

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235499	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2024
NAME OF PROVIDER OR SUPPLIER Grand Oaks Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Denmark St Baldwin, MI 49304	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120</p> <p>This citation refers to MI00146957.</p> <p>Based on interview and record review, the facility failed to report an allegation of mental and verbal abuse in a timely manner to the state survey agency for 1 of 6 residents (R5) reviewed, resulting in allegations of abuse not being reported timely to the state survey agency, all allegations of abuse not being accurately and completely reported to the state survey agency, the potential for allegations of abuse not being investigated timely, the potential for abuse to go undetected, and the potential for residents not being protected from abusive individuals.</p> <p>Findings include:</p> <p>A review of R5's Admission Record, dated 10/7/24, revealed R5 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 5's Admission Record revealed multiple diagnoses that included bipolar disorder and need for assistance during personal care.</p> <p>A review of R5's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 7/8/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R5 was cognitively intact.</p> <p>During an interview on 10/3/24 at 4:20 PM, R5 stated about a month ago a nurse named [first name of nurse] (R5 stated she did not know the nurse's last name but described her as the one with the long hair because there's two [first name of nurse]'s) yelled at her and intimidated her. R5 stated, she got right up and close to me. She was yelling at me telling me I had to do things on my own. R5 stated she felt the nurse was just talking loudly and was trying to encourage her to do things on her own. She stated she did not like the way the nurse spoke to her. I was crying. I was scared she would hit me. R5 further stated she asked [first name of nurse] if she was going to hit her and [first name of nurse] told her no, but she could if she wanted to and there's nothing she could do about it. R5 told her she was scared of her and [first name of nurse] told her that she could always call her husband (R5's) and tell him he could pick her up on the bench outside. [First name of nurse] told her she would take her outside and put her on the bench so he could pick her up. She stated she reported this to a nurse (she did not remember the nurse's name) and she was told it would be taken care of. R5 stated since then, [first name of nurse] has been nicer to her. However, she stated no one had spoken to her about her allegations or followed-up with her since she reported them to the nurse.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/3/24 at 4:30 PM, the Director of Nursing (DON) was informed of the conversation with R5 and the allegations. The DON was informed that R5 stated a nurse named [first name of nurse] had yelled at her, was close to her face, and R5 felt scared and intimidated by her. The DON was also informed that the nurse had stated she could hit R5 if she wanted to and had told R5 if she did not like it at the facility, R5 could call her husband and she would put R5 outside on a bench for him to pick her up. The DON identified the nurse as Licensed Practical Nurse (LPN) I and stated she was aware that R5 had accused LPN I of yelling at her. The DON stated LPN I had been educated. The DON further stated she was not aware that LPN I had told R5 she could hit her if she wanted to or that LPN I had told R5 that her husband could come and get her after she put her outside. The DON stated she would gather all the information she had on R5's previous complaint that LPN I had yelled at her, including any education that was provided to LPN I and that she would provide a copy to me. I also requested that the DON follow-up with me about what the facility's plan was and their actions related to the allegations that LPN I had told R5 she could hit her if she wanted to; that she could put her outside on a bench for her husband to pick her up if she did not like it at the facility; and that she (R5) was saying LPN I had yelled at her, scared her, and intimidated her (continuing issue or past issue that was resolved). The DON verbalized understanding.</p> <p>During an interview on 10/7/24 at 1:00 PM, the Nursing Home Administrator (NHA) stated she had spoken with R5 on 10/3/24 with the DON but did not indicate if this was before or after the DON was notified by me of the allegations R5 had made against LPN I. She stated she asked R5 about the nurse and what had happened with the nurse allegedly yelling at her. The NHA stated R5 did not mention that the nurse had threatened to hit her or have her call her husband and have him pick her up. She stated R5 has a personal protection order (PPO) against her husband, so she wouldn't be calling him to pick her up anyway. The NHA stated R5 has an extensive psychiatric history and that these allegations are a part of her psychiatric diagnosis. She stated R5 makes accusations when she is undergoing a mental crisis. We have to send her back and forth to the psych facility as she cycles (goes from no behaviors to behaviors related to a mental crisis). The NHA stated Thursday (10/3/24) was the first time she heard about the nurse threatening to hit R5 or have someone come and get her if she does not like it at the facility. She stated she will start an investigation now that I mentioned something to her.