Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Michigan Veterans Homes at Grand Rapids

Location: 2950 Monroe Ave, N.E., Grand Rapids, MI 49505

Onsite / Virtual: Onsite

Dates of Survey: 12/10/24 – 12/13/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 128

Census on First Day of Survey: 120

Surveyed By: Levetta Perry, RN; Lu Anne Heglie, RN; Stephen Fryar, RCP; Gwendolyn DuBose, MPA; Louis Smith (LSC); Cicely Robinson, VACO.

VA Regulation Deficiency	Findings
	Initial Comments: A VA State Veterans Home Annual Survey was conducted from December 10, 2024 through December 13, 2024 at the Michigan Veterans Homes at Grand Rapids. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.90 (b) (1) – (5) Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. (1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. (2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment. (3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault.	Based on observation, interview, record review, and review of facility policy, the facility failed to ensure the residents had the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion for one (1) of 120 residents. On 11/23/24, at 6:49 p.m., one (1) resident (Resident #9), sustained a fall while being transferred by one (1) Certified Nurse Aide (CNA) K from the toilet to the wheelchair. The resident experienced a change in level of consciousness and became lethargic. CNA K failed to follow the resident's assessment and Plan of Care which required two (2) staff members' assistance with toileting and transfer. The findings include:

(4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. (5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative. **Rating** – Not Met **Scope and Severity** – G **Residents Affected** – Few	A review of the facility's policy titled, "Clinical Services & Quality of Care, Safety & Accident Prevention: Fall and Fall Risk, Managing," Sec. CLNQC-SAF, Policy 5.8.005, revealed: "Policy - Based on previous evaluations and current data, the staff will identify interventions related to the member's specific risks and causes to try to prevent the member from falling and to try to minimize complications from falling…Member Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a member-centered fall prevention plan to reduce the specific risk factor(s) of falls for each member at risk or with a history of falls." A review of the facility's policy titled, "Member Behavior & Safety Abuse & Neglect Prevention Abuse Prevention Program," Sec. MBRSF-ABS, Policy 12.1.001, last reviewed 3/21/24, revealed: "Policy - Our members have the right to be free from abuse, neglect, misappropriation of property, and 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." A review of the facility's Clinical Services and Quality of Care policy titled, "Safety & Accident Prevention Fall and Fall Risk, Managing," Sec. CLNQC-SAF, Proc 5.8.005A, revealed: "In the event a member fall: Any staff member who discovers or witnesses a fall…will notify the licensed nurse, or house supervisor, immediately. Do not attempt to move the member… 6. If there is the potential for major injury, notify HS [House Supervisor] for guidance about moving the member." A review of the medical record of Resident #9 revealed he/she was admitted to the facility on 2/9/22, with diagnoses to include: Epilepsy, Depression, Restlessness and Agitation, and Altered Mental Status. He/she was currently in hospice care. A review of Resident #9's most recent annual Minimal Data Set (MDS), dated 9/16/24, identified a Brief Interview of Mental Status (BIMS) score of 10, which indicated he/she had moderate impairment of cognition. In addition, Resident #9 was assessed to require extensive assistance with transfers and toileting with two (2) person assistance. A review of the resident's most comprehensive Care Plan, most recently updated on 11/4/24, indicated this resident required extensive assistance of two (2) staff during transfers and toileting. A review of the most recent comprehensive Care Plan, dated 10/18/24, revealed that Resident #9 was a risk for falls due to poor safety awareness, impaired mobility, and a history of falls.

	Resident #9 had a history of seizures and impaired vision, and he/she was to never be left alone in the bathroom/toilet. A review of the Kardex document used to guide the nursing staff with all resident care needs revealed that on 11/23/24, the date the fall occurred, Resident #9 required extensive assistance of two (2) persons to do a toilet transfer. This Kardex was posted on the resident's bathroom door for quick reference of the resident's activities of daily living (ADL) needs. On 11/23/24, at 6:40 p.m., one (1) resident, Resident #9, sustained a fall while attempting to be transferred from the toilet to the wheelchair, and while being assisted by one (1) Certified Nurse Aide (CNA). Resident #9 experienced a change in level of consciousness and became lethargic. CNA K failed to follow the resident's assessment and Plan of Care requiring two (2) staff assistance with toileting and transfer. CNA G entered the resident's bathroom and witnessed both the resident and CNA K on the bathroom floor, and the resident was complaining of upper leg pain as his/her legs were trapped under Resident #9's body. CNA K failed to follow policy and moved the resident that had fallen prior to a Licensed Nurse assessing this resident for injury. CNA G then relocated the resident's legs, extending them in front of the resident's body. Resident #9 began to have rapid eye movement and became unresponsive. Resident #9 had a pulse and heartbeat but appeared to be having seizures. The resident had a pulse and was breathing at this time. When the Registered Nurse (RN) House Supervisor arrived, he/she assessed the resident's stability, and discovered the resident had low blood pressure and a slow heart rate. His/her assessment revealed it did not appear Resident #9 had struck their head, but Resident #9 remained very lethargic. The RN House Supervisor began to attempt to improve the resident's vital signs by placing Resident #9's feet higher than their head to improve blood pressure. Vitals were reassessed and found to be more stable for transport back to their bed. By using a mechanical lift, the resident was transferred back to bed where the RN House Supervisor and RN Charge Nurse identified that the resident had a shortening of the left leg and an inward rotation of the Left leg. As a result of CNA K's decision to attempt to perform a single person transfer, Resident #9 was placed in an unsafe condition. Resident #9 sustained a left femur fracture, and this caused him/her an impaired quality of life. On 12/10/24, at 7:33 p.m., this surveyor attempted to contact Resident #9's guardian, but they were unable to be reached by phone and a voicemail was left, but no return call was received.

