STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235545	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Whitmore Lake	8633 N Main St Whitmore Lake, MI 48189

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** 34705 This citation pertains to intake: MI00145821 Based on observation, interview and record review the facility failed to: 1.) ensure the safety, 2.) implement care-planned interventions, 3.) ensure that those interventions were functional and in place; and 4.) provide timely assessment and treatment for 1 of 3 sampled residents (R104) reviewed for supervision from a total sample of 4 residents, resulting in actual harm for R104's fall with left femur fracture on 6/7/24, delay in assessment, pain and transfer to the hospital. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R104 was a [AGE] year old female admitted to the facility on [DATE], with re-admission post hospital transfer 6/11/24 following displaced transverse fracture left femur with other diagnoses that included cerebral vascular accident with left side paralysis, spastic hemiplegia left side, hypertension (high blood pressure), lupus, cervical disc disorder, anxiety, and depression. The MDS reflected R104 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. Review of the complaint intake reflected concerns that included resident supervision, staff assistance with activities of daily living, and monitoring and assessing residents. Review of the facility provided Resident Matrix, dated 7/30/24, reflected R104 had a fall with major injury. Review of R104 Nursing Progress Notes, dated 6/7/2024 at 6:00 p.m., reflected, Writer and charge nurse alerted by CNA that resident slid out of her shower chair with the assistance of CNA. Resident was assisted to the floor, next to the right side of her bed, shower chair was near the foot of the bed. Resident assisted back into her shower chair, shower provided. When resident was placed back into her bed she was c/o pain in left knee and left elbow. Left knee swollen and left antecubital swollen. Resident stated she began to slide out of her shower chair when she leaned forward to look at vaginal discharge and CNA assisted her to the floor. Resident states her left knee began hurting when she was placed back into her bed from the shower chair .NP notified .Resident's emergency contact present at bedside .DON .notified. Xray ordered of left knee and left elbow due to pain/ swelling. Neuro checks x 24 hours. (continued on next page)

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 R104 Nursing Progress Note, dated 6/11/2024 3:07 p.m., reflected, patient returned 1410 via [named transport] on stretcher alert to baseline and in no apparent distress. patient seen and treated at [named hospital] s/p fall for left distal femur fracture. spouse, CN and physician notified. no med changes. full code. general diet. Review of R104 Nursing Summary Note, dated 6/11/2024 3:36 p.m., reflected, patient returned from hospital s/p fall with dx left distal femur fx. currently she denies pain and she has a full leg immobilizer in place. Review of R104 hospital discharge summary, dated 6/10/24, reflected principle diagnosis included closed bicondylar fracture of distal femur. During an observation and interview on 7/31/24 at 1:00 p.m., R104 was laying in bed and appeared calm pleasant and able to answer questions without difficulty. R104 reported had a fall 6/7/24 in room after staff assisted her to shower chair from her bed with one person assist pivot transfer. R104 reported aid was unable to position R104 far enough back in shower chair and stepped to doorway to get assistance from other staff. R104 reported she started to slip forward out of shower chair and fell on left side. R104 reported two staff members positioned R104 back in shower chair and completed the shower and the same aid transferred R104 from the shower chair to bed with pivot transfer. R104 reported developed left knee pain that was not controlled by medication and was transferred to the hospital. R104 reported she fractured left upper leg and chose not to have surgical intervention and was discharged back to facility after couple of days with immobilizer. R104 reported had fear of showers since fall but would prefer showers over bed baths. R104 reported has been getting bed baths and reported forgot she could use shower bed instead of chair and reported staff had not offered shower bed. R104 reported after fall remained in bed because of non-removeable immobillizer and pain for several weeks. R104 reported prior to fall had generalized pain controled with once daily medications at 5/10 pain level. R104 reported after the fall with fracture during staff assisted transfer had increased pain with need for two to three doses of narcotic pain medications daily with pain up to 8/10 on scale with 10 being worst pain. Reported also now has constipation. R104 reported is hesitant to get out of bed related to fear of another fall. Request for all of R104 incident/accident reports for past three months with complete investigation send by email request on 7/31/24 at 12:49 p.