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	10/09/2024

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical restraints imposed for the purpose of convenience in 1 of 1 resident (Resident #1) reviewed for restraints, resulting in the restriction of mobility and a potential for decline in physical functioning and psychosocial wellbeing. Findings Include: Review of the medical record revealed Resident #1 (R1) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness, dementia, and left femur fracture. The Minimum Data Set (MDS) dated [DATE] revealed R1 scored 1 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and required partial to moderate assist for rolling left to right in bed and substantial to moderate assist for transfers. On 10/9/24 at 9:35 AM, R1's door was shut. Upon entering the room, R1 was observed in bed, dressed in a gown. He was attempting to get out of bed independently. R1 was pleasant and conversant but with non-sensical answers to questions. The bed was positioned against the wall, with R1's legs hanging off the open side of the bed. His upper body was also hanging over the top half of the bed, and he was using the fitted sheet to pull himself toward the edge. Further observation revealed a foam wedge placed underneath the fitted sheet. Although the foam wedge was not directly under the resident, it appeared to be used to keep him contained in the bed. The wedge was triangular, measuring approximately 15 inches in width and 5 inches in height. It became evident during the observation that the foam wedge was the only thing preventing R1 from exiting the bed. While standing and attempting to interview R1, R1 continued to use his upper body to pull at the sheet in an attempt to exit his bed. A geriatric chair (geri-chair) was observed parked next to R1's bed. Geri-chairs specialized reclining chairs for residents who require more support or versatility than a conventional wheelchair. Geri chairs are typically padded and often come with various adjustable positions, including reclining and leg elevation. A geri-chair is ideal for residents who experience mobility issues. Geri-chairs cannot be propelled by the user, hence restrict movement in a resident that is able to propel in a manual wheelchair. On 10/10/25 at 9:16 AM, Certified Nursing Assistant (CNA) H entered the room. When queried what the purpose of the foam wedge was, CNA H stated that she was unsure, and that the foam wedge was underneath the fitted sheet when she started her shift. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 9:17 AM, Licensed Practical Nurse K entered the room. When asked what the purpose of the foam wedge was, LPN K stated that he was not sure and would have to look it up. Review of R1's Care plan revealed a Risk for Falls focus area initiated on 3/28/24. Interventions included encourage positioning of me nearer to/in view of staff when in day room which was created on 8/6/24. The same Care Plan listed another intervention which stated bed against wall to encourage entrance/exit right . initiated on 10/4/24. Review of an Incident report dated 8/2/24 revealed R1 experienced a fall when he reportedly stepped out of his geri-chair and lowered himself to the floor. Per the incident report, the intervention implemented after the fall was to encourage positioning of R1 nearer to/in view of staff when in day room (dining room and day room are the same room and will be used interchangeably). In an interview on 10/9/24 at 10:15 AM, LPN F confirmed that she was working on 9/20/24 when R1 experienced a fall. LPN F stated that R1 was reclined in his geri chair in the day room. LPN F she had stepped off the unit and when I came back, I saw him [R1] on the ground next to the geri chair. LPN F stated that there was only one CNA on the unit when R1 experienced his fall. In an interview on 10/9/24, CNA I reported familiarity with R1. CNA I reported that she was working on the day R1 was transferred to the hospital. CNA I reported observing thigh and groin bruising on R1 during care, which was reported to nursing. CNA I stated that staff was aware of the bruising, and had been waiting for x-ray to come image the left pelvic area for a couple of days. CNA I verified that R1 attempts to get out of bed and had observed him