STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235567	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsdale Hospital McGuire and MacRitchie Ltcu	168 South Howell St Hillsdale, MI 49242

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34705 Based on observation, interview and record review, the facility failed to competently assess and monitor for changes in condition and notify the physician of pertinent findings in a timely manner for 1 residents (Resident #3) resulting in potential for unrecognized, clinically significant changes in condition. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R3 was a [AGE] year old female admitted to the facility on [DATE], with re-admission post hospital admission 4/18/24 following displaced spiral fracture of the right femur and multiple pulmonary emboli with other diagnoses that included muscle weakness, repeat falls, history right hip replacement, lumbar vertebra fracture(low back), heart failure, hypertension(high blood pressure), and developmental delay. The MDS reflected R3 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was cognitively intact with no behaviors including rejection of care. Continued review of the significant change MDS, dated [DATE], reflected R3 dependent on staff for transfers, bed mobility, dressing, bathing, and toileting. During an observation on 10/01/24 at 10:47 AM, R3 was observed self propelling wheelchair in hall with bilateral arms with bilateral feet resting on foot pedals. During an observation on 10/01/24 at 12:40 PM, R3 was again self propelling wheelchair out to patio. R3 appeared in pleasant mood with minimal difficulty answering questions. R3 reported did not recall recent hospital transfer. Review of the Electronic Medical Record(EMR), dated 4/18/24 to current, reflected readmission with new diagnosis that included displaced spiral fracture of shaft of right femur. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3 Nurse Progress Note, entered as LATE ENTRY on 4/3/24 at 9:39 p.m., with effective date 3/31/24 at 6:55 p.m., reflected, Responded to CNA[certified nurse aide] call for assistance with Resident mid-shift change. Writer, followed by Day-shift nurse, walked into Resident room to discover Resident holstered upward suspended by arms in sling on sit-to-stand in upright position with bilateral legs bent down toward the floor. For safety, Writer and Day-shift nurse agreed to lower Resident down to the floor due to visible discomfort evidenced by Resident's bilateral arms noted holstered up in sling while suspended in sit-to-stand for greater than 10 minutes. Once lowered to the floor, pillows were placed under Resident for comfort while lying down on the floor until CNA returned with Hoyer lift. When Hoyer lift arrived, Writer, Day-shift nurse, and CNA worked together to place the sling under Resident, carefully lift Resident from the floor, and transfer Resident to the bed. No immediate signs or symptoms of injury were noted after Resident was positioned for safety and comfort while lying in bed. Resident admitted to pain present, stating, I hurt allover. Refused PRN Tylenol offered stating, It doesn't work. Agreeable to waiting for scheduled pain patch replacement. Sling removed; call light placed within reach. Plan of care followed with monitoring continued throughout shift. Note was completed by Licensed Practical Nurse (LPN) N. Review of R3 Nurse Note, dated 4/1/2024 at 1:35 a.m., reflected, Late Entry[4/3/24] Note Text: Responded to CNA report of change noted to Resident skin at right outer thigh. Reddened area appearing bruised noted at right outer thigh. Admits to soreness to touch at the site. Agreeable to ice placed on affected area at the time. Small, reddened area appearing bruised noted to front left knee. Admits to tolerating pain at left knee. Responding well as possible to pain patch replaced as scheduled during this shift AEB uninterrupted sleep continued through the night. POC followed with monitoring continued throughout shift. Note was completed by LPN N. Review of R3 Nurse Progress note, dated 4/3/2024 at 9:39 a.m., reflected, New skin condition. Large bruise noted on lateral right thigh and knee. Right knee swollen [named Medical Director O] notified and XR ordered. ' Note completed by Registered Nurse(RN) D. Review of R3 Nurse Progress Note, dated 4/3/24 at 1:25 PM, reflected, Right femur XR results: Severely displaced spiral fracture of the distal femoral diaphysis. [named MD O] and [named] (guardian) made aware. Resident is being transferred to ER. During an observation and interview on 10/02/24 at 9:55 AM, R3 was self propelling wheelchair down hall and reported was in pain all over and staff had given scheduled pain medications. NHA A provided one Incident Accident Report for R3 on 10/02/24 at 1:55 PM, dated 4/3/24 at 8:25 p.m. (incident actually occured 3/31/24). Review of the report titled, Fall During Staff Assist, reflected, Incident Description .In response to CNA call for assistance the Resident Writer walked into Resident room followed by Day-shift nurse to discover Resident suspended by arms in sling on