STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235541	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lodge at Taylor	22950 Northline Rd Taylor, MI 48180

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** 39465 This citation pertains to MI000151505. Based on observation, interview, and record review the facility failed to implement adequate interventions and supervision to prevent multiple falls for one (R103) of three residents reviewed for accidents, resulting in injuries and hospital visits. Findings include: On 5/6/25 at 1:30 p.m. R103 was observed in an activity room. The resident was observed attempting to propel herself in the wheelchair to exit the area. Unit Manager A was observed redirecting R103 multiple times by grabbing of the wheelchair and placing the resident back in the area. R103 was also observed motioning to UM A to move away from her when redirected by staff. R103 was non-interviewable due to cognitive impairment. On 5/6/25 at 2:20 p.m. R103's roommate was interviewed and stated, She is up all night, standing up by herself, and falls. She does not listen to anyone. Review of the electronic medical record (EMR) documented R103 was initially admitted into the facility on [DATE] with a readmission from the hospital (after a fall) on 3/14/25 with diagnoses that included impulsiveness, metabolic encephalopathy, seizure disorder, muscle weakness, bipolar disorder, generalized anxiety disorder, impulse disorder, and unspecified falls. According to the admission Minimum Data Set assessment dated [DATE], R103 had severe cognitive impairment (BIMS-2) and required extensive one-person assistance with activities of daily living. Review of the Fall care plan initially dated 2/4/25, with the last revision date of 4/30/25 documented in part the following: Resident is at risk for falls/injury related to weakness and foot drop, history of falls, attempting to ambulate without assistance, placing self on floor, cognition, behaviors, and unable to be re-directed. Goal: Reduce the risk of injury through the next review. Interventions: Keep resident in common area when awake (2/10/25). Structured activities to meet resident's needs (2/19/25). (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	Ensure the resident's room is free from accidents and hazards (2/4/25). Mat to floor next to bed (left side) (3/19/25). Low bed (2/5/25). There was no admission Fall Assessment for R103. Review of the Nursing Admission Evaluation dated 2/4/25 documented in the Safety section the following: Unsafe behaviors present: Attempts to climb over bed rails and/or get out of bed independently when they require assistance. Mobility: Unsafe wheelchair seating. The readmission Fall Risk Evaluation dated 5/1/25 documented in part the following: History of falls- During the last 90 days has the resident experienced a fall? Yes Comments- Resident continues to have multiple falls in facility due to behavior and cognition. Review of the nurse's progress notes in part documented the following falls: 2/4/25 20:53 (10:53 pm)- Writer was notified resident had fallen in room while walking unsupervised in room, fall was witnessed by roommate . R103' care plan was reviewed/updated on 2/4/25 and 2/5/25. 2/9/25 19:39 (7:39 pm)- Resident roommate turned call light on. Writer answered call light and observed resident on floor. Resident was sitting on her bottom. Resident roommate stated the resident got up out of her bed and was walking and then proceeded to fall. 2/10/2025 10:48 (10:48 am) - Writer witnessed blood on resident's left eyebrow. Resident's roommate stated resident had fallen and hit head on bed .sent resident out to the hospital . R103's care plan was reviewed/updated on 2/10/25. 2/11/2025 00:08 (12:08 am) - Resident arrived back from hospital at 2045. No new orders. Resident has 3 stitches on her left eyebrow. Bruises on left side of the body. 2/15/2025 08:12 (8:12 am) - On the morning of 2/15/25 the resident was observed sitting on bed. Writer was passing medication to the residents in (XX) resident was observed sitting on the bed with a bloody face. Writer immediately cleaned resident's face and noticed a large gash above residents left eye. Writer called 911, the resident was transported via EMS. R103's care plan was reviewed/updated on 2/19/25. 3/19/25 01:18 (1:18 am) - Resident was observed coming down the hall with laceration in the middle of her forehead . Resident sent out. Incident occurred on 3/18/25 (times not indicated). R103's care plan was reviewed/updated on 3/19/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/2025 23:28 (11:28 pm) - Patient attempted to get out of her chair and was observed on the floor. Patient was assessed, and no injuries were observed MD notified. However, there was no documented evidence the care plan was updated or revised at this time. 3/22/2025 06:55 (6:55 am) - The resident was observed by nursing staff sitting on the mat (near bedside) with blood coming from her suture site (mid forehead). However, there was no documented evidence the care plan was updated or revised at this time. 3/22/2025 23:41 (11:41 pm) - Prior to fall resident was sitting at nurse's station not in distress. At around 9:30 pm, was observed resident on the floor lying on the