</p> <p>A review of R5's electronic medical record, dated 7/30/24 to 10/7/24, failed to reveal any mention that R5 had made an accusation against staff or yelling at her, scaring her, intimidating her, threatening her with physical harm, or telling her she can leave the facility if she does not like it there.</p> <p>A review of [name of the State's Facility Reported Incident System] on 10/7/24 at 3:30 PM, failed to reveal that the facility had reported the allegations of verbal abuse that R5 made against LPN I (yelling at her, intimidating her, and/or threatening her) either recently or in the past.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/7/24 at 3:40 PM, the NHA was informed I had a concern that R5 stated a nurse had yelled at her up close, had scared and intimidated her, and had told her she could hit her if she wanted to. She was also informed I was concerned that the nurse had threatened R5 by telling her if she did not like it at the facility then R5 could call her husband to come pick her up and the nurse would put her on a bench outside for him. The NHA was also informed I was concerned that there did not seem to be any documentation an investigation had been started (or investigated in the past) or that R5 had made the allegations, even though the NHA had stated earlier that she would be starting an investigation. The NHA stated she was also concerned about this. The NHA further stated she had just spoken with R5 again prior to this interview. She stated R5 had told her that these allegations had occurred sometime in the winter. The NHA also stated that she had spoken to R5 several times about these allegations since 10/3/24 and R5 changed or varied her statement. She stated R5 changed when the incident occurred (i.e., recently vs. months ago) and/or the number/type/severity of allegations (e.g., yelling vs speaking loudly; one allegation of the nurse yelling at her close to her face vs the nurse yelling close to her face, telling her she could hit her if she wanted, and telling her she can call her husband and have him pick her up after the nurse puts her outside for him) when she had spoken to her. The NHA stated she has had a difficult time based on her interviews with R5 figuring out what the allegations actually were or when they occurred in order to investigate them. I requested any documentation that she may have regarding these allegations and what the facility has done or will do (e.g., documentation of R5's interview or staff interviews, report to the state survey agency, etc.). The NHA verbalized understanding.</p> <p>A review of [name of the State's Facility Reported Incident System] revealed the facility reported to the state survey agency on 10/7/24 at 4:33 PM (4 days after the incident was reported to the DON and 3.5 hours after it was again reported to the NHA by the surveyor) that R5 stated a nurse (LPN I) yelled at her in the past few weeks, month, when there was snow on the ground and denied any physical contact. The facility reported they were aware of the allegation on 10/3/24 at 4:30 PM. However, the facility failed to report that the surveyor had notified them of this allegation and that R5 had also reported that LPN I had also told her she could hit her if she wanted to, that R5 felt scared and intimidated by LPN I, and that LPN I had told R5 she could put her outside on a bench for her husband to pick her up if she did not want to stay at the facility (possibly when it was snowy and cold outside if it occurred at the same time that R5 stated the nurse yelled at her). Therefore, the facility failed to accurately and completely report all allegations of abuse on their initial report to the state survey agency.</p> <p>A review of the facility's Identification of Abuse Policy and Procedure, revised March 2019, revealed mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal abuse may be considered a type of mental abuse. Examples listed in the facility's policy for psychological, mental, or verbal abuse include harassing a resident; yelling or hovering over a resident, with the intent to intimidate; and threatening residents.</p> <p>A review of the facility's Abuse/Suspected Abuse: Crime Investigation and Reporting Policy and Procedure, revised February 2023, revealed, 8 . the facility will report all alleged violations (allegations) to the state survey agency and all other agencies as required and take all necessary corrective actions depending on the results of the investigations . 9. Reports are submitted online into the [name of the State's Facility Reported Incident System]: (1) Immediately but no later than 2 hours if the alleged violation involves abuse .</p>		