STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Durand Senior Care and Rehab Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE: 8750 E Monroe Rd Durand, MI 48429	

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 0580

Level of Harm - Actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34705

This deficiency pertains to Intake MI00150515

Based on interview and record review, the facility failed to provide timely notification to the physician for one Resident (#106) of three residents reviewed for a change in condition. This deficient practice resulted in a delay in medical treatment for a significant change in condition with diabetic ketoacidosis.

Findings include:

Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R106 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included multiple pelvic fracture post fall 2/4/25, hypertension(high blood pressure), insulin dependant diabetes mellitus (elevated blood sugar), and mild dementia. R106 was readmitted to the hospital 2/17/25 for diabetic ketoacidosis. The MDS reflected R106 had a BIM (assessment tool) score of 12 which indicated her ability to make daily decisions was moderately impaired.

During a telephone interview on 3/10/25 at 9:24 a.m., complainant H reported R106 was admitted to the facility on [DATE] for rehab after falling at home and breaking pelvis. The complainant H reported when the resident was at the hospital recovering from fall, the doctor changed R106's long-acting insulin to a short acting insulin with meals as needed. Complainant H reported R106 had been on 25 units long acting insulin prior to fall for diabetes with recent A1C(test that measures average blood sugar levels over past two to three months) of 7.8% (normal below 5.7%). Complainant H reported R106 had order for insulin from the hospital but was unsure if facility was giving R106 insulin. Complainant H reported on 2/14/2025 that R106 became very sick, including, nausea, vomiting and diarrhea and unable to keep anything down for three days and blood sugar was elevated. Complainant H reported Physician had discussed possibly related to Ozempic and Complainant H reported R106 had been on Ozempic for over three years. Complainant H reported requested R106 to be taken to the hospital because she was continuing to decline on 2/17/25. Complainant states the resident was taken to the hospital and R106's blood sugar level was over 650 and was told R106 was in diabetic ketoacidosis and later passed away 2/19/2025 after several life saving efforts. Complainant H reported the R106's medication list that the hospital doctors pulled from the facility didn't have insulin listed as a prescribed medication and facility Physician was aware R106 had been on long-acting insulin prior to admission.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235123	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
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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 0580 Level of Harm - Actual harm Residents Affected - Few	Review of R106 facility Progress Notes, dated 2/7/25 at 4:00 p.m., reflected, Res. is a [AGE] year old female, married. She is coming to the facility from [named] hospital after a fall at home. She has a dx[diagnosis] and hx[history] of non-displaced fx[fracture] L[left] acetabulum, fx L pubis, falls, DM2[diabetes mellitus type 2], GERD[gastroesophageal reflux disease], OA[osteoarthritis], HTN[hypertension], hyperlipidemia, Dementia, diverticulosis, osteoporosis, OA, depression. She is A&Ox3[alert and oriented x 3] to person, place, time. She is able to answer questions appropriately. She is able to make needs and wants known. She scored 12/15 on BIMS. She can be forgetful at times and may need reminders. Her mood appears stable, very social with writer and reminisced about daughter. She denied concerns with mood. She is on Lexapro. She declined psych services. No trauma indicated. Her speech is clear and understandable, can hear a normal conversation, no glasses present. She is a full code. She is here for short term rehab. Plan to return home with husband. Also has support of son and and granddaughter as needed. She was independent prior . Review of R106 Nurse Progress Note, dated 2/7/25 at 6:48 p.m., reflected, Resident admitted from [named] Hospital . Able to speak in full sentences .Wishes to be full code at this time. Denies any pain/ discomfort. Appears to be resting comfortably in bed with call light in reach. Family at bedside. Review of R106 Hospital Discharge Instructions, dated 2/7/25, reflected medication list that included, Continue Medications (10) These are your current medications to keep taking at home. The list included, Insulin Detemir(long acting insulin) U-100 100 units/ml pen, 10-15 units subcutaneous daily (hand written DC ok per provider next to order); metformin 1000 mg twice daily; Ozempic 0.5mg weekly. Continued review of hospital documents reflected R106 had received last dose of Insulin Detemir 10 units on 2/7/25 at 9:49 a.m. along with Lispro Insulin (fast acting insulin) per sliding scale of 3 units. Review of the Physician orders dated 2/7/25 through 2/15/25, reflected no orders for insulin for R106 with known insulin dependent diabetes mellitus. Continued review of R106 physician orders reflected, Accu-check two times a day related to TYPE 2 DIABETES MELLITUS WITH UNSPECIFIED COMPLICATIONS .Notify provider of blood sugar <70 or >400 Review of R106 Electronic Medical Record(EMR), dated 2/7/25 through 2/17/25, reflected R106 and 12 readings greater than 250 including 9 blood sugars over 300. Review of R106 Physician Note, dated 2/10/25 at 5:01 p.m., reflected, Chief Complaint / Nature of Presenting Problem: Fall with non-displaced left acetabular fracture with inferior left pubic rami fracture and left sacral ala fracture. History Of Present Illness: Available records reviewed. Patient was seen and examined 2/10/2025 .hospitalized at [named hospital] from 2/4/25 - 2/7/25. [named R106] is a 93 y.o w/f[year old white female], who fell backwards at home and landed on her buttocks. She had severe pain with movement and was taken to [named] Hospital where pelvic/hip x-ray revealed non-displaced left acetabular fracture with inferior left pubic rami fracture and left sacral ala fracture. Seen by ortho and recommended 4-6 weeks of non-weight bearing with PT/OT .Transferred to [named facility] for SAR[sub acute rehab] services. Seen with granddaughter and husband present with patient consent .Plan .Type 2 diabetes mellitus without complications: continue metformin, Ozempic, monitor bs, check hgba1c, appeared to be on insulin at home. Will monitor accu-checks and adjust meds///add Jardiance 10mg/d, hgba1c pending//accuchecks on high side . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Review of R106 Nutritional Note, dated 2/11/25, reflected, BS reviewed, ranging from 131-374mg/dL . Diet: regular texture/thin liquids, consuming 50-100% of meals per FARs. Agreeable to DM diet modifications. NKFA[no known food allergies]. Food preferences honored/updated. Tolerating current PO[oral] diet, no issues c/s food or fluids- wears dentures, fit well. Able to feed self and make wants and needs known. Review of R106 Rehab Services Screening Form, dated 2/12/25, reflected, BIMS 5/15. Kitchen staff reported to SLP [speech-language-pathologist] that pt[patient] was having difficulty swallowing; pt denies difficulties but further ST [speech therapy] assessment warranted. Pt stated she was (I) with IADLs[independent activities of daily living] at baseline, so further cognitive communication assessment warranted. Review of the Food Acceptance Record, dated 2/7/25 through 2/17/25, reflected R106 had decrease in food intake starting 2/14/25 including two consecutive refused meals. Continued review of the document reflected continued poor intake including 0-25% intake for three consecutive meals on 2/16/25. Review of R106 Nutritional Note, dated 2/15/25 at 11:05 a.m., reflected, Diet downgraded to mechanical soft texture 2/12 per SLP recommendations. Record review reflected R106 blood sugars were between 313 and 468 on 2/15/25 through 2/17/25 with limited food intake. Review of the Electronic Medical Record(EMR), dated 2/7/25 through 2/17/25, reflected no evidence Physician was notified of change in R106 condition on 2/14/25 or 2/15/25. Continued review of R106 EMR reflected Provider was contacted on 2/16/25 at 8:00 p.m. related to elevated blood sugar of 468 with no mention of poor intake for past 3 days. Review of R106 Nurse Progress Note, dated 2/17/25 at 2:26 p.m., reflected, Resident family expressed increased concern with residents lack of appetite and decreased fluid intake. Would like resident to be Sent to [named hospital] for further evaluation. MD[medical doctor] notified and management aware. Review of R106 Hospital History and Physical, dated 2/17/25, reflected, Problem/Assessment Plan 1-10: Problem 1: Diabetic ketoacidosis Plan 1: Insulin drip, ICU[intensive care unit] consult, secondary to discontinuation of medications and commendation of stress of illness. Problem 2: AKI (acute kidney injury) Plan 2: Secondary to intravascular depletion, IV hydration, dose meds Problem 3: Diarrhea Plan 3: Secondary to recent viral infection . (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Problem 4: Pelvic fracture Plan 4: Continue to monitor supportive care . CHIEF COMPLAINT .Nausea vomiting diarrhea .History of Present Illness .Is a [AGE] year-old female with history of diabetes type 2 who recently sustained a pelvic fracture 2 weeks ago. the patient was sent to subacute rehab. The patient presented with 3 days nausea vomiting diarrhea .The patient while hospitalized had her long-acting insulin discontinued and she was placed on short acting insulin. This was discontinued in the facility per family report. The patient was found to be in DKA[Diabetic Ketoacidosis]. She was started on a heparin drip. She was hospitalized in the ICU . Review of R106 Hospital Endocrinology Consult, dated 2/18/25, reflected, Problem 1: Diabetic ketoacidosis Plan 1: With a CO2 of 17 high anion gap high lactic acid high troponin and creatinine of 2 patient now going to tachycardia and possible cardiogenic shock .She states after her discharge from the hospital, patinet's insulin regimen was changed. Patients family states she was on Tresiba but it go discontinued at discharge. They state at the facility patient had been receiving metformin and Ozempic. They state about 3 days ago patient started having episodes of diarrhea .She states after 34 hours patient continued to have abdominal pain. They state that diarrhea hot less but patient started having episodes of nausea/vomiting. They also endorse patient was having increased thirst and urination. Family states since patient was not improving it prompted them to bring her to the ED[emergency department] .Upon arrival to ED .glucose 547 .Hemoglobin A1c 8.5 . Review of R106 Discharge Summary Physician, dated 2/19/25, reflected, Discharge .Time of death: 19-Feb-2025 02:55[2:55 a.m.]. Preliminary cause of death Asystole . During a telephone interview on 3/12/25 at 10:35 a.m. Licensed Practical Nurse (LPN) I reported was R106 nurse on 2/16/25 evening shift. LPN I reported completed Change of Condition document for R106 related to high blood sugar of 468 around 8:00 p.m. LPN I reported R106 did not have orders for insulin at that time. LPN I reported R106 had also been complaining of nausea and vomiting on 2/16/25 and reported was unsure if she reported to provider but should be documented on Change of Condition document.(Verified not mentioned). LPN I reported received order from provider to repeat R106 blood sugar check and administer 10 units Humalog (fast acting insulin) on 2/16/25 around 9:00 p.m. LPN I reported to day shift nurse on 2/17/25 around 7:00 a.m. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/13/25 at 11:32 a.m. Clinical Care Coordinator (CCC) C reported facility process for new admissions included three step check. CCC C reported CCC often assist with new admissions and enter medications from hospital discharge documents into EMR queue and before saving call placed to Medical Director to verify orders. CCC C reported if he makes changes staff hand write DC and initial next to medication on hospital discharge document. CCC C reported verify medications with two nurses then reported corporate Nurse Practitioner reviews for third check and reported was unsure who that might be. CCC C reported Medical Director(MD) G was present at facility every Monday, Wednesday, and Friday. CCC C reported MD G routinely adjusted resident diabetic medications on admission including insulin and facility did not use sliding scales. CCC G reported would expect staff to complete Change of Condition form for blood sugar greater than 400 per physician parameters. CCC C reported according to R106 food acceptance on 2/14/25 staff should have completed a Change of Condition form that would include notifying provider and responsible party related to two consecutive meals less than 25% eaten. Request was made for evidence that MD had been notified. Did not receive evidence Provider had been notified of Change of condition between 2/14/25 and 2/15/25 prior to survey exit on 3/13/25. During a telephone interview on 3/13/25 at 1:30 p.m. Medical Director(MD) G reported was familiar with R106. MD G reported staff contact him for new admissions and verify medications orders. MD G reported when R106 admitted to facility he recalled R106 being on a range scale for long acting insulin that was not typical. MD G reported continued R106 oral diabetic medication metformin and weekly Ozempic orders to monitor blood sugar. MD G reported after R106 admission visit on 2/10/25 added additional oral medication Jardiance because of added benefits and stated, low blood sugar is far more emergent than high as it takes years to show damage. MD G reported family was unsure how insulin was used at home and often takes caution related to insulin dosing. MD G reported would expect staff to notify provider of blood sugar greater than 400 as well as change in appetite, change in food acceptance, nausea, vomiting, or diarrhea. MD G reported did recall Nurse Practitioner visit and would plan to follow up with this surveyor. During a telephone interview on 3/13/25 at 2:11 p.m., MD G verified R106 was seen by provider on 2/17/25 and several medication were adjusted including adding insulin same day R106 was transferred to the hospital. MD G reported recalled discussing possible reasons for nausea included Ozempic. MD G verified was not notified of R106 change in intake, nausea, vomiting or elevated blood sugars between 2/14/25 through 2/16/25 at 8:00 p.m. and would expect staff to notify provider.

