STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235147	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schoolcraft Medical Care Facility	520 Main St Manistique, MI 49854

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978 This citation pertains to intake MI00146197. Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the identification and reporting of potential abuse for five Residents (#10, #12, #14, #18 and #20) of six residents reviewed for abuse, resulting in the potential for unidentified abuse and further exposure to abusive situations. Findings include: Resident #10 (R10) R10 was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R10's Minimum Data Set (MDS) assessment, dated 8/15/2024, revealed R10 was independent with transfers and ambulation. Further review of the MDS assessment revealed R10 had severe cognitive impairment. Review of R10's electronic medical record (EMR) revealed the following: 6/11/2024 23:02 [11:02 p.m.] Nurses Note. Resident [complained of] hand broken after being redirected from another resident's room . DON [Director of Nursing] notified . 6/12/2024 07:57 [7:57 a.m.] Nurses Note. Writer in the [morning] to assess reports of possible broken hand . 6/12/2024 11:16 [11:16 a.m.] Nurses Note. DPOA [Durable Power of Attorney] notified of incident that occurred last night and [x-ray] orders. Review of R10's incident reports for April 1, 2024 through August 19, 2024, provided by the Nursing Home Administrator (NHA), revealed the following: Injury of Unknown Source . Incident Description: Called into unit, CNA [Certified Nursing Assistant] upset, stated [R10] was in a female resident's bed and that she tried to get him out he punched her in the leg and called her a name. Sent CNA on break and in to assess resident. Resident unable to give description. Skin assessed on hand. ROM [range of motion] assessed and [positive] for pain when making a fist. Call placed to DON, notified of same. Instructions received to obtain x-ray of hand/wrist. CNA instructed to get nurse if residents need redirecting . The Injury of Unknown Origin, checklist attached to the incident report indicated both the DON and NHA were notified of the incident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Schoolcraft Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 520 Main St Manistique, MI 49854	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 8/20/2024 at 10:53 a.m., CNA D reported finding R10 in bed with a female resident on 6/11/2024. CNA D stated upon attempting to redirect R10 from the female resident's bed, R10 became combative. CNA D stated she did not remember who the female resident was or how R10 injured his hand. Further review of R10's EMR revealed the following: 7/29/2024 14:02 [2:02 p.m.] Nurses Note. Follow up from CNA behavior charting on 7/26 [7/26/2024]. Resident was found in bed with another male resident. [R10] was naked from the waste [sic] down. Other resident unaffected by this action. CNA immediately intervened with no issues. Review of R10's incident reports revealed no report to correspond with the incident documented in R10's EMR for 7/26/2024. Review of R10's point of care Behavior charting the following, entered by CNA C on 7/26/2024 at 6:55 a.m. Resident took of dry pants and [brief] and layed [sic] in bed with another resident twice. During a telephone interview on 8/20/2024 at 11:57 a.m., CNA C reported on 7/26/2024 she found R10 unclothed and lying in Resident #12's (R12's) bed with R12. CNA C stated she did not know what R10 was doing but she thought R12 was sleeping. When asked if she reported the incident, CNA C stated she alerted the nurse but was unsure if the nurse came in to assess either resident after the incidents were reported. CNA C could not identify the nurse she alerted to R10's behavior on 7/26/2024. CNA C reported R10 was not put on one-to-one supervision following the incident. During a telephone interview on 8/20/2024 at 11:59 a.m., the DON reported she was alerted to the incident involving R10 being found unclothed in bed with R12 by reviewing R10's behavior notes. The DON stated staff did not alert her when the incidents occurred on 7/26/2024. The DON reported she did not initiate an incident report, investigation or report the incident to the NHA or the State Agency (SA) as an allegation of abuse. Resident #14 (R14) Resident 14 was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety and anoxic brain injury (brain damage due to lack of oxygen). Review of R14's MDS assessment dated [DATE] revealed was independent with transfers and ambulation. Further review of the MDS assessment revealed R14 had severe cognitive impairment. Review of R14's EMR revealed the following: 6/15/2024 2216 [10:16 p.m.] Nurses Note. Resident (1) was found in resident (2) room laying on top of resident (2) when aid went in to try to get resident (1) off of resident (2), resident (1) tried to hit the aid and kick at her. So, aid got resident (2) out of bed to try to remove resident (1) other resident (3) came in the room and resident (1) tried to hit him, so he turned and tried to hit the aid. The note was entered by Licensed Practical Nurse (LPN) B. Review of R14's incident reports for April 1, 2024, through August 19, 2024, provided by the NHA, revealed no incident report to correspond with the incident documented in R10's EMR on 6/15/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Schoolcraft Medical Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 520 Main St Manistique, MI 49854	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 8/20/2024 at 11:33 a.m., LPN B she was alerted by a CNA of the incident on 6/15/2024. LPN B stated she was alerted R14 was found lying on top of Resident #18 (R18) in R18's bed. LPN B reported she was unsure of what R14 was doing or if there was a conflict prior to the CNA's attempts to redirect and separate the residents but remembered R20 was involved. LPN B could not recall the CNA who alerted her of the incident. A review of R14's EMR was conducted with the NHA on 8/20/2024 at 2:10 p.m. The NHA confirmed no incident report or investigation was initiated regarding the incident involving R14, R18 and R20 on 6/15/2024. The NHA stated she recognized the incident as an allegation of abuse and that it should have been reported to her and the SA. The NHA reported she was also unaware of the incident between R10 and R12 on 7/26/2024. The NHA stated a diagnoses of dementia and/or when residents state they do not remember an incident does not negate the facility's responsibility to identify allegations of abuse and report such allegations to the SA. Review of the undated facility policy titled Abuse, Prevention and Prohibition Of, revealed the following, in part: The facility employee or agent who becomes aware of abuse or neglect, including injuries of unknown source . shall immediately report the matter to the facility Administrator and/or the Director of Nursing . The facility Administrator, employee, or agent who has reasonable cause to believe any resident with whom they have direct contact has been subjected to abuse or neglect, or any allegation of abuse or neglect shall report or cause a report to be made to the mandated state agency per reporting criteria . Definitions: Abuse means the willful infliction of injury . intimidation . resulting in physical harm, pain or mental anguish . Willful means that individual intended the action . Special Note: A diagnosis of dementia (including Alzheimer's) does not rule out the ability of a person to form intent .