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Received one Incident/Accident(IA) Report for R104 for the past three months, dated 6/7/24 at 6:00 p.m., on 7/31/24 at 2:20 p.m., with no evidence of investigation noted. The IA was titled, Slid out of Wheelchair and included description, Writer and charge nurse alerted by CNA that resident slid out of her shower chair with the assistance of CNA. Resident was assisted to the floor, next to the right side of her bed, shower chair was near the foot of the bed. Resident assisted back into her shower chair, shower provided. When resident was placed back into her bed she was c/o pain in left knee and left elbow. Left knee swollen and left antecubital swollen. The report reflected injuries observed at the time of the incident included hematoma to left knee and antecubital(elbow) area. Continued review of the report reflected R104 was alert and oriented with predisposing physiological factors that included mood/behavior, weakness/fainted, and gait imbalance. Continued review reflected incomplete form as evidenced by no documentation under predisposing situation factors or predisposing environmental factors. Review of the provided Post Fall Evaluation reflected R104 had an observed fall on 6/7/24 at 6:00 p.m. The Post Fall Evaluation reflected R104 was receiving assistance from staff per care plan. The evaluation included, Re-Creation of Last 3 Hours Before Fall, with instructions, Below, the primary nursing assistant who observed and/or assisted the guest/resident during the three hours prior to the fall was interviewed and described the life of the guest/resident before the fall . The information reflected, Pt[patient] taken to bathroom in shower chair and showered. Staff turned for moment to get supplies. Pt leaned forward and began to fall. Staff intervened and lowered patient to floor. The evaluation reflected fall huddle with no changes in fall details and root cause of fall included environmental factors/items out of reach. The Post Fall Evaluation was completed by LPN C and signed by the Interdisciplinary team. Review of R104 Care Plans, dated 10/20/23, reflected, I am at risk for fall related injury and falls R/T: Hx of CVA with L. sided weakness, chronic back pain, Lupus, Osteoarthritis, recent L. distal closed Femur Fracture with routine healing, Non ambulatory status Date Initiated: 06/11/2024 Created on: 10/20/2023 .Hoyer Lift with 2 assists for all transfers. Date Initiated: 10/27/2023 . Review of R104 Medication Administration Record(MAR), dated 6/1/24 through 6/30/24, reflected once daily use of Oxycodone 10mg 6/1/24 through 6/7/24 with pain levels less than 6/10 on scale. Continued review of MAR reflected R104 pain level 8/10 on pain scale of several occasions with use of Oxycodone 10mg two to three times daily after return from hospital on 6/11/24 post fall with fracture during staff assisted transfer without following Care Planned interventions for transfer status. Review of the Functional Abilities and Goals assessment, dated 4/23/24 and 6/12/24, reflected decline in overall activities of daily living including eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The assessment reflected decline in overall mobility. The decline was a direct result of R104's fall with fracture during staff assisted transfer without following Care planned safetly interventions on 6/7/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Received witness statements from R104 fall on 6/7/24, after second request for complete investigation, on 7/31/24 at 3:07 p.m. Review of the, Quality Assurance Interview Summary, with first interview on document, dated 6/13/24 (six days after fall), for R104. The interview reflected, CNA sat me on the shower chair and walked away to get help because wasn't fully sitting back. Toppled to the floor onto left side. CNA came back with help to put me back in shower chair. Took me into shower then was helped back to bed. Pain started to left knee after back in bed. Review of the next interview for CNA D, dated 6/10/24 (three days after fall), reflected, Went in room to get [named R104] ready for a shower. Transferred [named R104] to the shower chair. She wasn't fully sitting back in chair. Went behind chair and tried to pull resident back in chair under her arms. [named R104] didn't fully scoot back into chair. Told resident to stay here and went to doorway to get co-worker to help. When turned around to head back in room seen [named R104] leaning forward. Ran over to resident and grabbed resident under her arms from behind as she was falling forward lowering [named R104] to the floor. She was laying on her left side with legs bent up and under her. Co-worker [named CNA J] entered the room and assisted with getting resident back into the shower chair. Took resident into shower room and gave her a shower. After shower assisted [named R104] back to bed. Little while later [named R104] began complaining of pain to left knee. While placing a pillow under her knee noticed her knee was swollen. Nurse notified of pain and that resident had been lowered to the floor. Review of the next interview for CNA J, dated 6/10/24, reflected, Entered doorway after [named CNA D] called out for help with [named R104]. Upon entering room resident noted to be laying on her left side with legs bent, shower chair positioned at the head of the resident. Assisted [named CNA D] with picking [named R104] up off the floor and getting her back in shower chair then left the room. Review of the next witness statement on the page for LPN C, dated 6/11/24(five days after fall), reflected, [named R104] husband came out in hallway stating [named R104] was having pain. Went into speak with [named R104]. She told me she had ended up on the floor. Assessed resident noted swelling to left knee. Medication provided for pain, nurse manager [named Nurse Manager K] notified of fall. X-rays ordered. Review of the Neurological Assessment, dated 6/7/24 at 6:00 p.m., reflected the assessments 6:00 p.m. through 8:15 p.m. with no signature for day shift staff 6/7/24. The form appeared to have same writing for 6/7/24 for both day shift and night shift assessments. Review of R104 einteract Change of Condition Evaluation, dated 6/8/24 