

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2025
NAME OF PROVIDER OR SUPPLIER Lake Orion Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 585 East Flint Street Lake Orion, MI 48362	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00150810, MI00150926, MI00151349</p> <p>Based on interview and record review, the facility failed to ensure one (R801) of three residents reviewed for accidents, was transferred in a safe manner with fully functioning equipment and with the proper level of assistance, resulting in the resident falling out of the mechanical lift sling and sustaining an acute impacted fracture (fracture typically caused by force or trauma) of the right hip, a distal intertrochanteric fracture (fracture between the bony protrusion of the thighbone) of the right hip, an acute intertrochanteric fracture of the left hip, and Focal round hyperdensity (spot brighter than the surrounding brain indicating an abnormality) within the right sylvian fissure (part of the brain) measuring approximately 5 mm (millimeters) .potentially representing aneurysm (bulging blood vessel) or hemorrhage (bleeding). Findings include:</p> <p>A review of a complaint submitted to the State Agency revealed an allegation that on [DATE], R801 was dropped out the (brand name for mechanical lift). There was only one care giver moving the resident. It was noted R801 was transferred to the hospital where it was determined she had broken both femurs (hips), left wrist, had a brain bleed, and heart stress. R801 had surgery on the femurs, was in the intensive care unit (ICU), and signed onto hospice services on [DATE].</p> <p>On [DATE] at 10:58 AM, the complainant provided additional information. It was reported R801 died on [DATE] and the death was deemed accidental according to the medical examiner. At that time, a copy of the death certificate was requested.</p> <p>A review of a second complaint submitted to the State Agency revealed an allegation that Certified Nursing Assistant (CNA) 'A' transferred R801 with a mechanical lift without the assistance of another CNA, did not have the sling under the resident appropriately, and R801 was dropped from the mechanical lift. It was alleged R801 had broken femur bones, a hematoma, a brain bleed, and remained hospitalized . It was further alleged CNA 'A' reported the mechanical lift was missing clamps.</p> <p>A review of a Facility Reported Incident (FRI) submitted to the State Agency revealed R801 slipped out of the mechanical lift while being transferred and sustained injuries.</p> <p>An unannounced, onsite investigation was conducted on [DATE].</p> <p>A review of R801's clinical record revealed the following:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R801 was admitted into the facility on [DATE], readmitted on [DATE], and discharged to the hospital on [DATE] with diagnoses that included: Multiple Sclerosis (MS). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition and was dependent on staff for transfers and all activities of daily living.</p> <p>A progress note dated [DATE] at 12:45 PM, written by Licensed Practical Nurse (LPN) 'C', noted, Writer called into room and upon arrival writer observed resident on floor. (CNA) stated that she was getting resident up in chair for lunch and bingo with the lift and a second person. She stated when she went to lift her up and move her she began to slide out of the sling and hit the floor. (CNA) was unable to tell if resident hit her head stating everything happen so fast. Writer assessed resident and noted large hematoma on top of resident L (left) hand, no lumps or bruises were noted to resident head at the time and resident had no c/o (complaints of) pain to her head .Resident communicating at baseline with staff. Due to the extent of resident fall a pillow was placed under resident head for comfort and resident was not moved , writer remained at resident side and sent for supervisor. Supervisor came to room and began the process of sending resident out 911. EMS (Emergency Medical Services) arrived to facility around 11:30 (AM) and resident was sent to (hospital) .</p> <p>A review of R801's care plans revealed care plan initiated on [DATE] that noted the following intervention: TF (transfer) with (brand name mechanical lift - a lift used to transfer residents who are unable to stand or assist with transfers).</p> <p>A review of R801's Imaging results from the hospital revealed the following:</p> <p>A CT (Computed Tomography) CHEST/ABDOMEN/PELVIS . completed [DATE] at 4:15 PM revealed, . REASON FOR EXAM: trauma, dropped from (mechanical lift) .Impression: 1. Acute impacted fracture in the subcapital region of the right hip. Additional distal intertrochanteric right hip fracture. 2. Acute intertrochanteric fracture of the left hip extending into the proximal left femoral shaft, incompletely visualized . 4. Suspect mildly impacted acute fracture of the distal left radius (wrist) .</p> <p>A CT HEAD WO (without) CONTRAST completed [DATE] at 4:15 PM revealed, .REASON FOR EXAM: trauma .Impression: Focal round hyperdensity within the right sylvian fissure measuring 5 mm. This appears new from prior study and is nonspecific, potentially representing aneurysm or hemorrhage .