	On 12/10/24, at 7:36 p.m., an attempt was made to contact Certified Nursing Aide (CNA) K by phone. The voicemail was full, and a message was unable to be left. A phone interview was conducted on 12/11/24, at 8:02 p.m., with the Registered Nurse (RN) House Supervisor for the second shift, 3:00 p.m., to 11:00 p.m. He/she stated they were the House Supervisor on 11/23/24, and at approximately 6:40 p.m., was called to Resident #9's room. He/she initially observed the resident when he/she entered the resident's room. Resident #9 was on the bathroom floor sitting up with both legs extended in front of him/her. He/she stated Resident #9 was not completely unresponsive but looked as if they had experienced some seizure like activity, and they were lethargic, which had been reported to the RN House Supervisor; however, he/she had not witnessed the seizure or rapid eye movement that was reported to have been observed prior to his/her arrival. He/she stated the concern was that the resident's heart rate (HR) and blood pressure (BP) were low, so he/she placed Resident #9 in a position to help with this (head lower than the feet) and placed pillows under Resident #9's legs to elevate them. The RN House Supervisor continued to recheck Resident #9's HR and BP and noted both to improve, and the resident began to follow them with their eyes. He/she stated that Resident #9 was stable enough to transfer back to bed, and used the mechanical lift with a long pad and rolled him/her from side to side to place the pad under their body. He/she explained that the resident began to complain of pain and pointed to their left leg. Upon additional assessments, the RN House Supervisor and RN Charge Nurse noted the resident's left leg to have an inward rotation with a one (1) inch shortening compared to the right leg. He/she began to arrange for an ambulance to transfer Resident #9 out of the facility for a higher level of care for the assessment of their injury. They contacted hospice care services and the nursing leadership on-call for permission to transfer the resident, which was granted. He/she started conducting the investigation of the incident, and it was determined that Resident #9 had been transferred to the toilet by CNA K alone. They tried two (2) attempts to transfer Resident #9 back to the wheelchair, and the resident became weak and collapsed, which resulted in the resident falling to the bathroom floor with their legs under their body. He/she stated that CNA G stated as he/she entered the resident's bathroom, after the resident had collapsed and was on the floor with CNA K, he/she made the decision to pull the resident's legs out from under their body. CNA G stated that he/she witnessed the resident having what appeared to be seizure like activity with rapid eye movements, and they became unresponsive. The RN House Supervisor stated this was a serious failure and could have contributed to a diagnosis of a left femur bone fracture.

