STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235360	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Manor Care Center	151 2nd St Spring Arbor, MI 49283

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 This citation pertains to MI00147519 Based on observation, interview and record review the facility failed to implement, revise and evaluate effectiveness of the care plan for one of two sampled residents (Residents #4) reviewed for falls resulting in unnecessary falls and hospitalization with major injury. Findings include: Resident #4 (R4) Review of the medical record reflected R4 was an initial admission to the facility on [DATE]. Diagnoses of [NAME] Matter Disease, Dementia with behavioral disturbance, Anxiety, Delusional Disorder, Restlessness and Agitation, Muscle Weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/09/2024, revealed R4 had a Brief Interview of Mental Status (BIMS) of 06 (severe cognitive impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R4 requires substantial assistance with personal care. During an interview on 10/22/24 at 1:08PM, Social Worker (SW) L stated with R4's falls, they met every week to review falls, go over the interventions in place. SW L also stated they have him on psych services and increased the involvement of activities. Also stated R4 was in the military service and the sound of alarms increases his anxiety. SW L stated that the family of R4 are the ones who initiated the discharge planning process. SW L also stated that the family were upset that R4 had had so many falls at this facility. SW L also added that the facility did not have enough staff to be with him 24/7 to watch him. SW L stated that the staff did every 15 minutes checks on him and periods of one on one, and ensuring the alarms were on him and working well and continue to observe. Writer asked who provided the one-on-one staff for him, SW L stated to check with the Director of Nursing (DON) B as SW L did not provide that. SW L stated that nursing was the discipline that addresses falls, and she only addressed cognition. Record review of activity log for one-on-one visits, revealed no interactions for the last 30 days. (continued on next page)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 1:38 PM, DON B was asked who puts interventions in place following a fall. DON B stated the reason the writer could not see them is because the family was not on board. DON B then stated they were using alarms, offering snacks, brought down to the nurse's station, brought out in the day room, was very common for them, not specific. DON B stated she talked to the family of R4 about his anxiety and was not in agreement to psych medications. DON B also stated that care conferences were not productive as family would yell at them and hang up the phone on them. DON B added several suggestions, but family did not want them. Writer asked for documentation of the suggestions and where family refused. DON B was looking for documentation that family were in agreement or not in agreement to the suggestions. DON B was unable to find any in the medical record, she stated she thought Unit Manager J put them in her notes. During the phone call from DON B to Unit Manager J, stated the last care conference on 08/29/24 did not include any documentation that family were not in agreement with suggestions. Unit Manager J came into DON B office. Writer asked for the care conference notes for 10/10/24. DON B provided the documentation which showed that social work section was the only section completed, nursing did not have anything documented, area was blank. Writer asked for the 15-minute check log for R4, Unit Manager J stated she had paper copies and went to get them. Writer asked DON B for the one-on-one log as it was documented they would provide if R4 got anxious or restless. DON B stated they would have someone watching him, not like a 24/7 thing, staff just knew if R4 got anxious, like taking him to the nursing station, have staff follow him around, but it wasn't documented or tracked. Unit Manager J provided the 15-minute checks log. The 15 minutes checks were from the date 10/19/24 at 1545 (3:45 PM) through 10/19/24 at 2000 (8:00 PM). The 15 minutes started back up on 10/20/24 at 6:00 AM until R4 was hospitalized on [DATE] at 1530 (3:30 PM). No 15-minute checks following any of the other falls. Writer asked DON B again about not updating the care plan with new interventions following each fall. DON B stated the fall on 10/12/24 alarm was alerting them, but they could not get to him in time to prevent the fall. Unit Manger J stated it was her responsibility to update the care plans. Unit Manager J also stated she didn't