STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235728	A. BUILDING _____ B. WING _____	C 06/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIGAN VETERANS HOME OF CHESTERFIELD TOWNSHIP	47901 SUGARBUSH RD CHESTERFIELD TOWNSHI, MI 48047

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F000	INITIAL COMMENTS Michigan Veterans Home Of Chesterfield Township was surveyed for an Abbreviated survey on 6/7/22. (Intakes: MI00127040 and MI00128306). Census= 61.	F000		
F600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) 483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. 483.12(a) The facility must- 483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00128306. Based on observation, interview, and record review the facility failed to prevent resident to resident abuse, for four sampled residents (R901, R902, R903, and R904) of four reviewed for abuse, resulting in an injury to R901's head and R904's hand. Findings include:	F600	F600/G Element 1 Resident 901 was assessed by RN, provided medical treatment, and continues to reside in the home. The home continues to monitor for signs of negative outcomes related to the deficient practice. Prior to the incident Resident 902 is noted to have agitated as evidence by exit-seeking, pacing difficult to redirect, profanity language, combative and engaged in a verbal disagreement with Resident 901. Following the incident, Residents room was changed to one with lower stimuli, provided 1:1 supervision, and continues to reside in the home; he appears to have no signs of negative outcomes related to the deficient practice. The residents care plan was reviewed and revised to include person centered interventions that indicate signs of agitation, and ways to protect others when resident displays agitated characteristics by redirecting the agitated resident successfully or removing other residents in his surroundings. Medical Services has reviewed medications and made appropriate changes. This resident continues to be followed by the homes	6/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/17/2022

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F600	Continued From page 1 Resident #901 (R901) A review of the facility's report incident allegation noted, "It was reported there was a resident-to-resident physical abuse incident which resulted in injury." On 6/7/22 at 12:03 PM, R901 was observed in the common area of the unit. R901 was interviewed and asked about the incident but was unable to recall the incident. A review of R901's medical record noted, "Incident 4/25/2022 19:28. Incident Note Text: After walking past a member (R902) who was playing horseshoes there was a verbal disagreement between the two that was easily redirected by nursing staff. Shortly after [R901] was walking back to R901's room and past the member (R902) who there was a disagreement with earlier when [R902] pushed [R901] and [R901] walker down. Staff was present and stated member had hit [R901's] head when [R901] fell. Vital signs were taken and member assessed while laying on floor. [R901] continued to whimper and cry but would not answer any questions. Member then had an episode of emesis; [R901] was log rolled to [R901's] side at this time. EMS (Emergency medical services) was contacted to transport member to the hospital. Member's son was contacted and requested [R901] be sent to [local hospital]. He wanted to talk to [R901], so phone was given to member and [R901] talked with him and answered questions appropriately. Ambulance arrived placed a c-collar on the member and transferred her to the cart." On 6/7/22 at 12:10 PM, the unit Nurses were asked about the incident with R901 and R902 and explained they were not there for that	F600	Behavioral Health contractor. Resident 903 was assessed by an RN, demonstrates no negative outcomes related to the deficient practice, and continues to reside in the home. This resident continues to be followed by the homes Behavioral Health contractor. Prior to the Resident 904 was noted to have period of agitation by evidence by yelling at other staffs, combative characteristics which includes refusal of medication days prior to this incident, attempting to hit staff, and difficult to redirect. Following the incident, Resident 904 was assessed by an RN, provided first aid, was assessed by the homes Behavioral Health provider, and demonstrates no negative outcomes because of the deficient practice and continues to reside in the facility. The residents room was moved to one closer to the nurses station for ease of providing location checks and increased monitoring. The residents care plan was reviewed and revised to include person centered signs of agitation, interventions, and ways to protect others when resident displays agitated characteristics by redirecting the agitated resident successfully or removing other residents in his surroundings. This resident continues to be followed by the homes Behavioral Health contractor. Element 2 All members residing in the home have the potential to be affected by the deficient practice. A quality review was conducted	