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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 - 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 34705

This citation refers to intake MI00150353, MI00149992

Based on observation, interview, and record review, the facility failed to provide adequate supervision, conduct timely root cause analysis of fall incidents, implement appropriate interventions to prevent future falls and re-evaluate the effectiveness of interventions for 3 residents (R103, R104, and R105) out of 3 residents reviewed for falls, resulting in R105 falling and re-fracturing recently repaired hip and R103 fall with laceration requiring emergency room treatment and R104 fall with fracture and subdural hematoma and overall decline.

Findings included:

Resident #105(R105)

Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R105 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included aftercare of left bipolar hemiarthroplasty(surgical repair of left ball of hip) post fall at home, peripheral vascular disease, orthostatic hypotension(drop in blood pressure with change in position), need for assistance with person care, heart disease, hypertension (high blood pressure), and diabetes mellitus. The MDS reflected R105 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required partial to moderate assist with transfers. Continued review of the MDS reflected dated 11/12/24 through 12/3/24 reflected three unplanned discharges to acute care.

An anonymous complaint received by the State Agency alleged the facility failed to prevent avoidable fall for R105 that resulted in re-fracture of the left femur on 12/3/24.

Review of R105 Nursing Progress notes, dated 11/12/24, reflected, Resident arrived via stretcher from [named] Hospital. He is alert and oriented times 4 .Lt(left) hip surgical site with derma bond dressing . Pain present at surgical site with movement .

Review of R105 Social Service Note, dated 11/13/2024 at 11:55 a.m., reflected, [named R105] was admitted here yesterday afternoon from [named] Hospital. Resident was admitted to hospital after fall at home. Resident has fx[fracture] of left femur. Resident is a [AGE] year WMM[year old white male]. Resident has been living fairly independent in own home with wife. He was independent with own ADL [activities of daily living] .Resident is planning on returning home after short term rehab .