have anything more to put on it. Writer asked DON B and Unit Manager J why there wasn't anything added to the fall section on the care plan or Kardex since admission of 07/05/24, no response. During an interview on 10/23/24 at 08:00 AM via email to DON B requested to see the incident reports on the falls for R4 since July of 2024. Record review revealed that the incident reports for the falls on R4 included 8 separate falls from 07/19/24 through 10/19/24 which resulted in a hospitalization with a femur fracture. Fall on 07/19/24 at 18:45, R4 found sitting on the floor beside his recliner, no injuries. Fall on 08/30/24 at 03:30, R4 found sitting on the floor on buttocks in his room leaning up against the bathroom door. Bed alarm was alerting, staff did not get there in time to prevent the fall. Fall on 09/22/24 at 20:20, R4 got out of bed, bed alarm was alerting, he was walking to the bathroom, was assisted by CNA to the toilet, CNA stepped out and R4 slid off the toilet. Found in a seated position in front of the toilet. Fall on 09/30/24 at 00:19, fell to the floor, skin tear to the right knee. Fall on 10/9/24 at 21:41, R4 became aggressive towards staff and lost balance and fell on to his knees. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall on 10/12/24 at 14:36, fell to the floor and hit his head on the floor resulting in a small lump forming to the right side of his head. Fall on 10/13/24 at 01:58, fell to the floor, hit his forehead, was bleeding, R4 was unable to give a pain level, sent out to emergency department. Fall on 10/19/24 at 03:53, fell to the floor in front of his bed, bed alarm did not alert staff that R4 got out of bed, wheelchair was beside R4 with the brakes unlocked. Record review revealed on 10/19/24 at 10:30 AM, R4 complained of left hip/femur pain, not able to lift left leg, would cry out when the left leg was moved. R4 sent out to emergency department for X-rays. Review of the X-ray results, R4 did not get his left hip or femur X-rayed, only head to lower spine was X-rayed. On 10/21/24 at 10:47 AM, R4 was still complaining of pain in his left hip/leg. On 10/21/24 at 12:35 PM, Nurse Practitioner (NP) Q assessed R4, ordered a stat X-ray of his left hip, pelvis and femur. On 10/21/24 at 15:28 PM, Stat X-ray results for R4's left hip, pelvis and femur came back with R4 having a left subcapital fracture (neck of femur fracture) and fracture involving the left proximal femur (break in the upper quarter of the thighbone, near the hip joint). R4 was sent to the hospital and admitted with a hip fracture. Record review revealed the care plan for falls, was not updated with any changes, revised or additions to the interventions after these 8 falls. Record review did not reveal any changes to R4's care plan, Kardex or task sheet in effort to prevent these falls from admitted [DATE] to being hospitalized for fractures on 10/21/24.

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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 - Some	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** 45135 This citation pertains to MI00147519 Based on observation, interview and record review, the facility failed to initiate new interventions to prevent falls for one resident (Resident #4) of two reviewed for falls, from a total sample of 5, resulting in continued falls and hospitalization for major injury. Findings include: Resident #4 (R4) Review of the medical record reflected R4 was an initial admission to the facility on [DATE]. Diagnoses of [NAME] Matter Disease, Dementia with behavioral disturbance, Anxiety, Delusional Disorder, Restlessness and Agitation, Muscle Weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/09/2024, revealed R4 had a Brief Interview of Mental Status (BIMS) of 06 (severe cognitive impairment) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R4 requires substantial assistance with personal care. During an interview and observation on 10/18/24 at 11:46 AM, R4 was sleeping in his bed fully dressed, hair was matted, face was scruffy from not being shaved. Noted the call light was out of reach for him, water glass on the over the bed table was room temperature with no date or time on the cup. Writer tried waking R4 up with verbal stimulation and tactile, he opened his eyes and then went back to sleep. During an interview and observation on 10/18/24 at 1:34 PM, Licensed Practical Nurse (LPN) O stated R4 was safe sitting in his wheelchair with an alarm under him. Writer observed R4 sitting in his wheelchair sitting in the hallway. Writer asked LPN O who provides the one-on-one supervision as documented in the progress notes. LPN O stated she didn't know they provided that because