</p> <p>A review of an investigation conducted by the facility revealed the following:</p> <p>(R801) was being transferred in a (mechanical lift) by (CNA 'A'). One of the sling's loops in the arm of the lift slipped off and (R801) slid to the floor during a transfer from her bed to her wheelchair. 911 was called after complaints of leg pain. Administrator notified on ,d+[DATE] that (R801) has an acute displaced spiral fracture of bilateral femoral metadiaphysis and mild foreshortening of the right femur. She has also a suspected nondisplaced radial styloid fracture. She is currently in the hospital. The lift was immediately pulled from the floor and inspected. It appeared to be in good working order however a safety clip on the arm was not present .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>.Investigation Summary/Actions Taken .(R801) .has been bed bound for a number of years .The Administrator and Director of Nursing (DON) met with (CNA 'A') and reenacted the incident with the same lift to determine the root cause. (CNA 'A') was using the (mechanical lift) to transfer (R801) from her bed to her wheelchair. She had another staff member present (Housekeeper 'B') .(CNA 'A') lifted her off the bed and then moved the lift away from the bed. She began to turn it towards her wheelchair, which was placed at the foot of her bed. As she was turning the lift, (R801's) body weight shifted, and the sling swung out. The legs of the lift were extended but the motion moved one of the slings loops off the arm of the lift and (R801) slid out of the sling and onto the floor. She began to complain of pain in her left hip and had a large hematoma on top of her left hand .She was immediately sent to (hospital) for evaluation .</p> <p>.It was determined the next day, while reviewed hospital paperwork, that she was diagnosed with Bilateral femur fractures and suspected left radial styloid fracture .Her initial CT of her head was negative. Repeat imaging was completed and neurosurgery stated that she likely sustained a mild traumatic brain injury with the development of a very small acute subarachnoid hemorrhage (brain bleed). (R801) is set to have surgery on ,d+[DATE] to repair her fractures .The family has decided to pursue palliative care and will not be returning to (facility) .</p> <p>.Investigation showed that preventative maintenance was completed quarterly on the lift and was just serviced on [DATE] .A post incident evaluation of the lift was completed and found that the only concern was a safety clip missing from one arm .It appears that the sling loop slipped out of the arm due to the safety clip not being present .At this time, it appears the missing safety clip played a pivotal role in (R801's) fall. A full nursing staff education is being completed .This education will be focused on the proper assessment of lift equipment prior to use, how to determine what type of transfer status a resident has been approved for .</p> <p>On [DATE] at 11:19 AM, an interview was conducted with Housekeeper 'B' via the telephone. When queried about what happened to R801 on [DATE], Housekeeper 'B' explained she went into R801's room and CNA 'A' was getting R801 ready for lunch. The sling for the mechanical lift was underneath R801 and R801 was lying in bed. When CNA 'A' lifted R801 up using the lift, R801 fell out of the sling and onto the floor. Housekeeper 'B' reported there were no other staff members in the room during the transfer. When queried about whether they were cleaning R801's room at the time, Housekeeper 'B' stated, I guess I was just in there. Housekeeper 'B' reported CNA 'A' asked her to come into the room to spot her with (R801). Housekeeper 'B' explained she was just in the room and did not provide any assistance to CNA 'A' during the mechanical lift transfer of R801. Housekeeper 'B' went to get the nurse after R801 fell .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:25 AM, an interview was conducted with CNA 'A'. CNA 'A' reported she began working in the facility in [DATE] and had been a CNA for [AGE] years. When queried about how R801 fell on [DATE], CNA 'A' explained she was getting R801 up for lunch and bingo afterwards. She got R801 dressed and did her hair and placed the sling (for the mechanical lift) underneath the resident who was on the bed. CNA 'A' reported she checked the battery for the lift and that the feet of the lift were fully expanded. CNA 'A' said she had a spotter in the room with her. CNA 'A' explained she got the sling hooked up to the lift, raised the resident up in the sling, turned the resident to position her over the wheelchair, and when she did that, R801's weight shifted and she fell out of the sling from the lift and onto the floor. When queried about who was assisting her with the transfer, CNA 'A' reported Housekeeper 'B' came in to spot. When queried about why she asked a housekeeper to spot and did not get a nurse or a CNA to assist