| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235444 | A. Building<br>B. Wing | 07/07/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westwood Nursing Center | 16588 Schaefer<br>Detroit, MI 48235 |

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 0604<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349<br><br>This citations pertains to intakes MI00120896, MI00120947, MI00120996.<br><br>Based on observation, interview, and record review, the facility failed to ensure resident remained free from physical restraints for the sole purpose of staff convenience in 1 of 4 residents (R501) reviewed for restraints, resulting in an immediate jeopardy when on 6/19/21 at approximately 4:39 PM, R501 who had severe cognition impairment and a history of wandering, was seen on video scooting out of the 2 South Dining Room while restrained to a chair by a bedsheet tied around her waist and two staff members visibly present. R501 was observed struggling to remove herself from the chair for eight minutes (4:39 PM - 4:47 PM) until R501 put her feet on the railing, pushed herself over, and fell on the floor still tied to the chair. The restraint then loosened and R501 was able to remove the restraint. This deficient practice is likely to cause serious injury, serious harm, and/or death to any resident in the facility who is subjected to a physical restraint that is not ordered by a physician and monitored accordingly.<br><br>Findings include:<br><br>According to a Facility Reported Incident (FRI) dated 6/19/21 at 10:15 PM and the subsequent Facility Investigation Report dated 6/28/21, the facility substantiated that R501 was physically restrained to a dining room chair with a bed sheet tied around her waist. The facility's investigation revealed that three employees, Licensed Practical Nurse (LPN) C, Certified Nurse Aide (CNA) D, and CNA E were present and/or aware of R01's physical restraint to the chair. These employees were immediately suspended on 6/19/21, and subsequently terminated on 6/24/21 after the results of the investigation were revealed.<br><br>On 7/6/21 at 8:30 AM during an interview with Administrator A she confirmed that R501 was physically restrained to a dining room chair with a bed sheet tied around her waist from approximately 4:39 PM until 4:47 PM after review of the video from the 2 South hallway.<br><br>(continued on next page) |