Review of R105 Nurse Progress Note, dated 11/19/2024 at 1:00 p.m., reflected, called and spoke with ortho office as resident has not returned since 10:45 appointment. Resident was sent to [named emergency department] from ortho office due to bleeding from left hip incision as well as poor mental status and lethargy .

Review of the Nurse Progress Notes, dated 11/20/2024 at 5:02 p.m., reflected R105 returned from the hospital.

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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 - Actual harm Residents Affected - Few	Review of R105 Physician Progress Note, dated 11/21/2024, reflected, .Chief Complaint / Nature of Presenting Problem: Lethargy, confusion .Patient seen and examined with note entered. [named R105] was initially admitted to [named facility] on 11/12/24 after suffering a fall and suffering a displaced left femoral neck fracture. He was admitted to [named hospital] for such and underwent left bipolar hemiarthroplasty on 11/7/24 .On 11/19/24 he went for follow-up orthopedics appointment but became unresponsive at the appointment and was sent back to [named hospital]. Labs revealed initial blood sugar by accu check of 56 . pt did have bout of hypoglycemia in facility and likely d/t hypoglycemia . Review of R105 Nurse Progress Note, dated 11/24/25 at 10:23 p.m., reflected, LN[licensed nurse] was called into resident room, resident was sitting in chair, shivering. Upon assessment, BP[blood pressure] 112/89, pulse 89, temp 99.1, O279% on room air, BS[blood sugar] 459. Physician was contacted, started on 3L[liter] of O2[oxygen]. Resident to be sent to [named hospital] for further evaluation. Review of the Hospital History and Physical, dated 11/24/25, reflected, Chief Complaint: fever, altered mental status .Code Status Discussed with?: Spouse (patient is not of sound mind to make this decision currently, no advanced directive on chart) .[named R105] is a [AGE] year old male with history of diabetes, hypertension, abdominal aortic aneurysm, claudication, emphysema and chronic kidney disease. Patient is currently residing at [named facility] for rehabilitation. This is his third admission this month since fracturing his left hip approximately 3 weeks ago. Prior to that spouse and son report that he was independent and functional. EMS[emergency medical services] was contacted by SNF[skilled nursing facility] staff due to altered mental status .At moderate risk for fall .Active Problems .Acute metabolic encephalopathy .Exam . Neuro: General: oriented to person and confusion (reports he is at church when asked) . Review of R105 Hospital Progress Note, dated 11/25/24, reflected, Patient admitted for sepsis secondary to UTI[urinary tract infection], there was also concern of possible surgical site infection of the left hip. The patient was started on broad-spectrum antibiotics .Patient seen and examined at bedside. He is alert and oriented to self only .Patient is exhibiting some confusion . Review of R105 Hospital Rehabilitation Service Note, dated 11/15/24, reflected, Acute Care OT(Occupational Therapy) Assessment .Transfers Sit to stand: Contact Guard .Toilet Transfer: Contact Guard Comments:: PT CURRENTLY REQUIRES US OF FWW[4 wheel walker] AND 1 PERSON ASSIST FOR TRANSFERS AND MOBILITY. Cognition Orientation: Minimally impaired .Judgement: Minimally impaired .Short Term Memory: Moderately Impaired .Follows Commands: Minimally Impaired .Comments . BED ALARM ON FOR SAFETY .Assessment: .UPON OT EVALUATION, PT IS PHYSICALLY FUNCTIONING SLIGHTLY BELOW HIS BASELINE STATUS OF MOBILITY AND INDEPENDENCE. HE FATIGUES QUICKLY. HE CONTINUES TO REQUIRE USE OF FWW TO ENSURE BALANCE AND SAFETY DURING MOBILITY AND TRANSFERS. HE REQUIRES 1 PERSON ASSIST FOR ADL ROUTINE. HE WILL BENEFIT FROM RETURNING TO REHAB IN ORDER TO MAXIMIZE INDEPENDENCE AND FUNCTIONING PRIOR TO RETURNING HOME WITH HIS WIFE . (continued on next page)