attempting to get out of bed or sitting up on the side of the bed after being laid down for the night. CNA I stated that she had been instructed to place a wedge underneath his sheet to try and keep him form getting out of bed . CNA I verified that R1 was able to propel himself around the unit in a manual wheelchair. In an interview on 10/9/24 at 2:57 pm LPN D stated that R1's family came in and noticed that his left leg was swollen, which was reported to staff. The Physician ordered stat x-rays on 9/24/24. LPN D stated that she assessed R1's leg and noticed that it was swollen and R1 was not able to lift his left leg. LPN D stated that the x-ray service had not arrived to the facility, so around 1 or 2 AM, LPN D called for a status update and was told that the x-ray service would be there in the morning. LPN D stated that the x-ray service did not show up to obtain the x-ray unit around 8:00 PM the following night (9/25/24), however, R1 had already been transferred out to the hospital. He is a busy guy, moves around and propels all over the unit. LPN D reported that R1 was a bust guy and would often self propel himself around the unit in a manual wheelchair. LPN D stated that at night, R1 tends to get fidgety so staff moved his bed up against the wall and placed the wedge on the other side of the bed in an attempt to keep him in bed and maintain his own safety. LPN D stated that since the placement of the wedge, R1 had not been successful in climbing out of bed. In an interview on 10/10/24 at 10:24 AM, Family Member (FM) R reported that they visit often. FM R stated that prior to the fall with fracture, R1 wound get into his manual wheelchair and self propel throughout the unit, as R1 is a very busy man. FM R stated that on the weekend, staff have a tendency to keep him in his geri-chair and reported to FM R that the purpose of the geri-chair is so that he cant get out and staff can watch him. FM R stated that often times, staff would place a standard chair under the footrest of the geri-chair so that R1 would not be able to lower the legs of the geri-chair and stand up. When the legs on the geri-chair were locked, R1 will attempt to exit the chair by crawling out of the geri-chair. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/10/24 at 10:41 AM LPN K stated that he and R1 had a good relationship and R1 has a tendency to get very restless in the geri-chair, however, once placed in a manual wheelchair which allows him to self propel around the unit, R1 seemed to be more content. LPN K reported that he would not use the geri-chair much prior to R1's fall with fracture, however, now the geri-chair is ordered to ensure R1 elevated his legs. LPN 'K stated that he had observed the leg's of the geri-chair being fixed in place and immovable with the use of a standard chair under the geri-chair legs. In an interview on 10/10/24 at 12:26 PM, CNA Q stated that fall prevention strategies for R1 included ensuring he is in view of staff at all times because R1 does not like to stay in his geri-chair. CNA Q stated that R1 enjoys propelling around in a manual wheelchair, however, CNA Q is instructed to place R1 in a geri-chair for safety. CNA Q stated that it was possible that the standard chair being placed underneath the geri-chair legs was due to the footrest of the geri-chair being broken. CNA Q reported that the purpose of the wedge on the perimeter of R1 bed was to ensure that he does not fall out of bed. Review of the Physician Order revealed an order for a geri-chair which was initiated on 10/3/24. In an interview on 10/10/24 at 12:59 PM, Director of Nursing (DON) B was queried about the wedge and the use of the geri-chair, DON B stated that it was her understand that the wedge should be used for positioning purposes only, and if correctly utilized, the wedge should be underneath the resident. The geri-chair was ordered post readmission to aide in elevating R1's lower extremities, however, DON B stated when R1 is awake and active, he should be placed in a manual wheelchair to allow for movement for R1. DON B stated that R1 was a very active man and a former runner, so he enjoyed having the ability to self propel in a wheelchair. DON B was unable to locate a work order for R1's geri-chair and was unaware of the chair being broken.

