STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Hillman	631 Caring St Hillman, MI 49746

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 - 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** 45123 This citation pertains to intake MI00150640. Based on interview and record review the facility failed to provide safe and adequate assistance with bed mobility for one Resident (#2) of three residents reviewed for accidents, hazards, and supervision. This deficient practice resulted in a fall with major injury, hospitalization , and death. Findings include: Resident #2 (R2) Review of a complaint submitted to the State Agency (SA) on [DATE], revealed, on [DATE], [Registered Nurse (RN) H] called the complainant and told them [R2] was having a routine brief exchange done by one staff member [Certified Nurse Assistant (CNA) D]. Complainant R stated that they were informed [CNA D] had rolled [R2] on her side. Complainant R stated that they were told that during this incident, [R2] fell out of bed, broke her shoulder and hip, and hit her head. Complainant R stated that [R2] passed away at the hospital on [DATE]. Complainant R stated that prior to this incident, there had always been two people present to change [R2]. Review of R2's hospital course, dated [DATE] through [DATE], revealed the following: a.) admitted to emergency department (ED) at 2:09 PM. b.) Results of x-rays suspected right proximal humeral fracture (broken bone in the upper arm that connects the shoulder and the elbow) and suspected impacted right subcapital femoral neck fracture (broken bone in the upper leg that connects the hip/pelvic area of the ball and socket joint that connects to the hip) at 3:50 PM. c.) Transferred to intensive care unit (ICU) and appeared toxic at 8:33 PM. d.) Went into rapid ventricular rate (RVR - irregular fast heartbeat), code blue (cardiac arrest), attempted arterial line (a thin, flexible tube inserted into an artery to monitor blood pressure and obtain blood samples), lifesaving emergency protocol was initiated including cardiopulmonary resuscitation (CPR) and advanced cardiovascular life support (ACLS), and emergently intubated (breathing tube inserted to assist with breathing) at 11:49 PM. (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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	235423	A. Building B. Wing	03/12/2025

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

e.) Death on [DATE] at 12:10 AM with death diagnosis of principle problem PEA (pulseless electrical activity) suspected embolic event. Some causes of a PEA are sepsis and trauma.

Review of R2's death certificate, dated [DATE], read in part, .contributing cause of death: Complications of mechanical fall with fractures with approximate interval between onset and (death) .Hours .

On [DATE] at 5:44 PM, Complainant R was called to review the allegations of the complaint intake. Complainant R stated, [R2] was undergoing a brief change with only one staff even though R2 was care planned to receive assistance from two. There were always two staff when we came to visit. The facility said [CNA D] was performing a brief change, [R2] was rolled onto her side. The facility claimed [R2] kicked her leg out, which contributed to the fall. Complainant R was asked if R2 was able to kick her leg out. Complainant R replied, No, [R2] could only stretch, and the facility staff had raised the bed. Emergency Medical Technician (EMT) said that they were not sure how [R2] got into the position she did. It made no sense to them. The facility said [R2] slid out of the bed and there is no way that she could do that.

On [DATE] at 6:12 PM, an interview was conducted with Family Member (FM) Q regarding R2's fall at the facility. FM Q replied, The facility Nursing Home Administrator (NHA) and the Director of Nursing (DON) said that the report from the ED stated that a staff member was trying to stand [R2] up, but she hasn't stood her up in years. The NHA and the DON told them that there was a nurse in there and they were changing [R2], and she picked up her leg and slid off the bed and slid down to the floor as they were cleaning her. There was a bruise on [R2's] face. There was only one person in the room with her apparently. When I came to the facility to visit there was always two staff providing care to do a brief change.

Review of R2's Emergency Medical Services (EMS) run report, dated [DATE] at 1:13 PM, read in part, . Dispatch priority: Critical (Priority 1) .Patient complaints: Right shoulder pain .Other symptoms: Pain: Hip . Cause: Fall from bed. Trauma criteria: Anticoagulants and bleeding disorders. Narrative: Dispatched via 911 to above address (local skilled nursing facility [SNF]) for a [AGE] year-old female who has fallen out of bed and has right arm pain. EMS arrive on scene to find patient lying supine [face up and on the back] on the floor next to her bed (at an approximate 45-degree angle from bed with head closer to bed and feet further from bed) .Staff x 3 at patient's side stating one staff was present and changing patients [brand name incontinence brief] when patient slid out of her bed. This staff states patient hit her head on the head of the bed rail as she was falling. Patient is on a blood thinner: Apixaban. No other details of fall were given .Patient states she has 9-,d+[DATE] pain in right shoulder. Patient says, Ow. Several times when there is a bump in the road .Approximately halfway through transport, patient states her hip hurts; this is a new onset per patient .Weight: 149.7 kg (kilograms) [329.34 pounds] .

