

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 10/28/2024
NAME OF PROVIDER OR SUPPLIER Canterbury on the Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271</p> <p>This citation pertains to intake #'s MI00147613 and MI00147486.</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical and verbal abuse by Certified Nursing Assistant C (CNA C) for one resident (R901) of two residents reviewed for abuse/neglect/mistreatment, resulting in R901 being in pain from being punched, kicked and the target of derogatory language. Findings include:</p> <p>On 10/28/24 a complaint submitted to the State Agency (SA) was reviewed that alleged R901 was physically and verbally abused by CNA C on 10/12/24.</p> <p>On 10/28/24 at approximately 8:57 a.m., during a conversation with the facility Administrator (who is also the abuse coordinator), the Administrator was queried pertaining to the allegation of physical and verbal abuse perpetrated by CNA C against R901 on 10/12/24 and the Administrator indicated that it did happen and was witnessed by Nurse D. The Administrator indicated the following: The event occurred on Saturday October 12th 2024 during the early morning and they were initially called on the phone by CNA C who informed them that Nurse D would be calling them about trying to get their glasses back from R901. A few minutes later, the Administrator reported receiving a phone call from Nurse D who indicated they were trying to have CNA C leave the facility but they would not leave. The Administrator then reported that they could hear CNA C yelling in the background and the Administrator informed Nurse D that if CNA C would not leave then to call the police. The Administrator then reported that Nurse D informed them that CNA C was being aggressive with staff but did not initially disclose the incident of abuse pertaining to R901. The Administrator indicated that they instructed Nurse D to write a statement pertaining to CNA C's behavior but that a few hours later, the Administrator received a phone call from the Director of Nursing (DON) that indicated abuse had occurred and at that time, the police department was notified. The Administrator reported that CNA C was arrested but that they were currently released from jail and that they had implemented a past-noncompliance procedure which included reeducating all staff on abuse/neglect/mistreatment and dealing with residents who display challenging behaviors.</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>On 10/28/24 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and had diagnoses including Dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 9/18/24 revealed R901 needed supervision from facility staff with personal hygiene. R901's BIMS score (brief interview for mental status) was 10 indicating moderately impaired cognition.</p> <p>A Nursing progress note dated 10/12/24 at 8:26 a.m., revealed the following: [CNA C] Asked me my name. she then asked what should she do if a resident has her glasses. I asked her which resident was she referring to she stated [R901]. I then entered the room and asked [R901] could I see her glasses she told me no that the doctor had prescribed them for her reading. before I could say the resident's name again [CNA C] ran up on [R901] grabbed her by the neck grabbed the glasses off of [R901] face swung on [R901] and kicked her leg and called her a [b****]. [R901] started swinging in defense I pulled them apart and told [CNA C] to leave immediately. I than proceeded to call [Administrator] I was told to walk her out of the building and to call the police if she did not leave. I then called the DON and was told police and state is being notified. Assessments are being completed. I came and asked to watch the floor while I reported the incident she then told [CNA B] she from zone eight and she will knock her out.</p> <p>A Vitals and Pain only note dated 10/12/2024 at 8:53 a.m., revealed the following: .Pain:</p> <p>Over the past 5 days, how often have you limited your day-to-day activities(excluding rehabilitation therapy sessions) because of pain: Rarely or not at all. Pain intensity: 3 Please rate the intensity of your worst pain over the last 5 days: Mild. Indicators of pain: Vocal complaints of pain.</p> <p>resident complained of being sore .