

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/12/2024
NAME OF PROVIDER OR SUPPLIER  Lake Woods Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1684 Vulcan St Muskegon, MI 49442	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37872</p> <p>This Citation pertains to Intake Number MI00144963.</p> <p>Based on observation, interview, and record the facility failed to protect the resident's right to be free from physical abuse by a resident for one resident (Resident #2) of three residents reviewed for abuse and neglect, resulting in Resident #2 being pushed, fracturing her right radius and the right femoral neck after falling.</p> <p>Findings include:</p> <p>Review of a Facility Reported Incident (FRI) submitted to the State Agency on 05/31/24 revealed there was a resident to resident altercation occurred when (Name of R1) pushed (Name of R2) stating that she was in his way near the front lobby/dining room area. Resident have been separated and assessed by a licensed nurse to have no injury. There was no harm or psychosocial distress.</p> <p>Resident #1 (R1):</p> <p>A review of R1's Admission Record, revealed R1 was a [AGE] year-old resident admitted to the facility on [DATE] with pertinent diagnosis that include Epilepsy, Bipolar Disorder, Post-Traumatic Stress Disorder, Cerebral infarction, and muscle weakness.</p> <p>A review of R1's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 4/15/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 11 which revealed R1 was mildly impaired.</p> <p>Review of R1's progress notes revealed an Interdisciplinary Documentation dated 5/31/2024 at 16:15, written by the DON, that noted, It was observed that resident pushed resident (identified as R2) in the entryway to the dining room. (Name of R1) states that he asked her to move several times and she was in his way, so he pushed her. (Name of R1) was very aggressive and agitated. (Name of R1) was observed with his shirt unbuttoned and yelling, using obscene language. (Name of R1) was assessed for injuries of which none were noted. (Name of R1) yelled out at writer to kick him out of here. Writer explained that was not the process.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's progress notes revealed an Interdisciplinary Documentation dated 6/01/2024 at 06:35, written by (Name of Registered Nurse (RN) D) noted, I had a conversation with resident this morning regarding incident he had last night, resident stated he is acting out because he doesn't want to be here anymore and wants to send him too someplace else. I explained having negative behaviors, using vulgar language, being disrespectful and hurting others in not the way to handle it. I asked for him to be kind, treat others with respect and to talk to me if he is feeling frustrated or getting upset before taking it out on others. I offered resident to eat his meals in his room or the day room's and he agreed to eat in the day rooms which is less stimulating of environment.</p> <p>Further review of R1's progress notes reflect R1 was having increasing behaviors days prior to 5/31/24 incident including:</p> <ul style="list-style-type: none"> <li>- On 5/26/2024 at 12:12, Patient observed being verbally aggressive towards staff, patient told staff to shut the fu*k up and stop talking! Staff tried to escort patient out of harbor dining room, but patient refused, writer then came to harbor DR to redirect patient to room for lunch, patient was reluctant but agreed to go to his room. Writer educated resident on behavior towards staff and staff is to monitor and identify early signs such as irritability or aggression and to redirect resident to have quiet time alone or to perform other fun activities that (Name of R1) can enjoy.</li> <li>- On 5/27/2024 at 07:26, Resident was cussing at CNA when she was talking to him about being kind and respectful if he were to eat in dining room for breakfast. Resident chose to have negative behaviors and told CNA said, go fuck yourself, fuck off . We then explained to resident for breakfast we would have him eat in his room.</li> <li>- On 5/28/2024 at 09:54, resident is expressing behaviors and outbursts of anger toward staff. This am resident was cussing at staff while in dining area. When resident was redirected to a calmer environment to help with agitation resident stated, just kick me out. resident was escorted out of dining area and incident was resolved.</li> </ul> <p>Review of Health Care Practitioner (HCP) Visit Progress Note dated 6/3/2024 at 13:30, revealed, . They are seen and examined today after report of violent behavior, pushing another resident over with both hands resulting in broken bones. Patient says he remembers the encounter and does not know why he did this.</p> <p>During an interview with a witness on 6/11/24 at 2:20 PM, Medical Records (MR) A stated, she was sitting here (front desk) when I looked up and saw (Name of R1) in his wheelchair jerk forward in his chair (right in the doorway) and then I heard and saw (through the dining room windows) (Name of R2) yell and fall to the dining room floor. She was shaking and on the floor. The nurse that was working on the cart nearby came quickly and did a full assessment including vitals. The resident stated her wrist hurt. Both residents were separated. MR A further revealed that the incident happened fast, I did not really hear anything prior to the incident. Just a sudden commotion, a raised voice, her falling.</p> <p>During an interview on 6/11/24 at approximately 3:00 PM, Registered Nurse (RN) D stated (Name of R1's) behaviors have been increasingly getting worse. He can't go to the dining room due to conflicts with other residents and staff. The day after the incident happened (Name of R1) told me he did it because he wanted to get out of this place. His goal was to act out and go to his former living situation. He told me he will do what he can to go back. He knows what exactly what he is doing is wrong.