STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235526	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boulder Park Terrace	14676 W Upright Charlevoix, MI 49720

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** 34568 Intake: MI00144784 Based on observation, interview and record review, the facility failed to implement appropriate interventions to prevent a fall for one Resident (R601) of three residents reviewed for falls. This deficient practice resulted in actual harm with R601 sustaining a fall with a right hip fracture requiring surgical interventions. Findings include: A review of R601's electronic medical record (EMR) revealed admission to the facility on [DATE] with diagnoses including symptoms and signs involving cognitive functions and awareness, unsteadiness on feet, and pain. R601 scored a 10/15 on the 2/27/24 Brief Interview for Mental Status (BIMS) score indicative of moderate cognitive impairment. R601 was noted to have one fall with no injury and one fall with major injury in section J of the 2/27/24 Minimum Data Set (MDS) assessment. R601's Fall Risk Assessment Tool dated 9/1/23 revealed a fall risk score of 22 points, indicative of a high fall risk. Review of the Facility Reported Incident submitted to the State Agency on 5/23/24 read, in part, .Resident (R601) had a fall on 5/20/24 at approximately 2:30 p.m. Resident initially thought to be without injury .Xray was ordered at 3:30 a.m. the morning of 5/22/24. Pain and BP (blood pressure) increased, so resident was sent to ER (emergency room) for x-ray and treatment at approximately 1 p.m. Resident was found positive for fracture that afternoon. Resident had hip displacement corrected by surgery that same afternoon . Review of the History and Physical from [Hospital Name] emergency room revealed R601 sustained an acute angulated intertrochanteric right hip fracture. (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 - Actual harm Residents Affected - Few	Review of R601's Progress Notes read, in part, 5/20/24 4:47 p.m. Resident was in her room sitting in her recliner with feet on the floor with grippy socks on her feet. Resident has been yelling wanting to drive a car. CNA (Certified Nurse Aide) and nurse in resident's room several times but resident didn't need anything. CNA called writer to residents' room, found resident lying on her left side of the floor. Resident denies hitting her head, states, she just fell . Resident is complaining of right hip pain, Medical Director (MD) D notified, hip Xray ordered. Resident was assisted to her bed with mechanical full lift and 2 CNA's. Full skin assessment resulted in no injuries or bruising noted at this present time but will continue to monitor as needed. Resident is currently lying in her bed, supine position, napping on and off, resident denies having any pain or discomfort at this time .Licensed Practical Nurse (LPN) A. Review of R601's Physician Note, dated 5/20/24 read, in part, .I was then urgently requested to see her later in the day after she attempted to self-ambulate from her reclining chair to her bed and fell on her left side .As I was leaning over her to examine her left side, she told me that it was the right side that hurts .Assessment . Cognitive impairment .Post fall I have ordered x-ray of the right hip/pelvis/knee and ankle to be done as soon as possible. I have instructed both resident and staff that she is to stay in bed until x-ray results are known . An interview was conducted with CNA B on 6/20/24 at 3:00 p.m. CNA B stated she heard an alarm going off and entered R601's room and found her on the floor. She then radioed for LPN A to come in and look at R601. CNA B stated LPN A never completed a full head to toe assessment on R601 and requested that two CNA's put her back into bed, which CNA B did and confirmed they did not use a mechanical lift but rather a gait belt and slid R601 onto the bed. CNA B confirmed MD D did exam R601 and ordered an x-ray be done as soon as possible, and R601 was to stay in bed until completed. When CNA B returned to work on 6/21/24, she was instructed to keep R601 in bed as the x-ray had not been completed. CNA B stated R601's blood pressure continued to increase but was instructed to let LPN A complete all vitals. An interview was conducted with LPN A on 6/20/24 at 3:08 p.m. LPN A stated R601 was restless all day long on 5/20/24 and wanted to spend as much time with the staff as possible. LPN A stated it was a CNA who placed R601 in her recliner chair and placed the recliner chair in an upright position, not allowing her feet to touch the floor and closed the door. LPN A stated she instructed the CNA to lay R601 in her bed as this was a restraint to have R601 in her chair unable to get out. LPN ' A stated she received a page over the radio to R601's room as she had fallen and upon entering the room did complete a full assessment. LPN A instructed two CNAs to lay R601 back in her bed and notified MD D. LPN A stated MD D took R601's chart after the assessment was completed. LPN A stated she did not receive the chart back prior to her leaving for the day but passed the information to her relief nurse. An interview was conducted with CNA C on 6/20/24 at 3:23 p.m. CNA C stated she was not R601's aide that day but did respond to the radio for assistance in R601's room. CNA C stated, when she got to R601's room, LPN A and CNA B were observing R601 who was lying on her left side facing the door into the hallway. CNA C stated she did not observe LPN A complete any post fall assessments and requested CNA B and CNA C place R601 back into her bed. CNA C confirmed they did place R601 back in bed with a gait belt, lifting and sliding her to the bed and hoisting her back. CNA C confirmed they should have used a mechanical lift to place R601 back into bed and did not receive further education on how to transfer a resident post fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 6/20/24 at 4:12 p.m. The DON confirmed she was working as a floor nurse on 5/20/24 along with LPN A. The DON stated it was LPN A who placed R601 into her wheelchair and placed the footrest in an elevated position because she was annoyed with the requests R601 was making. The DON stated she instructed LPN A to complete a bladder scan on R601, but LPN A refused. When the DON saw R601 after her fall, she confirmed R601 had to have attempted to stand from her recliner and her elevated footrest launched her onto the floor. The DON stated, according to witness statements, LPN A instructed the two CNAs to put R601 in bed and did not complete a post fall assessment and did not order for an x-ray per the physician order. An interview was conducted with R601 on 6/20/24 at 4:30 p.m. R601 was observed sitting in a recliner geri chair. R601 stated she fell a while back and continued to have pain from the fall. R601 could not explain further how she fell . Review of the termination record for LPN A read, in part, Termination 5/31/24; Violation Information; 5/20/24 Gross negligence and/or gross misconduct in the performance of duties. Violation of accepted professional standards pertaining to patient care and technical practices or ethics. Details of what occurred: On 5/20/24 you were assigned to perform a bladder scan and assist (R601) into bed due to her discomfort and restlessness. You were also asked to reach out to the doctor for a PRN (as needed) medication for anxiety as you said you had already given the resident something for anxiety that did not work. Upon investigation it was noted she did not have any PRN anxiolytic medications. Regrettably, it has come to our attention that you did not lay the resident down, which may have contributed to her falling. Furthermore, your decision to restrain the patient by putting her feet up potentially led to a distressing incident where the patient fell and sustained a hip injury. Despite the gravity of the situation, your failure to promptly follow through with the necessary verbal and written X-ray orders to rule out hip, knee, and pelvis fractures on the day of is deeply concerning. This lapse in providing essential medical care has led to a breach of our duty to ensure patient safety and well-being. Your initial explanation, citing a lack of awareness regarding the order for the X-ray, followed by a claim of incompetence in executing orders, reflects a pattern of inadequate communication and competency.