| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235584 | A. Building<br>B. Wing | 06/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Argentine Care Center | 9051 Silver Lake Road<br>Linden, MI 48451 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI00152642<br><br>Based on the observation, interview and record review, the facility failed to supervise a group activity of five residents and prevent a resident-to-resident for two residents (Res.#502 and Res. #503) of five residents reviewed for abuse, resulting in a hospital transfer for evaluation and treatment.<br><br>Findings include:<br><br>A review of the Facility Incident Report was reviewed on 6/3/25 at 10:30 AM. The facility indicated a resident-to-resident altercation between R502 and R503 occurred on 4/18/25 at 7:32 PM. It happened in the dayroom while playing a game with two other residents. The incident started with an argument between R502 and R503, where they threw beverages at each other and escalated to physical contact. R502 started punching R503, then R503 struck back, hitting R502 in the face. The brawl ended when R503 decided to leave the day room after hitting R502 back. Although the incident was unwitnessed by staff, the event was captured on video and was reviewed by the Administrator the following day.<br><br>As a result of the resident-to-resident physical altercation, R502 sustained some bruising and laceration on the bridge of her nose, and R503 complained of pain on her eye and left jaw. Both residents were separated after the incident. R502 resides on the main floor (first floor), and R503 resides on the second floor. Both R502 and R503 were transferred to the hospital where they were evaluation and received treatment.<br><br>A review of records on 5/29/25 at 3:00 PM, revealed that after the physical altercation, R503 received a CT Scan of maxillofacial /brain/ head while at the hospital emergency room due to complaints of jaw and eye pain. R503 also had a scratch on her right arm.<br><br>The Facility's Incident Report dated 4/18/25, concluded that, after completing the investigation by the Social Services and the Director of Nursing, the facility substantiated a resident-to-resident physical altercation. However, the facility's failure to supervise residents' activity after dinner at around 7:30 PM involving a group of five (5) residents with various levels of cognition in the day room and provide a safe environment free from physical harm was not mentioned as the root cause of the resident-to-resident altercation.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | According to the Administrator, on 5/29/30 at 3:30 PM, she revealed that staff had not witnessed the incident. The activity was unsupervised. The Administrator indicated she reviewed the video the following morning. She did not find any staff in the day room during the altercation. The incident ended when R503 was seen in the video exiting the dining room. After R503 left the dayroom, both were separated and assessed. R502 sustained a bruise under her right eye and a laceration on the bridge of her nose from her glasses. R503 complained of left eye and jaw pain. Both residents were sent to the hospital for evaluation.<br><br>R502:<br><br>Resident #502 (R502), [AGE] years old, was assessed with a Brief Interview of Mental Status (BIMS) Score of 15/15 assessed on (DATE). A score of 15 indicated that R502 was cognitively intact. R502 was admitted to the facility on [DATE] with the diagnosis of Atherosclerotic Heart Disease, Bipolar, and Anxiety Disorder in addition to other diagnoses. R504 is care planned for independent ADLs (Activities of Daily Living) with transfers. Although she ambulates independently all around the first floor, R502 is care planned as a fall risk related to new admission and medication use.<br><br>The surveyor reviewed R502's hospital discharge documents dated 4/19/25 and residents' statements at the time of the physical altercation on 4/18/2025 on 6/3/25 at 12:00 PM.<br><br>A brief interview with R502 was conducted on 6/3/25 at 3:45 PM. R503 recalled getting in trouble so many times but did not specify the resident-to-resident altercation. She explained how she got the laceration on her forehead when she fell sometime in May unrelated to the resident -to resident altercation<br><br>R503:<br><br>Resident #503 (R503),[AGE] years old, was assessed on 3/1/25, with a BIMS Score of 9/15 on 3/1/2025. A score of 9 means moderately impaired cognition. She was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, Type 2 Diabetes Mellitus, and Dementia, in addition to other diagnoses. R503, like R502, was deemed safe to ambulate independently around the facility.