STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235484	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Sterling Skilled Rehabilitation	34643 Ketsin Drive Sterling Heights, MI 48310

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake MI00147284. Based on interview and record review, the facility failed to implement interventions, assess and monitor one resident (R901) following a fall, out of three residents reviewed for falls. Findings include: A review of Intake: MI00147284 revealed the following, .Complainant states [they] received a call on 09/28/2024 at approximately 5:44PM from an unknown female 1st shift nurse informing [them] that she found the resident on the floor in [their] room .Complainant states 3 hours later, [they] got a call from a 2nd shift nurse (unknown female), informing [them] she found the resident unresponsive on the floor of her room . Complainant states [they] went to the facility on [DATE] and was told the residents chart shows that neuro-checks (Neurological exam used to assess a patient) were completed but they didn't take any fall precautions because they can't predict when or if the resident would fall again A review of R901's medical records revealed the resident was initially admitted into the facility on [DATE] with diagnoses that include Hepatic Encephalopathy, Hypokalemia, Diabetes, and Depression. Further review of the medical record revealed the resident was alert and oriented to person and place, and according to their fall assessment dated [DATE], the resident was high risk for falls. Further review of the R901's medical record revealed the resident also had a physician order for an blood thinner dated for 9/23/24, Enteric Coated Aspirin 81 mg (milligrams) tablet delayed release. Give 1 tablet by oral route one time day .Start date 9/23/24 . Further review of R901's medical record revealed the following progress notes: Entered By: [Licensed Practical Nurse (LPN) A] on 9/28/2024 8:17 pm, Type: Standard. Patient found on the floor on the right side laying, right hand on the back of her head. upon asking she denied falling from the bed. patient mentioned the she just rolled down from the bed while trying to wiping the floor. patient is alert and oriented times 2. patient had no injuries, no bleeding. patient vitals are b/p (blood pressure) 154/91, HR (heart rate) 83,osat (oxygen level) 93, RR (respirations)18. patient is in (on) aspirin. patient neuro checked had been done. [Physician] and the family member had been informed. patient bed is lower to the floor. call bell is within reach. patient had been monitor at all the time. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Entered By: [LPN B] on 9/29/2024 12:38 am, Type: Standard. Writer received resident in bed after 730pm, writer was informed in shift-to-shift report that resident had a fall at 6:30pm. Per previous nurse resident was observed on the floor next to bed laying on her right side, first neuro check initiated at 6:30pm. Writer did walking rounds before starting med pass & observed resident in bed, with bed in lowest position. At approximately 9:10pm writer was called into resident room by caregiver. Resident was observed on the floor next to her bed laying on her left side. Writer immediately rolled resident over & begin assessment, upon rolling resident over writer noted bruising over right eye, resident arms flaccid, resident grunting in response to questions, resident eyes opened spontaneous to pain/ sternum rub. Writer took several sets of vital signs due to elevated blood pressure when vital signs performed, writer had a second nurse come into the room & take a manual blood pressure to confirm the previous elevated blood pressures. Last noted blood pressure (manual) 200/160, blood glucose 177, spo2 97% on room air, pulse 81, respirations 18. Staff member stayed with resident while writer called resident physician, voicemail left for physician to contact facility as soon as possible & called 911 to transport resident to hospital due to unwitnessed fall, bruise on face & is on blood thinner. Resident was transferred to hospital via 911, family aware of incident & transfer to hospital, in house manager also aware. On 10/2/24 at 1:02 PM, an interview was completed with LPN A regarding R901's first fall, and she explained when she entered the room, the resident was on the floor, lying on their right side, with their hand on the back of their head. LPN A explained the resident told her she was attempting to wipe something off the floor and slid down. LPN A explained she contacted to physician, and did not receive an answer or return call therefore, she assessed the resident, completed a neuro check, and handed the concern over to the next shift nurse. On 10/2/24 at 1:19 PM, an attempt to reach LPN B was to no avail. A review of the Unusual Occurrence Report for R901's first fall revealed the following, What did you do to try to prevent the incident from happening again? The call light on (in) reach. Star program + (plus) Neuro checks. This report was signed by LPN A, the Director of Nursing (DON), the Physician, and the Nursing Home Administrator (NHA) on 9/30/24. A review of R901's Neuro Flow Sheet revealed the resident's name and room number, and noted R901 had one neuro check completed between her first fall at 6:30pm, and her second fall at 9:10pm. The Neuro Flow Sheet further revealed a timeline of when to Check Resident with the following times: Initial Assessment, Every 1 Hour Times 2, Every 2 Hours Times 3, Every 4 Hours Times 4, and Every Shift Times 24 Hours. On 10/2/24 at 12:48 PM, an interview was completed with the (DON) regarding R901's fall. The DON was asked about the neuro checks for R901 following her initial fall, and acknowledged additional neuro checks should have been completed however, the investigation of R901's falls are still in progress. The DON was asked about the physician not contacting the nurses back following the resident falls, and acknowledged this is an issue they are working on. On 10/2/24 at 2:10 PM, the NHA was asked about R901's fall, and explained LPN A's supervisor advised her to initiate the neuro check as a baseline and the resident reported she did not hit her head. Regarding the physician not returning the nurses' calls, she explained they did their due diligence to reach the physician per policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Fall Management Guidelines revealed the following, .3. When a fall occurs, the nurse should assess the resident for injury, and provide the appropriate first aide based on standard of practice. If there is a suspected head injury, neuro checks should be completed and contact the physician for further instruction .9. The nursing staff will assess the resident over the next 72 hours, and document in the nurses' notes to identify any possible injuries, including pain that may not be evident following a fall