On [DATE] at 5:36 PM, an interview was conducted with Paramedic P who was asked if they had recalled R2 and her transfer out of the nursing facility. Paramedic P replied, Yes, it was very odd, and our team questioned what happened because [R2] was in an odd position from sliding out of bed and it did not add up. [R2] was at an angle to the bed, and she had hit her right arm on the left side of the bed. It was a weird situation. The CNA changed [R2] by herself. [R2] was three hundred pounds, and our team [EMS crew of three] could not move her by ourselves. The facility staff and our team had used the Hoyer lift to put [R2] on the gurney. I recall the CNA having a small body frame size.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R2's transfer form, dated [DATE] at 1:31 PM, revealed an unplanned transfer to a local hospital from a fall, hitting head, and complained of pain ,d+[DATE] in right shoulder and shoulder blade. Code status - full code. Usual functional status - Not ambulatory. Review of R2's initial fall report, dated [DATE] at 2:14 PM, read in part, .Description other intervention(s): Education to staff that 2 people assists (sic) need to be done with two people . Review of R2's progress note, dated [DATE] at 2:13 PM, read in part, This nurse [RN H] was heading down the hallway with medication cart to pass medications and [CNA D] come out of this resident's [R2] room and said [R2] fell out of bed! This nurse [RN H] instructed housekeeping to grab me the vitals cart and then grab the clinical management out of another residents room .This nurse [RN H] walked into [R2's] room at 1:10 PM to see her lying on the floor naked next to her bed with a pillow under her head .Once vitals obtained . called [on-call providers name] at 1:12 PM and he ordered to ship resident .EMS arrived .two CNAs and two people from EMS helped get this resident up with the Hoyer lift. [R2] was then taken out of the facility by EMS . Review of R2's progress note, dated [DATE] at 6:25 PM, read in part, .called [local ED] on a update .resident will be admitted up to ICU, residents blood pressures were very low and a central line had to be inserted, and [name brand medication - a vasoconstrictor] started. Resident also has a right femoral neck fracture. Review of facility investigation report, date [DATE], read in part, Resident: [R2] is a [AGE] year-old female resident, admitted on [DATE]. Primary diagnoses include .hemiplegia [muscle weakness or partial paralysis on one side of the body], morbid obesity and heart failure. Resident has a BIMS [brief interview for mental status] of 13 [indicative of intact cognition] and requires 2-person assistance for transfers and ambulates independently in her wheelchair .Reported Incident .had a witnessed fall on [DATE] .x-ray's showed right femur fracture and humeral fracture .Investigation .At 1:15 PM, Aide [CNA D], had checked on [R2]. [R2's] brief was soiled so the aide [CNA D] gathered up supplies she needed to change the resident [R2]. The aide [CNA D] was cleaning up the resident and had the resident roll to her [R2's] side and grab the side rails for assistance. The resident [R2] rolled to her side, then the resident crossed one leg over the other and as she did that she continued to roll and fell on to the floor. The aide [CNA D] attempted to prevent the resident from falling but was unable to stop the fall .Investigation Conclusion: [R2] is a 2-person assist for bed mobility. Review of R2's fall root cause analysis investigation tool, dated [DATE] at 1:10 PM, read in part, .Fall Huddle (What was different THIS time?): Resident being assisted with one-person assist instead of two-person like care planned. Root Cause of This Fall: Care plan not followed . On [DATE] at 10:00 AM, an interview was conducted with RN H who was asked if she recalled the fall in December for R2. RN H replied, Yes, I was heading down the East Hall with my medication cart to pass medication and [CNA D] came out of [R2's] room stating that she [R2] fell out of bed. I immediately went to assess [R2], who was lying on the floor next to her bed with her feet further away from the bed and her head closer to the bed and asked for clinical management to come. [R2] is not mobile, and she does not walk. [R2] was complaining of pain in her right shoulder. I asked [CNA D] what happened and [CNA D] told me she did not know. After EMS left [CNA D] said she rolled [R2] up on her side away from her to wipe her and [R2] rolled off the bed and [CNA D] told me she was by herself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:35 AM, an interview