	During an interview, on 12/12/24, at 11:11 a.m., with CNA G, they stated that they witnessed Resident #9 being transferred by CNA K without assistance on 11/23/24. He/she stated that CNA K was attempting to transfer Resident #9 when he/she became weak and collapsed to the floor. CNA G stated that he/she made the decision to pull Resident #9's legs from under his/her body because the resident was complaining of leg pain. CNA G stated they then witnessed the resident have what appeared to be seizure like activity with rapid eye movements, and they became unresponsive. CNA G stated they had received training often on abuse and neglect. He/she stated neglect was not following the Kardex or a Care Plan, which included things that would put the resident in harm's way and failing to perform appropriate resident care. He/she stated the Kardex was changed as needed to identify the resident's Activities of Daily Living (ADL) needs, and this was communicated at the beginning of rounds for each resident. If changes were made, they were highlighted on the Kardex and the Plan of Care was modified, and this should always be checked at the beginning of the shift. The Kardex was posted on the back of each resident's bathroom door for quick reference. A review of a "Staff or Volunteer Interview Summary," dated 11/23/24, and not timed, and was conducted by the RN House Supervisor, revealed CNA K stated they had transferred Resident #9 to the toilet. Resident #9 said they were unable to go and asked to get back in the wheelchair. He/she stated that, as they stood him/her up and pulled his/her pants up, Resident #9 sat back down on the toilet. He/she told Resident #9 to take their time, and when he/she was ready, he/she would try again. As Resident #9 stood up and CNA K attempted with one (1) hand to pull his/her pants up again, Resident #9's knees began to give out. CNA K placed the emergency call light on for help. CNA G entered the room just as CNA K was lowering the resident to the floor. As he/she entered the bathroom, Resident #9 began to have rapid eye movements and became unresponsive. The RN House Supervisor and RN Charge Nurse were called to assess the situation after attempting a sternal rub and other things to bring Resident #9 to consciousness. The question was asked during this interview by RN House Supervisor if CNA K knew this resident was a two (2) person transfer, and CNA K answered "No." A review of a "Staff or Volunteer Interview Summary," dated 11/23/24, at 8:30 p.m., which was conducted by the RN House Supervisor, revealed the statement of Licensed Practical Nurse (LPN) E who was called into Resident #9's room because he/she was on the floor. The resident was sitting up with both feet in front of them with a transfer gate belt on. Resident #9 appeared to be having a seizure, was unresponsive, but

	breathing heavily and snoring. He/she was asked if they knew this resident was a two (2) person assist, and they answered "Yes." A review of a "Staff or Volunteer Interview Summary," dated 11/23/24, at 9:00 p.m., conducted by the RN House Supervisor, revealed the statement of CNA G, which revealed that, at about 6:40 p.m., on 11/23/24, the emergency call light was on in Resident #9's room. As they entered the room, they heard CNA K tell the resident to "Stand Up." CNA G stated they entered the bathroom door and CNA K had one (1) arm looped under the resident and the other hand holding his/her blue gait belt. Resident #9's knees "buckled," and CNA G did not have time to get to the resident to assist CNA K. He/she stated they went to get LPN E, and when CNA K returned, he/she straightened Resident #9's legs out in front of them because the resident was complaining of leg pain. Shortly after that, Resident #9 became unresponsive, and he/she could see rapid eye movement. An interview, on 12/12/24, at 10:10 a.m., with CNA G revealed the Kardex reflected the resident's ADL needs and was posted on the back of every resident's bathroom door and was replaced with a new one (1) every Wednesday. It was also located on the staff computer for review. He/she stated that neglect was not following a Kardex or Care Plan, and not performing ADLs as ordered. An interview, on 12/12/24, at 10:12 a.m., with CNA G, revealed the Kardex Care Plan system had been used for several years in the facility to identify the care areas and needs of residents. He/she stated neglect would include not answering call lights, ignoring resident requests, and not performing care as needed. He/she stated that Resident #9 had a Care Plan for a gait belt to be used, and they were to be transferred with assistance of two (2) staff. He/she stated that Resident #9's functional status had decreased since the fall, and now he/she required meals to be fed to him/her. He/she stated that Resident #9 could assist with a stand to transfer prior to the fall, but now he/she required assistance with a total lift using a mechanical lift because of their functional decline. An interview, on 12/12/24, at 10:22 a.m., with the RN Nurse Manager on the Sunset and Lakeshore units revealed Resident #9 had recently declined in health since the fall on 11/23/24. He/she stated that, prior to the fall, Resident #9 could assist with transfers, but currently he/she required total assistance with a mechanical lift. He/she stated that the Kardex represented the Plan of Care provided for each resident to help the staff quickly identify their need for assistance. He/she stated that Resident #9 had required a transfer back to the hospital after returning

