STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235116	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Woods Nursing & Rehabilitation Center	1684 Vulcan Street Muskegon, MI 49442

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intakes 2963901 and 2980259Based on interview and record review, the facility failed to complete a full assessment, after a fall and before moving one resident (Resident #100) out of three residents reviewed for accidents and hazards. Findings:Resident #100 (R100) Review of an admission Record revealed R100 was a [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of dementia, weakness, difficulty in walking, and need for assistance with personal care. Review of an Unwitnessed Fall report for R100, dated 3/15/26 at 11:00 PM, revealed (a) staff heard R100 yelling and went to her room to check on her, (b) R100 was observed on the floor and told staff that she felt like she broke her right leg and that her right knee and hip hurt, (c) staff were unable to do range of motion without causing pain to R100, (d) a skin tear to the right arm was assessed, cleaned and bandaged, and (e) pain medication was given to R100. The report also described R100's reaction to the pain as (a) repeated troubled calling out, loud moaning or groaning, and crying, (b) facial grimacing, and (c) unable to console, distract or reassure. The immediate intervention implemented .to assist R100 off off the floor, provide first aide and address pain.During an interview on 4/14/26 at 6:25 AM, Registered Nurse (RN) G stated that she responded to R100's room on 3/15/25 around 11:00 PM (along with Certified Nurse Aide C) after hearing R100 yelling out. R100 laid on the floor yelling out in pain. RN G and Certified Nurse Aides (CNA) C and D got R100 up into a wheelchair, then assessed R100 and checked neuro's. R100 had significant pain in her hip and was given a Norco. R100 was moved out into the common area in the wheelchair for increased supervision and CNA D and CNA O stood R100 up to complete a more thorough skin assessment and then sat R100 back down into the wheelchair. R100 was having increased pain in her leg and a dose of Morphine was given. R100 continued to call out I broke my leg, I broke my leg. RN G and two CNA's transitioned R100 into her bed with the use of stand and pivot transfer method and R100 did not want to put weight on her leg, yelled out during the transfer, and the transfer was a rough moment for R100.Review of a hand written 'Witness Statement completed by RN G and signed 3/15/26, reflected the following information related to R100's fall on 3/15/26: (a) heard screaming from R100's room, (b) ran to the room and found R100 on the floor, R100 expressed pain in her right knee and right hip, a skin assessment revealed a 13 centimeter skin tear on the right arm, and R100 was given pain medication and placed into the wheelchair. Review of a nursing Progress Note dated 3/16/26 at midnight reflected .(R100) stated that she feels like she broke her right leg and stated that her right knee and right hip hurt.During an interview on 4/13/25 at 10:50 AM, CNA C reported that on the evening of 3/15/26, R100 was heard yelling, staff went to R100's room and found her on the floor and yelling call an ambulance I broke my leg. CNA C assisted R100 into a wheelchair with the assistance of two other staff persons. R100 was moaning in pain. During an interview on 4/13/26 at 7:09 PM, CNA D reported (a) entering R100's room and RN G and CNA C were already in the room, (b) R100 laid on the floor yelling out in pain, (c) all three staff stood R100 up and moved her to a wheelchair, and (d) R100 was yelling most of the night because she was in pain. Review of the facility policy/procedure Accident/Incident Report Fall Management last revised 06/2018, revealed (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.when a resident is observed on the floor and presumed to have fallen, an initial sequential assessment that includes a minimum of the following will be completed by a licensed nurse (a) full body inspection for any obvious deformity, bleeding, bruising, laceration or other signs of traumatic injury, (b) assessment for pain, (c) assessment for active followed by passive range of motion, (d) assessment of head injury with initial neurological evaluation if indicated, (e) vital signs, and (f) evaluation of indication for emergency medical treatment .The resident should not be moved until the initial evaluation is completed .the goals of lifting and moving a resident with a suspected fracture are to minimize the chance of a lifting-related injury and to minimize movement and stress on the resident's injury .to meet these goals the licensed nurse will explain the plan to the caregivers and resident prior to lifting, taking care to guard or splint the injured area before moving. Review of an article After the fall: a step by step approach to post-fall assessment revealed .It is important not to move a resident who has fallen until they are evaluated. Make sure the resident has not been seriously injured, don't assume that no injury has occurred-this can be a devastating mistake .observe leg rotation and look for hip pain, shortening of the extremity and pelvic and spinal pain. https://blog.healthpropress.com/2018/01/after-the-fall-a-step-by-step-approach-to-post-fall-assessment/