<br><br>R503's hospital discharge documents dated 4/19/25 and the resident's statements at the time of the physical altercation between residents on 4/18/2025 were reviewed.<br><br>R503 was interviewed briefly on 6/3//25 at 1:30 PM at the dining room. She did not mention anything about the incident related to the resident-to-resident altercation. She did not apear to have bruising or discoloration. She denied any pain at the time of the interview.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 6/3/25 at 11:45 AM, Nurse B was interviewed on the phone. Nurse B revealed that she recalled a resident-to-resident incident in April. Nurse B indicated that she was passing medications after dinner the night it happened. She was the nurse on the first floor, and Nurse H (Nurse's name was mentioned) was on the second floor. There was no other staff in the day room when it happened because the staff was busy with patient care and putting residents to bed. Nurse B stated that R502 hit R503 first and R503 hit R502 hard that R502 ended up with a laceration on the bridge of her nose and bruising on one eye. There was blood coming from R502's nose after R503 punched her in the face. I evaluated R502 immediately because she was my resident on the first floor. R502 was immediately sent to the hospital for further evaluation. R503 lived on the 2nd floor. They were separated, and another nurse, Nurse P, evaluated R503 on the second floor. They were both sent to separate emergency rooms and were sent back the following day after treatment.<br><br>Nurse B was asked if activities are monitored or supervised, Nurse B stated there are no activities staff after dinner. They all go home. No group activities are scheduled after 5 PM. Residents should not be left unsupervised, and someone should be checking on them. Nurse B recalled that at least four residents were present during the incident on 4/18/25; some had dementia diagnoses, and some had behaviors. The aides were in and out of the residents' rooms. The video camera in the dayroom was reviewed and showed no staff present during the altercation.<br><br>Nurse H was interviewed on 6/3/25 at 11:22 AM by phone. Nurse H indicated that she worked the afternoon shift and was assigned to the second floor, where R503 stayed that day. Most of the time, R503 goes downstairs to the dayroom to play cards or other activities offered, and R503 enjoys spending time with other residents on the first floor. Nurse H described R503 to be impulsive at times because of her dementia and occasionally gets agitated. Although Nurse H did not see her physically act out, she corrected herself by saying, At least not with me. Nurse H further revealed that R503 was a little snippy verbally sometimes. Nurse H commented, Activities should have been monitoring residents in case there are residents with impulsive behaviors or dementia. Nurse<br><br>H described evaluating R503 after the physical altercation and recalled that R503 complained of jaw and eye pain when R502 hit her but did not see any obvious bleeding or bruising. R503 was sent to the nearby emergency room to be evaluated appropriately that night.<br><br>The Administrator indicated on 6/3/25 at 11:30 AM that staff did not witness the incident. The Administrator also revealed that the facility does not have an Activities Director and has now posted the position. When asked what the current plan is, the Administrator stated, There are no activities at night after dinner specified after 5:30 PM. The main dining is closed after dinner so our staff can get residents in bed. We do not have staff to conduct activities after dinner.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with the Social Services Director SSD was conducted on 6/3/25 at 3:45 PM. SSD revealed that both residents were receiving behavior care services. R503 has dementia and is taking some antipsychotic medications. Although R502 did not have dementia and her BIMS is 15, she does have some anxiety behaviors. R503 threw liquid on R502, and R502 hit R503 on the face. The SSD had indicated that 4/18/25 She received a call from the facility on 4/18 /25 after the physical altercation occurred because she had to call their families to inform them about the incident and that both residents were sent to the hospital for further evaluation. The SSD stated that the residents should have been supervised during the activities to start with because of mixed dementia and behaviors of residents participating in a group activity. R503's son emphasized that R503 should not have been left unsupervised. Regarding R502, even if her BIMS score is 15, she still needs supervision because of some behaviors. After dinner at 4:30 