STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235008	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Lawn Medical Care Facili	50 Sanderson Lane Coldwater, MI 49036

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This survey pertains to intake MI00146629. Based on observation, interview and record review, the facility failed to develop and implement person-centered care approaches for one resident (Resident #1) with dementia of three reviewed. Findings include: Review of the medical record reflected Resident #1 (R1) admitted to the facility on [DATE], with diagnoses that included Alzheimer's. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/17/24, reflected a Brief Interview for Mental Status (BIMS-a cognitive screening tool) should not be completed, as R1 was rarely/never understood. The same MDS reflected R1 had short-term and long-term memory impairments and severely impaired cognitive skills for daily decision making. On 9/5/24 at 12:08 PM, R1 was observed seated in her room, in a Broda chair (specialty chair). A staff member was observed to propel R1 to the dining room, while seated in the Broda chair. A hoyer (mechanical lift) lift sling was observed beneath R1. She was wearing padded arm protectors on both arms. On 9/6/24 at 9:26 AM, R1 was observed seated in a Broda chair, in her room. A hoyer lift sling was beneath her. She was wearing a long sleeve shirt, and a padded arm protector was observed on her right arm. R1 did not verbally respond when spoken to and kept her eyes closed. The left side of her bed was observed against the wall. A nightstand was observed approximately one foot away from the right bedside, near the head of the bed. An Incident Report, dated 8/26/24 at 7:50 AM, reflected staff was providing morning care, and R1 became combative and began hitting and squeezing her arm. When staff was putting R1's shirt on, blood was observed. The report reflected a skin tear injury to the right forearm, measuring 4.5 inches in length by 4 inches in width and 1.5 centimeters deep. An emergency room note for 8/26/24 at 9:16 AM reflected R1 presented with an extremity laceration. The documentation reflected the tissue was avulsed (torn away) to the subcutaneous fat (beneath the skin), and muscle was exposed. The note further reflected, .Given the depth of the laceration, concern was it needed repaired . (continued on next page)

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.

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

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An emergency room note for 8/26/24 at 1:10 PM reflected R1 was seen in the Emergency Department with a large laceration/avulsion to the right forearm. The wound was cleansed and closed using a combination of deep sutures, which would dissolve on their own, and sutures on the skin that were to be removed in 10 days. During an interview on 9/6/24 at 9:52 AM, Certified Nurse Aide (CNA) I reported R1 required total assistance from staff for care. She reported R1 had behaviors of being combative with care, swatting at staff, twisting the arms of staff, as well as twisting her own arms. CNA I stated she went in to provide care around 7:35 AM to 7:40 AM (on 8/26/24). While washing R1, she began swatting at CNA I and hitting and twisting her own right arm, using her left arm to do so. CNA I reported she had visualized R1's skin prior to the start of care, and no skin tears were noted. While putting R1's shirt on over her right arm, she observed blood. When she pulled R1's sleeve back, she noticed a huge skin tear, then went to the hall to get the nurse. CNA I reported seeing muscle tissue and bright red blood. CNA I stated she did not see R1's injury occur but observed R1 twisting her arm while care was being provided. CNA I reported she would normally call a second CNA in to help but could not find anyone to help her with care. When R1 became combative, CNA I stated she tried to reassure her that she was getting washed up for breakfast, that it was ok, and she (CNA) was trying to help her. CNA I reported she continued providing care to R1 that morning as she exhibited behaviors throughout the care. CNA I stated she did not stop performing R1's care that morning but probably should have, per her report. CNA I reported R1 exhibited behaviors with care pretty much daily, each time care was performed. She stated other shifts also reported the same behaviors. CNA I stated she had reported behaviors to the nurses but was unsure if anything was documented. During an interview on 9/6/24 at 12:00 PM, Registered Nurse (RN) G reported being the charge nurse the morning of 8/26/24. She reported CNA I was providing perineal care to R1, while R1 held a stuffed dog in her arm. She was notified by CNA I that blood was observed on R1's arm protector. RN G reported observing a softball sized saturation of blood and stated R1's arm was still bleeding and dripping onto her sheets. RN G reported R1's right hand was on her stuffed dog, and her left hand was squeezing her right forearm. Blood was observed around the cuticles, fingernails and under all five fingers of R1's left hand. Upon assessment, RN G stated adipose (fatty) tissue was noted on the skin flap. Under the deepest part, muscle and tendon were visible. According to RN G, CNA I did not know what happened and stated the injury was not present at the start of care. RN G reported the Physician assessed R1's arm and ordered for her to be sent to the emergency room . RN G reported R1 could become aggressive and liked to grab onto herself, such as her thumb, fingers, pant legs, shirt, bed sheets or the clothing of staff. She stated she always made sure R1 had something to hold onto to calm and soothe her. If that did not work, she would reapproach. In an interview on 9/6/24 at 12:17 PM, Social Worker (SW) H stated staff had not reported physical behaviors during care to her, for R1. She reported she previously stopped having staff chart behaviors on a sheet (behavior log) for R1 because they were all blank, but behaviors would be documented in the medical medical record. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nursing Home Administrator (NHA) A and Director of Nursing (DON) B on 9/6/24 at 1:23 PM, it was reported that staff training for the care of residents with dementia and behaviors included, if a resident was refusing or if there were issues during care, staff should ensure resident safety, leave, reapproach them or have other staff reapproach them and possibly having the resident hold onto something soothing. Record review reflected CNA I completed training related to dementia care, including but not limited to, Handling Difficult Behaviors in Residents with Dementia on 5/22/24.