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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 - Actual harm Residents Affected - Few	Review of the Fall Incident/Accident report, dated 12/3/24 at 4:30 p.m., reflected R105 had an unwitnessed fall in bathroom after self-transfer with left thigh fracture. The document reflected, Immediate Action taken: Neuro assessment completed prior to transferring resident from floor to wheelchair. Resident's ROM in left leg decreased .Resident rated pain in left hip 4/10. Resident transferred from floor to wheelchair with 2PA[two person assist], NWB[non weight bearing] to LLE[left lower extremity] maintained during transfer. VS[vital signs] obtained, BP[blood pressure] slightly low without s/sx[signs and symptoms] of hypotension. Skin tears present on left elbow & left forearm. Both areas cleansed & treatment with Xeroform completed. All appropriate parties notified. Provider ordered a STAT[immediately] left hip X-ray to R/O fx[rule out fracture]. Resident educated regarding use of call light for safe transfers & ambulation. Continued review of the document reflected, Predisposing Situation Factors, including the following marked; call light not used, admitted within last 72 hours, Ambulating without assistance. The document reflected R105 wife was present in room at time of fall and no witness statements found. Continued review reflected R105 wife was notified at 4:30 p.m. and the Provider at 4:40 p.m. and the form was completed by CCC D.(Not R105's nurse at the time.) Review of Electronic Medical Record (EMR) Census, dated 12/3/24, reflected R105 readmitted to the facility on [DATE] at 4:08 p.m.(Just prior to R105 unwitnessed fall with fracture on 12/3/24). Review of the Progress Notes, dated 12/3/24, reflected no mention of R105 fall. Review of R105 Nursing Progress Note, created 12/3/24 at 6:36 p.m., reflected, Resident arrived to facility via private transportation. Resident has had full skin assessment performed with no skin breakdown noted on bony prominences. Residents lungs cta[clear to auscultation],heart rate regular. No cough or sob[short of breath] noted. Residents' radial and pedal pulses present and palpable bilaterally. Resident has swelling noted to left lower extremity from hip to toes. Resident has left hip incision with large scab noted and swelling with no heat redness or drainage noted. Resident has been re-oriented to facility, resident able to use call light unassisted. Resident aware that he is not to get up unassisted. Resident wife here at bedside. (No mention of R105 fall that occurred about two hours prior to note created.) Review of R105 fall assessment, dated 11/20/24, reflected, Fall risk assessment completed upon admission. Resident is at high risk for fall secondary to hx[history] of falls .Additional fall risks include; medical hx, recent hospitalization , & medications .Staff to follow current POC [plan of care]. Review of R105 Fall Assessment, dated 12/3/24 at 4:30 p.m., reflected, Root Cause: Resident is at high risk for falls r/t to recent hospitalization s, medical history & medications. Resident has multiple cormorbidities that attribute to fall risk including; recent left hip replacement, active infections (UTI & bacteremia), fatigue & weakness, hx of falls, pain, intermittent claudication of B/L Les[bilateral lower extremities], & PVD[peripheral vascular disease]. Resident assisted to bathroom prior to fall. CENA[competency evaluated nursing assistant] instructed resident to pull call light when he was ready to exit bathroom (resident a&o x4 with a bims of 15). Resident did not comply with CENA instructions and attempted to self-transfer/ambulate. Resident stated he thought he could get out of the bathroom without help. Immediate Safety Intervention: Resident educated regarding use of call light for safe transfers & ambulation [Not effective intervention as was already attempted and failed resulting in fall]. IDT review day #1 12-4-24: IDT agrees with root cause and intervention. Care plan reviewed and updated. Will continue to monitor. X-Ray obtained post fall. Femur fracture noted. Resident sent out to hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R105 Brief interview of Mental Status (BIMS), dated 12/3/24 at 6:57 a.m.(over eight hours prior to R105 return to the facility), reflected BIMS score of 15. Review of R105 Rehab Services Screening Form, dated 12/3/24 at 6:38 p.m., reflected, Per discussion with nurse, patient sustained a fall while he was in the bathroom and attempted to self-transfer shortly after he was admitted . Awaiting x ray to r/o[rule out] fracture. OTR[Occupational Therapist, Registered] spoke with family and educated about not bearing weight into lower extremities until x ray is completed and imaging report is received. Will hold therapy evaluation until clearance is provided on weight bearing status. Review of the eINTERACT Transfer Form, dated 12/3/24 at 8:30 p.m., reflected, R105's most recent admission was 12/3/24 at 4:08 p.m. with diagnosis that included, sepsis, urinary tract infection, fracture of unspecified part of neck of left femur. Review of R105 Nurse Progress Note, dated 12/3/24 at 8:30 p.m., reflected, Resident transferred to hospital after X-ray results came in. Dr. G ordered. Nurse notified resident's wife [named] and on call manager of send out. Resident a&ox3 and states pain is 8/10. Review of R105 Radiology Report, dated 12/3/24 at 7:32, reflected the left hip and pelvis indicated, Acute nondisplaced mid femoral fracture extending away from the distal tip of the femoral THA[total hip arthroplasty] stem. During an interview on 3/11/25 at 2:45 p.m., Interim Director of Nursing (IDON) B reported had soft file on R105's fall on 12/3/24 and facility had completed Past Non-Compliance related to falls with alleged compliance date 1/31/25 after recognizing several falls including falls with major injury. IDON B provided complete investigation for R105, R104 and R103 falls along with past noncompliance binder. Review of the facility Staffing Assignment Sheet, dated 12/3/24 2nd shift, reflected R105 nurse was Clinical Care Coordinator Registered Nurse (CCC) C and two Certified Nurse Aids(CNA) were assigned to R105 hall(CNA J and CNA E) with a facility census of 93. Review of R105 Fall investigation Interview Statement, dated 12/4/24, reflected CNA J completed witness statement. The document reflected, To whom it may concern on the day in question. [named CNA E] and I were told to go assist with getting [named R105] out of the car. He had just arrived at our facility. We brought him into the building and immediately took him to get weighted. On the way to his room, he stated he had to go to the restroom. [named CNA E] and I assisted him with gait belt from his wheelchair to the toilet. He stated he needed a few minutes so we educated him on pulling the red string on the call light so it would let us know he was finished. [named CNA E] and I left him on the toilet . Review of R105 fall investigation witness statement, undated and unsigned, reflected, Resident was placed on toilet by CNAs, CNAs gave resident call light and was told to call when ready, CNAs left resident for privacy, CNA asked if he was ready, but needed more time, CNA went to answer call light going off and upon returning resident was on the floor. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Durand Senior Care and Rehab Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 8750 E Monroe Rd Durand, MI 48429	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R105 Fall investigation Interview Statement, undated, signed by CCCRN C reflected R105 had fall on 12/3/25. The statement reflected, Resident readmitted to the facility apx[approximately] 18:15 p.m.[6:15 p. m.]. Resident arrived via private transportation with wife present. Resident had initial skin assessment vital signs and education performed at apx 1820[6:20 p.m.] Resident was recently a resident in this same room and hallway, during education resident remembered the names of staff assisting him. He was aware of where he was, date, moth and also remembered room, bathroom and how to use call light. Resident was toileted per his request at apx 18:25[6:25 p.m], he was transferred to toilet with 2 CNAs . (Interview statement does not appear to reflect correct time according to all other documents and evidence). During a telephone interview on 3/12/25 at 1:57 p.m., Certified Nurse Assistant (CNA) K reported knows how to care for residents by reviewing Kardex and verified received recent fall training from facility at end of January. CNA K reported residents with high risk for falls should never be left alone in bathroom especially with history of post hip surgery related to fall. During an interview on 3/12/25 at 3:30 p.m., CNA J reported was working on 12/3/24 when R105 fell in bathroom. CNA J reported her, and CNA E were told to assist R105 from personal car, driven by wife, into the facility. CNA J reported obtained R105 weight and then R105 reported had to use restroom and the two CNAs assisted R105 from the wheelchair onto the toilet and instructed to use call light when done and left R105 in bathroom alone. CNA J reported had returned to check on R105 who was not ready and upon returning again had fallen in the bathroom after attempting to self-transfer. CNA J reported assisted R105 off the floor with two to three staff by picking up under R105 arms and transferring to the wheelchair then from wheelchair to bed with pivot transfer and at least two assist. CNA J reported nurse took over from there. CNA J reported completed witness statement after fall but not same day as R105 fall and received education from facility to not leave residents alone especially if high risk for fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview 3/13/25 at 10:49 a.m., R105's Family Member F reported R105 was doing well enough at the hospital, and she transported him in a personal car from the hospital to the facility on [DATE]. FM F reported two staff met her at the car and they wheeled R105 in the facility. FM E reported R105 had to use the bathroom right away so two staff took R105 in his bathroom and before nurse staff could even complete body check. FM F reported stepped out of room for moment to make call and returned and asked roommate, is he still in there?' and