current state and federal regulations within prescribe time frames. If the events involve abuse/result in serious bodily injury, they will be reported immediately, but no later than two hours after the allegation is made. Procedure for response and reporting allegations of abuse/neglect/exploitation: any employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency hotline without fear of retaliation. When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated: 1. The Licensed Nurse will: A. Respond to the needs of the resident and protect him/her from further incident. B. Remove the accused employee from resident care areas. C. Notify the administrator or Director of nursing. D. Monitor and document the residents condition, including response to medical treatment or nursing interventions. E. Document actions taken in the medical record. F. Complete an incident report and submit it to the administrator/DON. Review of a Face Sheet revealed Resident #101 was a [AGE] year-old female, originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 2/1/20 revealed a Brief Interview for Mental Status (BI[CONDITION]) score of 13, out of a total possible score of 15, which indicated Resident #101 was cognitively intact. During an interview on 3/3/20 at 10:52 A.M., Certified Occupational Therapy Assistant (COTA) E reported that during a group meeting on 2/1/20 at approximately 10:00 A.M., Resident #101 reported to her wanting to get out of bed last night.and staff were holding her down and squeezed her leg and now it was sore. COTA E reported that she reported her concern to Resident #101's nurse Licensed Practical Nurse (LPN) D immediately. COTA E reported that LPN D stated that she was already aware of situation. COTA E reported that she did not inform Nursing Home Administrator (NHA) A or Director of Nursing (DON) B what Resident #101 had reported to her because she thought that LPN D had already addressed Resident #101's concerns. COTA E reported that during the afternoon on 2/1/20, Resident #101's significant other (SO) Q had reported to her that Resident #101 was held down and had a hard time with staff last night. COTA E reported that LPN D then came into the conversation and stated that Resident #101 had been confused and trying to get out of bed last night. During an interview on 3/3/20 at 11:57 A.M., LPN D reported that on 2/1/20 in the afternoon, Significant Other (SO) Q had reported that Resident #101 had been roughed up by staff overnight. LPN D reported that she did not consider Resident #101's concerns as abuse, based on the report that Registered Nurse (RN) H had given her that morning. LPN D reported that RN H had reported that Resident #101 was restless during the night, so she was gotten out of bed and placed at the nurse's station. LPN D reported that if COTA E had reported these same concerns, LPN D would have passed it off as what she had already heard in report from RN H. LPN D reported that she did not contact NHA A or DON B to report Resident #101's concerns, and stated I should have. During an interview on 3/3/20 at 11:57 A.M., LPN D reported that she had passed medication to Resident #101 on 2/1/20, but did not assess Resident #101 until her next shift on 2/2/20 and at that time she did not visualize a bruise on Resident #101's leg, but felt a hard lump. During an interview on 3/4/20 at 2:31 P.M., Family Member Power of Attorney (FM-POA) S reported that on 2/1/20 approximately 8:00 P.M., Resident #101 had reported to her being roughed up during the night and pointed to her right leg. FM-POA S reported that Resident #101 had a bruise.firm.swollen area on her right inner thigh. At that time FM-POA contacted Resident #101's nurse RN I and explained that Resident #101 had reported being roughed up during the night and that she had a bruise on her leg . RN I had reported that LPN D had informed her about Resident #101's concerns during report at 3:00 P.M. today. FM-POA S then asked LPN D, why she hadn't received a call about it and asked if it had been reported to NHAA. During an interview on 3/3/20 at 3:29 P.M., DON B reported that when a resident reports an allegation of abuse, that first, the nurse should be notified to ensure the safety of the resident and to perform an assessment. DON B reported that the next step would be that staff informs NHA A or DON B. DON B reported that it was the facility's policy that all staff are responsible for reporting abuse to the NHA A or DON B and that it was not the sole responsibility of the nurse. DON B reported that it was not a clear allegation of abuse until FM-POA S visited Resident #101 on 2/1/20 at approximately 8:20 P.M. and reported her concerns to RN I. During an interview on 3/3/20 at 3:29 P.M., NHA A reported that it was his understanding that Resident #101's allegation was not considered an allegation of abuse until FM-POA S reported her concerns to RN I at approximately 8:20 P.M. on 2/1/20. During an interview on 3/4/20 at 2:18 P.M., Nurse Educator (NE) C reported that her expectation of staff response to a resident's report of being held down or squeezed by a staff member would be to report it immediately to the nurse and then the nurse would notify NHA A or DON B. During an interview on 3/5/20 at 10:16 A.M., DON B reported that LPN D did not interpret Resident #101's concerns of being roughed up by staff as a possible abuse concern, therefore it was not reported. DON B reported that the staff members that had taken care of Resident #101 prior to the allegation were CNA M and RN H, but that FM-POA S was concerned only about CNA M. DON B reported that CNA M was already off work until 2/5/20 and then placed on a different wing at the request of FM-POA S and not to be assigned to care for Resident #101. DON B reported that RN H continued to take care of Resident #101 until just recently when RN I left the facility for employment elsewhere. Review of Nursing Assignment Sheets indicated that CNA M was assigned to Resident #101's wing on 1/31/20 Night Shift (10:00 P.M.-6:00 A.M.) and again on 2/1/20. Review of Time Clock Sheets indicated that CNA M worked 2/1/20 from 10:11 P.M.-6:37 A.M. Indicating that CNA M worked the night shift following Resident #101's allegation of abuse. During an interview on 3/4/20 at 11:21 A.M., Therapy manager P reported that her expectation for COTA staff is that they report all allegations of abuse directly to the nurse assigned to the resident and to NHA A and/or DON B. During an interview on 3/3/20 at 11:42 A.M., Certified Nursing Assistant (CNA) K reported that if a resident reports being abused, she would document it and report it to a nurse or 2. During an interview on 3/3/20 at 11:46 A.M., Housekeeper R reported that if a resident reported abuse, she would tell the nurse. During an interview on 3/4/20 at 9:39 A.M., CNA O reported that if a resident reported abuse that she would notify the nurse immediately and that she would expect the nurse to notify NHA A or DON B. Review of Abuse Inservice document revealed, When abuse occurs or you suspect that abuse has occurred: 1. Tell your nurse about it immediately. The first priority is to make sure the resident and any other at risk residents are safe. This may mean that the alleged abuser will be asked to leave until the investigation has been done. Be assured that the investigation will be thorough and fair. 2. All forms of abuse must be reported to the administrator or DON immediately even if it is the middle of the night. Do not wait for your supervisor to call. Don't report it to someone else expecting that they will report it to the administrator for you.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
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 intake #MI 125 Based on interview and record review, the facility failed to prevent the potential for abuse after an allegation of abuse for 1 out of 3 sampled residents (Resident #101), resulting in an allegation of abuse not being identified and reported timely, the resident not being assessed immediately, and the potential for future mistreatment and/or abuse. Findings include: Review of a facility policy last revised 7/2019 revealed It is the policy of (facility name) to maintain an environment free of abuse and neglect. 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