right side. Skin assessed. Skin redness noted at right cheek. However, there was no documented evidence the care plan was updated or revised at this time. 3/31/2025 05:34 (5:34 am) - Writer observes resident standing at desk at 5:15am writer comes to resident to assist back in chair, writer observes blood coming from forehead of patient, writer assist resident into chair, resident's wheelchair in room, writer observes a blood trail leading from resident's room to nursing station, two Cena's arrive to assist with wet towels as writer grabs supplies to tend to wound on forehead. Resident had prior stitches that have opened, resident having blood scattered over her face with blood clots . resident appears to have knot on forehead, injury to lip, and blood coming from nose with a scratch on nose . ambulance arrived for pick up. Resident leaving out at 5:40am. However, there was no documented evidence the care plan was updated or revised at this time. 4/6/2025 02:50 (2:50 am) - Prior to fall resident was observed in bed resting with no signs of distress or pain. Upon rounds Cena observed resident on bed with her previous injury on forehead bleeding and a new laceration on the bridge of her nose bleeding . However, there was no documented evidence the care plan was updated or revised at this time. 4/7/2025 09:21 - IDT Team met to discuss unwitnessed fall that occurred in resident room. Staff observed resident on her bed, bleeding from face with laceration to bridge of nose. Prior to that, the resident was sleeping in bed. Resident unable to state what occurred. Nurse assessed. Laceration cleansed. MD notified. Care Plan reviewed. Fall mat in place. Team will evaluate for bolster mattress. 4/14/2025 19:26 (7:26 pm) Resident was observed attempting to walk and fell forward onto a nurse. The nurse then slid down to floor . However, there was no documented evidence the care plan was updated or revised at this time. 4/15/2025 9:27 - IDT Team met to discuss incident with the resident. Resident got out of her wheelchair and was trying to walk. Staff member caught resident before she fell . Lowered to the ground . Care Plan reviewed. Resident is not able to be educated r/t impaired cognition and behaviors. However, there was no documented evidence the fall care plan was updated or revised at this time. 4/19/2025 21:00 (9:00 pm) - Resident was observed with swelling and bleeding to her forehead. Resident was sitting at the nurse's station when she inflicted harm to herself when she hit her head on desk . Writer notified Dr and was ordered to send resident out to the hospital. Resident was transferred by two paramedics via ambulance . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/2025 00:00 (12:00 am) - Resident observed placing self onto floor several times throughout the shift . 4/29/2025 19:51 (7:51 pm) - Patient continues to place herself onto floor and show signs of being combative and resistant to redirection for safety. Patient attempted continually to get up and threw herself onto the ground on her face Patient observed bleeding from her mouth and nose . Patient being sent out to hospital per unit manager. Care plan was reviewed/revised on 4/30/25. 5/2/2025 22:32 (11:32 pm) - While heading towards resident, observed resident stand up from wheelchair and sit down onto floor while at nursing station . However, there was no documented evidence the fall care plan was updated or revised at this time. On 5/7/25 at 1:30 p.m. the Nursing Home Administrator (NHA) was interviewed regarding R103 having multiple falls. The NHA stated, We have done everything. I don't know what to do to keep her from falling. We discussed it in the IDT meetings and talked about getting a wheelchair seat belt, but because she can't release the wheelchair seat belt, it would probably be a form of a restraint. On 5/8/25 at 11:30 a.m. Unit Manager (UM) A was asked about interventions for R103 falls that occurs during the evening/night time and UM A reported there were none for the evening and the focus was for day time. UM A added, Maybe she should have some (activities) during the night as an intervention for when she tries to get out of bed or some activities like music to help keep her calm and something to do. I think that would have helped her from so many falls. Review of the care plans revealed there was no facility follow up for bolsters for the bed documented in the nurse's progress notes or on the care plan. There were no additional interventions implemented after 3/19/25. On 5/8/25 at 1:38 p.m. the Director of Nursing (DON) presented a Structure Day Program and said the facility have currently started using the program for R103's falls. The DON stated, I think it will be helpful in preventing the residents from falling. Eleven falls is a lot and hopefully the program will be effective. Review of the facility's policy titled Fall Prevention Program dated 10/26/23 documented the following in part: Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls . Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk . When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program . Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. Interventions will be monitored for effectiveness. The care plan will be revised as needed .