STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30675

This citation pertains to intake #MI00146443.

Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident between two (R803 and R804) of 11 residents reviewed for abuse.

Findings include:

Review of a Facility Reported Incident (FRI) revealed there was a resident to resident incident that resulted in injury.

On 9/16/24 at 10:00 AM, R803 was observed reading while seated in wheelchair next to their bed. When asked about the incident that occurred with R804 on 8/4/24, R803 pointed to the top of their right wrist and stated the scratch there won't go away. There was a linear scab approximately three inches in length to the top right wrist area. The resident reported R803 just came into their room and when they asked R803 to get out, that resident started beating them in the head and arm.

Further review of the facility's investigation into the incident on 8/4/24 documented:

[R803] has been a resident at the facility since September 24, 2018. He is [AGE] years of age and has a BIMS (Brief Interview Mental Status exam) score of 15 (indicating intact cognition).

Resident has a diagnosis of Cerebral Infarction, Major Depressive Disorder and Hemiplegia.

[R804] has been a resident at Canterbury on the Lake since October 13, 2023. She is [AGE] years of age and has a BIMS score of 4 (indicating severe cognitive impairment).

Resident has a diagnosis Cognitive Communication Deficit, Vascular Dementia, Adjustment Disorder and Unspecified Dementia.

On August 4, 2024 at 1920 hours (7:20 PM), [R803] approached [Nurse 'D'] and informed him that Resident [R804], entered his room and became physically aggressive with him causing abrasions to the top of his head and right upper arm. Resident stated that 'she came into my room and I told her to get out and she just started beating me in the head'. Resident stated that he felt afraid and unsafe.