	from the fall due to a decrease in level of consciousness. He/she stated that forms of neglect included a resident not receiving proper care, and the staff not following the Care Plan. He/she stated that Resident #9 always required the maximum assistance of two (2) staff with transfers. This meant that staff should always get help before attempting to transfer Resident #9. He/she stated they expected that if a resident was found after a fall, the nurse should be notified immediately, and the resident was not to be moved for any reason. He/she stated it was unacceptable practice for a resident to be moved after an incident prior to the licensed staff performing an assessment, and such movement could potentially cause additional injury. An interview, on 12/12/24, at 10:40 a.m., CNA H revealed that the Plan of Care for any resident could be found on the computer via Point Click Care (computerized medical record) and on the Kardex that was located behind the door of each resident's bathroom. He/she stated that if a resident was found on the floor, they were to determine the status of the resident, never leave the resident unattended, and call for help, but to never move a resident before the licensed nurse assessed them. He/she stated that a CNA did not have the skills to perform an assessment after a resident had fallen. During an interview, on 12/12/24, at 10:44 a.m., with CNA I, they stated that this was their first day on this job. He/she stated that if a staff member was unsure of the care needs of a resident, they should look at the Care Plan and/or Kardex, and they could ask the nurse for clarification. If a resident had fallen, they were to stop and check on the resident, call for help, and never move the resident without the assessment and direction of the licensed nurse. He/she stated that neglect was a form of abuse, and included leaving a resident to go get help and not following the resident's Care Plan or Kardex. An interview, on 12/12/24, at 10:50 a.m., with CNA J, revealed the best ways to identify the resident's care needs was to ask the nurse, check the Care Plan, and review the Kardex on the resident's bathroom door before each shift in case there were changes. He/she confirmed that if a resident fell, they were not move them, and were call for help. He/she identified abuse and neglect as failing to provide care, not following a Care Plan, or not checking the Kardex before every shift. An interview, on 12/12/24, at 10:58 a.m., with LPN F revealed the ADL care was identified on the resident's Kardex in their bathroom or the Care Plan on the computer. He/she stated some forms of neglect included not answering a resident's call light and leaving a resident unattended if care was needed. If a resident had fallen, the CNA should never move the resident and should get the help of the licensed nurse.

	An interview, on 12/12/24, at 11:42 a.m., with the Staff Development Coordinator revealed all staff received education on where to find the resident's care needs, which was on the Kardex in the resident's bathroom, and also on the Care Plan. He/she stated that the Kardex was updated as needed, but were reprinted with any changes on Wednesday of every week. If a change occurred before the Wednesday reprint, the staff nurse would make the change on the Kardex, and it was highlighted in pink. It was the staff's responsibility to check the Care Plan or Kardex at the beginning of each shift. He/she stated that the concerns of staff not following the Kardex or Plan of Care included the risk of a resident becoming injured. He/she stated that not following the guidance of the Care Plan was a form of neglect. They confirmed that all staff were trained on abuse and neglect during initial employee orientation, and annually with occasional opportunities throughout the year. He/she stated that they provided frequent reminders to the staff about how to identify and report an allegation of abuse or neglect. All staff were provided with educational material regarding abuse and neglect, and how to report such occurrences. An interview, on 12/12/24, at 11:44 a.m., with the Physical Therapist (PT) revealed Resident #9 was currently under Hospice care, but had previously been treated for a fractured left femur after a fall. He/she stated this resident had fluctuated with assistance needs, but always needed assistance with transfers. He/she stated Resident #9 had a long history of difficult transfers and required extensive assistance. During an interview, on 12/12/24, at 11:47 a.m., with the Director of Nursing (DON), they stated that Resident #9 had a history of seizures. Resident #9 had required transfers back to the hospital for a decreased level of consciousness since the fall on 11/23/24. He/she stated CNA K should have known not to transfer him/her without assistance, and a resident who had fallen should never be moved before being assessed by the licensed nurse. An interview, on 12/12/24, at 11:48 a.m., with the Administrator revealed that he/she agreed CNA K transferred Resident #9 by themselves, and that CNA K was immediately suspended and then terminated because the investigation showed there was a failure to follow a resident's Care Plan. He/she stated the facility had a zero-tolerance policy for not following a Care Plan, and staff member would be terminated for failure to follow a Care Plan. He/she stated that a form of neglect was when a staff member did not follow the Care Plan. He/she stated the first failure of this incident was that CNA K transferred Resident #9 without the assistance of another staff member. He/she stated that when they asked CNA K why they did not check the