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F600	Continued From page 2 incident. On 6/7/22 at 1:32 PM Nurse "A" was asked about the incident with R901 and R902 and stated, "I was taking my garbage out, shift was changing when I came back, I heard the noise and the reaction." Nurse "A" explained that R901 and R902 had a verbal incident prior to R902 pushing R901, but they had intervened and kept them away from each other. Nurse "A" explained that after the verbal incident with R901 and R902, later that day R902 yelled from across the room and pointed at R901 and said stupid. R901 jumped up and became upset that R902 called them stupid. Nurse "A" further explained that right before the push that they had just took [R901] to [their] room around 7:00 pm. Nurse "A" further explained that when R901 was on the floor, [R901] said my pain my pain and grab at [their] head, then started to throw up and sounded like they were praying in a different language. On 6/7/22 at 1:40 PM, CNA "B" was asked about the incident and stated, "It was getting close to end of the shift, I was pulling trash and doing charting. When I walked back [R901] was going down." CNA "B" explained that R902 was very hard to redirect that day. CNA "C" written statement, "At 6:45pm I [CNA "C"] was coming from putting soiled linen and trash away I saw [R902] one of the members toss [R901] another member to the floor. [R902] grabbed [R901's] walker and proceeded to push [R901] and the walker. [R901] fell back and hit [their] head very hard and after 2 or 3 minutes [R901] started to vomit. [R902] hovered around while [R901] laid on the floor." CNA "B" written statement, "At 645pm I was	F600	by the Director of Nursing or Designee to ensure that all residents with a diagnosis of dementia with behavioral disturbance and those who are known to demonstrate physically aggressive behaviors towards others have detailed care planned interventions regarding the need for supervision and intervention when the member is agitated towards others have detailed care planned interventions regarding the need for supervision and intervention when the member is agitated and ways to protect others should the resident display agitation. Person centered interventions will include ways to recognize individual signs of agitation and distress and include how to protect other residents during these times. Element 3 The home has reviewed the policy titled Abuse & Neglect Prevention: Abuse Prevention Program and determined to be adequate. All staff have been re-educated by the homes Staff Educator or Designee on the components of the homes Abuse Prevention Program with emphasis on recognizing signs of agitation (pacing, exit seeking, pumping fists in the air, use of profanity, etc.) and protecting the resident and others when signs of increased agitation are noted, by intervening before a situation escalates beyond control. Appropriate interventions include relocation to an area of lesser stimulation or removing other residents away from resident(s) that present with agitated behaviors, PRN medication administration and diversional activities. Element 4	

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F600	Continued From page 3 charting with (staff member) and suddenly I heard (staff member) scream "[R902] No" and immediately we both began running over to the situation. As we were running, [R901] was mid air falling and [R902] had [R901] walker in [their] hands and at that point we were trying to make sure [R901] was ok and stable. I was then directed by the nurse to get security. Prior to this happening it was brought to the house supervisor attention that [R902] has been exit seeking as well as being VERY agitated and aggressive towards staff members. We tried redirecting him multiple times, play horseshoes and calm [R902] down nothing was working." CNA "D" written statement, "Upon my arrival to my shift at 6:45pm I walked on the unit [R902] and another male resident was talking then I noticed [R901] walking up to them then that's when [R902] grabbed her walker and slung her around then proceeded to push [R901] really hard and then threw her to the floor." Nurse "A" written statement, " During pm shift, at 15:45 member (R902) was pacing, getting close to any doors. Around 16:25 writer took member for a walk, we stopped at Activity room, [R902] was shoving writer [their] projects. After returning to a unit [R902] had dinner, played horseshoes with writer and another member. While [R902] was playing, [R901] walked to [their] room, [R902] made a comment addressed to [R901] about interruption their game. [R901] member get into the [their] room, writer followed [them], [R901] showed writer picture of there son, shortly [R901] was coming back to common area, meeting [R902] again. Once again, [R902] made a comment, using inappropriate "F" word. [R901] member came back to the table, where [they] was working on puzzle, from the distance, [R902] member point to [R901] and called	F600	The Director of Nursing or Designee will randomly conduct quality reviews weekly x4 then biweekly x 2 months to ensure residents who have demonstrated aggressive behaviors towards others are provided person centered interventions to assist them with agitation and that no other resident is harmed. The findings of the quality reviews will be reported to the facility Quality Assurance Performance Improvement Committee monthly until the committee determines substantial compliance has been met. Alleged Date of Compliance: June 17, 2022	