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41978

This citation pertains to intake MI00146197.

Based on interview and record review, the facility failed to thoroughly investigate allegations of abuse for five Residents (#10, #12, #14, #18 and #20) of six residents reviewed for abuse. Findings include:

Resident #10 (R10)

R10 was admitted to the facility on [DATE] with a primary diagnosis of dementia. Review of R10's Minimum Data Set (MDS) assessment, dated 8/15/2024, revealed R10 was independent with transfers and ambulation. Further review of the MDS assessment revealed R10 had severe cognitive impairment.

Review of R10's incident reports for April 1, 2024, through August 19, 2024, provided by the Nursing Home Administrator (NHA), revealed the following:

Injury of Unknown Source . Incident Description: Called into unit, CNA [Certified Nursing Assistant] upset, stated [R10] was in a female resident's bed and that she tried to get him out he punched her in the leg and called her a name. Sent CNA on break and in to assess resident. Resident unable to give description. Skin assessed on hand. ROM [range of motion] assessed and [positive] for pain when making a fist. Call placed to DON, notified of same. Instructions received to obtain x-ray of hand/wrist. CNA instructed to get nurse if residents need redirecting . The Injury of Unknown Origin, checklist attached to the incident report indicated both the DON and NHA were notified of the incident.

Review of the written statement signed by CNA D and dated 6/11/2024 at 10:15 p.m., revealed the following:

[R10] was in bed with another resident. When I went to get him out he swung at me and while I was getting him out of the female resident's bed he punched me in my leg and called me a [expletive]. Finally got him in his own room.

It was noted there was no documentation in R10's EMR or in the incident report and witness statement, dated 6/11/2024, as to how R10 injured his hand.

During a telephone interview on 8/20/2024 at 10:53 a.m., CNA D reported finding R10 in bed with a female resident on 6/11/2024. CNA D stated upon attempting to redirect R10 from the female resident's bed, R10 became combative. CNA D stated she did not remember who the female resident was or how R10 injured his hand.