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(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** 46954 Based on observation, interview, and record review the facility failed to obtain an x-ray in a timely manner for 1 (Resident #1) of 3 reviewed for delay of care, resulting in a resident not receiving timely treatment for a hip and femur fracture. Findings include: Review of the medical record revealed Resident #1 (R1) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness, dementia, and left femur fracture. The Minimum Data Set (MDS) dated [DATE] revealed R1 scored 1 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and required partial to moderate assist for rolling left to right in bed and substantial to moderate assist for transfers. On 10/9/24 at 9:35 AM, R1's door was shut. Upon entering the room, R1 was observed in bed, dressed in a gown. He was attempting to get out of bed independently. R1 was pleasant and conversant but with non-sensical answers to questions. The bed was positioned against the wall, with R1's legs hanging off the open side of the bed. His upper body was also hanging over the top half of the bed, and he was using the fitted sheet to pull himself toward the edge. In an interview on 10/9/24 at 9:55 AM, CNA J reported that she was familiar with R1 and his care needs, CNA J stated that R1 was a fall risk. CNA J stated that on 9/21/24 during care, CNA J discovered significant bruising to the scrotum and groin area of R1. CNA J stated that she was shocked by the amount of bruising and swelling, and immediately notified the nurse on duty. CNA J verified that R1 was mobile and was able to self propel in a standard wheelchair. Review of an Incident report dated 8/2/24 revealed R1 experienced a fall when he reportedly stepped out of his geri-chair and lowered himself to the floor. Per the incident report, he intervention implemented after the fall was to encourage positioning of R1 nearer to/in view of staff when in day room (dining room and day room are the same room and will be used interchangeably). Review of an Incident reported dated 8/3/24 revealed R1 experienced a fall. The Incident report stated writer exited dining room for less than two minutes. When writer entered back in room, patient [R1] was on buttocks, scooting on floor next to chair . The Incident report confirmed the fall was unwitnessed and the intervention listed on the same Incident report was again, to encourage positioning of R1 nearer to/in view of staff when in day room. Review of an Incident Report dated 9/20/24 revealed R1 experienced another fall. The Incident Report stated resident [R1] observed on floor in dining room laying on side next to geri-chair . Following an assessment, R1 was assisted into a standard wheelchair. In an interview on 10/9/24 at 10:15 AM, LPN F confirmed that she was working on 9/20/24 when R1 experienced a fall. LPN F stated that R1 was reclined in his geri chair in the day room. LPN F she had stepped off the unit and when I came back, I saw him [R1] on the ground next to the geri chair. LPN F stated that there was only one CNA on the unit when R1 experienced his fall. Review of an Nurses Note dated 9/24/2024 at 11:54 AM revealed Family notified writer of swelling to left thigh. NP (nurse reactionary) notified . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Regency at Whitmore Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 8633 N Main St Whitmore Lake, MI 48189	

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(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	Review of the Physician order's revealed that a stat (as soon as possible) x-ray was ordered on 9/24/24 at 3:25 PM. Review of a Nurses Note dated 9/24/2024 at 9:44 PM revealed 21:44 Residents left thigh and hip area swollen. Not moving left leg. X-Ray's of left hip and Femur were ordered . Review of a Nurses Note on 9/25/2024 at 1:58 AM revealed Called [radiology] concerning X-ray's have not been completed. Stated they will be out in the morning . In an interview on 10/9/24, CNA I reported familiarity with R1. CNA I reported that she was working on the day R1 was transferred to the hospital. CNA I reported observing thigh and groin bruising on R1 during care, which was reported to nursing. CNA I stated that staff was aware of the bruising, and had been waiting for x-ray to come image the left pelvic area for a couple of days. CNA I verified that R1 attempts to get out of bed and had observed him attempting to get out of bed or sitting up on the side of the bed after being laid down for the night. CNA I stated that she had been instructed to place a wedge underneath his sheet to try and keep him form getting out of bed . CNA I verified that R1 was able to propel himself around the unit in a manual wheelchair. In an interview on 10/9/24 at 2:57 pm LPN D stated that R1's family came in and noticed that his left leg was swollen, which was reported to staff. The Physician ordered stat x-rays