	Kardex, CNA K replied that it was their fault they did not check the Kardex before making the transfer. He/she stated that this occurrence was identified as noncompliance with the facility policy on a resident's ADL care. An interview, on 12/12/24, at 4:16 p.m., with the RN Charge Nurse revealed the staff were aware that if a resident was assessed and had a Care Plan for assistance of two (2) staff, then they should never attempt to transfer that resident with one (1) person. If a mechanical lift was to be used, then staff were to comply with that Care Plan. An interview, on 12/12/24, at 4:22 p.m., with CNA J revealed a Plan of Care could be found on the computer, on the Kardex, and in the book at the nurse's station. He/she stated that if a resident had fallen, staff were not to move the resident and were to get the nurse to assess the resident. A nursing assessment must always be completed before moving a resident. An interview, on 12/12/24, at 4:24 p.m., with the Assistant Director of Nursing revealed that any resident who had fallen must receive an initial assessment from the licensed nurse before the resident could be moved. CNAs could not make the decision to move a resident after a fall prior to a licensed nurse's assessment of injury. He/she confirmed that all staff in the facility were educated on abuse and neglect annually, and more often if needed. The staff were to report an allegation of suspected abuse immediately.
§ 51.90 (c) (2) Staff treatment of residents. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. **Rating** – Not Met **Scope and Severity** – D **Residents Affected** – Few	Based on interview and record review, the facility failed to report an allegation of neglect for one (1) of 120 residents after CNA K failed to transfer Resident #9 with the assistance of two (2) staff members. Resident #9 was assessed for and had a Care Plan that required extensive assistance of two (2) staff members. As the result of the neglectful act of an inappropriate transfer, Resident #9 sustained a fall on 11/23/24, at 6:30 p.m., with a major injury (left femur fracture) which required surgical intervention. The findings include: A review of the facility's policy titled, "Member Behavior and Safety Abuse and Neglect Prevention program," Sec. MBRSF-ABS, policy 12.1.001, last reviewed 3/21/24, stated: "our members have the right to be free from abuse, neglect, misappropriation of property, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the member's symptoms." A review of the facility's Clinical Services and Quality of Care policy titled, "Safety and Accident Prevention: Fall and Fall Risk,

	Management Procedures," Sec. CLNQ-SAF, Procedure 5.8.005A, found stated: "in the event a member falls…4. Any staff member who discovers or witnesses a fall will notify the licensed nurse or house supervisor, immediately. Do not attempt to move the member…6. If there is the potential for major injury, notify the house supervisor for guidance about moving the member." A review of the medical record of Resident #9 revealed he/she was admitted to the facility on 2/9/22, with diagnoses to include: Epilepsy, Depression, Restlessness and Agitation, and Altered Mental Status. He/she was currently in hospice care. A review of Resident #9's most recent annual Minimal Data Set (MDS), dated 9/16/24, identified a Brief Interview of Mental Status (BIMS) score of 10, which indicated he/she had moderate impairment of cognition. In addition, Resident #9 was assessed to require extensive assistance with transfers and toileting with two (2) person assistance. A review of the resident's most comprehensive Care Plan, most recently updated on 11/4/24, indicated Resident #9 required an extensive assist of two (2) staff during transfers and toileting. A review of a recent comprehensive Care Plan, dated revised 11/4/24, stated that this resident was at risk for falls due to poor safety awareness, impaired mobility, and a history of falls. Resident #9 had a history of seizures and impaired vision, and he/she was to never be left alone in the bathroom/toilet. A review of the Kardex document used to guide the nursing staff with all residents' care needs, revealed that on 11/23/24, the date the fall occurred, Resident #9 required extensive assistance of two (2) persons to do a toilet transfer. This Kardex was posted on the resident's bathroom door for quick reference for the resident's activities of daily living (ADL) needs. Record review revealed on 11/23/24, at 6:49 p.m., Resident #9 sustained a fall while being transferred from the toilet to the wheelchair and while being assisted by one (1) CNA. Resident #9 experienced a change in level of consciousness and became lethargic, and collapsed to the floor. CNA K failed to follow the resident's assessment and Plan of Care, which required assistance of two (2) staff with toileting and transfers. CNA G entered the resident's bathroom and witnessed both the resident and CNA K on the bathroom floor, and the resident was complaining of upper leg pain as his/her legs were trapped under his/her body. CNA G failed to follow policy and not move a resident who had fallen prior to a licensed nurse assessing this resident for injury. CNA G then relocated the resident's legs, extending them in front of the resident's body. Resident