(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: 235555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Canterbury on the Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 Hatchery Rd Waterford, MI 48329	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident sustained an abrasion to this head and right upper arm. [Nurse 'D'] treated the residents skin abrasions. The Administrator was immediately notified and [R804] was sent to the hospital for evaluation and returned later that evening and was placed on a 1 on 1 supervision. [R804] was diagnosed with a Urinary Tract Infection which is being treated by Antibiotics. [NAME] witnessed this event. [Nurse 'D'] was interviewed by the Director of Nursing and stated, [R803] approached me stating that [R804] entered his room and became physically aggressive with him causing abrasions to the top of his head and his Right Upper Extremity. Both residents were immediately separated. [R803] states, 'I told her to get out and she just started beating me in the head. Resident stated that he felt afraid and unsafe. I notified the DON (Director of Nursing) and Administrator immediately.' [Social Service Tech/SST 'C'] interviewed [R803], [SST 'C'] stated, [R803] was calm when I met him. He stated [R804] came into his room. He told her to leave. She then started hitting him and scratched him. Which scared him. [R804] also wandered over to [R803's] roommate [name redacted] and tried to take his splint. This was the second time [R804] had been in his room that day. {R804] had followed the nurse in [R803's] room that day when the nurse came in to give [R803] his medication. The nurse redirected her out of the room. [R803] stated [R804] had been setting off alarms all day. [R803] said it really upset him and he doesn't want her to come into his room. He is worried that she will. [SST 'C'] interviewed [R804] on August 4, 2024. [R804] does not recall doing any of this. Other residents were interviewed by [SST 'C'], and there was no one that had any concerns related to [R804]. 1 resident stated that she has come into her room in the past but she is easily redirectable CONCLUSION: [R804] did go into [R803's] Room and hit him causing an abrasion to this head and his arm. [R804] was sent to the hospital and upon return has been placed on 1 on 1 supervision. Both resident care plans have been reviewed and revised as indicated and are being monitored by Social Work weekly. Further review of the clinical records for R803 and R804 included: An entry on 8/4/24 at 10:23 PM by [Nurse 'B'] read, Writer called to room [redacted] where resident states he told [R804] to get out and she attacked him. An entry on 8/4/24 at 9:43 PM by Nurse 'B' read, Resident Sent to [name of local hospital] for exacerbation of aggression towards other residents . (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 1:40 PM, an interview was completed with the Administrator who was also the facility's Abuse Coordinator. When asked about the details of the resident-to-resident altercation on 8/4/24, the Administrator confirmed the same as documented. The Administrator was informed of the concern that on the same day the incident occurred, R804 had gone into R803's room while following the Nurse for medication administration and although had been redirected at that time, was able to gain unsupervised access to R804 which resulted in physical abuse to R803 and feelings of being afraid and unsafe. The Administrator acknowledged the concerns and offered no further explanation. According to the facility's policy titled, Abuse & Elder Justice Act Policy dated 1/18/2024: .Examples of Physical Abuse: 1. Striking the resident by using a part of the body, such as hitting, slapping, pinching, punching, kicking, pushing, shoving, or spitting .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #s: MI00146438, MI00146642, and MI00146819. Based on observation, interview, and record review, the facility failed to provide one-to-one feeding assistance for one resident (R806) of three residents reviewed for activities of daily living. Findings include: Review of multiple complaints reported to the State Agency alleged residents were not being offered feeding assistance per their plan of care. The facility was previously determined to be out of compliance for concerns with provision of Activities of Daily Living (ADLs) during the recertification survey conducted on 7/17/24 with an alleged compliance date of 8/20/24. On 9/16/24 at 9:45 AM, R806 was observed in their room, laying in a reclined position in a gerichair. Their meal tray was observed placed on an overbed tray table directly in front of them that contained a Styrofoam container and a Styrofoam cup with a straw. R806 did not have a clothing protector on and was observed to have scrambled egg in the front of their neck and clothing. Upon approach, R806 reported they were upset since they usually were brought to the dining room for meals, but this morning they were not because they said it was due to a covid outbreak. When asked about if they were offered the use of a clothing protector, R806 reported no one did that, they just brought the meal in and left it. The meal ticket on the tray indicated R806 was not to have any straws, and also indicated they were to receive 1:1 feeding assistance. When asked about whether anyone had come in to offer assistance with feeding, R806 reported no one had and they were usually up and ate in the dining room where that was done. At approximately 9:50 AM, Certified Nursing Assistant (CNA 'E') entered the room to ask to remove the meal tray. They were not wearing a name badge and when queried about why not, they reported they were from the agency staff. When asked about the meal ticket that indicated R806 was not to have any straws, and they were required to have 1:1 feeding assistance, CNA 'E' reported they were not aware of either of those things, and they had not set up the resident's tray, someone else had dropped that off earlier. Review of the clinical record revealed R806 was admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: dysphagia (difficulty swallowing foods or liquids), acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, pneumonia unspecified organism, and other toxic encephalopathy. Review of R806's Kardex (plan of care) documented, in part: 1:1 assistance with meals as ordered per ST (Speech Therapy) recommendations EATING: 1:1 assist (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235555	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[R806] is to be sitting upright for all meals per ST recommendations Review of the Resident Tasks documented: .Special Instructions: NO STRAWS, 1:1 assist . On 9/17/24 at 9:15 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who was covering for the clinical needs due to the Director of Nursing being out sick. When asked about the facility's process for ensuring agency staffing were aware of the resident's plan of care for example if the resident needed feeding assistance, they reported they should be doing a shift-to-shift report, but if not, then the nurse is responsible to go around and let them know. They were informed of the concerns with the observation and interviews from 9/16/24 and reported that should not have happened. According to the facility's policy titled, Activities of Daily Living (ADLs) dated 3/17/2019: .Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Prior to any procedure, the care plan will be checked for specific instructions on each individual resident .

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30675

This citation pertains to intake #s MI001146438, MI00146642, and MI00146819.

Based on observation, interview, and record review facility failed to provide sufficient nursing staff to meet the needs of residents, including four (R802, R804, R805, and R806) of four residents reviewed for sufficient nursing staff. This deficient practice has the potential to affect all residents that reside at the facility.

Findings include:

Review of multiple concerns reported to the State Agency included allegations that residents were left for long periods of time in wet/soiled briefs, not provided with feeding assistance per plan of care, and were not being supervised adequately.