roommate reported yes. FM F reported waited outside the door for maybe five minutes and figured staff were in the bathroom with him and then heard a big crash. FM F reported opened the door and R105 was on the floor with no staff present. FM F reported it concerned her R105 had been left alone because he was such a high fall risk they had not been back in facility for more than 15 minutes. FM F reported went and found the nurse and reported R105 was on the floor, who responded, can he get up? FM F reported they got him in bed did body check, they didn't see anything significant but R105 was complaining of pain to left hip area. FM F reported they ordered X-ray right away, but it was a few hours before they got there and it was around 8:00 p.m., when they received call R105 left leg was broken and facility planned to send R105 to local hospital. FM F reported local hospital transferred R105 to a trauma center who performed eight-hour surgery to repair R105 re-fractured, shattered left leg. FM F reported R105 was currently on hospice and stated, it shouldn't have happened .To leave him unassisted and I don't know the circumstances, I know they were busy and understaffed, that's not a reason to leave him unattended. FM F reported R105's second fall with fracture on 12/3/24 extended the first one and shattered left leg and hardware had to be removed and replaced and continued to decline. FM F reported staff did not mention using call light after the fall and was chaotic scene. FM F reported the roommate thought the staff was in bathroom with R105 but staff must have exited shared room door because the roommate said they never saw the staff leave the bathroom. FM F was queried of R105 would have used call light when done? FM F stated, I would not have trusted him to do that even if he was well enough. During a telephone interview on 3/13/25 at 12:35 p.m., CNA E reported was working on 12/3/24 when R105 had a unwitnessed fall in the bathroom. CNA E reported CCCRN C requested CNA E and CNA J assist transfer R105 from personal car to room. CNA E reported transported R105 in wheelchair from parking lot with CNA J to room and R105 requested to use the bathroom, and both CNAs assisted R105 from wheelchair to toilet. CNA E reported was not told R105 could not be left alone and both CNAs left R105 on toilet alone and left to answer call lights on the hall. CNA E reported returned in about five minutes and R105 was on the bathroom floor, called for Registered Nurse (RN) L, FIT team paged overhead (fall team). CNA E reported Occupational Therapy Staff (OT) M was present and R105 was transferred from floor to wheelchair but unable to recall how and reported R105 was then transferred from wheelchair to bed with two-person pivot assist with OT M. CNA E reported resident acuity was high that day for only two CNA staff on hall. CNA E verified he wrote witness statement several days after R105 fall that was not dated or signed. CNA E reported was not aware R105 was high fall risk or even know transfer status when told to assist R105 from personal car on 12/3/24, prior to readmission. During an interview on 3/13/25 at 1:13 p.m., OT M reported was called down to 100 hall on 12/3/24 after R105 had fallen in bathroom by CNA E. OT M reported R105 was sitting on bathroom floor with definite signs of pain including facial grimacing. OT M reported was familiar with R105 because worked with R105 after original admission post hip repair within prior month. OT M reported RN L was present after fall and R105 was transferred from the floor to the wheelchair with 2-person assist with gait belt. OT M reported did not complete witness statement because she did not witness fall. OT M reported staff are expected to follow hospital transfer status until therapy evaluation completed at facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/13/25 at 1:50 p.m., CCC C reported was R105 nurse on 12/3/24 at the time of R105's unwitnessed fall in the bathroom that resulted in re-fracture of left hip and later transfer to hospital. CCC C reported completed R105 admission assessment shortly after arrival and then R105 requested to use the bathroom and was transferred by two CNA staff. When asked if the resident had fallen before or after admission assessment CCC C reported I am sure R105 had fallen after but do not recall and stated, what does my documentation say? CCC C was unable to say why witness statement did not match EMR documents related to R105 fall. Resident #103 (R103) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R103 was an [AGE] year old female admitted to the facility on [DATE], and most recently re-admission post fall with facial hematoma and contusion with other diagnoses that included dementia, heart disease, atrial fibrillation with use of blood thinners, hypertension (high blood pressure), depression and anxiety. The MDS reflected R103 had a BIM (assessment tool) score of 11 which indicated her ability to make daily decisions was moderately impaired. During a telephone interview on 3/10/25 at 11:29 p.m. R103 Family Member (FM) N reported R103 had an unwitnessed fall on 1/23/25 with facial injuries that required transfer to hospital. FM N reported facility was not able to answer how R103 fall occurred or how long R103 was on the floor before staff found R103. FM N reported R103 had significant facial bruising over entire face with open area to area above left eye several days after alleged fall. During an observation on 3/10/25 at 1:47 p.m., R103 was observed sitting in Main Dining Room during group activity with nickel size scabbed area located above left eyebrow. Review of R103 Nurse Progress Note, dated 1/23/2025 at 11:11 p.m., reflected, LN[licensed nurse] was alerted resident was on the floor of residents room. resident was laying on her stomach next to bed. resident stated she slipped out of her chair. Helped resident back into her chair. contacted on call doctor on call manager and residents daughter. [NAME] checks were started at 1920[7:20 p.m.]. resident sent to hospital for CT[computed tomography] scan as resident is on a blood thinner. Review of R103 Nurse Progress Note, dated 1/24/2025 at 6:07 a.m., reflected, resident returned from the hospital via ambulance after a fall. assessment completed. all bony prominences checked and intact. Review of R103 Fall Incident/Accident Report, dated 1/23/25 at 8:42 p.m., reflected R103 had an unwitnessed fall in room and was found lying on stomach next to the bed with abrasion noted on face. The report reflected, Resident states that she slipped off her chair . The report reflected R103 had impaired memory and no witness statements were found and Physician was contacted at 7:30 p.m.(Report had discrepancy in times, no mention of interventions that were in place on not in place including footwear, dysem or grip strips on floor). Review of R103 Hospital Radiology Report, dated 1/23/25, reflected CT scan of the brain revealed, LEFT frontal scalp soft tissue contusion and/or organized hematoma . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R103 Physical Therapy Assessment, dated 1/24/25, reflected, Reason for Referral/Current Illness: Patient is a [AGE] year old female with history of dementia who is a LTC[long term care] resident of the facility. She has a history of falls and has had 5 falls in the last year. She has been referred to skilled PT services following patient having a recent fall on 1/23. She sustained a bump with bruising to her forehead. She was transferred to the hospital for further evaluation and then returned to this facility. Per nursing notes, patient reported she slipped out of her w.c[wheelchair]. Patient told PT this date that she was walking without AD[assistive device] and only had socks on and slipped on the floor. Educated patient on having assistance, wearing shoes/grippy socks and using walker for safety . Review of R103 Physician Progress Note, dated 1/29/25, reflected, [named R103] had a fall the other day and was sent to ED[emergency department] as she has been on eliquis for hx of paroxysmal atrial fib . quarter size hematoma on left frontal area/diffuse echymosis both cheeks, infraorbital with subconjunctival hemorrhages bilateral . s/p fall with facial bruising d/t eliquis/ASA[aspirin] hx[history] paroxysmal atrial fib, currently in NSR[normal sinus rhythm] by exam//feel risk of continuing eliquis at this time outweighs the benefit and will stop and continue to assess as needed . Review of R103 Fall Care Plan, dated 10/28/2019, reflected, FALLS: At risk for falls due to Dementia, weakness, medications, Major Neuro cognitive Disorder, insomnia, bowel and bladder urgency .Interventions .I have gripper strips in front of my bed to prevent slipping .I will wear non-slip footwear for all transfers and walking . Review of R103 Fall Risk assessment, dated 11/23/25, reflected, The resident continues to be at risk for falls due to poor cognition and poor safety awareness. She continues at risk for further falls. Resident stood up unassisted and fell back when she missed her chair. Intervention: Upon standing, remind me to reach back for wheel chair before sitting . During an interview on 3/12/25 at 3:15 p.m., Certified Nurse Aid (CNA) O reported had found R103 on 1/23/25 in room on the floor after fall. CNA O reported was unsure if R103 had grip socks or shoes on or if wheelchair breaks were on or if gripper strips were in place on the floor by bed. CNA O reported did not complete witness statement because she did not witness fall. CNA O reported was unsure how long resident had been no floor prior to finding and reported facility had recently provided fall training at end of January. CNA O reported training included more frequent supervision of all residents especially residents with increased risk for falls to be able to encourage assistance and make sure interventions were in place. During an observation and interview on 3/13/25 at 9:30 a.m., R103 was sitting in Main Dining Room in wheelchair watching television with regular socks with no grip on them. R103 had nickel size abrasion noted to area above left eyebrow and was very hard of hearing. R103 reported fell out of bed and laid on floor until staff arrived and then was sent to hospital for several hours. R103 reported she is careful now and was told she had to wear shoes. Resident #104 (R104) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R104 was an [AGE] year-old male admitted to the facility on [DATE], and most recently re-admission post fall at facility with left displaced hip fracture requiring surgical repair, compression fracture T-12(spinal fracture, and traumatic subdural hematoma. R104 had other diagnoses that included dementia, hypertension (high blood pressure), depression and anxiety. The MDS reflected R104 had a BIM (assessment tool) score of 3 which indicated his ability to make daily decisions was significantly impaired. The MDS reflected R104 did not have behaviors including wandering or rejection of care. An anonymous complaint received by the State Agency alleged the facility failed to prevent fall for R104 that resulted in hip fracture and passed away. Review of R104 Nursing Note, dated 2/4/25 at 1:52 p.m., reflected, Resident agitated. Hitting staff. Staff is unable to redirect resident. Resident throwing LN[licensed nurse] equipment off of medication cart. LN was eventually able to get resident to sit in his recliner in his room LN sat with him for a few minutes. Resident then got back out of his chair and starting yelling again. Review of R104 Social Service Note, dated, 1/5/2025 at 9:11 a.m., reflected, IDT[interdisciplinary team] reviewed alert for res.