3:48 p.m., reflected R104 fall and uncontrolled pain with note that reflected, resident complained of pain 10/10 not relieved by Oxy or Tylenol. resident requested to go to the hospital. On call provider notified. DON notified. Husband was here and also requested resident go to the hospital. resident had a fall at 1800 on 06/07/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/1/24 at 9:37 a.m., Licensed Practical Nurse(LPN) C reported was R104 nurse on 6/7/24. LPN D reported was first aware of R104 fall on 6/7/24 when R104's husband came to LPN C about two hours after the fall around 6:00 p.m. and reported R104 was having pain related to fall earlier that day. LPN C reported spoke with R104 and completed assessment and was informed by R104 had fall during a staff assisted transfer prior to shower that day out of shower chair and was currently having pain to left leg. LPN C reported then spoke Certified Nurse Aid(CNA) D who informed LPN C that prior to R104 shower that day around 4:00 p.m. R104 slid out of shower chair and CNA D lowered R104 to the floor. LPN C reported CNA D reported R104 was placed back in shower chair with another staff assist, shower completed and R104 was transferred back to bed and then complained of pain to left leg. LPN C reported thought R104 was required hoyer lift assistance with transfers at the time of the fall. LPN C reported staff are expected to follow transfer status according to care plan and kardex. LPN C reported R104 had swelling in left knee area and complained of pain in left knee and hip area. During the interview on 8/1/24 at 9:37am, LPN C reported did not complete any neurological assessments for R104 after reported fall and was not aware of R104 fall until about two hours after event. LPN C reported staff are expected to notify nurse of all falls and not to move residents until assessed by nurse. During an interview on 8/1/24 at 9:51 a.m., CNA E reported facility process for resident falls required staff to assure resident is safe, notify nurse immediately if fall is suspected or witnessed and nurse to complete assessment prior to moving resident. CNA E reported aware of resident transfer status by reviewing the kardex. CNA E reported was not present for R104 fall on 6/7/24, however all staff received education after fall related to importance of following kardex interventions including transfer status and definitions of falls and fall policy. CNA E reported staff educated to report all falls to nurse immediately and not to move resident. During an interview on 8/1/24 at 10:03 a.m., CNA F reported had worked at the facility for over seven years and reported aware of resident needs by review of Kardex including transfer status. CNA F reported if resident fall is suspected or observed staff expected to make sure resident is safe, notify nurse and not to move resident for any reason prior to notification of the nurse. During an interview and record review on 8/1/24 at 10:15 a.m., LPN G reported would expect staff to report all falls to her immediately prior to moving residents. LPN G reported all staff received fall re-education within past 2 months and resident alerts were updated in binder observed at nurse stations that included residents at risk for falls. LPN G reported staff expected to follow resident Kardex including transfer status needs During an interview on 8/1/24 at 10:20 a.m., CNA H reported had worked at the facility for over 9 years. CNA H reported staff expected to report to nurse immediately if fall suspected or observed and not to move resident and follow resident Kardex care interventions. During an interview on 8/1/24 at 10:46 a.m., NHA A was asked (for the third time) if this surveyor had been provided with R104 complete fall investigation from 7/6/24. NHA A stated, No, we have a past non-compliance. Surveyor again requested complete investigation first requested 7/31/24 at 12:39 p.m. NHA A reported completed staff education along with past survey that exited 6/5/24 with concerns with fall supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	This surveyor requested residents with falls in from June and July 2024. During an interview and record review on 8/1/24 at 11:01 a.m., NHA A reported had not provided this surveyor with the supporting documentation of compliance yet because she was attempting to combine the recent Plan of Correction, with exit date 6/5/24 and requested Past Non-Compliance documents. NHA A reported was informed by corporate staff could provide named resident accident reports. Residents with facility falls, dated 6/1/24 through 7/19/24, reflected 38 resident falls at the facility. During a telephone interview on 8/1/24 at 11:07 a.m., CNA D reported was R104 CNA on 6/7/24 at the time of the fall between 4:00 p.m and 5:00 p.m. and had worked a double shift that day. CNA D verified witness statement and reported transferred R104 from the bed the the shower chair with one person assistance with pivot transfer. CNA D reported was unable to position R104 in shower chair correctly on own and went to bedroom door and asked CNA J to assist. CNA D reported turned around saw R104 lean foreword and ran toward R104 because she was coming out of chair and caught her under her arms and lowered R104 to floor. CNA D reported she assessed R104 by asking if she had pain and observing and CNA J assisted her transfer R104 off the floor back into the wheelchair with two person manual assist. CNA D reported proceeded to take R104 to shower room and completed shower. CNA D then reported transferred R104 from the shower chair into bed with one person pivot assist. CNA D reported was approach by LPN C who asked what had happened with