R802

On 9/17/24 at 9:10 AM, R802 was observed lying in bed. R802 was asked about the care at the facility. R802 explained staffing had been a great issue lately; on the 2nd floor, there were only four CNA's scheduled, and usually at least one called in, so there would only be three CNA's to care for all the residents. When asked how many nurses were on the 2nd floor, R802 explained the nurses do not count, all the nurses do is pass medications, they never help with care. R802 was asked about food at the facility. R802 explained they were a one-to-one (1:1) feeding assist, but they only received assistance if there was enough staff to assist them . someone would bring in the tray and set in down on the over-bed table, then the tray would sit there until someone was able to come and assist them .the food was cold when it arrived, but by the time they were able to eat it, the food would be stone cold. When asked about their breakfast tray that morning, R802 explained the breakfast tray had not come yet.

Review of the clinical record revealed R802 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: multiple sclerosis, unspecified lack of coordination and muscle spasm. According to the Minimum Data Set (MDS) assessment dated [DATE], R802 was cognitively intact and required the assistance of staff for all Activities of Daily Living (ADL's).

Review of R802's nutritional care plan revealed an intervention initiated 4/11/24 that read, Requires 1:1 feeding assistance at meals.

R804

Review of a facility reported incident in which R804 was involved in a physical altercation resulting in injury to another resident on 8/4/24, revealed R804 had been placed on a 1:1 sitter and per the Administrator would remain with a 1:1 sitter.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the clinical record revealed R804 was admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: cognitive communication deficit, adjustment disorder with anxiety, and dementia. According to the MDS assessment dated [DATE], R804 had severe cognitive impairment. R805 A complaint was filed with the State Agency (SA) on 9/6/24 that alleged in part, .(R805) is supposed to receive 45 minutes of one-on-one care, but (R805) is only being provided with 20 minutes of one-on-one care. Staff members walk out of the room when the timer sounds . Review of the closed record revealed R805 was admitted into the facility on [DATE] with diagnoses that included: cerebral aneurysm, mood disorder and systemic lupus erythematosus. According to the Minimum Data Set (MDS) assessment dated [DATE], R805 was cognitively intact and required the assistance of staff for activities of daily living (ADL's). Review of R805's preferences care plan revised 9/13/24 read in part, .Care needs met in two hour intervals with a maximum of 45 min (minute) time allotted to complete tasks . Review of R805's progress notes included: A Resident Programs Note dated 7/18/24 at 5:12 PM read in part, .It took 3 cena and this writer (nurse) to changed/ bed bath resident for about 80 minutes . A Nursing Note dated 7/19/24 at 2:51 AM read in part, .Writer (nurse) and 3 staff members administered care to resident starting at (1:30 AM) .Staff finished peri care at (2:45 AM) . A Social Services Note dated 7/19/24 at 9:53 AM read in part, .after 4 staff members performed residents care, staff had been in with resident for over an hour providing care to resident . A Behavior Note dated 7/19/24 at 6:00 AM read in part, .writer (nurse) and x3 staff assisted resident .At this time it is care planned for 2 staff members at all times to enter the room . A Nursing Note dated 7/26/24 at 6:32 AM read in part, It took 53 mins and four staff members to perform routine care on the resident his morning . A Behavior Note dated 7/28/24 at 2:08 AM read in part, Writer (nurse) and 2 other staff members entered resident's room at approximately (12:50 AM) to provide routine peri care and reposition resident .Writer and staff completed routine peri care and repositioning at (1:50 AM) . A Behavior Note dated 8/4/24 at 2:12 AM read in part, .Writer (nurse) answered call light, resident requested to be changed and repositioned, 3 staff persons assisted resident with routine peri care . Staff were in the room for 2 hours completing care . A Nursing Note dated 8/11/24 at 4:12 AM read in part, .Writer (nurse) and 2 staff members .spent approximately an hour and a half to complete peri care. Writer and staff spent an additional half hour repositioning resident . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Behavior Note dated 8/14/24 at 4:30 PM read in part, .Resident care is running into dinner time, causing staff to run behind with other residents care . A Behavior Note dated 8/17/24 at 7:09 AM read in part, .Writer (nurse) explained to resident that aide on duty was in (R805's) room for almost 2 hours during shift and she will come to assist (R805) again once she has provided care to other residents on her assigned unit . A Behavior Note dated 8/18/24 at 6:43 AM read in part, .It took writer (nurse) and 2nd nurse approximately 1. 5 hours to adjust resident in bed .CNA's were in the resident's room for over 2 hours providing care . A Behavior Note dated 8/18/24 at 8:21 PM read in part, Writer (nurse) and fell ow nurse .Total care was rendered and took approximately 2 hours . R806 On 9/16/24 at 9:45 AM, R806 was observed in their room, laying in a reclined position in a gerichair. Their meal tray was observed placed on an overbed tray table directly in front of them that contained a Styrofoam container with a Styrofoam cup with a straw. R806 did not have a clothing protector on and was observed to have scrambled egg in the front of their neck and clothing. Upon approach, R806 reported they were upset since they usually were brought to the dining room for meals, but this morning they were not because they said it was due to covid outbreak. When asked about if they were offered the use of a clothing protector, R806 reported no one did that, they just brought the meal in and left it. The meal ticket on the tray indicated R806 was not to have any straws, and also indicated they were to receive 1:1 feeding assistance. When asked about whether anyone had come in to offer assistance with feeding, R806 reported no one had and they were usually up and ate in the dining room where that was done. R806 further reported they had been left to sit in their wet/soiled briefs for hours this past weekend due to not having enough nursing staff. They reported they were worried about their skin breaking down and that their skin burned a little. At approximately 9:50 AM, Certified Nursing Assistant (CNA 'E') entered the room to ask to remove the meal tray. They were not wearing a name badge and when queried about why not, they reported they were from the agency staff. When asked about the meal ticket that indicated R806 was not to have any straws, and they were required to have 1:1 feeding assistance, CNA 'E' reported they were not aware of either of those things, and they had not set up the resident's tray, someone else had dropped that off earlier. CNA 'E' was asked about their assignment and reported they had the entire hallway. When asked if they were able to complete their tasks, they reported they were doing the best they could. Review of the clinical record revealed R806 was admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: dysphagia (difficulty swallowing foods or liquids), acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, pneumonia unspecified organism, and other toxic encephalopathy. Review of R806's Kardex (plan of care) documented, in part: 1:1 assistance with meals as ordered per ST (Speech Therapy) recommendations (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	EATING: 1:1 assist [R806] is to be sitting upright for all meals per ST recommendations TOILETING HYGIENE: Dependent TRANSFERS: MAXI MOVE x 2 PERSON ASSIST Assist [R806] to reposition every 1 hour while sitting in a chair and as needed. Review of the Resident Tasks documented: .Special Instructions: NO STRAWS, 1:1 assist . Further review of the Certified Nursing Assistant (CNA) documentation revealed multiple blank documentation of care provided to R806, including the evening shift on Saturday 8/31/24, and the evening and night shift on Sunday 9/1/24 and all shifts on Sunday 9/15/24. On 9/16/24 at 4:22 PM, an interview was conducted with the facility's staffing scheduler (Staff 'I'). They reported they had been in that role for about two years and also worked as the facility's central supply staff. When asked about the facility's nurse staffing, Staff 'I' reported typical staffing for the second floor is for five CNAs (Certified Nursing Assistants) and three nurses. They further reported the nurses worked 12 hour shifts, and the CNAs worked 8.5 hour shifts. When asked if they utilized any agency staffing, Staff 'I' reported typically no, but for today, they had three agency CNAs assigned to the second floor. Staff 'I' reported there were challenges with staff call-ins and at times, the Nurses and CNAs were required to split hallways and assignments. According to the facility's documentation for their Facility Assessment last reviewed 6/28/24: .Staff is adjusted accordingly as acuity and census fluctuates, up with increased census/acuity or down with decline in census/acuity. The tool under staff PPD (Per Patient Day) is used to assist in making staff adjustments .See Staffing PPD tab for Nursing Staff . Further review of the staffing PPD for nursing staff ratios by census documented: For CNAs: There should be 5 CNAs on Days (7:00 AM - 3:30 PM) for a census of 46-60. There should be 5 CNAs on Afternoons (3:00 PM - 11:30 PM) for a census of 46-60. There should be 4 CNAs on Midnights (11:00 PM - 7:30 AM) for a census of 36-60. For Nurses: There should be 3 Nurses on Day Shift (7:00 AM - 7:00 PM) for a census of 41-60. