"Scared to Death of What He Will Do"

The nursing home failed to ensure a CNA reported an injury to nursing staff for resident 901, resulting in delayed treatment and pain.

Resident 901 was cognitively intact (BIMS score of 15 out of 15) and required extensive one person assist for most activities of daily living.

A nursing home incident report was submitted to the State Agency alleging that one night at 11:00 PM, CNA L either hit or ran over resident 901's foot with a wheelchair causing it to bleed, applied bandages on their own, and failed to report the incident/injury to a nurse for an assessment.

A day after the incident at around 7:00 AM, a physical therapist approached Nurse P and stated, "Can you come look at R901, she is not herself...she is emotional...she has a bandage on her leg that has blood on it, you can tell that she is just not herself." S/he later indicated, "the resident was in pain and "felt scared about reporting what happened because she was fearful, he (CNA L) would retaliate against her."

Nurse P went and assessed resident 901 immediately. Upon arrival, the resident was emotional and had four Band-Aids on her right shin area noted kerlix wrap to the right lower leg with dried blood. The nurse noted minimal swelling to the resident's right foot (the resident's operative leg).

The nurse asked what has happened and resident 901 began crying and said, "CNA L hit my leg and was rough...he yelled at me." The resident said that CNA L told her, "It's 11 o'clock, I am not doing any incident reports. It takes too much paperwork." The resident said that CNA L proceeded to put the band aid on her "after a bleed everywhere." She added, "After he got me to the bathroom, he either hit my foot on the wheelchair or ran over it with the wheelchair," said while pointing to her right foot.

The nurse noted three skin tears rolled under with some purplish bruising...with active bleeding on the right lower leg. The resident was offered an icepack and [name of medication] for right foot pain. The resident rated the pain at 8 out of 10 and added, "This is not the first time."

The nurse called the Director of Nursing and the Administrator to inform them about the incident.

The next morning after the physical therapist discovered it, resident 901 reported she is "scared that CNA L is going to find out she had to report this and is scared to death of what he will do."

When interviewed, CNA L stated, "I think the only thing I did wrong is that I did not tell the nurse the resident got a skin tear. I know I did wrong. I should have reported it."

Name of Nursing Home	Fox Run Village / Provider ID: 235634
Address	41215 Fox Run Road, Novi, Michigan
Date investigation completed	November 23, 2021
Type of deficiency issued	F684 – Quality of care
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235634/health/complaint?date=2021-11-23