was conducted with CNA D who was asked if she recalled the fall in December for R2. CNA D replied, Yes, I went in to [R2's] room because she had her call light on. [R2] was soiled so I went to get stuff to clean her up and, in the process, [R2] lifted her leg over her other leg, and she rolled off the bed onto the floor. CNA D was asked if there was another CNA working at the time she was providing care for R2 and replied, Yes, but she was with another resident. CNA D was asked if R2 was a one or two-person assistance for incontinence care and replied, I could have sworn she was a one-person assist, but I guess she was a two-person assist. [R2] had paralysis on her left side both upper and lower. On [DATE] at 10:55 AM, an interview was conducted with RN O / East Unit Manager who was asked if she recalled R2's fall in December. RN O replied, Yes, I was in the area. Staff came and got me and told me [R2] had fallen out of bed onto the floor. [R2] said her arm hurt. RN O was asked who was in the room at the time of the fall. RN O replied, [CNA D] was cleaning her up. RN O was asked how many staff should have been assisting with a brief change. RN O replied, [R2] required two staff assistance for a brief change. On [DATE] at 1:45 PM, an interview was conducted with the DON regarding R2's fall in December. The DON stated I was in the next room with the NHA doing a 72-hour care conference with another resident when staff came and got me. [CNA D] was not sure how [R2] fell exactly, but she put her leg over her other leg and lost her balance. [CNA D] tried to catch [R2] but could not. I interviewed [CNA D] and asked her why there was only one aide in the room and [CNA D] stated, I could do it by myself. The DON went on to further explain that [CNA D] was able to state what [R2's] Kardex and care plan was and repeated it to me. [CNA D] rolled [R2] away from her while she was providing care and did not follow policy. Review of R2's care plan, dated [DATE], read in part, .Goal: Resident has an ADL (Activities of Daily Living) self-care performance deficit related to fluctuating ADLs, generalized weakness, hemiplegia .Interventions . Bed mobility: 2 person assist .Toileting: 2 person assist .Goal: Resident is at risk for falls/injury related to decreased strength and endurance, history of falls .hemiplegia and hemiparesis . Review of R2's ADL report, dated [DATE] through [DATE], revealed R2 was dependent for toileting and was assisted by one staff. Review of policy titled, Activities of Daily Living (ADLs), dated [DATE], read in part, Policy: The facility takes measures to minimize the loss of residents' functional abilities, including activities of daily living (ADLs) Policy Explanation and Compliance Guidelines .2. The facility provides maintenance and restorative programs to assist residents in achieving and maintaining the highest practicable outcome based on their comprehensive assessment. 3. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .5. The facility maintains individualized objectives of the care plan through periodic review and evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of policy titled, Accidents and Supervision, dated [DATE], read in part, Policy: Each resident will be assessed for accident risk and will receive care and services in accordance with their individualized care plan. Each resident will receive adequate supervision and assistive devices to prevent accidents .3. Implementing interventions to reduce hazard(s) and risk(s). 3. Implementation of Interventions - using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes .e. ensuring that the interventions are put into action .5. Supervision - Supervision is an intervention and means of mitigating accident risk. The facility provides adequate supervision to prevent accidents. Adequate supervision is .b. Based on the individual resident's assessed needs and identified hazards in their environment . Review of policy titled, Fall Prevention Program, dated [DATE], read in part, Policy: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls .Policy Explanation and Compliance Guidelines .5. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care . Review of policy titled, Falls - Clinical Protocol, dated [DATE], read in part, Policy Explanation and Compliance Guidelines .2. Based on the assessment an initial plan of care will be developed and implemented to address identified risks .5. Interventions should be developed and implemented per the assessed needs .6. In addition, interventions for direct care givers should be placed on the CNA care card or similar format .