PM, residents who stay in the day room area for independent activities should be supervised to prevent this. They have not been supervised enough in activities, especially after dinner. After dinner, they are supposed to close the dining room, but some residents prefer to stay and watch television or play games with other residents. However, the staff is busy with other residents and schedules no activities after dinner. When activities staff leave at 5:30, they close the dining room. Sometimes, residents stay out in the hallway to talk to each other, but no activities are scheduled because there are no activities staff to hold and get residents to participate. The facility has been trying to figure it out up to now. It's been over a month.<br><br>On 6/3/25 at 3:30 PM, the facility's Abuse Policy dated 4/8/23 was reviewed. It indicated that the facility (name of facility specified) will not tolerated Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident's Property.<br><br>Definitions:<br><br>.Physical Abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment .<br><br>.Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI00153237<br><br>Based on observation, interview, and record review, the facility failed to follow the standards of practice and physician's order to reduce the methadone dosage administered to one resident (Resident #502) of four residents reviewed for medication errors. Resident 502 received the wrong dosage five times (5/17/25, 5/18/25, 5/19/25, 5/23/25, and 5/24/25), and potentially a second dosage was administered on 5/24/25.<br><br>Findings include:<br><br>Resident #502 (R502):<br><br>R502's Electronic Medical Record (EMR) was reviewed on 6/3/25 at 11:00 AM. R502 was [AGE] years old and admitted to the facility on [DATE], with the diagnosis of Atherosclerotic Heart Disease, Gastro-esophageal Reflux Disease, Altered Mental Status, Major Depressive and Bipolar Disorder in addition to other diagnoses. R502's Brief Interview for Mental Status (BIMS) Score is 15/15, assessed on 4/23/2025. A score of 15 means R502 is cognitively intact. The Minimum Data Set (MDS) revealed that R502 is independent of ambulation, transfers, and mobility. R502 receives trazodone and Xanax for the diagnosis of Anxiety and Depression. R502 also receives Methadone 100 mg (1 tablet) daily for chronic pain as care planned.<br><br>During a record review of R502's Physician's orders on 6/3/25 at 11:00 AM, it was noted that on 5/16/25, the physician changed the Methadone order to reduce the dosage due to a recent fall sustaining a laceration to her forehead. The change of order form was filled out and was noted as follows:<br><br>Methadone-Scheduled II<br><br>Concentrate: 10 mg/ml: amt: 70 mg: oral<br><br>Frequency: Once A Morning at 6:00 AM<br><br>Special Instructions: Give 70 mg (7 mL) by mouth every morning<br><br>A verbal order by R502's primary physician received by the DON on 5/16/25 at 2:02 PM.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Director of Nursing (DON) was interviewed on June 3, 2025, at 1:30 PM. She recalled the change of R502's Methadone dosage order. She admitted that she received a report from staff of a medication error was reported on 5/25/25. The DON provided the surveyor with an Incident Report dated 5/29/25. When asked why it took so long to do the Incident Investigation? Why did the Med Error investigation start on 5/29/25 when the surveyor was already at the facility? The DON stated that the incident was reported to her on 5/25/25, but she couldn't get to it until 5/29/25. The day the surveyor was at the facility. The DON revealed that the nurse who administered the wrong dosage, Nurse C, received an in-service with other nurses and one-on-one counseling on medication errors on 5/29/25. When asked if another nurse made the same error, The DON was unaware of a second nurse who had given the wrong dosage of Methadone to R502 or multiple episodes of an incorrect dosage administered on 5/17, 5/18, and 5/19. She only knew about the 5/23/25.<br><br>A review of the R502's narcotic log entitled: Controlled drug receipt/Record/Disposition Form was conducted with the DON on 6/3/25 at 1:35 PM. It revealed that despite a written and verbal physician's order to reduce the methadone from 7.5 mL to 7.0 ml daily at 6:00 AM. Two Nurses continued to administer a 7.5 dosage and were not following the most current order given by the physician.