Further review of R10's EMR revealed the following:

7/29/2024 14:02 [2:02 p.m.] Nurses Note. Follow up from CNA behavior charting on 7/26 [7/26/2024]. Resident was found in bed with another male resident. [R10] was naked from the waste [sic] down. Other resident unaffected by this action. CNA immediately intervened with no issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R10's incident reports revealed no report to correspond with the incident documented in R10's EMR for 7/26/2024. Review of R10's point of care Behavior charting the following, entered by CNA C on 7/26/2024 at 6:55 a.m. Resident took of dry pants and [brief] and layed [sic] in bed with another resident twice. During a telephone interview on 8/20/2024 at 11:57 a.m., CNA C reported on 7/26/2024 she found R10 unclothed and lying in Resident #12's (R12's) bed with R12. CNA C stated she did not know what R10 was doing but she thought R12 was sleeping. When asked if she reported the incident, CNA C stated she alerted the nurse but was unsure if the nurse came in to assess either resident after the incidents were reported. CNA C could not identify the nurse she alerted to R10's behavior on 7/26/2024. CNA C reported R10 was not put on one-to-one supervision following the incident. Further review of the EMRs for R10 and R12 revealed no documentation of physical or psychosocial assessments by licensed staff following the incidents on 7/26/2024. In addition, no documentation of physical or psychosocial assessments were conducted in relation to the incident involving R10 and R14 on 6/11/2024. During a telephone interview on 8/20/2024 at 11:59 a.m., the DON reported she was alerted to the incident involving R10 being found unclothed in bed with R12 by reviewing R10's behavior notes. The DON stated she interviewed R10 and R12 and found neither Resident recalled the incidents, therefore an investigation was not conducted. The DON reported no physical or psychosocial assessments were completed on R10 and R12 in relation to the incident since they did not remember, and she did not feel any harm was done. Resident #14 (R14) Resident 14 was admitted to the facility on [DATE] and had diagnoses including dementia, anxiety and anoxic brain injury (brain damage due to lack of oxygen). Review of R14's MDS assessment dated [DATE] revealed was independent with transfers and ambulation. Further review of the MDS assessment revealed R14 had severe cognitive impairment. Review of R14's EMR revealed the following: 6/15/2024 2216 [10:16 p.m.] Nurses Note. Resident (1) was found in resident (2) room laying on top of resident (2) when aid went in to try to get resident (1) off of resident (2), resident (1) tried to hit the aid and kick at her. So, aid got resident (2) out of bed to try to remove resident (1) other resident (3) came in the room and resident (1) tried to hit him, so he turned and tried to hit the aid. The note was entered by Licensed Practical Nurse (LPN) B. Review of R14's incident reports for April 1, 2024, through August 19, 2024, provided by the NHA, revealed no incident report to correspond with the incident documented in R10's EMR on 6/15/2024. During a telephone interview on 8/20/2024 at 11:33 a.m., LPN B she was alerted by a CNA of the incident on 6/15/2024. LPN B stated she was alerted R14 was found lying on top of Resident #18 (R18) in R18's bed. LPN B reported she was unsure of what R14 was doing or if there was a conflict prior to the CNA's attempts to redirect and separate the residents but remembered R20 was involved. LPN B could not recall the CNA who alerted her of the incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R14's EMR was conducted with the NHA on 8/20/2024 at 2:10 p.m. The NHA confirmed no incident report or investigation was initiated regarding the incident involving R14, R18 and R20 on 6/15/2024. The NHA stated the incident should have been investigated as an allegation of abuse. The NHA reported she was also unaware of the incident between R10 and R12 on 7/26/2024. The NHA stated a diagnosis of dementia and/or when residents state they do not remember an incident does not negate the facility's responsibility to identify and investigate allegations of abuse. Review of the undated facility policy titled Abuse, Prevention and Prohibition Of, revealed the following, in part: Resident abuse must be reported immediately to the Director of Nursing . and the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action . Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Employees will be interviewed who were working on the specific hall/wing . If the resident is not interviewable, question the roommate and any family or friends who visit frequently to assist with completion of a questionnaire. Follow-up counseling should be made available . Definitions: Abuse means the willful infliction of injury . intimidation . resulting in physical harm, pain or mental anguish . Willful means that individual intended the action . Special Note: A diagnosis of dementia (including Alzheimer's) does not rule out the ability of a person to form intent .