sit-to-stand in upright position with bilateral legs bend to the downwards. Continued review of the incident report reflected, Reported by CNA, Resident let go of sit-to-stand bar during transfer, knees together and bent over to one side. The report reflected R3 responsible party was notified 4/3/24(three days after fall), and physician was notified 4/1/24(12 hours after fall). The report included summary of investigation completed by Nurse Manager B. The reported included, Deficiencies: Education for CNAs and reporting, Education thinking things are normal passing on as abnormal, Understanding of what need reported by agency staff (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/24 at 2:54 PM, Medical Director(MD) O reported was unable to recall when he was notified of R3 fall that resulted in right femur fracture on 4/3/24. MD O reported would expect staff to call and notify him of all falls at the time fall. During an interview on 10/02/24 at 3:27 PM, Nurse Manager B Reported was responsible for staff education. Requested evidence of staff education for sit-to-stand prior to R3 incident 3/31/24. During an interview on 10/02/24 at 3:50 PM, Nurse Manager B reported would expect nurse staff to assess resident post fall including pain and skin and document in progress notes and complete risk management form(Incident/Accident form) at the time of the fall. During an interview on 10/2/24 at 4:40 PM, LPN F reported worked 4/1/24 days shift and was told in report about R3 fall from 3/31/24 from the sit-to-stand by RN N. LPN F reported R3 used sit-to-stand 4/1/24 with no more pain than resident usually reported. LPN F reported was under the impression the physician had already been contacted. LPN F reported after fall staff expected to complete fall check list including risk management form(Incident/accident form), along with progress note that includes details of fall and what was done,according to check list, for 24 and 48 hours. LPN F reported after fall staff expected to contact physician and responsible party and document details. During a telephone interview on 10/03/24 at 10:03 AM, RN P reported encouraged staff to use two staff for transfers because R3 and was unsure if anyone told CNA Q who was newer a newer staff. RN P reported CNA Q had transferred R3 on 3/31/24 with 1 person assist with use of sit-to-stand. RN P reported her and night shift nurse entered R3 room about 7:00 p.m. and observed CNA Q attempting to lower R3 to the ground with R3 in a squatted position. The three staff lowered R3 to the ground and R3's right leg was tucked under left leg and RN P was unable to recall who disconnected or how, when sit-to-stand straps were disconnected. RN P reported LPN N completed assessment. LPN P reported was not in room when R3 was transferred back to bed. RN P reported management provided staff education after R3 fall that included sit-to-stand training, fall process including to follow Post Fall Checklist that included assessment, notify physician, house manager, responsible party, document in EMR assessment including pain, location, when, how, who notified, new orders, and add order for every shift charting for 48 hours. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3 Hospital History and Physical(H&P), dated 4/3/24, reflected chief complaint was leg pain. The document reflected, History of Present Illness .She presents here, transferred from [named facility Hospital] for RIGHT femoral fracture s/p a reported fall at the SNF .[named R3] reportedly lives at [named facility]; she is wheelchair/bed-bound at baseline requiring multiple people to assist with transfers to and from her chair/bed, but she reportedly fell out of bed 2-3 days ago. She was brought to the [named local] ER earlier today where it was discovered that she had suffered a RIGHT femoral fracture and was thus transferred to our ER. Per the ED physician, she arrived in no acute distress and hemodynamically stable (apart from tachycardia), saturating well on room air; patient's presentation was suspicious for potential thrombotic/embolic process due to evidence that the extended femoral fracture had not been reduced, thus patient was pan scanned with a CT chest revealing evidence concerning for multiple bilateral pulmonary emboli . Continued review of the H&P reflected, Physical exam: Marked swelling to right proximal lower extremity, with obvious shortening and deformity .Bruising and ecchymosis present on the lateral aspect of the RIGHT lower extremity extending from the hip/upper thigh through the knee .Plan .heparin infusion . closed displaced spiral fracture of diaphysis of RIGHT femur, acute blood loss anemia .Trauma services will follow along during admission for management of Bucks Traction and further collaboration with Orthopedic surgery. Due to diagnosis of PE, [named](ortho surgery) reports he will fix patient once appropriate . Review of R3 Hospital Trauma Evaluation, dated 4/3/24, reflected R3 arrived at 5:19 p.m. by Emergency Medical Services. Continued review of evaluation reflected R3 received 2 units packed red blood cells in emergency room for Hemoglobin of 7.5. Review of the Hospital Operative Report, dated 4/9/24, reflected R3 had Open Reduction Internal Fixation periprosthetic right Femur fracture. Continued review of the report reflected, Indications for procedure: The patient is a [AGE] year old female was found to have right periprosthetic femoral shaft fracture. She was diagnosed with bilateral pulmonary emboli. We attempted to do her surgery 5 days ago but she was not cleared by pulmonology or the medical team. We boarded her for open reduction internal fixation today after clearance . Review of R3 Hospital Discharge Summary, dated 4/18/24, reflected, Problem List .