

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>235439</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/11/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>HEARTLAND HEALTH CARE CENTER-ALLEN PARK</b>		STREET ADDRESS, CITY, STATE, ZIP <b>9150 ALLEN RD ALLEN PARK, MI 48101</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 0600  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> F600 This citation pertains to intake MI 1458 (FRI) On, interview, and record review, the facility failed to maintain an environment free of physical abuse for a vulnerable resident (403), resulting in the potential for the abuse of additional vulnerable residents in the facility. Findings include: According to the FRI (Facility Reported Incident) summarized via the facility administrator, the administrator was notified on 3/14/20 via a facility nurse that she witnessed another facility nurse aggressively rip the blood pressure cuff off the arm of resident 403. The administrator followed up the verbal report with a face-to-face meeting with resident 403 approximately one hour after the alleged incident. Resident 403 stated, that nurse pulled the BP (blood pressure) cuff off my arm hard, and she did it on purpose. The resident stated, it hurt my arm. Resident was admitted to the facility on [DATE], his [DIAGNOSES REDACTED]. According to resident 403's most recent quarterly MDS (minimum data set) dated 2/20/20, the resident's BIMS (brief interview of mental status) score was 11/15, indicating moderate cognitive (thought processes) impairment. Resident 403 required extensive one-person assistance with activities of daily living such as: toileting, hygiene, bed mobility, and hygiene. Resident 403 received vital signs (to include the taking of a blood pressure) daily due to a history of [MEDICAL CONDITION] with associated medications. On 3/14/20, the administrator asked the identified RN (registered nurse) did she aggressively remove the blood pressure cuff from the arm of resident 403. The RN stated, I guess, I'm not sure. The RN was immediately suspended pending investigation. The allegation was substantiated following the investigation, and the RN terminated; in addition, the RN's nursing license was reported for review to the State of Michigan Licensing Board via the facility Administrator.		
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.