

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>235444</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/24/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>WESTWOOD NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>16588 SCHAEFER DETROIT, MI 48235</b>	
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 0609  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake: MI 1 Based on interview and record review, the facility failed to report an incident of resident to resident abuse to the state agency. The abuse involved one resident (resident # 805) out of seven residents sampled for abuse; resulting in the potential for future abuse to go undetected and corrective measures taken. Findings included: On 6/23/20 at 9:00 AM the administrator was asked to provide copies of all incidents and accident reports investigated by the facility over the past 90 days. The administrator provided the surveyor 4 incident and accident reports; the reports did not include resident 805. Resident 805 was the subject of a complaint filed with the state agency. A record review was conducted on 6/23/20 at 9:30 AM, it was noted resident 805 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the resident's Quarterly MDS (minimum data set) dated 1/26/20 the resident scored 6/15 on the BIMS (Brief Interview Mental Status), categorizing the resident as severely cognitively (thought processes) impaired. An interview was conducted with resident 805 on 6/23/20 at 10:55AM. The resident was asked, had she ever been hurt by another resident in the facility? The resident replied, no. According to a record review conducted on 6/24/20, there was a nursing note dated, 5/17/20. Nurse I heard a scream coming from the room of Resident 805. Nurse I observed the room mate of Resident 805 standing over Resident 805. The roommate had blood on her fingers and her night gown. Nurse I assessed resident 805 and noted scratches on her face. Nurse I cleaned the resident's face with Normal Saline and applied A&D ointment to the scratches. According to the incident report completed via Nurse I, the family, a nurse practitioner, the DON, and the Administrator were notified of the incident. The roommate of resident 805 was moved to another room following this incident. On 6/24/20, the Administrator was asked for the Incident and Accident Report involving Resident 805. The Administrator stated, I have it. The Administrator returned with a folder that contained Incidents and Accident Reports involving resident 805. The administrator was queried as to why this incident of resident to resident abuse had not been reported to the state agency. The administrator stated, I can't tell you why it was not reported, this incident happened on 5/17/20 and I started working here on 5/15/20. I did not submit this FRI (Facility Reported Incident) to the state. The Administrator provided a policy entitled: Abuse, Neglect, and Exploitation, dated 2019. Section VII of the report entitled Reporting/Response, stated, The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies (e.g. law enforcement when applicable) within specified time frames ( e.g. Immediately when the event involves abuse or not later than 24 hours when the events do not involve abuse and do not result in serious bodily harm).		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.