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/11/24 at 3:45 PM, Social Services (SS) B revealed that R1's guardian wants the resident treated in house by our psych provider. SS B confirmed R1's behaviors have recently increased and as a result he was started on Ativan this morning. Resident previously lived in an independent living situation, and he wants to go back. He acts out because he thinks he can get out and get free.</p> <p>During an interview on 6/12/24 at 10:10 AM, R1 stated, I was told I pushed someone, but I don't remember. Resident further stated, she wouldn't move, she was whining and yelling at me when she was on the floor. Resident completed the interview by stating he didn't want to talk.</p> <p>Resident#2 (R2):</p> <p>A review of R2's Admission Record, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE] with pertinent diagnosis that include Peripheral Vascular Disease, Dementia, major depressive disorder, and anxiety disorder.</p> <p>A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/11/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 03 which revealed R2 was severely cognitively impaired.</p> <p>On 6/11/24 at 2:26 PM, R2 was observed in her bed sleeping with her arm in a sling.</p> <p>During an interview on 6/11/24 at 2:30 PM, Registered Nurse (RN) C stated R2 was verbalizing pain today. RN C revealed prior to her fall she would walk and was independent with most cares. She now needs assistance with her cares an allowed staff to assist her with her lunch today due to her injury and being right-handed.</p> <p>During an interview on 3/11/24 at approximately 3:50 PM, SS B revealed (Name of R2) had been out in about the last couple of months eating her meals in the dining room and going to watch the activities. Not necessarily participate but she would go and watch.</p> <p>During an observation/interview on 3/12/24 at 9:23 AM, R2 is in bed and reveals she is in pain. Resident revealed some guy/man was mean to her and pushed her down in the dining room. When asked if she felt safe resident stated, I hurt.</p> <p>Review of R2's progress notes revealed an Interdisciplinary Documentation dated 5/31/2024 at 16:15, written by DON, that noted, It was witnessed that resident (Identified as R1) pushed resident in the entryway of the dining room causing her to fall onto her buttocks. Residents were immediately separated and assessed for injury, (Name of R2) reported that her right wrist hurt. FROM, no tenderness with palpation, no bruising. Order obtained for X-ray of right wrist.</p> <p>Review of R2's progress notes revealed an Alert Note dated 5/31/2024 at 21:57, Nurse writer was in hallway at med cart when commotion was heard in dining room. Nurse (writer) put med's away and went to dining room. Resident was noted on the floor laying on her back. BP 161/74, P 96, R 19, O2 98% RA, T 97.4 temporal. Resident noted guarding right wrist. Bruising and swelling noted. Right arm elevated on pillow. Upon skin assessment, skin tear noted to right elbow measuring 4 cm x 1 cm x 0 cm. First aid applied. Awaiting x-ray.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of progress note dated 6/01/2024 at 19:06, reflected, Writer obtained x-ray results for resident.</p> <p>Results read as follows: Acute fractures of the distal radius and ulna styloid process. Writer contacted physician on call and received verbal order to send to ER for further evaluation and treatment. Resident made aware and guardian made aware. Writer also informed DON. No new concerns.</p> <p>Review of R2's hospital After Visit Summary dated 6/01/24 -6/05/24 revealed that resident was seen an admitted to the hospital for displaced right femoral neck fracture and a comminuted intra-articular distal radius fracture on the right side with some shortening and impaction.</p> <p>Review of R2's progress note dated 06/05/2024 at 18:04 revealed, Care plan updated - falls, transfer status, bed mobility, dressing, toileting.</p> <p>Review of R2's Section GG Data Collection -2023 for discharge Effective Date 6/03/2024 revealed the resident required the following Self Care assistance at, 05. Setup or clean-up assistance: Helper sets up or cleans up: resident completes activity. Helper assists only prior to or following the activity. In the areas listed below:</p> <p>1A. EATING: The ability to use suitable utensils to bring food and / or liquid to the mouth and swallow food and/or liquid once the meal has been placed before the resident.</p> <p>2B. ORAL HYGIENE: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing using the equipment:</p> <p>3C. TOILET HYGIENE: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.</p> <p>4D. PERSONAL HYGIENE: The ability to maintain personal hygiene, including combing hair, shaving, applying make-up, washing/drying face, and hands. (excludes baths/showers, and oral hygiene).</p> <p>Further review of R2's assessment reflected in all areas of Mobility she was 06. Independent: resident completes the activity by themselves with no assistance from a helper. The Mobility areas that were reviewed included: 5B. MOBILITY - SIT TO LYING: The ability to move from sitting on the side of the bed to lying flat on the bed.</p> <p>6C. MOBILITY - LYING TO SITTING ON THE SIDE OF THE BED: The ability to move from lying on the back to sitting on the side of the bed and with no back support.</p> <p>7D. MOBILITY SIT TO STAND: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.</p> <p>8E. MOBILITY CHAIR / BED-TO-CHAIR TRANSFER: The resident ability to transfer to and from a bed to a chair (or wheelchair)</p> <p>9F. MOBILITY TOILET TRANSFER: The ability to get on and off a toilet or commode.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Review of R2's Care Plan reflected numerous intervention/task areas have been initiated and revised on or after 6/05/24 as a result of residents fall.</p> <p>Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.</p> <p>Willful, as defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p>		