<br><br>The following data was noted: R502 received incorrect dosages on:<br><br>5/17/25 R502 received 7.5 mL at 6:00 AM, given by Nurse B<br><br>5/18/25 R502 received 7.5 ml at 6:00 AM by Nurse C<br><br>5/19/25 R502 received 7.5 ml at 6:00 AM by Nurse C<br><br>Error continued on<br><br>5/23/25 R502 received 7.5 ml at 6:00 AM by Nurse C<br><br>5/24/25 R502 received 7.5 ml at 6:00 AM by Nurse C<br><br>and another entry was noted:<br><br>5/24/25 %502 received 7.0 (correct dosage) given by Nurse B<br><br>A review of R502's Progress Notes dated May 2025 on 6/3/25 at 11>05 AM indicated No physician's progress notes were noted related to the medication errors on 5/17, 5/18, 5/19, 5/23/ & 5/24/2025.<br><br>Upon further review of R502's Narcotic Log on 6/3/25 at 1:30 PM, the DON further explained that the error on 5/24/25 was that the second entry was on the date. Nurse B made a mistake in putting the correct date, 5/25/25, instead of 5/24/25. The DON was not sure if R502 received two doses on 5/24/25.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON indicated that Nurse C had signed the Med Error Incident report and received education about the error on 5/29/25. On the other hand, Nurse B, the second nurse who made an error, did not receive in-service educational counseling. The Medication Error Incident report addressed the dates 5/23 and 5/24/25. The medication error filed did not address the dates 5/17, 5/18, and 5/19, which also had a dosage error. The DON revealed she did not know about another set of errors until now. The DON only knew of the 5/24/25 and was unaware that there were six episodes of medication errors, as evidenced by R502's narcotic log. The DON assured the surveyor that Nurse B would receive the appropriate education and counseling for medication administration errors (Med Errors) this week.<br><br>Nurse B was interviewed by telephone on 6/3/25 at 11:25. She reported the medication errors made for R502 by Nurse C. She denied receiving an in-service education related to medication errors herself. Nurse B denied any mistakes made by her.<br><br>Nurse D was observed on 6/3/25 at 12:30 PM. When Nurse D was asked to do a narcotic count for R502's controlled medications, Nurse D warned the surveyor that the narcotic count for R502's Xanax would be wrong because she had marked the sheet as given today but was not administered. The Xanax count sheet says 21 tablets left, but found 22 tablets in the blister pack. Nurse D apologized and stated she had not given the medication to R502 but had marked it earlier as given. Nurse D apologized for making the error.<br><br>In an interview on 6/3/25 at 4:30 PM, the Administrator stated she was unaware of the Med Error and was not informed of any discrepancy with R502's medication. Otherwise, we would have immediately investigated it and brought it to the QA (Quality Assurance) committee.<br><br>The facility's Policy on Medication Errors, Revised on February 2023, was reviewed on 6/3/25 at 4:00 PM. It indicated:<br><br>1.<br><br>A medication error is defined as the preparation or administration of drugs or biological's that are not in accordance with a physician's order, manufacturer specifications, or accepted professional standards and principles of the professional (s) providing services.<br><br>2.<br><br>Examples of Medication errors include:<br><br>a. Omission- a drug ordered but not administered.<br><br>b. Unauthorized drug- a drug is administered without a physician's order.<br><br>c. Wrong dose (e.g., Dilantin 12 mL ordered, Dilantin 2 mL given) .<br><br>3. A significant medication-related error is defined as:<br><br>a. Requiring modification, discontinuation, or dose modification.<br><br>b. Requiring hospitalization or extending a hospitalization.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Resulting in disability.<br><br>d. Requiring treatment with a prescription medication.<br><br>e. Resulting in cognitive deterioration or impairment.<br><br>f. Life threatening.<br><br>g. Resulting in death<br><br>The facility provided a 2-paged medication error policy only for the surveyor to review, but on the bottom of page 2, it noted: continues on next page. The surveyor was not provided with the following pages of the policy. The first two pages did not emphasize the importance of notifying the physician when the Medication error occurred or was discovered. The medication error was not indicated in the progress notes nor when the physician was notified.<br><br>The facility's Medication Administration Policy was reviewed on 6/3/25 at 4:15 PM. Policy Statement: Medications are administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation specified:<br><br>.4. Medications are administered in accordance with prescriber orders, including any required time frame . 6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training .10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and the right method (route) of administration before giving the medication . |