| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235433 | A. Building<br>B. Wing | 07/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Greenfield Rehab and Nursing Center | 3030 Greenfield Ave<br>Royal Oak, MI 48073 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283<br><br>This citation pertains to intake # MI00145182.<br><br>Based on observation, interview, and record review facility failed to complete appropriate assessment(s) and provide appropriate interventions and follow the standard(s) of care for Activities of Daily Living (ADL's) resulting in a fall from bed for one (R801) of one Resident reviewed for falls. Findings include:<br><br>A complaint received by the State Agency alleged R801 had a fall while staff were providing care.<br><br>R801<br><br>R801 was long term resident of the facility originally admitted on [DATE]. R801's admitting diagnoses included: osteoarthritis, stroke, and benign (non-cancerous) brain tumor. R801's Minimum Data Set (MDS) assessment dated [DATE], was reviewed and revealed R801 had a Brief Interview of Mental Status (BIMS) score of 15/15, indicative of intact cognition.<br><br>An initial observation was completed on 7/1/24, at approximately 11:30 AM. R801 was not in their room. R801 had a regular size bed with regular mattress. There was chair (with an arm rest) on the right side of the bed that was placed against the wall, facing the bed. There was approximately 1.5 to 2 feet of space between the bed and the chair. The bed was not observed to have any assistive/mobility devices/bars.<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/1/24 at approximately 3:55 PM, R801 was observed in the dining room. R801 independently self-propelled from the dining room back to their room and an interview was conducted at that time. During the interview R801 was inquired about the recent fall. R801 reported the incident happened when a staff member was assisting them in the bed. R801 was able to recall the name of the staff who assisted them on the day of the fall. R801 proceeded to further report the staff member was standing on the right side of the bed trying to assist them to roll to the left side. R801 said they were attempting to grab the arm rest of the chair, they missed and rolled out of bed during the process. They also reported it was discovered the arm rest chair was broken at that time. When asked further about the incident and why they were trying to reach for the arm rest of the chair, R801 reported they needed something to hold on to during care when staff members assisted them from the right side and they needed to roll to the left side for care. R801 added staff had been assisting them the same way for a long time. During the interview R801's bed was observed to have two assist/mobility bars installed and R801 reported the bars had been installed earlier in the day on 7/1/24.<br><br>A follow up observation was completed on 7/2/24 at approximately 8:40 AM. R801 was observed in their bed. R801 reported they were now using the assist bars that were installed on 7/1/24. R801 was asked again about the fall, and reported the same sequence of events as reported on 7/1/24.<br><br>Review of R801's Electronic Medical Record (EMR) revealed a progress note dated 6/21/24 at 6:58 that read, Resident was getting care in bed on her left side. Resident reached for a chair and slipped out of bed onto her knees (left side). Family contacted an MD (Medical Doctor) called back and order X-ray for both knees. Resident currently in bed safe with belongings within reach. Writer will continue to monitor resident for the duration of shift . Further review of the EMR revealed post fall interdisciplinary team assessments were completed and additional x-rays of right wrist and hand were ordered on 6/24/24.<br><br>Review of the incident/accident report read in part, .Staff called writer back to the resident room to inform me that resident slipped out of bed. Resident was trying to hold on to the chair while getting care in the bed .<br><br>A review of a care plan revealed R801 needed 1 person staff assistance with their mobility in bed, effective 3/10/2023. Further review of R801's care plan for fall prevention included multiple interventions including: bed in low position when resident is in bed, initiated on 4/23/24; education on appropriate stabilization during ADL care initiated on 6/21/24; and assist bars to bilateral (both) sides of the bed initiated on 7/1/24, during the survey.<br><br>A review of a Physical Therapy (PT) and Occupational Therapy (OT) evaluation that was received via e-mail from the facility and administrator revealed that R801 had a PT evaluation completed on 6/24/24 and an OT evaluation completed on 6/27/24. Review of the PT evaluation revealed R801 was evaluated due to a recent fall. The document revealed the care giver failed to appropriately position the resident during care as was verbalized by R801 during the evaluation. the evaluation further revealed the staff member was standing on the right side of the R801 assisting them to roll to right side, they pushed the resident harder while attempting to assist, and the resident rolled out of bed when trying to reach for the chair. Further review of evaluations revealed a note that read in part, Staff encourage to use a remote to adjust the appropriate height during care, and use appropriate positioning, sequencing, and technique during care.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was completed with Director of Rehabilitation (DOR C) on 7/1/24, at approximately 11:50 AM. DOR C was asked about R801's fall incident on 6/21/24. They reported R801 rolled out of bed during care and they were referred for physical and occupational therapy. They reported the evaluations were completed, R801 was functioning at their baseline and they were receiving restorative nursing services. They further indicated they educated the staff member on the using the proper techniques for bed mobility.<br><br>A telephone interview was completed with a Licensed Practical Nurse (LPN) D on 7/1/24 at approximately 1:40 PM. LPN D' was the charge nurse assigned to care for R801 on 6/21/24. LPN D reported they no longer worked at the facility. LPN D was queried about the fall incident for R801 on 6/21/24. LPN D reported they remembered the incident. They added the incident happened while the Certified Nursing Assistant (CNA) was assisting R801 in the room. They further reported the CNA was assisting the resident and when R801 tried to grab the chair, they rolled out of bed. LPN C was asked where the CNA was positioned while they were trying to assist them (front or back of the resident) and LPN C reported the CNA was in the back of the resident and they did not know if the chair moved or resident misjudged and leaned too far.<br><br>An interview with Registered Nurse (RN) A who oversaw staff development was completed on 7/2/24 at approximately 9 AM. RN A was queried about R801's incident. They reported they followed up after the fall. When they were queried about how the incident happened, RN A said they did not know the events preceding the fall and reported they were focused on following up after the fall event. They also reported during their follow-up they noticed the chair at R801's bedside was broken and they replaced the chair. RN A was queried about the facility process of assisting a resident to roll in bed. They reported staff should be rolling the resident towards them and the staff member should be on the side of the resident they were attempting to roll.<br><br>A facility provided document titled Fall Management Guidelines with a revision date of 12/13/23 read in part, Fall management goals: Reduce the risk of falls by intervening in modifiable risk factors. Reduce the risk of injuries as a result of a fall .Fall Risk Evaluation:<br><br>A fall risk evaluation will be completed for residents upon admission, readmission, quarterly, and with a significant change of condition .The licensed nurse will review the resident's medical record, speak with the resident and/or their representative, and evaluate the resident to determine the resident's fall risk factors. Factors included in the fall risk evaluation include:<br><br>Mental status, History of falling within the last three months, Elimination status, Vision status<br><br>Balance while standing, transferring, and/or walking, Safety awareness, Medication use<br><br>Predisposing diseases and conditions, A comprehensive resident assessment instrument (RAI) process includes the Minimum Data Set (MDS), the Care Areas Assessment (CAA) for falls and other triggered CAAs. The MDS is an information gathering tool that assists in the identification of resident strengths and limitations. The MDS identifies several possible indicators for falls or fall risk including: fell in the past 30 days, fell in the past 31-180 days.<br><br>Wandering, Functional abilities . |