| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235041 | A. Building<br>B. Wing | 10/15/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mackinac Straits Long Term Care Unit | 1140 North State Street<br>St. Ignace, MI 49781 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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.

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2638726 and 2641135.Based on observation, interview and record review the facility failed to provide safe transport to an outside appointment for one Resident (#10) of three residents reviewed for accidents/hazards. This deficient practice resulted in harm when R10 sustained a fractured left hip from being improperly secured during transport and fell from her seat when the transport van hit an obstacle in the road. Findings include:Resident #10 (R10)Review of the Minimum Data Set (MDS) assessment, dated 9/10/2025, revealed R10 was admitted to the facility on [DATE] and had diagnoses including diabetes and heart failure. Section GG of the MDS indicated R10 required substantial/maximal assistance with lower body dressing, was dependent on staff for transfers and scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating cognition was intact.On 10/15/2025 at 12:45 p.m., R10 could be heard yelling out in pain from her room. Upon entering the room, R10 was observed seated in bed with a troubled expression on her face. When asked if she was ok, R10 reported yes but she had just been repositioned by staff and that movement made her bones hurt. When asked where her pain was originating from, R10 placed her hand on her left thigh and stated, it's my bones. R10 was queried about prior injury and reported she recently fractured her left thigh and underwent surgical repair after a fall in the facility van while being transported to an appointment. When asked to describe the incident, R10 reported she was seated in her wheelchair in the back of the van and when the van hit a bump in a construction zone, she went flying from her wheelchair into the back of the seat in front of her, jamming her left knee into the back of the seat. R10 stated, my bone cracked, and I knew something was wrong right away. R10 reported she had significant pain in her left leg following the event. When asked if she had been wearing a seatbelt, R10 reported her wheelchair was tied down but she was not wearing a seatbelt, and the facility did not have any type of safety belt device for use during transport that would fit her wheelchair.Review of the incident report and investigation summary provided by the Director of Nursing (DON), dated 10/1/2025, revealed the following: Nursing supervisor was notified by CNA [Certified Nursing Assistant] what had happened. CNA informed [sic] that a bump was hit and [R10's] left knee hit the back of the seat and she c/o [complained of] pain in her leg. CNA asked for guidance and was instructed to take her to her [appointment] and then come back to facility. Once back to facility, order for x-rays was already obtained and she went down for x-rays and results came back that she had a fracture . 911 was called and she was sent to [acute care hospital] for treatment.Review of the Incident Summary, submitted to the State Agency (SA) on 10/1/2025 at 12:34 p.m., revealed the following: [R10] was on a transport in our wheelchair accessible van . she was accompanied by CNA [ A] and Activity Aide [AA B] (who was driving). Per [CNA A] during the transport, the van stopped due to oncoming construction, which caused [R10] to slump in her wheelchair. [R10's] knee hit the seat in front of her. When she returned from the appointment, she began to complain of pain.Review of the Investigation Summary, submitted to the SA on 10/8/2025 at 9:54 a.m., revealed the following: Director of Nursing [DON] interviewed both staff members, [CNA A and AA B], who were with [R10] during the transport at the time of the incident. Both staff members confirmed that the slow down the van needed to make was not a severe or harsh stop that caused significant force when the resident slid from her wheelchair and her left leg moved into the car seat in front of her. [CNA A] stated during interview with DON that she felt [R10's] leg lightly hit the front seat .It was noted there was no mention of whether R10 was provided with a seatbelt during the transport on 10/1/2025 per the documents submitted by the facility to the SA on 10/1/2025 and 10/8/2025.During an interview on 10/15/025 at 1:00 p.m., CNA A recalled the incident involving R10 which occurred during transport on 10/1/2025. CNA A reported R10 was seated in her wheelchair while being lifted into the back of the transport van. CNA A reported securing the wheelchair in the van using the tie-downs and hooks on the floor of the van and proceeded to take a seat in the first passenger row of the van, with R10 in her wheelchair seated behind her. CNA A reported AA B was driving the van and hit a bump while going through construction at which time R10 started to yell out. CNA A reported upon hearing R10 yell out she turned around to find the Resident slid partially out of her chair with her left foot off the foot pedal of the wheelchair, bent over with her left shoulder and knee up against the back of the passenger row of seats. CNA A was queried as to whether or not R10 expressed pain after the incident to which she reported she [R10] said her leg [left] hurt and that R10 expressed worry about the pain when arriving to her appointment and again when arriving back at the facility. When asked if she witnessed R10 slide out of the chair, CNA A reported she did not witness R10 come out |