STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235261	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Leonard	1700 Leonard St N E Grand Rapids, MI 49505

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** 41027 This citation pertains to intake MI00144400 Based on observation, interview, and records review, the facility failed to safely transfer 1 of 3 residents (Resident #101) resulting in a fall and serious injury requiring a transfer to the hospital, and surgery to treat a distal left femoral (upper leg) fracture. Findings include: Review of an Admission Record revealed Resident #101 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #101 was cognitively intact. Review of Resident #101's Kardex (care guide) and Care Plan prior to her fall on 4/25/24 revealed, . Transfers: Sit to stand x 2 assist . This had been created on 11/20/2023, and last revised on 4/12/2024. Review of Resident #101's current Kardex and Care Plan revealed, .Transfers: mechanical lift Hoyer (mechanical lift) updated 4/30/24 due to fall with sit to stand . In an interview on 5/29/24 at 1:38 PM, Resident #101 reported that she had fainted a few weeks ago while being transferred using the sit to stand (mechanical lift), and straps were not buckled around my chest or legs and stated, .the sling slid up my back and squeezed my lungs .that's why I fainted .I went down onto the floor hard .there was only 1 person there .there was no one to catch me . Resident #101 reported that she immediately had severe pain in her left leg, was sent to the hospital and required surgery to repair a fracture to her leg. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #101's Incident Report dated 4/25/24 revealed, .Staff member states she was transferring pt (patient) from toilet to the bed with the sit to stand. She had her arm straps on but no chest strap or leg straps. CNA (Certified Nursing Assistant F) was by myself (sic) during the transfer. I was behind her while I wheeled her closer to the bed. Pt released both hands from the arms of the lift and slid out of the sit to stand, I assisted her to the floor.Resident ROM (range of motion) unable to assess as resident refused to allow touching of the left leg .remained with resident until EMS (emergency medical service) arrived .Staff member did not follow Kardex or care plan of 2 person assist with sit to stand . Review of Resident #101's Hospital Records indicated that she arrived in the emergency roiagnom on [DATE] at 2:22 PM, where she had multiple x-rays taken to evaluate her injuries from a fall at the facility earlier that day. Resident #101 was consulted by the orthopedic trauma team on 4/25/24 for a fracture of left femur, and subsequently underwent surgery the next day to repair the fracture. Resident #101 was discharged from the hospital on 4/30/24. In an interview on 5/29/24 at 3:54 PM, RN D reported that CNA F came to her and reported that Resident #101 was on the floor. RN D reported that when she entered Resident #101's room the resident was laying on the floor on her back, and complaining of pain in her left leg. RN D stated, .(CNA F) told me that (Resident #101) let go of the grips and slid out of the sling, landing on her back . RN D reported that this type of accident had happened once before, but that the resident insisted on still using the sit to stand for transfers. In an interview on 5/29/24 at 3:31 PM, Registered Nurse (RN) H reported that she was the second nurse to respond to a report that Resident #101 had fallen out of the lift due to her letting go of the bars, and when she entered the room the resident was on the floor and complaining of severe pain in her left leg. RN H noted that the resident was not wearing any socks or shoes, and that when using the sit to stand lift, residents should be wearing appropriate footwear. Attempts were made to contact CNA F on 5/29/24 and 5/30/24 via phone and via email, with no response. Review of CNA F's employee file indicated that she had been suspended on 4/25/24, and terminated on 5/2/24, due to failing to adhere to policies and procedures related to transferring a resident using a mechanical lift, which resulted in a resident sustaining a fall with serious injury. In an interview on 5/30/24 at 10:06 AM, Rehab Director (RD) J reported that at the time of Resident #101's fall she had been receiving therapy and working on upper body strength and stated, .we were trying to get her stronger and less painful . RD J reported that Resident #101 was capable of safely using the sit to stand lift, as long as she was fully buckled in and with 2 assist from staff. Review of the facility policy Mechanical Lifts dated 7/11/2018 revealed, .8. There will always be 2 staff to assist resident. 1 staff will control the lift as the other will guide resident and support back and neck to transfer surface .10. Place sling on resident's back. Ensure that it is properly placed for support . Review of the facility past noncompliance documentation revealed the following action plan to resolve the noncompliance: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Action taken during the investigative process: 1. Nursing assessment completed for (Resident #101). 2. NHA (Nursing Home Administrator), DON, and Physician notified. 3. Resident that requires sit to stand for transfers reviewed and deemed safe by therapy. 4. Care Plans for (Resident #101) updated. 5. Mechanical lift policy reviewed by NHA/DON and deemed appropriate. Area identified requiring quality improvement: 1. Staff educated on proper use of sit to stand per the facility policy outlined in the mechanical lift policy. 2. Demonstration provided to each staff member. How facility identified residents affected and residents with potential to be affected: All Residents that are dependent on sit to stand lifts in the facility have the potential to be affected. Quality improvement measures or systemic made: 1. Initiation of a QAA (quality assessment and assurance) investigation on 4/25/24 . 2. In this case, it was identified that facility employees failed to follow facility policy of mechanical lifts . 3. Education for all RN/LPN (Licensed Practical Nurse)/CNA on the policy of mechanical lift was initiated on 4/25/24 .Any RN/LPN/CNA who has not received the education by 4/25/24 will receive the education prior to the start of their next shift. 4. Audits were developed to ensure staff competency of the mechanical lift policy. How the facility monitors the effectiveness of its quality improvement measures: 1. DON/Designee will conduct at least 5 random audits weekly x 4 weeks and then monthly x 2 months to sure staff are compliant with mechanical lifts, until substantial compliance is maintained. Results of these audits will be submitted to the QAA Committee weekly for review and further recommendations. 2. The administrator will be responsible for maintaining compliance with this plan of correction. During the abbreviated survey, this surveyor reviewed documentation, conducted interviews and made observations of the preceding interventions, and past non-compliance was accepted by the state agency as of 4/29/24.