R104. CNA D reported after R104 fall and shower was called to Nursing Home Administrator (NHA) A office for another resident investigation and was met by LPN C when returned to the unit to report R104 fall around 5:00 p.m. CNA D reported was suspended pending investigation. CNA D reported knows resident care needs including transfer status by asking residents and staff report and Kardex. CNA D reported had been transferring R104 with one person assist for several weeks. CNA D reported should have reviewed the Kardex and used hoyer lift per the Kardex. CNA D' reported did not think at first R104 fall on 6/7/24 was an actual fall because she was lowered to the floor so did not notify nurse prior to transferring R104 from the floor back to the shower chair with 2 person physical assist. CNA D reported was informed was terminated over a week later. During an interview and record review on 8/1/24 at 12:15 p.m., NHA A reported each fall was discussed at Quality Assurance and Performance Improvement (QAPI) meetings on 6/20/24 and 7/30/24. Review of the meeting notes, dated 6/20/24, reflected no evidence R104 fall concerns were discussed. NHA A reported completed Past Non-Compliance for R104 fall because fall was not immediately reported to the nurse and CNA staff moved resident post fall prior to nurse assessment. NHA A reported fall trends discussed at QA meetings and verified R104 fall on 6/7/24 was not issue of trending. During an interview on 8/1/24 at 12:30 p.m., Director of Nursing (DON) B reported was unable to verifiy that falls were reviewed at 6/20/24 QAPI meeting. DON B verified neurological checks completed and appeared all same writing covering more than one shift. DON B verified 6/7/24 day nurse did not sign it and reported was unsure who completed form. During an interview on 8/1/24 at 12:45 p.m., Registered Nurse (RN) K reported completed R104 incident accident report on 6/7/24 to assist floor nurse related to busy day. RN K reported was informed by CNA D that R104 was lowered to the floor and did not consider that a fall. RN K reported any change in elevation was fall and reported R104 fall should have been reported immediately to the nurse. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 8/1/24 at 2:58 p.m., LPN L report worked 6/7/24 on R104 hall after fall on night shift that started at 6:45 P.m. Received in report that R104 had fallen during the day and the nurse had not been notified until around 6:00 p.m. LPN L reported when husband arrived to the facility requested resident be sent to the hospital related to unrelieved left leg pain post fall. LPN L reported assessed R104 who continued to have elevated pain in left leg and both husband and R104 requested to be transferred to the hospital. LPN L reported called 911 services, DON B and on call provider and resident sent out. LPN L reported day nurse completed one set of neurological assessments and she completed remaining until transferred out and reported she added day shift assessment to new form. During an interview and record review on 8/1/24 at 4:10 p.m., DON B reported R104 fall on 6/7/24 was not reported immediately and when reported and R104 complained of elevated pain sent to the hospital. DON B reported started asking everyone after notified R104 had left femur fracture. DON B reported would expect staff to follow Kardex including transfer status and call nurse prior to moving resident off the floor. DON B reported the facility completed investigation that included final summary and verified was part of R104 fall investigation. Informed DON B this surveyor had not yet received R104 fall summary for 6/7/24 after three requests from to the NHA A for the complete investigation. DON B left the area and returned with a typed fall summary for R104 dated 6/7/24.(over 24 hours after request for complete investigation). DON B reported were unable to determine when fall occurred even though documented on incident/accident report at 6:00 p. m. DON B reported knows fall occurred earlier in day and reported R104 shower was documented as given at 2:58 p.m.(not part of investigation). DON B reported wound expect staff to follow facility Fall Policy. DON B verified the Post Fall investigation was completed by the day nurse on 6/7/24 who was confused about where the fall took place and verified had indicated was in shower room but did occur in resident room. Continued review of R104 fall summary included, In Conclusion: Action Taken: Resident was assessed, The resident MD and RP were notified of the resident occurrence, X-ray ordered, Pain Medication offered, Care plan updated. No mention that R104 Care Plan and Kardex were not followed related transfer status of Hoyer lift of three staff assisted transfers and no mention of staff moving resident post fall without notifying nurse or delay in notification. As a direct result of R104 staff assisted transfer with fall and fracture on 6/7/24 R104 has increased pain and need for increase in pain medications with increased likelihood of constipation, decrease in activity related to fear of transfers and overall increased likelihood of worsening depressing. Review of the Fall Management Policy, dated 9/22/23, reflected, Fall Defined: Fall refers to unintentionally coming to rest on the ground .When a fall occurs, the licensed nurse will evaluate the resident for injury. Do not move the individual until he/she had been examined by a nurse. The first responder (first person to identify that the resident has fallen) will summon a nurse after ensuring the resident is safe, and then ask the resident what they were attempting to do. A hall huddle will be held to determine the root cause of the fall .