[resident] agitated, hitting staff, yelling out, throwing things. Staff reapproach, assist to calmer environment. Did yell out again. The review reflected no mention of staffing or adjustments. Review of R104 Unusual Occurrence Note, dated 1/6/2025 at 3:46 p.m., reflected, LN was alerted by a family member (visitor) that resident was laying on the floor at the end of the hallway. When LN arrived at residents side he was laying on his left side, head up against the wall feet outstretched into the hallway, by room [ROOM NUMBER] at the end of 500 long hall. Resident was noted picking up his hat when he fell over. Resident did not ask for assistance with his hat. Resident is noted wearing hipsters and non-slip footwear. Resident was noted ambulating in the hallway 15 minutes prior and offered a chair to rest. LN asked resident what he was attempting to do when he fell over? resident stated, just give me my damn hat LN did a full head to toe assessment on resident has full range of motion of both upper extremities without pain or difficulty. Resident has full range of motion in right hip. LN noted external rotation of left hip upon assessment. C/O[complained of] pain with minimal movement. no other injuries noted. Staff members were unable to assistance resident off the floor with a gait belt, resident was assisted off the floor by a hoyer lift with a sling and assisted to his bed. A staff member sat with resident until EMTS[emergency medical technicians] arrived . Review of R104 Social Service Note, dated 1/12/25 at 10:10 a.m., reflected, [Named R104] was readmitted yesterday evening from Hospital. Resident was readmitted with Dx of HX[history] of interchanteric FX[fracture] of left femur. Unspecified part neck Left Femur. Traumatic subdural hemorrhage without loss of consciousness. Occlusion and stenosis of unspecified cardio artery. Falls. CKD[chronic kidney disease] stage 3. Gastro reflux. Anxiety disorder. Insomnia, Alzheimer's disease. Vascular dementia. Hyperlipidemia. HTN[hypertention]. Major depression. Resident remains alert and oriented to person or name. No significant change in cognition. Staff anticipate and assist with support care and redirection . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R104 Hospital Discharge Summary, dated 1/11/25, reflected, .Hospital Course-80 y M[year male] with history of .dementia as a transfer from [named] after being found down at his facility. Patient sustained Parietal subdural hematoma, Left displaced comminuted intertrochanteric femur fracture and acute compression fracture of T12. Patient underwent Left intertrochanteric InterNail repair on 1/7/25. The parietal SDH[subdural hematoma] and T12 compression fracture was managed non-op[non-operative]. Hospital course was significant for agitation that was managed with Zyprexa. Otherwise, patient progressed will during hospital course. Patient is weight-bear as tolerated to the left lower extremity with a walker and is to be on TLSO[thoracolumbar sacral othosis] brace when out of bed . Review of R104 Fall Incident/Accident Report, dated 1/6/25 at 2:15 p.m., reflected R104 had a fall in the hall, unwitnessed by staff, with 10/10 left pain hip with hipster in place. The Incident accident report indicated left leg had external rotation and staff were unable to stand with gait belt(with assessment of external rotation and Range of Motion not tolerated to left hip). The report reflected R104 was transferred from the floor in hall to bed with hoyer lift then sent by ambulance to hospital. The report had section for predisposing physiological factors that had the following marked; confused, impaired memory and gait imbalance. Continued review of the report reflected section for predisposing situational factors that had the following marked; call light not used, wandering, and ambulating without assistance. Review of R104 Change in Condition assessment, dated 1/6/25, reflected had fall in hall and R104 not cognitively able to rate pain and showed the following signs of pain; short periods of hyperventilation, repe [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 This citation pertains to intakes: MI00149397, MI00150353, Based on observation, interview and record review, the facility failed to ensure sufficient levels of nursing staff to meet resident needs and supervision for three residents (Resident #103, #104, #105) and per resident council with the potential for unmet care needs and facility residents to not attain or maintain the highest practicable physical, mental, and psychosocial well-being. Finding include: An anonymous complaint received by the State Agency alleged the facility failed to maitain sufficient staff levels to meet resident needs including supervision. During an interview on 3/10/25 at 10:45 a.m., Nursing Home Administrator(NHA) A reported facility census was 106. Resident #105(R105) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R105 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included aftercare of left bipolar hemiarthroplasty(surgical repair of left ball of hip) post fall at home, peripheral vascular disease, orthostatic hypotension(drop in blood pressure with change in position), need for assistance with person care, heart disease, hypertension (high blood pressure), and diabetes mellitus. The MDS reflected R105 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact, and he required partial to moderate assist with transfers. Continued review of the MDS reflected dated 11/12/24 through 12/3/24 reflected three unplanned discharges to acute care. An anonymous complaint received by the State Agency alleged the facility failed to prevent avoidable fall for R105 that resulted in re-fracture of the left femur on 12/3/24. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Fall Incident/Accident report, dated 12/3/24 at 4:30 p.m., reflected R105 had an unwitnessed fall in bathroom after self-transfer with left thigh fracture. The document reflected, Immediate Action taken: Neuro assessment completed prior to transferring resident from floor to wheelchair. Resident's ROM in left leg decreased .Resident rated pain in left hip 4/10. Resident transferred from floor to wheelchair with 2PA[two person assist], NWB[non weight bearing] to LLE[left lower extremity] maintained during transfer. VS[vital signs] obtained, BP[blood pressure] slightly low without s/sx[signs and symptoms] of hypotension. Skin tears present on left elbow & left forearm. Both areas cleansed & treatment with Xeroform completed. All appropriate parties notified. Provider ordered a STAT[immediately] left hip X-ray to R/O fx[rule out fracture]. Resident educated regarding use of call light for safe transfers & ambulation. Continued review of the document reflected, Predisposing Situation Factors, including the following marked; call light not used, admitted within last 72 hours, Ambulating without assistance. The document reflected R105 wife was present in room at time of fall and no witness statements found. Continued review reflected R105 wife was notified at 4:30 p.m. and the Provider at 4:40 p.m. and the form was completed by CCC D.(Not R105's nurse at the time.) Review of Electronic Medical Record (EMR) Census, dated 12/3/24, reflected R105 readmitted to the facility on [DATE] at 4:08 p.m.(Just prior to R105 unwitnessed fall with fracture on 12/3/24). During an interview on 3/11/25 at 2:45 p.m., Interim Director of Nursing (IDON) B reported had soft file on R105's fall on 12/3/24 and facility had completed Past Non-Compliance related to falls with alleged compliance date 1/31/25 after recognizing several falls including falls with major injury. IDON B provided complete investigation for R105, R104 and R103 falls along with past noncompliance binder. Review of the facility Staffing Assignment Sheet, dated 12/3/24 2nd shift, reflected R105 nurse was Clinical Care Coordinator Registered Nurse (CCC) C and two Certified Nurse Aids(CNA) were assigned to R105 hall(CNA J and CNA E) with a facility census of 93. During an interview on 3/12/25 at 3:30 p.m., CNA J reported was working on 12/3/24 when R105 fell in bathroom. CNA J reported her, and CNA E were told to assist R105 from personal car, driven by wife, into the facility. CNA J reported obtained R105 weight and then R105 reported had to use restroom and the two CNAs assisted R105 from the wheelchair onto the toilet and instructed to use call light when done and left R105 in bathroom alone. CNA J reported had returned to check on R105 who was not ready and upon returning again had fallen in the bathroom after attempting to self-transfer. CNA J reported assisted R105 off the floor with two to three staff by picking up under R105 arms and transferring to the wheelchair then from wheelchair to bed with pivot transfer and at least two assist. CNA J reported nurse took over from there. CNA J reported completed witness statement after fall but not same day as R105 fall and received education from facility to not leave residents alone especially if high risk for fall. (continued on next page)