</p> <p>A Nursing note dated 10/12/2024 at 9:16 a.m., revealed the following: Received report from MN (midnight) nurse shift. Police officers arrived. Face sheet of resident provided. MN nurse provided witness statement. EMS (Emergency Medical Services) arrived, assessed resident and reported to writer that resident did not want to go to hospital at this time</p> <p>A Nursing note dated 10/12/2024 at 2:12 p.m., revealed the following:Resident's daughter/guardian, [Name of daughter] visiting this afternoon. Daughter requests that the resident get checked out further in the emergency room . Resident gave verbal consent as well</p> <p>A Nursing note dated 10/12/2024 at 8:59 p.m., revealed the following: Resident returned from hospital via ambulance, on stretcher with 2 attendants. Awake and alert and talking with staff. Assisted in to room and declined wanting to go to her bed. Up with RW (rolling walker) and in to the bathroom. She states she is hungry and CNA warmed her meal tray up, which had been saved for her. Resident stated she feels ok and is not having any extra pain right now. She says she hurt some at the hospital but they 'fixed her up' and she is only having a little bit of leg pain now .</p> <p>A copy of R901's hospital documentation on 10/12/24 revealed the following: radiology Orders: XR (x-ray) Chest 1 View Portable 10/12/24. Reason: Patient assaulted, punched/beat on chest .XR elbow Complete 3+ views Left 10/12/24-Reason: Patient assaulting, complaining of left hand pain, swelling. XR Hand Complete 3+ views Left 10/12/24-Reason: Patient assaulting, complaining of left arm pain, swelling.</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>A Speech therapy (ST) evaluation dated with an onset date of 10/12/24 and start of care date of 10/15/24 revealed the following: Reason for referral: .was referred to a skilled ST evaluation following discharge from the hospital with complaints of pain during swallow. Pt (patient) presented to the hospital secondary to an incident resulting injury to her neck, complaints of pain and dysphagia upon hospitalization pt agreeable to remaining on ST caseload to treat and follow for pain during swallow and continued changes to diet orders. St educated pt guardian on results of evaluation and risks and benefits for MBSS (modified barium swallow study) to visualize swallow for potential dysphagia secondary to assault trauma .</p> <p>On 10/28/24 at approximately 11:01 a.m., the DON was queried regarding the abuse allegation pertaining to R901 and CNA C on 10/12/24 and they indicated that they had first talked to Nurse D on the phone at around 7:30 a.m., that day and that Nurse D had informed them of what had happened between R901 and CNA C that included CNA C punching, kicking, grabbing the neck and calling R901 at b****. The DON indicated that Nurse D had broken up the fight and told CNA C to leave the facility. The DON indicated by the time they had spoken with Nurse D, CNA C had left the building and after they got off the phone with Nurse D, they called the Administrator and informed them of the abuse committed by CNA C and the police were notified.</p> <p>On 10/28/24 at approximately 11:33 a.m., R901 was observed in their room, laying on their bed and dressed appropriately. R901 was queried if they remembered the incident with CNA C being physical with them and they indicated they did remember it. R901 indicated that CNA C thought they had their glasses and that they came into their room with the Nurse. R901 then reported that CNA C started to attack them including being punched and kicked and that CNA C also grabbed their neck. R901 indicated they were trying to fight back with their reacher device. R901 further reported that the other staff person (Nurse D) had to get CNA C off of them and get them out of the room. R901 was queried how they felt about the incident afterward and they reported they did not feel good. R901 was queried if they felt safe in the facility and they reported they did not but that they had not seen CNA C since the incident. R901 indicated they were glad CNA C was gone and if they ever saw her again, they would try to whoop her. R901 was queried if they were hurt and they indicated they were and that they were punched in the chest and kicked in the leg and they hurt their arm when CNA C was grabbing them.</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>On 10/28/24 at approximately 12:30 p.m., Nurse D was queried regarding their observations of the incident between R901 and CNA C on 10/12/24. Nurse D indicated that the incident started by CNA C asking them what to do if a resident has their glasses and they asked C who the resident was and they indicated it was R901. Nurse D then reported going to R901's room and CNA C followed them behind. Nurse D queried R901 if they had CNA C's glasses and at that time, CNA C jumped in front of them and then punched and kicked R901 along with grabbing their neck and calling them a b**** to their face. Nurse D reported they had to get CNA C off of R901 and then removed them