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There should be 3 Nurses on Night Shift (7:00 PM - 7:00 AM) for a census of 41-60. Further review of the facility's census for the second floor and assignment/punch detail reports provided by the facility identified the following nurse staffing concerns: On Monday 9/16/24, the second floor census was 50. Although there were five CNAs scheduled on day shift, the fifth CNA was assigned as a 1:1 for R804, which left four CNAs to split the remaining 49 residents. There were only four evening/afternoon CNAs on the schedule which included the fourth CNA as a 1:1 for R804, which left three CNAs to split the remaining 49 residents. There were only two nurses on the schedule for the midnight shift. On Sunday 9/15/24, the second floor census was 51. There were four CNAs scheduled on day shift, the fourth CNA was assigned as a 1:1 for R804, which left three CNAs to split the remaining 50 residents. There were only three evening/afternoon CNAs on the schedule which included the third CNA as a 1:1 for R804, which left two CNAs to split the remaining 50 residents. The assignment sheet also documented the two nurses assigned were to split the CNA assignments between the two CNAs, but also were the scheduled Nurse. There were only two Nurses on the schedule for the midnight shift. On Sunday 9/1/24, the second floor census was 53. Although there were five CNAs scheduled on day shift, the fifth CNA was assigned as a 1:1 for R804, which left four CNAs to split the remaining 52 residents. Although there were five CNAs scheduled on evening/afternoon shift, the fifth CNA was assigned as a 1:1 for R804, which left four CNAs to split the remaining 52 residents. There was only one Nurse on the schedule for the midnight shift. The facility later reported a Nurse Manager came in to work so there were two Nurses (this was not reflected on the actual assignments provided for review). Review of the documentation provided for open nursing positions included: There were three full time Nurse positions open for the 1st shift; two part time positions for the day shift, and one part time position for the evening/afternoon shift. There was one full time CNA position for the day shift; one part time position for the day shift; two part time positions for the evening/afternoon shift; and two part time positions for the midnight shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/17/24 at 8:39 AM, Nurse 'J' who was one of three nurses assigned to the second floor was asked about the nursing staff for the second floor today and reported there were three nurses, four cnas and one 1:1. When asked about whether they were able to perform all the duties, they reported it was difficult at times but that's how it was now. When asked about care was provided for those residents that required two or more person assist, Nurse 'J' reported they tried to help when the CNA (Certified Nursing Assistant) lets them know. When asked if that was typical staffing for the second floor, Nurse 'J' reported that was. On 9/17/24 at 1:40 PM, an interview was conducted with the Administrator. When asked about how many residents required 1:1 feeding assistance on the second floor, the Administrator reported they would follow up. They later reported there were currently 12 residents that required 1:1 feeding assistance. When asked about why staffing ratios had not been revised in accordance with acuity needs of residents, such as for R805 that required a minimum of 45 minutes and up to four nursing staff at a time as per their plan of care, the Administrator offered to further explanation. When informed of the observations and concerns with lack of provision of care per plan of care such as feeding assistance and multiple complaints of being left in wet/soiled briefs for extended periods of time, especially on the weekends, the Administrator acknowledged the concerns but did not offer any further explanation. According to the facility's policy titled, Staffing dated 4/5/2021: .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care .Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee. 39592