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Durand Senior Care and Rehab Center, L L C	8750 E Monroe Rd Durand, MI 48429

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview 3/13/25 at 10:49 a.m., R105's Family Member F reported R105 was doing well enough at the hospital, and she transported him in a personal car from the hospital to the facility on [DATE]. FM F reported two staff met her at the car and they wheeled R105 in the facility. FM E reported R105 had to use the bathroom right away so two staff took R105 in his bathroom and before nurse staff could even complete body check. FM F reported stepped out of room for moment to make call and returned and asked roommate, is he still in there?' and roommate reported yes. FM F reported waited outside the door for maybe five minutes and figured staff were in the bathroom with him and then heard a big crash. FM F reported opened the door and R105 was on the floor with no staff present. FM F reported it concerned her R105 had been left alone because he was such a high fall risk they had not been back in facility for more than 15 minutes. FM F reported went and found the nurse and reported R105 was on the floor, who responded, can he get up? FM F reported they got him in bed did body check, they didn't see anything significant but R105 was complaining of pain to left hip area. FM F reported they ordered X-ray right away, but it was a few hours before they got there and it was around 8:00 p.m., when they received call R105 left leg was broken and facility planned to send R105 to local hospital. FM F reported local hospital transferred R105 to a trauma center who performed eight-hour surgery to repair R105 re-fractured, shattered left leg. FM F reported R105 was currently on hospice and stated, it shouldn't have happened .To leave him unassisted and I don't know the circumstances, I know they were busy and understaffed, that's not a reason to leave him unattended. FM F reported R105's second fall with fracture on 12/3/24 extended the first one and shattered left leg and hardware had to be removed and replaced and continued to decline. FM F reported staff did not mention using call light after the fall and was chaotic scene. FM F reported the roommate thought the staff was in bathroom with R105 but staff must have exited shared room door because the roommate said they never saw the staff leave the bathroom. FM F was queried of R105 would have used call light when done? FM F stated, I would not have trusted him to do that even if he was well enough. During a telephone interview on 3/13/25 at 12:35 p.m., CNA E reported was working on 12/3/24 when R105 had a unwitnessed fall in the bathroom. CNA E reported CCCRN C requested CNA E and CNA J assist transfer R105 from personal car to room. CNA E reported transported R105 in wheelchair from parking lot with CNA J to room and R105 requested to use the bathroom, and both CNAs assisted R105 from wheelchair to toilet. CNA E reported was not told R105 could not be left alone and both CNAs left R105 on toilet alone and left to answer call lights on the hall. CNA E reported returned in about five minutes and R105 was on the bathroom floor, called for Registered Nurse (RN) L, FIT team paged overhead (fall team). CNA E reported Occupational Therapy Staff (OT) M was present and R105 was transferred from floor to wheelchair but unable to recall how and reported R105 was then transferred from wheelchair to bed with two-person pivot assist with OT M. CNA E reported resident acuity was high that day for only two CNA staff on hall. CNA E verified he wrote witness statement several days after R105 fall that was not dated or signed. CNA E reported was not aware R105 was high fall risk or even know transfer status when told to assist R105 from personal car on 12/3/24, prior to readmission. Resident #103 (R103) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R103 was an [AGE] year old female admitted to the facility on [DATE], and most recently re-admission post fall with facial hematoma and contusion with other diagnoses that included dementia, heart disease, atrial fibrillation with use of blood thinners, hypertension (high blood pressure), depression and anxiety. The MDS reflected R103 had a BIM (assessment tool) score of 11 which indicated her ability to make daily decisions was moderately impaired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Durand Senior Care and Rehab Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 8750 E Monroe Rd Durand, MI 48429	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 3/10/25 at 11:29 p.m. R103 Family Member (FM) N reported R103 had an unwitnessed fall on 1/23/25 with facial injuries that required transfer to hospital. FM N reported facility was not able to answer how R103 fall occurred or how long R103 was on the floor before staff found R103. FM N reported R103 had significant facial bruising over entire face with open area to area above left eye several days after alleged fall. Review of R103 Fall Incident/Accident Report, dated 1/23/25 at 8:42 p.m., reflected R103 had an unwitnessed fall in room and was found lying on stomach next to the bed with abrasion noted on face. The report reflected, Resident states that she slipped off her chair . The report reflected R103 had impaired memory and no witness statements were found and Physician was contacted at 7:30 p.m.(Report had discrepancy in times, no mention of interventions that were in place on not in place including footwear, dysem or grip strips on floor). Review of R103 Hospital Radiology Report, dated 1/23/25, reflected CT scan of the brain revealed, LEFT frontal scalp soft tissue contusion and/or organized hematoma . Review of R103 Physical Therapy Assessment, dated 1/24/25, reflected, Reason for Referral/Current Illness: Patient is a [AGE] year old female with history of dementia who is a LTC[long term care] resident of the facility. She has a history of falls and has had 5 falls in the last year. She has been referred to skilled PT services following patient having a recent fall on 1/23. She sustained a bump with bruising to her forehead. She was transferred to the hospital for further evaluation and then returned to this facility. Per nursing notes, patient reported she slipped out of her w.c[wheelchair]. Patient told PT this date that she was walking without AD[assistive device] and only had socks on and slipped on the floor. Educated patient on having assistance, wearing shoes/grippy socks and using walker for safety . During an observation and interview on 3/13/25 at 9:30 a.m., R103 was sitting in Main Dining Room in wheelchair watching television with regular socks with no grip on them. R103 had nickel size abrasion noted to area above left eyebrow and was very hard of hearing. R103 reported fell out of bed and laid on floor until staff arrived and then was sent to hospital for several hours. R103 reported she is careful now and was told she had to wear shoes. Resident #104 (R104) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R104 was an [AGE] year-old male admitted to the facility on [DATE], and most recently re-admission post fall at facility with left displaced hip fracture requiring surgical repair, compression fracture T-12(spinal fracture, and traumatic subdural hematoma. R104 had other diagnoses that included dementia, hypertension (high blood pressure), depression and anxiety. The MDS reflected R104 had a BIM (assessment tool) score of 3 which indicated his ability to make daily decisions was significantly impaired. The MDS reflected R104 did not have behaviors including wandering or rejection of care. An anonymous complaint received by the State Agency alleged the facility failed to prevent fall for R104 that resulted in hip fracture and passed away. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R104 Unusual Occurrence Note, dated 1/6/2025 at 3:46 p.m., reflected, LN was alerted by a family member (visitor) that resident was laying on the floor at the end of the hallway. When LN arrived at residents side he was laying on his left side, head up against the wall feet outstretched into the hallway, by room [ROOM NUMBER] at the end of 500 long hall. Resident was noted picking up his hat when he fell over. Resident did not ask for assistance with his hat. Resident is noted wearing hipsters and non-slip footwear. Resident was noted ambulating in the hallway 15 minutes prior and offered a chair to rest. LN asked resident what he was attempting to do when he fell over? resident stated, just give me my damn hat LN did a full head to toe assessment on resident has full range of motion of both upper extremities without pain or difficulty. Resident has full range of motion in right hip. LN noted external rotation of left hip upon assessment. C/O[complained of] pain with minimal movement. no other injuries noted. Staff members were unable to assistance resident off the floor with a gait belt, resident was assisted off the floor by a hoyer lift with a sling and assisted to his bed. A staff member sat with resident until EMTS[emergency medical technicians] arrived . Review of R104 Social Service Note, dated 1/12/25 at 10:10 a.m., reflected, [Named R104] was readmitted yesterday evening from Hospital. Resident was readmitted with Dx of HX[history] of interchanteric FX[fracture] of left femur. Unspecified part neck Left Femur. Traumatic subdural hemorrhage without loss of consciousness. Occlusion and stenosis of unspecified cardio artery. Falls. CKD[chronic kidney disease] stage 3. Gastro reflux. Anxiety disorder. Insomnia, Alzheimer's disease. Vascular dementia. Hyperlipidemia. HTN[hypertention]. Major depression. Resident remains alert and oriented to person or name. No significant change in cognition. Staff anticipate and assist with support care and redirection . Review of R104 Hospital Discharge Summary, dated 1/11/25, reflected, .Hospital Course-80 y M[year male] with history of .dementia as a transfer from [named] after being found down at his facility. Patient sustained Parietal subdural hematoma, Left displaced comminuted intertrochanteric femur fracture and acute compression fracture of T12. Patient underwent Left intertrochanteric InterNail repair on 1/7/25. The parietal SDH[subdural hematoma] and T12 compression fracture was managed non-op[non-operative]. Hospital course was significant for agitation that was managed with Zyprexa. Otherwise, patient progressed will during hospital course. Patient is weight-bear as tolerated to the left lower extremity with a walker and is to be on TLSO[thoracolumbar sacral othosis] brace when out of bed . Review of R104 Fall Incident/Accident Report, dated 1/6/25 at 2:15 p.m., reflected R104 had a fall in the hall, unwitnessed by staff, with 10/10 left pain hip with hipster in place. The Incident accident report indicated left leg had external rotation and staff were unable to stand with gait belt(with assessment of external rotation and Range of Motion not tolerated to left hip). The report reflected R104 was transferred from the floor in hall to bed with hoyer lift then sent by ambulance to hospital. The report had section for predisposing physiological factors that had the following marked; confused, impaired memory and gait imbalance. Continued review of the report reflected section for predisposing situational factors that had the following marked; call light not used, wandering, and ambulating without assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R104 Change in Condition assessment, dated 1/6/25, reflected had fall in hall and R104 not cognitively able to rate pain and showed the following signs of pain; short periods of hyperventilation, repeated troubled calling out, loud moaning or groaning, crying, facial grimacing, fists clenched, knees pulled up, [NAME] or pushing away, striking out and unable to console. The assessment reflected, Since the change of condition occurred have the symptoms or signs gotten: Stayed the same[marked] .Things that make the condition or symptoms worse are: movement and touch .Things that make the condition or symptoms better: laying still medication .This condition, symptom or sign has occurred before: No[marked]. Review of R104 Physical Therapy Evaluation, dated 10/22/25, reflected, Patient is a [AGE] year old male with history of dementia who is a LTC[long term care] resident of this facility. He has had 7 falls since he was admitted here. He usually chooses to transfer and ambulate on his own without assistance despite therapy recommendation for 1 person assist. He has been referred to skilled PT[physical therapy] services by nursing following his most recent fall on 10/20. Per nursing documentation, it was a witness fall by the nurses station and parient's only comments were that he was tired. Patient is demonstrating decreased BLE[bilateral lower extremity] strength, impaired standing balance, impaired safety awareness, impaired ability to follow direction and reduced functional activity tolerance . Review of R104's requested Fall Incident reports, 10/1/24 through 3/10/25, reflected R104 had the following falls; 1/20/24 at about 2:44 p.m. fell while wandering/actively exit seeking, 11/28/24 at about 2:04 a.m. fell while wandering, ambulating without assistance. 12/12/24 at about 4:02 a.m. fell during attempted self-transfer, ambulating without assistance. 1/6/25 at about 2:15 p.m. fell while wandering, ambulating without assistance. (Resulting in left hip fracture, compression fracture of T12, and acute subdural hematoma) 1/12/25 at about 7:02 a.m. fell in room resulting in skin tear. During an observation on 3/10/25 at 1:50 p.m. resident in room [ROOM NUMBER] called this surveyor into room from hall and reported needed assistance. Call light was observed to be illuminated in room and resident reported was waiting for staff for over 30 minutes to use bathroom. Verified at nurse station call light had been on since 1:14pm (35 minutes) according to call light electronic system at the Nurse station. Continued review of the call light system reflected room [ROOM NUMBER]b call light on since 1:30 p.m. (20 minutes), and room [ROOM NUMBER]a on since 1:46 p.m. (6 minutes). Continued observation reflected staff turned room [ROOM NUMBER] call light off at 1:53 p.m. and turned it back on and exited the room. Staff entered returned to room [ROOM NUMBER] at 2:01 p.m. (47 minutes after resident used call light) During an observation on 3/11/25 at 9:00 a.m., 300 hall call light system reflected room [ROOM NUMBER]b call light had been on since 8:40 a.m.(20 minutes). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone call on 3/12/25 at 11:08 a.m., CNA S returned was on break when R104 fell on [DATE] and R104 was in bed. CNA S reported four CNA staff on 500 hall and two go on break at a time. CNA S reported assisted R104 change cloths and brief and clean R104 after bowel movement. CNA S reported R104 was agitated, in pain with verbal outburst screaming and yelling with movement. (R104 had been transferred with hoyer lift, provided incontinence care and clothing changed prior to EMS arrival with displaced left hip fracture. During a telephone interview on 3/12/25 at 11:18 a.m., RN T reported was on break when R104 fell on [DATE] and when returned R104 was in bed and appeared scared, in pain and repeat attempts to get out of bed and was told may have broke hip. RN T reported R104 often walked the halls independently. RN U reported sat with R104 until EMS arrived and repeatedly saying, help me, with repeat attempts to get out of bed. RN S reported R104 returned to facility after left hip surgery and was very anxious, no longer ambulatory and was admitted to hospice and passed away. During an interview on 3/12/25 at 1:50 p.m., CNA V reported did not witness R104 fall on 1/6/25 but was R104 CNA at the time. CNA V reported was assisting another resident at time of fall. During an interview and observation on 3/13/25 at 3:50 a.m., Confidential Resident(CR) X was sitting in bed and appeared able to answer questions without difficulty. CR X had family at bedside who verified resident was own responsible person. CR X reported call light response times are often over 1 hour long mostly on night shift and told not allowed to go to bathroom on without assist. CR X reported often waits for long time then gets up on own and goes and staff get upset with him and stated, I don't want to poop myself. Review of the facility Resident Council Minutes, September 2024 through February 2025, reflected three of past six months had reported concerns with call light response times with follow up that indicated discussed at staff meeting.