on 9/24/24. LPN D stated that she assessed R1's leg and noticed that it was swollen and R1 was not able to lift his left leg. LPN D stated that the x-ray service had not arrived to the facility, so around 1 or 2 AM, LPN D called for a status update and was told that the x-ray service would be there in the morning. LPN D stated that the x-ray service did not show up to obtain the x-ray unit around 8:00 PM the following night (9/25/24), however, R1 had already been transferred out to the hospital. He is a busy guy, move around and propels all over the unit. LPN D reported that R1 was a bust guy and would often self propel himself around the unit in a manual wheelchair. LPN D stated that at night, R1 tends to get fidgety so staff moved his bed up against the wall and placed the wedge on the other side of the bed in an attempt to keep him in bed and maintain hi safety. LPN D stated that since the placement of the wedge, R1 had not been successful in climbing out of bed. In an interview on 10/10/24 at 10:41 AM LPN K stated that he initiated R1's transfer to the hospital on 9/25/24. LPN K stated that R1's leg was bruised and appeared to be weaker. LPN K stated that the stat x-ray should have arrived within 6 hours and acknowledged that there was a delay in obtaining imaging on R1's left leg. LPN K stated that he and R1 had a good relationship and R1 has a tendency to get very restless in the geri-chair, however, once placed in a manual wheelchair which allows him to self propel around the unit, R1 seemed to be more content. LPN K reported that he would not use the geri-chair much prior to R1's fall with fracture, however, now the geri-chair is ordered to ensure R1 elevated his legs. LPN 'K stated that he had observed the leg's of the geri-chair being fixed in place and immovable with the use of a standard chair under the geri-chair legs. Review of a Nurses Note dated 9?25/24 at 1:05 PM revealed R1 was transferred out to the hospital. Review of a Nurses Note dated 10/2/2024 at 8:53 PM revealed R1 readmitted to the facility after a hospitalization . (continued on next page)

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(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	Review of the Hospital paperwork dated 9/25/24 revealed R1 was being seen for leg pain for a fall that occurred five days prior. Imaging showed an acute left distal femoral shaft periprostetic fracture and chronic subcapital femoral neck fracture .Orthopedic was consulted who recommended operative fixation. In an interview on 10/10/24 at 12:59 PM, Director of Nursing (DON) B confirmed that R1's fall was unwitnessed and R1 should have had a staff member in the room to provide supervision. Regarding the delay on the x-ray, DON B stated that the stat x-ray should have been completed within the shift and concerns regarding the delay of obtaining the x-ray were currently being discussed by the interdisciplinary team.

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(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** 46954 Based on observation, interview and record review, the facility failed to develop and implement interventions to prevent falls for one (Resident #1) of three reviewed for falls, resulting in a fall with major injury. Findings include: Review of the medical record revealed Resident #1 (R1) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle weakness, dementia, and left femur fracture. The Minimum Data Set (MDS) dated [DATE] revealed R1 scored 1 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and required partial to moderate assist for rolling left to right in bed and substantial to moderate assist for transfers. On 10/9/24 at 9:35 AM, R1's door was shut. Upon entering the room, R1 was observed in bed, dressed in a gown. He was attempting to get out of bed independently. R1 was pleasant and conversant but with non-sensical answers to questions. The bed was positioned against the wall, with R1's legs hanging off the open side of the bed. His upper body was also hanging over the top half of the bed, and he was using the fitted sheet to pull himself toward the edge. Further observation revealed a foam wedge placed underneath the fitted sheet. Although the foam wedge was not directly under the resident, it appeared to be used to keep him contained in the bed. The wedge was triangular, measuring approximately 15 inches in width and 5 inches in height. It became evident during the observation that the foam wedge was the only thing preventing R1 from exiting the bed. While standing and attempting to interview R1, R1 continued to use his upper body to pull at the sheet in an attempt to exit his bed. A geriatric chair (geri-chair) was observed parked next to R1's bed. Geri-chairs specialized reclining chairs for residents who require more support or versatility than a conventional wheelchair. Geri chairs are typically padded and often come with various adjustable positions, including reclining and leg elevation. A