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235555	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury on the Lake	5601 Hatchery Rd Waterford, MI 48329

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #s: MI00146642 and MI00146819. Based on observation, interview, and record review, the facility failed to provide drink and adaptive utensils per assessment and individualized care plan for one (R806) of three residents reviewed for dining. Findings include: Review of multiple complaints reported to the State Agency alleged residents were not being provided with food and drink per their plan of care. On 9/16/24 at 9:45 AM, R806 was observed in their room, laying in a reclined position in a gerichair. Their meal tray was observed placed on an overbed tray table directly in front of them that contained a Styrofoam container and a Styrofoam cup with a straw. R806 did not have a clothing protector on and was observed to have scrambled egg in the front of their neck and clothing. Upon approach, R806 reported they were upset since they usually were brought to the dining room for meals, but this morning they were not because they said it was due to a covid outbreak. When asked about if they were offered the use of a clothing protector, R806 reported no one did that, they just brought the meal in and left it. The meal ticket on the tray indicated R806 was not to have any straws, and also indicated they were to receive 1:1 feeding assistance. When asked about whether anyone had come in to offer assistance with feeding, R806 reported no one had and they were usually up and ate in the dining room where that was done. There was no weighted cup or utensils observed for use on the meal tray. At approximately 9:50 AM, Certified Nursing Assistant (CNA 'E') entered the room to ask to remove the meal tray. They were not wearing a name badge and when queried about why not, they reported they were from the agency staff. When asked about the meal ticket that indicated R806 was not to have any straws, and they were required to have 1:1 feeding assistance, CNA 'E' reported they were not aware of either of those things, and they had not set up the resident's tray, someone else had dropped that off earlier. On 9/17/24 at 8:33 AM, there was a Styrofoam cup of water with a straw on the bedside dresser. At that time, Speech Therapist (ST 'G') was about to enter R806's room and was asked about the resident's use of straws. ST 'G' reported they were covering for the main ST (ST 'H' who was on vacation) but reported due to their history of pneumonia and recent peg-tube placement (percutaneous endoscopic gastrostomy - a feeding tube insertion through the skin and stomach wall), R806 should not be using any straws since the risk of ingesting too much liquid and aspirating was high for the resident. Review of the clinical record revealed R806 was admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: dysphagia (difficulty swallowing foods or liquids), acute respiratory failure with hypoxia, acute respiratory failure with hypercapnia, pneumonia unspecified organism, and other toxic encephalopathy. According to R806's Kardex (plan of care): (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident to use cup with lid. Double handled cup and weighted utensils w/ (with) meals per ST, [R806] is OK to have thin liquids when under supervision via free water protocol provide (Diet): Regular/thin liquids, NO LETTUCE, NO STRAWS, per ST recommendations Review of the Resident Tasks documented: .Special Instructions: NO STRAWS, 1:1 assist . On 9/17/24 at 9:15 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who was covering for the clinical needs due to the Director of Nursing being out sick. When asked about the facility's process for ensuring resident's that have orders for no straws is followed, they reported there have been some issues with the kitchen staff sending cups with straws but should be identified by staff and corrected. They were asked about who was responsible to ensure the water cups in the rooms were provided and they reported that would be the CNAs. The ADON was informed of the concerns with the observations from 9/16 and 9/17 from both the liquids provided by the kitchen and the nursing staff that had straws for a resident with specific plan of care for no use of straws, or adaptive equipment (double handled cup and weighted utensils with meals). According to the facility's policy titled, Resident Rights dated 11/21/2016: .Each resident shall be provided with appetizing meals which meet the recommended dietary allowances for their age and which may be modified according to special dietary needs or ability to chew .