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F600	Continued From page 4 [R901] stupid, [R901] reacted back right away, [R901] stood up, raised both hands/fists and moved forward to [R901's] opponent. Writer stopped [R901] and calmed [them] down. Shortly, while writer was taking trash out to Soil room, writer heard a voice, when writer entered the unit, [R901] was on the floor, face up, head was on floor, eyes were closed." "4/27/2022 11:00. Nurses Progress Note Text: Writer spoke with nurse at [local hospital], nurse reported that [R901] is being treated for a UTI (Urinary tract infection) with IV (Intravenous) Rocephin and has a subdural hematoma..." Further review of R901's medical record noted, Hospital discharge document, "Visit Summary For: [R901] Discharge Diagnosis: Advanced dementia; Assault; Fall; Leukocytosis; Subdural hematoma; UTI symptoms. Comment: Discharge Wound Care Instructions: May remove dressing in 24 hours..." R901 was admitted on 1/04/22 with diagnoses of Dementia with behavioral disturbance, Post-traumatic stress disorder, cognitive communication deficit, and major depressive disorder. Minimum Data Set (MDS) assessment noted a severe cognitive impairment. Resident #902 (R902) R902 was admitted on 11/30/2021 with diagnoses of Alzheimer's disease, Dementia, Post-traumatic stress disorder, cognitive communication deficit, and major depressive disorder. MDS assessment noted a severe cognitive impairment. According to the facility's summary R902's care plan identifies [R902] as being high risk for wandering and elopement, having inappropriate sexual behaviors and	F600		

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F600	Continued From page 5 physical aggression/agitation, having impaired cognitive function due to Alzheimer's, communication deficit due to hearing loss, use of psychotropic medications, and having mood problems related to depression, anxiety and PTSD (Post Traumatic Stress Disorder). Some interventions for R902 include a wander guard for safety, frequent intentional rounding, redirection and distraction with food, offering activities of [R902] liking, and walks. Resident #903 (R903) On 6/7/22 at 12:10 PM, the unit Nurses reported that there was a unwitnessed incident with R903 and R904. The Nurse explained that R904 came into their (R903) room and grabbed their arm and they scratched R904's hand. On 6/7/22 at 12:10 PM, R903 was asked about the incident with R904 and was unable to be interviewed due to cognitive impairment. On 6/7/22 at 1:40 PM, CNA "B" was asked about the incident with R903 and R904 and stated, "I was on break they gave me report and told me what happened." A review of R903's medical record revealed, "5/31/22 17:15 Nurses Progress Note Text. Writer noted that member came out of room with increased agitation and pacing. Member verbally stated that she was angry and that there was a man in her room that did not belong. Upon assessment member was calmed and assured her that she was safe. There were no noted injuries and member denied pain. Member stated that the man came in her room and grabbed at her hand..." R904	F600		

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F600	Continued From page 6 On 6/7/22 at 12:18 PM, R904 was interviewed and asked about the injury to their hand and was unable explain it due to cognitive impairment. A review of R904's medical record revealed, "Altercation form: Date 5/31/22 Writer sitting at nurses' station, when CNA came from back hallway reporting a hand injury. Member ambulated towards nurse with blood dripping from hand. Sat at table in common area. Wound cleaned, steri-stripped and bandage. No anxiety noted..." Progress note revealed, "5/30/22 22:37 Behavior Note Text: Member has been very agitated, yelling at staff, refusing medication, and refusing to use walker when reminded. Member still refusing after educated on why medication and walker are important." "5/31/22 20:16 Alert Note Text: Member attempted to hit CNA in her face. Other staff intervened nurse notified. Attempted to redirect member and offer a snack and activities, member refused." On 6/7/22 at 1:08 PM, the Director of Nursing and Nursing Home Administrator (NHA) was interviewed about the incident and confirmed the details from the witnesses, and that education was provided to staff after the incident. The NHA was asked about the incident with R903 and R904 and explained, therapy had just left R904's room, R904's room was next to R903 and the room was changed after the incident. A review of the facility's policy revealed, titled, "Abuse & Neglect Prevention: Abuse Prevention Program" dated 4/16/21 noted, "POLICY: Our members have the right to be free from abuse, neglect, misappropriation of property, and	F600		

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F600	Continued From page 7 exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the member's symptoms. GUIDELINES Policy Explanation and Compliance Guidelines: As part of the member abuse prevention program, the home's administration will: 1. Protect our members from abuse by anyone including, but not necessarily limited to staff, other members, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual..."	F600		

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