from R901's room and told CNA C to leave the building, but CNA C would not go and was still across the hall agitated. Nurse D then indicated they went and got help from another CNA to watch the floor and protect R901 from CNA C while they went to another floor to call the Administrator and get help to remove CNA C from the facility. Nurse D reported they called the Administrator and informed them of what happened and that in return the Administrator instructed them to call the police if CNA C still refused to leave the facility. Nurse D was queried if they informed the Administrator of the witnessed abuse from CNA C towards R901 and they indicated that they did and that the Administrator told them not to call police at that time. Nurse D also reported they had called the DON but there was no answer so they left a voicemail. Nurse D Stated that they got help from another Nurse aide to go back to the unit where CNA C was to remove them from the building and CNA C was overheard threatening the other aide who was watching the floor and protecting R901. Nurse D then indicated that CNA C ended up getting their belongings shortly after and left the facility. Nurse D was queried if they ever notified the police department of the witnessed abuse and they indicated they did not because CNA C had left the facility. Nurse D was queried regarding R901's status after CNA C left and they indicated they were nervous/anxious about the incident but that it was expected. Nurse D was queried what time the abuse occurred at and they reported it was sometime between 4:00 AM. and 5:00 AM.</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>On 10/28/24, the facility investigation pertaining to R901's abuse allegation perpetrated by CNA C on 10/12/24 was reviewed and revealed the following: [R901] five day report .On Saturday October [no date] [CNA C] called [Administrator], the Administrator/Abuse Coordinator at 5:11 a.m. [CNA C] reported to this writer that [R901] had taken her glasses and that she had gone into [R901]'s room to attempt to remove her glasses from [R901]'s face and that the Nurse would be calling this writer. At 5:15 a.m., [Nurse D] LPN (Licensed Practical Nurse), called this writer to inform me that [CNA C] was being loud and was aggressive to the staff and that [Nurse D] had asked [CNA C] to leave the building, but [CNA C] would not leave. This writer advised [Nurse D] to tell [CNA C] to leave and if she did not to call the police. [CNA C] has been suspended pending investigation. On October 15, 2024 [CNA C]'s employment was terminated. This writer told [Nurse D] to write her statement, to complete an incident report and a pain and skin assessment and give it to [DON] Director of Nursing. At approximately 7:42 am. [DON], Director of Nursing call this writer and informed this writer of the content of [Nurse D]'s statement. The statement read, '[CNA C] asked what should she do if a resident has her glasses. I asked her which resident and [CNA C] said [R901]. I entered [R901]'s room and asked [R901] could I see the glasses. [R901] stated, no those glasses was given to her by her doctor. I then tried to respond to [R901], but before I could call her name again, [CNA C] grabbed [R901] by her neck, swung on [R901], kicked her and called her a b***. [R901] was swinging back and had a grabber swinging it for defense. I separated [CNA C] and [R901] and told [CNA C] that she had to leave immediately and I then called [Administrator], the Abuse Coordinator.' Upon hearing this from [DON], this writer instructed [DON] to call the police and to notify the State of Michigan. The [Local Police Department] arrived at the the community with EMS-Case Number [Case Number] [Name of Local Police Officer]. They wanted to take [R901] to the hospital for evaluation but [R901] refused. The Police Officer was provided with information regarding [CNA C]-Date of birth, address, phone number etc .On Saturday October 12, 2024 at 2pm, the Administrator checked on [R901] and spoke to her daughter. Her daughter identified that [R901] was able to recall the event and that she was tearful and shaky but in good spirits. [R901]'s daughter confirmed that the police had contacted her and she stated that she is pressing charges against [CNA C]. [R901]'s daughter was able to convince [R901] to go to the hospital for evaluation on Saturday afternoon. [R901] was evaluated at [Name of local hospital]. Results were resident was complaining of Dysphagia, left hand pain and left arm pain. Resident was returned to the community following the evaluation. Resident is receiving pain medication and is being evaluated by Speech Therapy for Dysphagia On Monday October 