geri-chair is ideal for residents who experience mobility issues. Geri-chairs cannot be propelled by the user, hence restrict movement in a resident that is able to propel in a manual wheelchair. On 10/10/25 at 9:16 AM, Certified Nursing Assistant (CNA) H entered the room. When queried what the purpose of the foam wedge was, CNA H stated that she was unsure, and that the foam wedge was underneath the fitted sheet when she started her shift. On 10/10/24 at 9:17 AM, Licensed Practical Nurse K entered the room. When asked what the purpose of the foam wedge was, LPN K stated that he was not sure and would have to look it up. In an interview on 10/9/24 at 9:55 AM, CNA J reported that she was familiar with R1 and his care needs, CNA J stated that R1 was a fall risk. CNA J stated that on 9/21/24 during care, CNA j discovered significant bruising to the scrotum and groin area of R1. CNA J stated that she was shocked by the amount of bruising and swelling, and immediately notified the nurse on duty. CNA J verified that R1 was mobile and was able to self propel in a standard wheelchair. (continued on next page)

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(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	Review of R1's Care plan revealed a Risk for Falls focus area initiated on 3/28/24. Interventions included encourage positioning of me nearer to/in view of staff when in day room which was created on 8/6/24. The same Care Plan listed another intervention which stated bed against wall to encourage entrance/exit right . initiated on 10/4/24. Review of an Incident report dated 8/2/24 revealed R1 experienced a fall when he reportedly stepped out of his geri-chair and lowered himself to the floor. Per the incident report, he intervention implemented after the fall was to encourage positioning of R1 nearer to/in view of staff when in day room (dining room and day room are the same room and will be used interchangeably). Review of an Incident reported dated 8/3/24 revealed R1 experienced a fall. The Incident report stated writer exited dining room for less than two minutes. When writer entered back in room, patient [R1] was on buttocks, scooting on floor next to chair . The Incident report confirmed the fall was unwitnessed and the intervention listed on the same Incident report was again, to encourage positioning of R1 nearer to/in view of staff when in day room. Review of an Incident Report dated 9/20/24 revealed R1 experienced another fall. The Incident Report stated resident [R1] observed on floor in dining room laying on side next to geri-chair . Following an assessment, R1 was assisted into a standard wheelchair. In an interview on 10/9/24 at 10:15 AM, LPN F confirmed that she was working on 9/20/24 when R1 experienced a fall. LPN F stated that R1 was reclined in his geri chair in the day room. LPN F she had stepped off the unit and when I came back, I saw him [R1] on the ground next to the geri chair. LPN F stated that there was only one CNA on the unit when R1 experienced his fall. Review of an Nurses Note dated 9/24/2024 at 11:54 AM revealed Family notified writer of swelling to left thigh. NP (nurse reactionary) notified . Review of the Physician order's revealed that a stat (as soon as possible) x-ray was ordered on 9/24/24 at 3:25 PM. Review of a Nurses Note dated 9/24/2024 at 9:44 PM revealed 21:44 Residents left thigh and hip area swollen. Not moving left leg. X-Ray's of left hip and Femur were ordered . Review of a Nurses Note on 9/25/2024 at 1:58 AM revealed Called [radiology] concerning X-ray's have not been completed. Stated they will be out in the morning . In an interview on 10/9/24, CNA I reported familiarity with R1. CNA I reported that she was working on the day R1 was transferred to the hospital. CNA I reported observing thigh and groin bruising on R1 during care, which was reported to nursing. CNA I stated that staff was aware of the bruising, and had been waiting for x-ray to come image the left pelvic area for a couple of days. CNA I verified that R1 attempts to get out of bed and had observed him attempting to get out of bed or sitting up on the side of the bed after being laid down for the night. CNA I stated that she had been instructed to place a wedge underneath his sheet to try and keep him form getting out of bed . CNA I verified that R1 was able to propel himself around the unit in a manual wheelchair. (continued on next page)