	#9 began to have rapid eye movement and became unresponsive. Resident #9 had a pulse and heartbeat, but appeared to be having seizures. The resident had a pulse and was breathing at this time. When the Registered Nurse (RN) House Supervisor arrived, he/she assessed the resident's stability, and discovered the resident had low blood pressure and slow heart rate. His/her assessment revealed that it did not appear Resident #9 had struck their head, but they remained very lethargic. The RN House Supervisor began to attempt to improve the resident's vital signs by placing Resident #9's feet higher than their head to improve blood pressure. Vital signs were reassessed to be more stable for transport back to their bed. By using a mechanical lift, the resident was transferred back to their bed, where the RN House Supervisor and RN Charge Nurse identified the resident had a shortening of the left leg and an inward rotation of the left leg. As a result of CNA K's decision to attempt to perform a single person transfer, Resident #9 was placed in an unsafe condition. Due to Resident #9 sustaining a left femur fracture, their quality of life was impaired. An interview, on 12/12/24, at 11:47 a.m., with the Director of Nursing, revealed Resident #9 had a history of seizures. Resident #9 had required several transfers back to the hospital for a decreased level of consciousness since the fall on 11/23/24. He/she stated that CNA G and CNA K should have known not to transfer this resident without assistance, and to never move a resident that had fallen before they were assessed by the licensed nurse. He/she stated that the facility consulted with their leadership team regarding the potential for neglect, which would have been reported, but was informed this was not neglect and the facility should not report it as such. An interview, on 12/12/24, at 11:48 a.m., with the Administrator revealed he/she agreed that CNA K transferred Resident #9 by themselves to and from the toilet without the assistance of another staff member, and that CNA K was immediately suspended pending the investigation. He/she was terminated because the investigation determined there was a failure to follow a resident's Care Plan. He/she stated the facility had zero tolerance for not following a Care Plan, and staff would be terminated for failure to follow a Care Plan. He/she stated that a form of neglect was when a staff member did not follow a resident's Care Plan. He/she stated the first failure in this incident was that CNA K transferred Resident #9 without the assistance of another staff member. He/she stated that when they asked CNA K why they did not check the Kardex, CNA K replied it was his/her fault he/she failed to check for the resident's ADL needs. The Administrator stated this occurrence demonstrated noncompliance with the facility policy. The facility had completed an investigation of the incident, but did not feel it was a neglectful act, so the incident was not reported.

§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Rating** – Not Met **Scope and Severity** – G **Residents Affected** – Few	Based on interview and record review, the facility failed to ensure that staff followed professional standards for one (1) of 120 residents related to the resident centered Care Plan and facility policy for Resident #9, which resulted in a fall with major injury causing a significant decline in their activities of daily living (ADLs). The findings include: A review of the facility's policy titled, "Member Behavior and Safety Abuse and Neglect Prevention program," Sec. MBRSF-ABS, policy 12.1.001, last reviewed 3/21/24, found stated: "our members have the right to be free from abuse, neglect, misappropriation of property, involuntary seclusion, verbal, mental, sexual or physical abuse and physical or chemical restraint not required to treat the member's symptoms." A review of the facility's Clinical Services and Quality of Care policy titled, "Safety and Accident Prevention: Fall and Fall Risk, Management Procedures," Sec. CLNQ-SAF, Procedure 5.8.005A, found stated: "in the event a member falls…4. Any staff member who discovers or witnesses a fall will notify the licensed nurse or house supervisor, immediately. Do not attempt to move the member…6. If there is the potential for major injury, notify the house supervisor for guidance about moving the member." A review of the medical record of Resident #9, revealed he/she was admitted to the facility on 2/9/22, with diagnoses to include: Epilepsy, Depression, Restlessness and Agitation, and Altered Mental Status. He/she was currently in hospice care. A review of Resident #9's most recent annual Minimal Data Set (MDS), dated 9/16/24, identified a Brief Interview of Mental Status (BIMS) score of 10, which indicated he/she had moderate impairment of cognition. In addition, Resident #9 was assessed to require extensive assistance with transfers and toileting with two (2) people. A review of the resident's most comprehensive Care Plan, most recently updated on 11/4/24, indicated this resident needed extensive assist of two (2) staff during transfers and toileting. A review of the most recent comprehensive Care Plan, dated revised 11/4/24, found stated that this resident was a risk for falls due to poor safety awareness, impaired mobility, and a history of falls. Resident #9 had a history of seizures and impaired vision, and he/she was to never be left alone in the bathroom/toilet.

	A review of the Kardex document used to guide the nursing staff with all resident care needs, revealed that on 11/23/24, the date the fall occurred, Resident #9 required extensive assistance of two (2) persons to do toilet transfers. This Kardex was posted on the resident's bathroom door for quick reference of the resident's ADL needs. On 11/23/24, at 6:49 p.m., Resident #9 sustained a femur fracture from a fall while transferring from the toilet to the wheelchair by one (1) CNA. Resident #9 experienced a change in level of consciousness and became lethargic. CNA K failed to follow the resident's assessment and Plan of Care, which required two (2) staff assistance with toileting and transfers. CNA G entered the resident's bathroom and witnessed both the resident and CNA K on the bathroom floor, and the resident was complaining of upper leg pain as his/her legs were trapped under their body. CNA K and CNA G failed to follow policy and not move a resident that had fallen prior to a Licensed Nurse assessing the resident for injury. CNA G then removed the resident's legs from under the resident's body and extended them in front of the resident's body. Resident #9 began to have rapid eye movement and became unresponsive. Resident #9 had a pulse and heartbeat, but appeared to be having seizures. The resident had a pulse and was breathing at this time. When Resident #9 became stable, the RN House Supervisor approved for the resident to be transferred back to their bed using a mechanical lift. The RN House Supervisor and RN Charge Nurse identified the resident had a shortening of the left leg and an inward rotation of the left leg. As a result of CNA K's decision to attempt to perform a single person transfer, Resident #9 was placed in an unsafe condition. Due to Resident #9 sustaining a left femur fracture, Resident #9 had an impaired quality of life since the time of the fall. On 12/10/24, at 7:36 p.m., an attempt was made to contact CNA K by phone. The voicemail was full, and the surveyor was unable to leave a message. A phone interview was conducted, on 12/11/24, at 8:02 p.m., with the RN House Supervisor for second shift, 3:00 p.m., to 11:00 p.m. He/she stated that they were the House Supervisor on 11/23/24, and at approximately 6:40 p.m., he/she was called to Resident #9's room. He/she initially observed, when he/she entered the resident's room, that Resident #9 was on the bathroom floor sitting up with both legs extended in front of the resident. He/she stated that Resident #9 was not completely unresponsive, but looked as if they had experienced some seizure like activity, which had been reported to the RN House Supervisor; however he/she did not witness the seizure or rapid eye movement that was reported to have been observed prior to his/her arrival. He/she stated the concern was of the resident's