14, 2024, Social Worker [Social Worker E] interviewed [R901]. [R901] stated, 'The staff member came into my room and had an actual fight with me. The girl came in and told me that those are my glasses and snatched them off my face. The girl hit and punched me and took my walker away and threw stuff around in there room. I told her that I was going to call the police. I went out to the hospital because of it. My neck, face and right leg hurts. The Doctor prescribed me something for pain. I feel safe in the facility and I am glad that the staff member is out of the building. I was told me that the staff member had been arrested so that makes me feel better .On Monday October 14, 2024 Detective F interviewed this writer, [DON] and [R901]. He stated that he is pursuing Elder Abuse Charges for this event Based on this investigation, [CNA C] did grab [R901]'s throat hit her and called her a b**** .</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>A Citizen Statement form from the local police department that documented Nurse D's statement was reviewed and revealed the following: [CNA C] asked what should she do if a resident has her glasses. I asked her which resident she said [R901]. I entered [R901]'s room and asked her could I see the glasses. [R901] stated no those glasses was given to her by her Doctor. I then tried to say [R901] but before I could call her name again [CNA C] had grabbed [R901] by the neck swung on [R901] kicked her and called her a b****. [R901] was swinging back and had a grabber swinging it for defense. I separated them and told her she had to leave immediately. I then called the abuse coordinator [Administrator].</p> <p>A typed witness statement from CNA B that was signed on 10/17/24 was reviewed and revealed the following: Nurse came in room [ROOM NUMBER] where I was rendered <sic> came hysterically and told me that CENA beat a resident up, choked kicked her and call her names. Nurse said can you watch up here until I come back. After finishing care to the resident, I went around to [R901]'s room. Went to [R901] room and consoled resident she was shaking. I hugged her and told her I love her. [CNA C] ran into [R901]'s room and said 'you took my f***** glasses and you know you did. You bitch' I turned around and told [CNA C] to leave while standing in front of [R901] blocking [CNA C] from her and demanded that she get out and leave now. [CNA C] left out and went to desk, I went to edge of door and [CNA C] screamed at me that she was going to bust you up [CNA B]. She said you say something again I'm going to bust you up. Another CENA [CNA A] came up there saying what happen. I don't believe you did that. [CNA C] was saying I want my glasses. [CNA A] said I was supposed to be walking you out. [CNA C] continued packing back and forth</p> <p>A termination letter dated 10/15/24 for CNA C revealed the following: This letter serves to inform you that your employment at [Name of facility] has been terminated effective October 15, 2024, related to the incident that occurred on October 12, 2024, which have been documented and deemed detrimental to the safety and well-being of our staff and residents .</p> <p>On 10/28/24 a facility document titled [Facility] Abuse&Elder Justice Act Policy: was reviewed and revealed the following: Policy-It is our policy to maintain an environment free of abuse, neglect, exploitation, mistreatment and misappropriation of resident property. The resident has the right to be free from verbal , sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, clinicians, volunteers, staff or other agencies servicing the resident family members or legal guardians, friends or other individuals .</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>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** 38271</p> <p>This citation pertains to intake #MI00147486.</p> <p>Based on observation, interview and record review the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act resulting in a delay in notification of the allegation to the abuse coordinator and delay in reporting the allegation to the State Agency for one resident (R901) of two residents reviewed for abuse/neglect/mistreatment. Findings include:</p> <p>On 10/28/24 a complaint submitted to the State Agency (SA) was reviewed that alleged R901 was physically and verbally abused by CNA C on 10/12/24.</p> <p>On 10/28/24 an initial FRI (facility reported incident) was reviewed in the State of Michigan reporting system that indicated the initial report of the allegation was submitted on 10/12/24 at 8:56 a.m., by the Director of Nursing (DON).