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

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| F 0604<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 7/6/21 at 10:30 AM the 2 South video was reviewed with Maintenance Director (MD) H and Administrator A. The video showed that on 6/19/21 at 4:33 PM, CNA E walked out of the 2 South dining room and left the 2 South unit. At 4:36 PM CNA D walks into the dining room doorway for a brief moment and then both LPN C and CNA D walked out of the 2 South dining room. LPN C walked into the nurse's station area which has one chair that directly faced toward the dining room, approximately 8 feet away but is out of video range and CNA D walked into the storage area located behind the nurses station. At 4:39 PM R501 was seen scooting out of the dining room doorway pushing an empty dining room chair in front of her while being restrained to another dining room chair with a bed sheet tied around her waist like a belt. Both LPN C and CNA D were at the nurses station, LPN C was out of range, but CNA D was visible approximately 8 feet away with her back towards R501. At approximately 4:41 PM R501 was clearly visible in the 2 south hallway still restrained to the dining room chair, struggling to free herself. CNA D walked away from the nurses station and was seen looking directly at R501 who was struggling to free herself of the restraint. CNA D returned to the nurses station within one minute, standing with her back to R501. At 4:47 PM R501 put her feet up on the 2 South doorway and hand rail pushed backward and fell to the floor sideways, on her left side into the 2 South dining room. R501's legs were seen in the doorway and her upper body was out of camera range inside the 2 South dining room. LPN C and CNA D were seen in the 2 South hallway going toward R501. Within a few seconds R501 walked out of the dining room on her own accord. LPN C and CNA D appeared to be having a discussion between themselves and CNA E returned to the unit.<br><br>On 7/6/21 at 8:42 AM, during an interview with CNA D she said that on 6/19/21 at approximately 4:30 PM she was standing at the 2 South nurses station when she heard a thud. CNA D said she turned around to see R501 laying sideways on the floor, tied to a dining room chair with a sheet around her waist in the doorway of the 2 South dining room. CNA D said R501 removed the sheet and immediately got up and walked away without any signs of injury. CNA D said she was unaware that R501 was restrained to a chair with a sheet until the time she fell .<br><br>On 7/6/21 at 12:00 PM during an interview with LPN C she said that on 6/19/21 at approximately 4:30 PM she went into the 2 South dining room to complete a skin treatment for R503 when she saw that R501 had a sheet tied around her waist and was restrained to a dining room chair. LPN C said that CNA E was present at this time and she told her (CNA E) to remove the restraint. CNA E said that the sheet was not tied and just laying across R501's lap and not a restraint. LPN C said she directed CNA E to remove it anyway and then began to do the skin treatment on R503. LPN C said that she did not remove the restraint on R501 because she thought CNA E was going to remove it.<br><br>On 7/6/21 at 1:24 PM during an interview with CNA E she said that on 6/19/21 at approximately 4:30 PM she was in the dining room with several residents including R501 and R503. When LPN C came into the 2 South dining room she (CNA E) decided to go on her break. CNA E said, I never tied anyone up with a bed sheet. I just laid the sheet across her (R501's) lap because I didn't want anyone to fall on it. CNA E said when she returned from her break she heard that R501 was restrained to a chair and fell . CNA E offered no explaination as to why a bedsheet would have been in the dining room.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 7/6/21 at approximately 9:00 AM R501 was observed in her room seated on her bed receiving morning care by CNA P. R501 was free from any visible signs of injury and was unable to be interviewed due to severe cognition impairment. R501 refused to wear her shoes at this time, stood up and took several steps away. CNA P attempted to redirect her by gently placing his hand on her right forearm and R501 fell on to the bed in a seated position. R501 did not sustain any injury, immediately stood up and freely ambulated out of her room and into the 2 South hallways with one-to-one supervision by CNA P. CNA P said he attempted to put R501's shoes on, but she refused. R501 was observed wandering at a fast pace down 2 South hallway with an abnormal but fairly steady gait, unassisted by CNA P.<br><br>According to R501's face sheet, she initially admitted to the facility on [DATE] with multiple diagnoses that included Dementia, dysphagia, restlessness and agitation, and anxiety disorder. The Minimum Data Set (MDS) dated [DATE] identified R501 to have severe cognition impairment with daily behaviors of wandering with intruding on others privacy. A review of physician's orders and progress notes revealed there was no documentation to support any type of restraint for R501. A care plan for 'supervision/falls' was revised on 6/20/21 to include one-to-one supervision for R501 at all times.<br><br>During an interview with the facility's Medical Director (MD) S on 7/7/21 at 11:50 AM he said that he was unaware that R501 was physically restrained and sustained a fall until today (7/7/21). MD S said that he would never write an order for a bed sheet restraint around the waist, nor has he ever wrote any type of order for a restraint at the facility. MD S said he would not support any type of restraint for the residents at the facility.<br><br>The IJ was identified on 7/6/21. The Administrator A was notified on 7/6/21 at 12:44 PM of the IJ that began on 6/19/21 at approximately 4:36 PM when the facility failed to ensure R501 was free from the use of a physical restraint.<br><br>The Immediate Jeopardy was removed on 7/7/21 at 12:30 PM based on surveyor verification that the facility had implemented the following to remove the Immediate Jeopardy:<br><br>Resident R501 was evaluated on 6/19/21 and there were no new injuries as the result of the incident of her being tied to a chair.<br><br>The employees involved in the incident were suspended on 6/19/21 pending investigations and terminated on 6/23/21 and 6/24/21.<br><br>On 7/6/21, the facility has started the process for reporting the cenas certification to the state agency and the nurse's license to the Michigan Licensing Board. This was completed on 7/7/21.<br><br>The Administrator and DON reviewed the Abuse and Restraint Policy on 6/21/21 and deemed it appropriate as written.<br><br>The facility started inservicing the staff on the Abuse and Restraint Policy on 6/28/21 and it's ongoing. There have been 81 out of 82 staff members inserviced as of 7/7/21 at 12:30 PM.<br><br>Effective 6/19/21, resident R501 had a sitter daily and in the event the sitter has to leave the Unit, the Unit Managers/Nurses will continue monitoring Resident R501 whereabouts until the sitter returns. One on one monitoring continues for Resident R501.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | The Social Worker conducted 54 resident interviews on 6/24/21 regarding mistreatment and restraints. No resident verbalized witnessing or experienced any mistreatment of being restrained at the facility. As of 7/7/21 at 10:30 AM 62 out of 63 residents had been reviewed.<br><br>Starting the week of 6/27/21, the Social Worker and/or designee will conduct random weekly interviews with the residents to ask if they've witnessed and/or experienced mistreatment of residents. The Social Worker and/or designee will report findings to the Administrator weekly.<br><br>Although the Immediate Jeopardy was removed on 7/7/21, the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimum harm that is not immediate jeopardy pending the completion of inservice training of all staff and confirmation of the facility's ability to maintain sustained compliance, as verified by the State Agency (SA). |