	possibility of sustaining of an injury, and Resident #9's heart rate (HR) and blood pressure (BP) were low. He/she put Resident #9 in a position with their head lower than their feet and placed pillows under Resident #9's legs to elevate them, and continued to recheck HR and BP, and noted both came up and the resident began to follow him/her with their eyes. He/she stated that Resident #9 was stable enough to transfer back to their bed, and the RN House Supervisor used the mechanical lift with a long pad, rolling Resident #9 from side to side to place the pad under their body. He/she explained that the resident, at this time, was beginning to complain of pain, and pointed to their left leg. Upon additional assessments, the RN House Supervisor and RN Charge Nurse noted the resident's left leg to have an inward rotation with approximately a one (1) inch shortening compared to the right leg. He/she began to arrange for an ambulance to transfer Resident #9 out of the facility for a higher level of care for the assessment of their injury. They contacted hospice care services and the nursing leadership on-call for permission to transfer, which was granted. He/she started conducting the investigation of the incident. It was determined that this resident was transferred to the toilet by CNA K alone. They tried two (2) attempts to transfer Resident #9 back to the wheelchair, and the resident became weakened and collapsed, which resulted in the resident falling to the bathroom floor with their legs under their body. He/she stated CNA G stated that, as he/she entered the resident's bathroom, the resident had collapsed and was on the floor with CNA K. CNA G stated that he/she witnessed the resident have what appeared to be seizure like activity with rapid eye movements, and they became unresponsive. CNA G reported to the RN House Supervisor that he/she made the determination to move the resident's legs from under their body. The RN House Supervisor stated this was a serious failure and contributed to Resident #9 sustaining a left femur bone fracture. An interview, on 12/12/24, at 10:10 a.m., with CNA G revealed that neglect was determined to be not following a Kardex or Care Plan and not performing ADLs as ordered, and that moving the resident could have led to an injury. An interview, on 12/12/24, at 11:47 a.m., with the Director of Nursing, revealed CNA K and CNA G should have known not to transfer Resident #9 without assistance, and to never move a resident who had fallen before they were assessed by the licensed nurse. He/she stated this was a direct violation of the facility policy. An interview, on 12/12/24, at 11:48 a.m., with the Administrator revealed that he/she agreed that CNA K transferred Resident #9 by themselves to and from the toilet, which led to a fall with major injury. He/she stated that neglect was when a staff