</p> <p>On 10/28/24 at approximately 8:57 a.m., 8:57 a.m., during a conversation with the facility Administrator (who is also the abuse coordinator), the Administrator was queried pertaining to the allegation of physical and verbal abuse perpetrated by CNA C against R901 on 10/12/24 and the Administrator indicated that it did happen and was witnessed by Nurse D. The Administrator indicated the following: The event occurred on Saturday October 12th 2024 during the early morning and they were initially called on the phone by CNA C who informed them that Nurse D would be calling them about trying to get their glasses back from R901. A few minutes later, the Administrator reported receiving a phone call from Nurse D who indicated they were trying to have CNA C leave the facility but they would not leave. The Administrator then reported that they could hear CNA C yelling in the background and the Administrator informed Nurse D that if CNA C would not leave then to call the police. The Administrator then reported that Nurse D informed them that CNA C was being aggressive with staff but did not initially disclose the allegation of abuse pertaining to R901. The Administrator indicated that they instructed Nurse D to write a statement pertaining to CNA C's behavior but that a few hours later, The Administrator received a phone call from the Director of Nursing (DON) that indicated abuse had occurred and at that time, the police department was notified. The Administrator reported that CNA C was arrested but that they were currently released from jail and that they had implemented a past-noncompliance procedure which included reeducating all staff on abuse/neglect/mistreatment and dealing with residents who display challenging behaviors.</p> <p>On 10/28/24 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and had diagnoses including Dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 9/18/24 revealed R901 needed supervision from facility staff with personal hygiene. R901's BIMS score (brief interview for mental status) was 10 indicating moderately impaired cognition.</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>On 10/28/24 a facility investigation pertaining to R901's abuse allegation perpetrated by CNA C on 10/12/24 was reviewed and revealed the following: [R901] five day report .On Saturday October [no date] [CNA C] called [Administrator], the Administrator/Abuse Coordinator at 5:11 a.m. [CNA C] reported to this writer that [R901] had taken her glasses and that she had gone into [R901]'s room to attempt to remove her glasses from [R901]'s face and that the Nurse would be calling this writer. At 5:15 a.m., [Nurse D] LPN (Licensed Practical Nurse), called this writer to inform me that [CNA C] was being loud and was aggressive to the staff and that [Nurse D] had asked [CNA C] to leave the building, but [CNA C] would not leave. This writer advised [Nurse D] to tell [CNA C] to leave and if she did not to call the police. [CNA C] has been suspended pending investigation. On October 15, 2024 [CNA C]'s employment was terminated. This writer told [Nurse D] to write her statement, to complete an incident report and a pain and skin assessment and give it to [DON] Director of Nursing. At approximately 7:42 am. [DON], Director of Nursing call this writer and informed this writer of the content of [Nurse D]'s statement. The statement read, '[CNA C] asked what should she do if a resident has her glasses. I asked her which resident and [CNA C] said [R901]. I entered [R901]'s room and asked [R901] could I see the glasses. [R901] stated, no those glasses was given to her by her doctor. I then tried to respond to [R901], but before I would call her name again, [CNA C] grabbed [R901] by her neck, swung on [R901], kicked her and called her a b***. [R901] was swinging back and had a grabber swinging it for defense. I separated [CNA C] and [R901] and told [CNA C] that she had to leave immediately and I then called [Administrator], the Abuse Coordinator.' Upon hearing this from [DON], this writer instructed [DON] to call the police and to notify the State of Michigan</p> <p>On 10/28/24 a facility document titled [Facility] Abuse&Elder Justice Act Policy: was reviewed and revealed the following: Policy-It is our policy to maintain an environment free of abuse, neglect, exploitation, mistreatment and misappropriation of resident property. The resident has the right to be free from verbal , sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, consultants, clinicians, volunteers, staff or other agencies servicing the resident family members or legal guardians, friends or other individuals .In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: 1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures .:</p>		