STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235062	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandvue Medical Care Facility	1728 South Peninsula Road East Jordan, MI 49727

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. This deficient practice pertains to Facility Reported Incident (FRI) MI00153071. Based on observation, interview, and record review, the facility failed to maintain a complete and accurate medical record following an unwitnessed fall for one Resident (#1) of 3 residents reviewed for medical records. Findings include: Resident #1 (R1) Review of R1's electronic medical record (EMR) revealed initial admission to the facility on 8/21/23 with diagnoses including dementia, repeated falls, bone density disorder, and cognitive communication deficit. Review of R1's most recent Minimum Data Set (MDS) assessment, dated 5/9/25, revealed a Brief Interview for Mental Status (BIMS) score of 2/15, indicative of severe cognitive impairment. Review of the facility investigation report received by the State Agency (SA) on 5/14/25 at 1:39 PM read, in part: Incident Summary: On May 4, 2025, [R1] was discovered on the floor in another resident room .During the early morning hours of May 6, staff noted a bruise to [R1's] left heel . an x-ray was ordered. At 11:04 AM, on May 7, the x-ray results returned with the diagnosis of superior calcaneus [heel] fracture . Investigation Summary: On May 6, 2025, the night house supervisor, [Licensed Practical Nurse (LPN) B] reported to the [Director of Nursing (DON)] [R1] had a large bruise to her left heel. [LPN B] also reports skin tears to [R1's] right forearm. [LPN B] completed a chart review and found no note regarding an injury . [Certified Nursing Assistant (CNA) E] informed [LPN B] [R1] had been observed on the floor, in another resident room, on May 4. The two [LPN B and CNA E] feel the bruising and skin tears likely came from that incident . On 5/15/25 at 2:45 PM, R1 was observed sitting in a wheelchair with her left leg propped up on an elevated footrest covered with a soft cast and bandages. LPN D reported R1 had just returned to the facility after undergoing orthopedic surgery on her left heel at a local hospital. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 12:09 PM, an interview was conducted with LPN D who verified she was on duty when R1 was found on floor in another resident's room by CNA E on 5/4/25. LPN D stated although she was not the nurse responsible for R1's direct care on 5/4/25, she responded first to the report that CNA E had discovered R1 on the floor. LPN D recalled R1 was observed in a sitting position on the floor with her legs extended and right arm resting on the bed frame. LPN D stated after a brief assessment, R1 was assisted into the hallway as the resident who occupied the room was becoming distressed with the commotion. LPN D stated she observed a skin tear on top of R1's right forearm and vaguely recalled covering the wound with a band-aid. LPN D stated Registered Nurse (RN) C then came over to further assess R1. On 5/15/25 at 11:46 AM, a telephone interview was conducted with RN C who confirmed R1 was under her direct care when she was discovered on the floor in another resident's room on 5/4/25. RN C stated by the time she walked over, R1 was already in the hall and LPN B had completed a skin assessment. RN C stated R1 had an open spot on her right forearm that was bleeding. RN C stated LPN D had already covered the area with a band-aid but later in the day it had increased in size, so she covered it with non-stick gauze and tape. RN C stated R1 had a care plan that indicated she liked to sit on the floor, she did not count the incident as a fall and therefore did not complete a corresponding event report in R1's EMR. Review of R1's plan of care revealed a focus area initiated 8/21/23 which read: FALLS: High risk of falls r/t [related to] high risk medications for behavior disturbances/symptoms, confusion, gait/balance problems, poor communication/comprehension, unaware of safety needs, wandering, deformities of feet, walks on her toes, incontinence, falls with fractures, pain, osteoporosis. A care planned fall intervention, initiated 9/6/23, read: Per her sister, [R1] often sits down right on the floor when at home. If you witness this happening, it is intentional and not a fall . On 5/15/25 at 12:22 PM, an interview as conducted with CNA E who confirmed she found R1 sitting on the floor in another resident's room on 5/4/25 after responding to a motion alarm. CNA E stated she had not witnessed R1 sitting on the floor but instead found her in a seated position with both legs extended. CNA E stated R1 had a visible skin tear on her right forearm. In the late evening on 5/5/25, CNA E stated she saw bruising on R1 left heel as LPN A was applying medicated lotion. CNA E stated she immediately reported the finding to LPN A. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 12:32 PM, a telephone interview was conducted with LPN A who verified she discovered bruising to R1's left heel while providing care in the late-night hours of 5/5/25. LPN A stated she had not been on duty for the previous couple days, but CNA E informed her R1 had been previously found sitting on the floor in a resident room. When LPN A asked CNA E if she informed the on-duty nurse, CNA E stated she had but the nurse stated R1 was care planned to be able to sit on the floor, so it had not been counted as a fall. LPN A stated, I was confused because [R1's] care plan states that sitting on the floor had to be witnessed and this was not. LPN A stated she also observed two skin tears on R1's right arm located both above and below her elbow. LPN A recalled one skin tear was covered with a piece of gauze and paper-tape and the other just had a band-aid. LPN A stated, Nobody mentioned the skin tears, they were not reported or charted about. I was not able to verify where those had come from. LPN A relayed her concerns to the night house nurse supervisor, LPN B and completed a note in R1's EMR. LPN A stated the incident should have been recorded in R1's EMR as a Risk Management Event per facility policy. Review of R1's EMR revealed a progress note written by LPN A on 5/5/25 at 11:16 PM which read: During this shift I noticed two skin issues (tears) to resident's right arm. And a large bruise to resident's left heel that looks as though it is starting to wrap around the ankle as well. The two skin issues (tears) both have been attended to. The one further up on the arm has a band-aid applied, and the other one looks to have a non-stick [bandage] and paper tape . CNA [CNA E] alerted me to a possible situation that occurred .where resident was . observed sitting on one resident's blue mat. This could be a probable situation where these skin tears and bruise could have originated . On 5/15/25 at 12:47 PM, a telephone interview was conducted with LPN B who verified she was the night house supervisor on 5/5/25-5/6/25. LPN B stated she could not find any documentation regarding R1's skin tears or bruising to the left heel. LPN B stated she notified the on-call provider because, the concern was R1 didn't sit on the floor on 5/4/25 but likely fell. When LPN B was asked about facility protocol after a fall or discovering skin integrity issues she stated, The normal protocol would be to do the Risk Management documentation . I don't know why it was not done. Review of the radiology report of the left foot dated 5/7/25 read, in part: This is a fracture involving the superior calcaneus . Review of an undated document completed by Care Coordinator (CC) F titled Nursing Post Fall Evaluation, read, in part: When notified of skin + [and] pain concerns from NOC [night shift] nurse, we noted a charting from 5/4 stating [R1] sat on floor in another resident room - unwitnessed. Now w/ [with] skin tears noted to R [right] arm and L [left] heel bruising . reviewed CP [care plan] fall focus - clearly states if you witness [R1] sitting on the floor it is [not] a fall - this was unwitnessed. Therefore, proper action from NN [night nurse] was required - risk mngment [management] - unwitnessed fall . On 5/15/25 at 3:35 PM, an interview was conducted with Care Coordinator (CC) F who verified a risk management document should have been completed for R1's unwitnessed fall and skin tears. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 3:45 PM, a follow-up phone call was conducted with RN C regarding facility risk management documentation protocol. When asked why risk management documentation was not completed after the unwitnessed fall, RN C stated, Because I thought [R1] sat down . It was a busy time of day. When asked why risk management documentation was not completed for R1's skin tears, RN C replied, Because it wasn't really a skin tear . it was like [R1] just bumped it and it was bleeding. And later in the day, it looked like an abrasion . so I covered it so it wasn't open and passed it along in verbal report. On 5/15/258 at 3:15 PM, an interview was conducted with the DON regarding expectations following an unwitnessed fall or skin tear. The DON stated risk management documentation should be completed for any unwitnessed fall or skin abnormalities. Review of the undated Facility Policy titled, Skin Injuries read, in part: .If an injury is identified on a resident, please complete the Risk Management . What Needs to have a Risk Management completed? See list below: .skin tear.