#acute hypoxic respiratory failure #iron deficiency anemia #acute bilateral pulmonary emboli .On admission Hb 7.6; s/p 2 units PRBCs, and today her Hb is 8.4; s/p another unit of PRBCs on 4/8 .# closed displaced spiral fracture of diaphysis of RIGHT femur # iron deficiency anemia # history of compression fracture of L2 . # protein calorie malnutrition .# diastolic congestive heart failure # primary hypertension # mixed hyperlipidemia . Continued review of Summary reflected R3 reported right hip throughout hospitalization . Continued review reflected, 4/18 On the day of discharge, patient was medically stable. There were no further episodes of bleeding, and the patient's hemoglobin remained stable. Symptomatically, her pain was improving and she continues to require pain medications less frequently than previously. Patient will be discharged today to [named facility]. We explained to patient that she will be receiving Lovenox injections 70 mg every 12 hours until 5/8/2024. Starting on 5/9/2024, she will start taking oral eliquis 5 mg two times daily. She will also obtain a complete blood count in one week and will follow-up with the orthopedic specialists on April 23rd, 2024 (appointment already scheduled). We told the patient that she will need to come back to the emergency department if she falls again or if she notices bleeding, foul discharge, redness, increased warmth, or swelling from the operative site. She should also return to the ED if she experiences symptoms of anemia including dizziness, headache, fatigue, etc . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/03/24 at 11:35 AM, Licensed Practical Nurse (LPN) N reported was just coming in for night shift on 3/31/24 and finishing up shift report with day nurse RN P when heard R3 call light and call for help. LPN N reported entered R3's room and observed R3 was on sit-to-stand yelling in agony, help me and crying with lift belt around chest, under under arms, suspended. LPN N stated, visual you can't unsee. LPN N reported R3 feet were not on the lift platform and there was no strap behind R3 legs. LPN N reported R3 left knee was out of the machine but bent with foot off platform and right knee was bent with foot partially off side of platform and was unable to recall if R3 had shoes on. LPN N reported both her and RN P had to reposition R3 legs away from the machine to lower R3 to the floor. LPN N reported R3 did not appear to have any new indication of pain. LPN N reported did not consider R3 incident as fall because she was lowered to the floor and did not complete fall checklist or contact physician for that reason. LNP N reported around 3:00 am cna staff reported R3's knee, just didn't look right. LPN N reported completed assessment and reported R3 right knee was swollen, red and warm to touch and applied ice and reported did not notify Physician related to change. LPN N reported was contacted 4/1/24 by Nurse Manager B about R3 fall from sit-to-stand and advised to completed fall report after reporting what took place. LPN N report completed Fall Incident/Accident report next shift worked on 4/3/24 along with late progress notes. LPN N reported NHA A and Nurse Manager both contacted her about the incident and asked several questions but never asked if the sit-to-stand leg strap was in place even though she had told them R3 knees were going in different directions. Review of R3 Fall Care Plan, dated 10/19/2022, reflected intervention that included,Transfer via EZ stand lift and 2 extensive assist. The intervention reflected resolve date of 6/3/24. (R3 fall with fracture during one staff assisted transfer was on 3/31/24.) Review of R3 Physician orders, dated 3/11/24, reflected, Skilled note/night skilled charting Q shift every day and night shift for skilled. During an interview on 10/03/24 at 1:40 PM, RN D reported observed R3 had very large bruise right lateral knee to hip that was dark purple in color on 4/3/24 and notified Medical Director O who ordered Xrays. RN D reported was the first time seeing that bruise and the only thing that could possible be from was fall 3/31/24. RN D reported was told by radiology staff R3 right femur fracture was seen at bedside. RN D reported to physician and R3 sent to emergency room . RN D reported management provided fall education after incident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/24 at 11:53 AM, Nurse Manager B reported would expect staff to follow facility fall policy and checklist that included assessment, notify