with the transfer, CNA 'A' reported the other CNA assigned to the hall was in with another resident, the CNA orientee was showering a resident, she did not know where the other CNA was, and the nurse was busy passing medications. According to CNA 'A', the paper she received during orientation regarding mechanical lift transfers only mentioned having a second person in the room as a spotter and she understood that to mean another set of eyes and not actually assisting with the transfer. CNA 'A' further reported one of the clips on the hanger bar to the lift (the part where the sling is clipped too) was missing. CNA 'A' explained that the sling is hooked onto the bar and a clip locks the sling in place. CNA 'A' reported she noticed it was missing on the hook located by R801's right leg and stated, It is what we had available and explained she continued to transfer the resident with the missing clip. CNA 'A' explained she did not think the sling would come off the hook with or without the clip because everyone had been using the mechanical lifts with missing clips, but she could see how that may have contributed to her fall because it was the side R801 fell from.</p> <p>On [DATE] at 12:58 PM, an interview was conducted with the Administrator. When queried about what was discovered through the facility's investigation into R801's fall, the Administrator reported CNA 'A' walked her through what happened and explained after examining the sling and the lift, the side R801 slipped out of was the side with the missing safety clip so they determined that to be the likely cause of R801's fall from the lift. The Administrator further reported after reviewing the facility policy regarding mechanical lift transfers at the time of R801's fall, it was discovered it said two people were required, but did not specify what that meant. It was further reported that the manufacturer's manual for the mechanical lift did not mention the safety clips so it was unclear if it was important. When queried about the purpose of the clips, the Administrator reported the clip locked the sling into place on the hook but that the importance of them was likely not clearly communicated to nursing staff. When queried about CNA 'A' asking a Housekeeper to spot during a mechanical lift transfer requiring two people to assist, the Administrator reported CNA 'A' made a bad decision and should have waited for a member of the nursing staff team to assist.</p> <p>On [DATE] at approximately 3:30 PM, an observation of the type of mechanical lift used on [DATE] with R801 was conducted. On each end of the hanger bars were hooks that secured with a metal clip. At that time, CNA 'D' was interviewed regarding the safety clips on the mechanical lifts. CNA 'D' explained before a month ago, there were times where they would be missing from the lift. CNA 'D' further said they were easy to remove and demonstrated how to remove them and stated, I have never done it, but could see someone taking the clip off because it would be easier to get the sling off the hook after the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 4:45 PM, an interview was conducted with LPN 'C'. When queried about what happened to R801, LPN 'C' reported she was notified by Housekeeper 'B' that R801 fell from the mechanical lift. LPN 'C' was not in the room when it happened, but assessed R801 after the fall. When queried about whether CNA 'A' requested assistance with transferring R801, LPN 'C' reported she did ask for assistance, but she was in the middle of administering medication. LPN 'C' reported CNA 'A' said she needed assistance, but after LPN 'C' passed the medication, CNA 'A' was in the resident's room and did not return to ask for help.</p> <p>A review of a .Discipline Employee Counseling Report dated [DATE] revealed CNA 'A' received counseling regarding not following the policy regarding lift safety and have a second person during a mechanical lift that was a trained caregiver.</p> <p>A review of a form titled, Orientation - CNA Expectations signed by CNA 'A' upon hire on [DATE] revealed, . Lifts demonstrated first time as 'spotter'/second person .</p> <p>A review of an undated facility policy titled, Resident Transfers revealed, in part, the following, .Prior to transferring the resident, refer to the Care Card for the appropriate transfer status .Safety is our primary concern with transfers .</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included inspection of all mechanical lifts to ensure they were in working order and updated the policy to include ensuring safety clips were part of the safety check process, education was provided to all licensed nursing staff to include proper safety checks of the mechanical lifts and to ensure appropriate assistance is provided according to the resident's plan of care. The facility conducted audits of staff who provide transfers using a mechanical lift to ensure they were used in a safe manner and audits of the mechanical lifts to ensure they were inspected and in proper working order. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		