| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **235624** | A. BUILDING _____ B. WING _____ | **03/12/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PORTAGEPOINTE** | **500 CAMPUS DRIVE 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) |
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| F 0600<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to prevent abuse and neglect for two Residents (#100 and #200) from five reviewed for abuse. This deficient practice resulted in feelings of humiliation for Resident #200 and the potential for skin breakdown and infection for Resident #100. Findings include: This citation pertains to Intakes #MI 516 and MI 525. The facility submitted a self reported incident to the State Agency (SA), alleging Certified Nurse Aide, (CNA) D abused Resident #200 by confining the Resident to the dining room and deliberately providing her meals last in an effort to prevent her from returning to her own room. According to the facility investigation documentation, Move In Record (commonly known as a face sheet), printed 3/11/20, Resident #200 was moderately cognitively impaired, with [DIAGNOSES REDACTED]. During an interview on 3/12/20 at 3:17 p.m., Registered Nurse (RN) H confirmed CNA A reported that CNA D confined Resident #200 to the dining room on 2/22/20 and 2/23/20, by placing other Residents who could not self propel their wheel chairs, in front of Resident #200's path out of the dining room. CNA A also alleged CNA D shut Resident #200's door and placed a STOP sign across the doorway, and told the Resident she could not enter her own room. During an interview on 3/11/20 at 3:08 p.m., CNA A confirmed she reported her observations on 2/22/20 and 2/23/20, to RN H, regarding CNA D's confinement of Resident #200 and serving the Resident last, as well as restricting the Resident from her room. CNA A confirmed she also called the Administrator to report her concerns. When asked why she thought CNA D would do the things alleged, CNA A said Resident #200 requested to use the bathroom frequently and CNA D did not want to provide that care so frequently. The above interview was congruent with the facility investigation interview, dated [DATE], conducted with CNA A. An attempt was made to contact CNA D via phone on 3/12/20 at 1:39 p.m., without success. The investigation document interview with CNA D, dated 2/26/20, confirmed CNA D delayed toileting and restricted Resident #200 from her room, as well as served her last in the dining room. The facility incident summary, not titled or dated, confirmed a thorough investigation that resulted in finding CNA D violated policies: .Identified Abuse .Preventing freedom of movement .handling elder wrongly .confinement resulting in mental anguish, and patient perception of punishment .Involuntary seclusion .identified that (CNA D) was not telling the truth as verified by 3 separate witnesses .Limiting room access .Preventing timely toileting .Mental abuse (due to) deprivation of needed services and humiliation .neglect causing mental anguish .Serving elder last for meal with intention of keeping elder in dining room longer . CNA D was terminated as of 2/27/20, as a result of the findings of the facility investigation. The facility submitted to the SA, a self reported incident alleging CNA E neglected to provide required cares for Resident #100. All investigation documents were reviewed. According to the Move In Record (face sheet), printed 3/12/20, Resident #100 was severely cognitively impaired, with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment, dated 1/29/20, revealed the Resident required extensive assistance with most ADLs (activities of daily living), including toileting. During a phone interview on 3/12/20 at 2:21 p.m., CNA E confirmed she left messes of dirty linen and clothes and toiletries in Resident #100's bathroom against policy. CNA E also confirmed she rushed through cares, sat more than she should, instead of providing care, and did not follow care plans. CNA E confirmed that at least one colleague confronted her with the infractions, but she did not respond to the colleague. During an interview on 3/12/20 at 2:42 p.m., CNA A was asked what concerns she had with CNA E's performance. CNA A said she observed Resident #100 put to bed too early and without cares being performed. When asked how she knew the bedtime cares were not performed, CNA A said the linens in the bathroom were untouched. Another time, CNA E was sitting in the alcove with a Resident who smelled of feces, but CNA E did not take the Resident to be cleaned up and changed. CNA A said often CNA E would leave Resident #100's room a mess with dirty briefs and clothes and toiletries strewn in the room and bathroom. The facility investigation documents interviews with CNA A on 2/7/20, CNA I on [DATE], CNA J on 2/10/20, CNA F on [DATE], and CNA K on 2/5/20 all corroborated the same concerns with care provided or not provided by CNA E. The investigation document Staff Concerns, dated 2/3/20, revealed on 1/27/20 around 6:00 p.m., Resident #100 was assisted on the toilet by CNA E and CNA G observed the Resident had a bowel movement, but the linens in the bathroom were not used to clean the Resident following the bowel movement. The facility investigation document interview with CNA E, dated 2/10/20, revealed CNA E admitted to providing poor care and rushing without cause to rush care. CNA E also admitted not caring for a Resident who smelled of feces. The facility Incident Summary, not dated, revealed a thorough investigation that resulted in corroborated witness statements of neglectful care by CNA E of Resident #100, and .self -identified .care was neglect and mistreatment. Based on this and the trend of consistency in (almost all interviews) reports and the substantial impact of elder safety from harm the determination of the neglect & mistreatment was substantiated . CNA E was terminated as of 2/11/20, based on the findings of the facility investigation. The policy LTC (Long Term Care) Breech of Elder's Rights, dated 1/20/20, revealed, .Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting .mental anguish (includes the deprivation by an individual .of goods or services necessary to attain or maintain physical, mental and psychosocial well being) .Mental Abuse: Includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation .Mistreatment: Means to handle an Elder roughly or wrongly .Neglect: Means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness .Involuntary Seclusion: Is defined as separation of an Elder from .his/her room .against the Elder's will .Statement of Policy: It is the responsibility of every member of the health care team to safeguard the Elder's welfare. This home will not condone abuse of any type by anyone .Any type of abuse of the Elders by a staff member is prohibited .The staff demonstrates a heightened awareness of the rights of an Elder in a compromised physical condition . |

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