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(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	In an interview on 10/9/24 at 2:57 pm LPN D stated that R1's family came in and noticed that his left leg was swollen, which was reported to staff. The Physician ordered stat x-rays on 9/24/24. LPN D stated that she assessed R1's leg and noticed that it was swollen and R1 was not able to lift his left leg. LPN D stated that the x-ray service had not arrived to the facility, so around 1 or 2 AM, LPN D called for a status update and was told that the x-ray service would be there in the morning. LPN D stated that the x-ray service did not show up to obtain the x-ray unit around 8:00 PM the following night (9/25/24), however, R1 had already been transferred out to the hospital. He is a busy guy, move around and propels all over the unit. LPN D reported that R1 was a bust guy and would often self propel himself around the unit in a manual wheelchair. LPN D stated that at night, R1 tends to get fidgety so staff moved his bed up against the wall and placed the wedge on the other side of the bed in an attempt to keep him in bed and maintain hi safety. LPN D stated that since the placement of the wedge, R1 had not been successful in climbing out of bed. In an interview on 10/10/24 at 10:24 AM, Family Member (FM) R reported that they visit often. FM R stated that prior to the fall with fracture, R1 wound get into his manual wheelchair and self propel throughout the unit, as R1 is a very busy man. FM R stated that on the weekend, staff have a tendency to keep him in his geri-chair and reported to FM R that the purpose of the geri-chair is so that he cant get out and staff can watch him. FM R stated that often times, staff would place a standard chair under the footrest of the geri-chair so that R1 would not be able to lower the legs of the geri-chair and stand up. When the legs on the geri-chair were locked, R1 will attempt to exit the chair by crawling out of the geri-chair. In an interview on 10/10/24 at 10:41 AM LPN K stated that he initiated R1's transfer to the hospital on 9/25/24. LPN K stated that R1's leg was bruised and appeared to be weaker. LPN K stated that the stat x-ray should have arrived within 6 hours and acknowledged that there was a delay in obtaining imaging on R1's left leg. LPN K stated that he and R1 had a good relationship and R1 has a tendency to get very restless in the geri-chair, however, once placed in a manual wheelchair which allows him to self propel around the unit, R1 seemed to be more content. LPN K reported that he would not use the geri-chair much prior to R1's fall with fracture, however, now the geri-chair is ordered to ensure R1 elevated his legs. LPN 'K stated that he had observed the leg's of the geri-chair being fixed in place and immovable with the use of a standard chair under the geri-chair legs. In an interview on 10/10/24 at 12:26 PM, CNA Q stated that fall prevention strategies for R1 included ensuring he is in view of staff at all times because R1 does not like to stay in his geri-chair. CNA Q stated that R1 enjoys propelling around in a manual wheelchair, however, CNA Q is instructed to place R1 in a geri-chair for safety. CNA Q stated that it was possible that the standard chair being placed underneath the geri-chair legs was due to the footrest of the geri-chair being broken. CNA Q reported that the purpose of the wedge on the perimeter of R1 bed was to ensure that he does not fall out of bed. Review of a Nurses Note dated 9?25/24 at 1:05 PM revealed R1 was transferred out to the hospital. Review of a Nurses Note dated 10/2/2024 at 8:53 PM revealed R1 readmitted to the facility after a hospitalization . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235545	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Regency at Whitmore Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 8633 N Main St Whitmore Lake, MI 48189	

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(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	Review of the Hospital paperwork dated 9/25/24 revealed R1 was being seen for leg pain for a fall that occurred five days prior. Imaging showed an acute left distal femoral shaft periprostetic fracture and chronic subcapital femoral neck fracture .Orthopedic was consulted who recommended operative fixation. Review of the Physician Order revealed an order for a geri-chair which was iniated on 10/3/24. In an interview on 10/10/24 at 12:59 PM, Director of Nursing (DON) B confirmed that R1's fall was unwitnessed and R1 should have had a staff member in the room to provide supervision. Regarding the delay on the x-ray, DON B stated that the stat x-ray should have been completed within the shift and concerns regarding the delay of obtaining the x-ray were currently being discussed by the interdisciplinary team. When queried about the wedge and the use of the geri-chair, DON B stated that it was her understand that the wedge should be used for positioning purposes only, and if correctly utilized, the wedge should be underneath the resident. The geri-chair was ordered post readmission to aide in elevating R1's lower extremities, however, DON B stated when R1 is awake and active, he should be placed in a manual wheelchair to allow for movement for R1. DON B stated that R1 was a very active man and a former runner, so he enjoyed having the ability to self propel in a wheelchair. DON B was unable to locate a work order for R1's geri-chair and was unaware of the chair being broken.