physician/responsible party, maybe nurse manager/NHA A, implement new interventions, complete risk management form(incident/accident report), document every shift for 48 hours in Nurse Progress note. Nurse Manager B reported every shift Nurse Progress Notes should include details of assessment, pain, skin, resident reports, interventions in place, and any changes and notify physician with any changes. Nurse Manager B reported was notified of R3 fall incident from 3/31/24 on 4/1/24 during morning huddle when told R3 had to be assisted off the floor post Sara lift transfer. Nurse Manager B reported she contacted Medical Director O at that time and notified of incident. Nurse Manager B reported placed call to LPN N(night shift staff at time of fall) and discussed R3 fall incident from 3/31/24 and was told LPN N did not complete fall check list because she did not consider incident a fall and provided staff education that R3 incident was a fall because it was an unplanned changed in elevation and a risk management form needed to be completed. Nurse Manager B verified LPN N completed documentation 4/3/24 and was unable to say why every shift Nurse Progress Notes that included detailed assessment were not completed 4/1/24 and 4/2/24.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 34705 Based on interview and record review, the facility failed to provide written notification to the State Long-Term Care (LTC) Ombudsman of facility-initiated transfers/discharges over past 12 months, resulting in the potential for all residents to be discharged without an advocate who can inform them of their options and rights. Findings include: During an interview on 10/04/24 at 11:00 AM, Admission/Discharge (ADM) staff T responsible for providing residents and or responsible party discharge/transfer documents with Ombudsman and facility contact information at time of discharge or transfer. Reported no knowledge of communication with Ombusdman related to resident discharges. During an interview on 10/04/24 at 11:40 AM, Nurse Manager B reported not aware of system in place to report resident transfers and/or discharges to the State Long-Term Care Ombudsman on a routine basis and not aware of regulation.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review, the facility failed to 1) accurately assess pressure ulcers (Resident #6) and 2) failed to prevent a pressure ulcer (Resident #27) in 2 of 2 residents reviewed for pressure ulcers resulting in the development of a pressure ulcer and inaccurate assessments. Findings include: Resident #6 (R6) Review of the medical record revealed Resident #6 (R6) was admitted to the facility on [DATE] with diagnoses that included dementia, type 2 diabetes and heart failure. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed R6 had severe cognitive impairment. On 10/01/24 at 10:41 AM, R6 was observed in bed, dressed in a nightgown, and listening to the television. R6 smiled and interacted when interviewed. R6 acknowledged that she had a wound (pressure ulcer) on her bottom, however, reported that her memory was not good therefore, could not recall any details regarding the pressure ulcer. Review of the facility provided Pressure Ulcer history timeline revealed R6 developed an opening on the skin on her coccyx on 1/6/24. Further review of the same Pressure Ulcer history timeline and a skin assessment dated [DATE] revealed that R6 currently had the same pressure ulcer on her coccyx, however, the pressure ulcer was described as a stage 3 (Full-thickness loss of skin). Review of R6's skin assessments revealed that many of the skin assessments lacked documentation of the description of the pressure ulcer, including size and wound characteristic. In an interview on 10/03/24 at 3:41 PM, Registered Nurse (RN) C reported that the assessments of the pressure ulcers, including wound size and characteristics, are included on the weekly skin assessments. Review of R6's weekly skin assessments and the Pressure Ulcer history timeline, dated back to 1/6/24 revealed R6 had thorough pressure ulcer assessments on the following dates; 2/6/24 5/29/24 10/3/24 The remainder of the weekly skin assessments did not contain measurements and/or description of the wound. Several skin assessments did not identify the staging of the pressure ulcer, rather, identifying the pressure ulcer as an open area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/04/24 at 10:49 AM, Licensed Practical Nurse (LPN) G reported that the skin assessments had recently changed. LPN G reported that the skin assessment was to be completed at the time of the pressure ulcer dressing change. LPN G explained that the old skin assessments contained an assessment form that contained wound descriptions that you could click to select the characteristics of the pressure ulcer, however, the new skin assessment form required staff to fill out the description and measurements of the pressure ulcer prior to completing the assessment. In an interview on 10/04/24 at 11:16 AM, Nurse Manager (NM) B stated that the pressure ulcer documentation should be completed every time there is a