	member did not follow a resident's Care Plan. He/she stated the first failure of this incident was that CNA K transferred Resident #9 without the assistance of another staff member. He/she stated that when they asked CNA K why they did not check the Kardex, CNA K replied it was his/her fault. He/she stated this occurrence showed noncompliance with the facility policy. Secondly, CNA G should have known not to move the resident prior to an assessment by the licensed nurse.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Rating** – Not Met **Scope and Severity** – F **Residents Affected** – Many	Based on observation, interview, and review of facility policy, the facility failed to ensure that food was prepared under sanitary conditions in the kitchens that served all residents of the facility. This was evident by the staff failing to properly sanitize items in the kitchens of the facility. The findings include: A review of the facility policy titled, "Nutrition Services General Sanitation Meal Assembly," Sec. Nutrn-gen, Policy 14.1.008, last reviewed 6/17/24, revealed that: "MVH [Michigan Veteran Homes] prioritizes meal assembly to ensure foods are handled safely and held at proper temperatures to prevent the spread of bacteria that may cause food borne illness…3. During meal assembly, staff shall:…f. Change gloves when activities are changed, or when the type of food being handled is changed, or when leaving the workstation." A review of the facility policy titled, "Nutrition Services General Food Safety Requirements," Sec. Nutrn-gen, Policy 14.1.007, last reviewed 5/25/23, revealed: "It is the policy of MVH to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety…Definitions…'Potential Hazardous Food (PHF)' or 'Time/Temperature Control for Safety (TCS) Food' means food that requires time/temperature control for safety to limit the growth of pathogens (i.e., bacterial, or viral organisms capable of causing a disease or toxin formation). Examples of PHF/TCS foods include ground beef, poultry, chicken, seafood (fish or shellfish), cut melon, unpasteurized eggs, milk, yogurt, and cottage cheese. Guidelines…6. All equipment used in the handling of food should be clean and sanitized (using heat or chemical sanitizing solutions) and handled in a manner to prevent contamination…(h) Food thermometers used to check food temperatures are clean, sanitized and calibrated for accuracy." An observation of the main kitchen, on 12/11/24, at 10:26 a.m., revealed Cook A to utilize an approved food thermometer to test the temperature of pizzas taken directly from the oven. Pizzas

	were tested two (2) at a time, cut with a rotary pizza cutter, then they placed the thermometer and cutter directly on the preparation surface. The two (2) pizzas were taken out of the workstation and placed into warming boxes. Cook A re-entered the workstation area three (3) times without a glove change, during which he/she contacted a portable metal transport cart and the handles of the hot box, which other staff had been in contact with while not using gloves. At no time between temperature checks were the thermometer or rotary cutter cleaned or sanitized after being left in contact with the food preparation table. Once all six (6) pizzas were stored, Cook A submerged the tip of the probe thermometer into a red sanitation solution bucket with a single insert of less than one (1) second, then wiped off the probe with an unclean preparation cloth and replaced the thermometer back into the protective case; they then placed the cutter in the dirty dishwashing area. An interview with Cook A, on 12/11/24, at 10:42 a.m., revealed he/she was aware of leaving the workstation and failing to change gloves after he/she contacted the handles on the cart and the handles on the warming box. He/she was aware they failed to use proper sanitation techniques to sanitize the thermometer and cutter. He/she stated the sanitization solution buckets were always used to sanitize items in the kitchen area, but was not aware the probe should be exposed to the solution for a minimum of 10 to 30 seconds, and they should not have used the kitchen cloth after using sanitizer solution. He/she stated this could have caused cross contamination and the residents could get sick. An observation, on 12/11/24, at 10:48 a.m., revealed Dietary Service Aide (DSA) B took food temperatures to test various types of food that were removed from the warming box used for transportation of food from the kitchen. He/she obtained a temperature with an approved thermometer, and was observed to wash the thermometer off in the sink of the satellite kitchen, then submerge the probe into the red sanitation solution for less than one (1) second, and then they used a paper towel from the dispenser to wipe off the probe. He/she proceeded to test the entire prepared meal, which contained various types of food. At the conclusion of the temperature check, DSA B was asked to test the sanitation solution in the bucket, which gave a result of zero (0) parts per million (ppm) of sanitizing solution. He/she confirmed they always used the red bucket sanitation solution to sanitize the food thermometer. An interview, on 12/11/24, at 11:10 a.m., with DSA C revealed the food thermometer should be cleaned between each food item tested, and should be sanitized using the sanitizing solution

	or sanitation wipes. The sanitizing solution concentration should be maintained at 200 ppm or greater. On 12/11/24, at 11:23 a.m., during an interview with the Registered Dietitian/Food Service Director, they stated that all staff were to clean the food-related utensils, such as the thermometers and rotary cutters, with a sanitation method to prevent the development of any food borne illness that could cause the residents to become ill. He/she stated that the staff had sanitation wipes available to them, but it had been their practice throughout the kitchen areas to use the red buckets which contained sanitizing solution. The staff were to submerge items such as probe thermometers in the sanitizing solution for at least one (1) minute, and the sanitizing solution water temperature must be tested for both temperatures of less than 95° F (degrees Fahrenheit), and for 200 ppm of sanitizing solution concentration for it to be effective. The staff should not be wiping off the probe thermometers after they were sanitized. His/her overall concerns were the risk of cross contamination and the potential for a food borne illness outbreak. An interview, on 12/11/24, at 11:10 a.m., with DSA D revealed that he/she always used the sanitizing solution to clean the probe thermometer, but that they should not have used the sink water or paper towel after using the sanitizing solution. He/she was not aware of where to find the sanitation wipes to use in place of sanitizing solution. His/her concern of lack of proper sanitation was that the residents could get sick.