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review the facility failed to ensure the facility assessment was reviewed and revised in accordance with current regulatory requirements including changes in resident care needs (R805) and administrative changes, resulting in insufficient resources to provide for resident care and emergency/disaster needs for all 97 residents. Findings include: According to the Centers for Medicare & Medicaid Services (CMS) memo: QSO (Quality Safety & Oversight)-24-13-NH, dated 6/18/2024, revised Facility Assessment requirements effective 8/8/2024 included: .The facility assessment must address or include the following .The care required by the resident population . consistent with and informed by individual resident assessments as required under 483.20 .In conducting the facility assessment, the facility must ensure .Direct care staff, including but not limited to, RNs (Registered Nurses), LPNs/LVNs (Licensed Practical Nurses/Licensed Vocational Nurses), NAs (Nurse Aides), and representatives of the direct care staff .The facility must also solicit and consider input received from residents, resident representatives, and family members .Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population .Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population . R805 A complaint was filed with the State Agency (SA) on 9/6/24 that alleged in part, .(R805) is supposed to receive 45 minutes of one-on-one care, but (R805) is only being provided with 20 minutes of one-on-one care. Staff members walk out of the room when the timer sounds . Review of the closed record revealed R805 was admitted into the facility on [DATE] with diagnoses that included: cerebral aneurysm, mood disorder and systemic lupus erythematosus. According to the Minimum Data Set (MDS) assessment dated [DATE], R805 was cognitively intact and required the assistance of staff for activities of daily living (ADL's). Review of R805's preferences care plan revised 9/13/24 read in part, .Care needs met in two hour intervals with a maximum of 45 min (minute) time allotted to complete tasks . Review of R805's progress notes revealed: A Resident Programs Note dated 7/18/24 at 5:12 PM read in part, .It took 3 cena and this writer (nurse) to changed/ bed bath resident for about 80 minutes . A Nursing Note dated 7/19/24 at 2:51 AM read in part, .Writer (nurse) and 3 staff members administered care to resident starting at (1:30 AM) . Staff finished peri care at (2:45 AM) . (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A Social Services Note dated 7/19/24 at 9:53 AM read in part, .after 4 staff members performed residents care, staff had been in with resident for over an hour providing care to resident . A Behavior Note dated 7/19/24 at 6:00 AM read in part, .writer (nurse) and x3 staff assisted resident . At this time it is care planned for 2 staff members at all times to enter the room . A Nursing Note dated 7/26/24 at 6:32 AM read in part, It took 53 mins and four staff members to perform routine care on the resident his morning . A Behavior Note dated 7/28/24 at 2:08 AM read in part, Writer (nurse) and 2 other staff members entered resident's room at approximately (12:50 AM) to provide routine peri care and reposition resident . Writer and staff completed routine peri care and repositioning at (1:50 AM) . A Behavior Note dated 8/4/24 at 2:12 AM read in part, .Writer (nurse) answered call light, resident requested to be changed and repositioned, 3 staff persons assisted resident with routine peri care . Staff were in the room for 2 hours completing care . A Nursing Note dated 8/11/24 at 4:12 AM read in part, . Writer (nurse) and 2 staff members . spent approximately an hour and a half to complete peri care. Writer and staff spent an additional half hour repositioning resident . A Behavior Note dated 8/14/24 at 4:30 PM read in part, .Resident care is running into dinner time, causing staff to run behind with other residents care . A Behavior Note dated 8/17/24 at 7:09 AM read in part, .Writer (nurse) explained to resident that aide on duty was in (R805's) room for almost 2 hours during shift and she will come to assist (R805) again once she has provided care to other residents on her assigned unit . A Behavior Note dated 8/18/24 at 6:43 AM read in part, .It took writer (nurse) and 2nd nurse approximately 1. 5 hours to adjust resident in bed . CNA's were in the resident's room for over 2 hours providing care . A Behavior Note dated 8/18/24 at 8:21 PM read in part, Writer (nurse) and fell ow nurse . Total care was rendered and took approximately 2 hours . Review of the documentation provided by the Administrator for the Facility Assessment revealed this was last reviewed on 6/28/24. Further review of the contents of the facility assessment revealed multiple missing revisions to the facility's administrative staff changes, including the Administrator, Infection Preventionist, Social Services Manager, and multiple other staff that were no longer employed. Additionally, this documentation had not been updated in accordance with increased acuity needs for R805 once admitted from 7/15/24 or throughout their stay through 9/13/24; as well as there was no indication the facility assessment had been revised to include current regulatory requirements in regard to staffing requirements to include involvement with direct care staff, including RNs, LPNs, Nurse Aides, and representatives of direct care staff as applicable and that solicitation and consideration input was received from residents, resident representatives, and family members. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/17/24 at 1:40 PM, an interview was conducted with the Administrator. They confirmed their most recent facility assessment had been completed on 6/28/24. When asked about how many residents required 1:1 feeding assistance on the second floor, the Administrator reported they would follow up. They later reported there were currently 12 residents that required 1:1 feeding assistance. When asked why the facility assessment had not been updated to reflect the specific staffing needs based on changes to it's resident population, including R805, as well as the lack of involvement with direct care staff, residents, and/or families, and lack of revisions to the identified administrative staff changes, the Administrator reported they were not aware of any regulatory changes and would reach out to the company that was purchasing them effective 10/1/2024 for assistance. 39592