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	02/18/2025

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 0689 Level of Harm - Minimal harm or potential for 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** 28776 This citation pertains to Intake MI00150202. Based on observation, interview, and record review, the facility failed to knock and announce themself prior to entering a room for one sampled resident (R803) of three reviewed for falls, resulting in a fall with a head injury. Findings include: A review of an Intake noted on 1/28/25 at 3:30 AM, the Certified Nursing Assistant (CNA) did not announce their presence by knocking and opened the door and hit R803's walker which caused R803 to fall and hit their head on the furniture. On 2/18/25 at 2:09 PM, CNA A was asked about the incident. CNA A explained they were in the day room when they heard a call light start to ring, they went to the panel to see which room it was. CNA A confirmed she did not knock before she entered R803's room because, when a call light is ringing (activated) it indicates the resident is waiting for us to come in and help. CNA A explained that R803 had to be directly behind the door when she entered, because she heard the door hit the walker and looked behind the door and saw R803 on the floor. On 2/18/25 at 2:55 PM, the camera recording was reviewed with the Nursing Home Administrator (NHA) which revealed, R803's door was at the far end from the camera, R803's call light was on, CNA A was observed to enter the resident's room, CNA A's right hand was observed to move the door to open it. A knock to announce they're entrance could not be observed. A review of R803's medical record revealed, R803 was admitted to the facility on [DATE] with diagnosis of aftercare following joint replacement surgery. R803 was readmitted to the facility after the fall on 1/31/25. A review of R803's Minimum Data Set (MDS) assessment dated [DATE] indicated R803 with an intact cognition and with a functional abilities of partial/moderate assistance- Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R803's medical record noted, progress note, Resident put on call light approx. (approximately) 3:30am. CNA (CNA A) answered right away. When CNA (CNA A) opened door to resident room, resident was directly behind the door with walker. Door hit walker and resident fell backwards hitting head on the drawer near the ground. Hematoma noted to back of head. No LOC (loss of consciousness). Resident made statement, I didn't think you'd be here that quick. I always take myself. I didn't want to make a mess all over myself. NP (Nurse Practitioner) notified, orders to send resident out. 911 called. 1/28/25 at 4:14 AM. A review of R803's incident documentation noted, Situation, Background, Assessment, and Recommendation (SBAR) communication form and progress note indicated, 1/28/25 3:47 AM, Situation: fall, hit back of head. A review of the hospital documentation revealed, History of Present Illness: ., recent left femoral neck fracture s/p (status post) left total hip arthroplasty on 1/10/25 is [R803] s/p fall. [R803] states [they were] up in the bathroom at [their] SAR (subacute rehab), when the nurse tried to come in to help [them], causing the door to hit [them] and knock [them] over. [R803] reports [they] hit [their head but denies LOC . [R803] denies any worsened hip pain. [R803] reports mild pain to the back of [their] head where [they] hit it. [R803] denies dizziness, syncope, neck pain, chest pain, shortness of breath, abdominal pain, N/V (Nausea and Vomiting), numbness and tingling. [R803] has no other complaints or concerns at this time. Hospital physical therapy note documentation dated 1/29/25 10:50 AM noted, Pertinent History of Current Functional Problem: [R803] is currently residing at a subacute rehab, on Lovenox and aspirin for DVT (deep vein thrombosis) prophylaxis. The patient states that [they] had to go to the bathroom early in the morning. As [R803] was ambulation with [their] walker, a nursing assistant accidentally opened the door into the patient's walker, causing the patient to fall backwards and strike [their] head. [They] denies any loss of consciousness. [R803] was only reporting pain to the back of the head with the associated hematoma. [R803] is denying any pain or concern elsewhere. [R803] has ambulated since the fall. A review of R803's care plan noted, Problem: Falls. With interventions put in place my risks for functional decline will be minimized Goal: With interventions put in place my risks for functional decline will be minimized Interventions: Toileting: I might need assistance with toileting and cleaning myself. Focus: Fall risk effective date 1/16/25. Etiology: My gait is unsteady. I am not always aware of my limitations. As Evidenced By: I fall when I bend over or stand up quickly. I had fallen at home. Additional Detail: I am afraid of falling. I don't want to break anything. I want to walk by myself. I don't want to ask someone to help me get up and down, but I forget I'm weak/unsteady. Goals: My risks for injuries will be reduced with interventions put in place. 3/1/25. On 2/18/25 at 2:40 PM, the Unit Manager (UM B) was asked about the incident. UM B explained R803's call light was answered within one minute, R803 has a history of getting up alone without assistance. UM B further explained, R803 is not independent with care, they need one person for assistance. UM B was asked if CNA A was supposed to knock before entering the room with the call light on. UM B confrimed they should be knocking on the door (to let the resident know they are entering). A review of the facility's policy titled, Fall Management Guidelines and the Resident Rights did not address the above concern.