they do not have enough staff to provide that. Writer asked when R4 had his last shower, LPN O stated on 10/14/24, and blamed R4's behaviors made it hard to provide. Writer asked LPN O what other interventions they had tried to get him to take a shower. LPN O stated they just left him alone for a while and then try again. Writer asked if R4 would be getting a shower today as he appeared dirty. LPN O stated I am sure the CNA washed him up this morning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 1:08PM, Social Worker (SW) L stated with R4's falls, they met every week to review falls and go over the interventions in place. SW L also stated they had him on psych services and increased the involvement of activities. Also stated R4 was in the military service and the sound of alarms increases his anxiety. SW L stated that the family of R4 are the ones who initiated the discharge planning process. SW L also stated that the family were upset that R4 had had so many falls at this facility. SW L also added that the facility did not have enough staff to be with him 24/7 to watch him. SW L stated that the staff did every 15 minutes checks on him and periods of one on one, and ensuring the alarms were on him and working well and continued to observe. Writer asked who provided the one-on-one for him, SW L stated to check with the Director of Nursing (DON) B as SW L did not provide that. SW L stated that nursing was the discipline that addresses falls, and she only addressed cognition. Record review of activity log for one-on-one visits, revealed no interactions for the last 30 days. During an interview on 10/22/24 at 1:38 PM, DON B was asked who puts interventions in place following a fall. DON B stated the reason the writer could not see them is because the family was not on board. DON B then stated they were using alarms, offering snacks, brought down to the nurse's station, brought out in the day room, was very common for them, not specific. DON B stated she talked to the family of R4 about his anxiety and was not in agreement to psych medications. DON B also stated that care conferences were not productive as family would yell at them and hang up the phone on them. DON B added that several suggestions, but family did not want them. Writer asked for documentation of the suggestions and where family refused. DON B was looking for documentation in the medical record that family were not in agreement to the suggestions. DON B was unable to find any, she stated she thought Unit Manager J put them in her notes. During the phone call from DON B to Unit Manager J, stated the last care conference on 08/29/24 did not include any documentation that family were in agreement or not in agreement with suggestions. Unit Manager J came into DON B office. Writer asked for the care conference notes for 10/10/24. DON B provided the documentation which showed that social work section was the only section completed, nursing did not have anything documented, area was blank. Writer asked for the 15-minute check log for R4, Unit Manager J stated she had paper copies and went to get them. Writer asked DON B for the one-on-one log as it was documented they would provide if R4 got anxious or restless. DON B stated they would have someone watching him, not like a 24/7 thing, staff just knew if R4 got anxious, like taking him to the nursing station, have staff follow him around, but it wasn't documented or tracked. Unit Manager J provided the 15-minute checks log. The 15 minutes checks were from the date 10/19/24 at 15:45 (3:45 PM) through 10/19/24 at 2000 (8:00 PM). The 15 minutes started back up on 10/20/24 at 6:00 AM until R4 was hospitalized on [DATE] at 1530 (3:30 PM). No 15-minute checks following any of the other falls. Writer asked DON B again about not updating the care plan with new interventions or revisions following each fall. DON B stated the fall on 10/12/24, alarm was alerting them, but they could not get to him in time to prevent the fall. Unit Manger J stated it was her responsibility to update the care plans. Unit Manager J also stated she didn't have anything more to put on it. Writer asked DON B and Unit Manager J why there wasn't anything added to the fall section on the care plan or Kardex since admission of 07/05/24, no response. During an interview on 10/23/24 at 0800 AM via email to DON B requested to see the incident reports on the falls for R4 since admission in July 2024. Record review revealed that the incident reports for the falls on R4 included 8 separate falls from 07/19/24 through 10/19/24 which resulted in a hospitalization with a femur fracture. (continued on next page)

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