pressure ulcer dressing change and should include the characteristics of the pressure ulcer and measurements. NM B reported that she had noticed the lack of wound assessments and stated that expectation and education will be discussed at the next nurses meeting. Resident #27 (R27) Review of the Face Sheet revealed Resident #27 (R27) was admitted to the facility on [DATE] with diagnoses that included type two diabetes and muscle weakness. Review of the Minimum Data Set (MDS) dated [DATE], revealed R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 10/02/24 on 8:38 AM, R27 was observed seated in her recliner chair. R27 reported that she had had some pain in her hip and on her bottom. When queried about the source of pain on her bottom, R27 stated that the pain was from a bedsore. Review of R27 Admission assessment revealed that R27 admitted to the facility with blanchable redness (skin that is red however, turns to white when pressure is applied) to her coccyx. Review of R27's Risk for Skin Breakdown Care Plan initiated on 8/26/24 included interventions such as reposition every 2 to 3 hours and daily skin checks. Review of the Physician Order's revealed an order initiated on 8/13/24 which stated Allyvn to Coccyx for protection, one time a day every 7 day(s) AND as needed. The order was discontinued on 8/20/24. Review of the Treatment Administration record for August 2024 revealed the one-time Physician Order dated 8/20/24 for applying Allyvn (foam dressing) to R27's coccyx was never signed off as completed. No other preventative or protective Physician Orders for R27's blanchable redness area to the coccyx were in the electronic medical record. In an interview on 10/03/24 at 9:54 AM, Certified Nursing Assistant (CNA) H reported that R27 sits in her chair the majority of the time and requires the assistance of one staff for turning and repositioning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nurse's note dated 9/9/2024 at 10:21 AM revealed Duoderm [hydrocolloid dressing] placed to pea-sized opened area to sacrum. Slough [dead tissue within a wound, often appearing as a yellow, tan, or white] noted. Duoderm ordered to be changed Q5D/PRN [every 5 days and as needed]. Encouraged to reposition frequently to prevent further skin breakdown. On 9/12/24 a Roho cushion [specialized type of cushion designed to relieve pressure with the use of air cells that are located in the cushion] was added to R27's recliner. Review of R27's skin assessments revealed on skin assessment with the date of 9/24/24 that contained measurements and characteristics of R27's wound. In an interview on 10/04/24 at 11:16 AM, Nurse Manager (NM) B stated that the pressure ulcer documentation should be completed every time there is a pressure ulcer dressing change and should include the characteristics of the pressure ulcer and measurements. NM B reported that she had noticed the lack of wound assessments and stated that expectation and education will be discussed at the next nurses meeting. Regarding the development of R27's coccyx pressure ulcer, N, B stated that she would have preferred more pressure ulcer preventions would have been implemented prior to R27's development of her pressure ulcer.

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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 Based on observation, interview and record review the facility failed to: 1.) ensure the safety of resident during staff assisted transfer, 2.) implement care-planned interventions, and 3.) provide timely assessment and treatment for 1 of 3 sampled residents (R3) reviewed for accidents, resulting in actual harm for R3's fall during staff assisted transfer with displaced right femur spiral fracture on 3/31/24, delay in assessment and treatment, pain, and transfer to the hospital for surgical repair of right femur and treatment for multiple pulmonary emboli. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R3 was a [AGE] year old female admitted to the facility on [DATE], with re-admission post hospital admission 4/18/24 following displaced spiral fracture of the right femur and multiple pulmonary emboli with other diagnoses that included muscle weakness, repeat falls, history right hip replacement, lumbar vertebra fracture(low back), heart failure, hypertension(high blood pressure), and developmental delay. The MDS reflected R3 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was cognitively intact with no behaviors including rejection of care. Continued review of the significant change MDS, dated [DATE], reflected R3 dependent on staff for transfers, bed mobility, dressing, bathing, and toileting. Review of R3 Fall Care Plan, dated 10/19/2022, reflected intervention that included,Transfer via EZ stand lift and 2 extensive assist. The intervention reflected resolve date of 6/3/24. During an observation on 10/01/24 at 10:47 AM, R3 was observed self propelling wheelchair in hall with bilateral arms with bilateral feet resting on foot pedals. During an observation on 10/01/24 at 12:40 PM, R3 was again self propelling wheelchair out to patio. R3 appeared in pleasant mood with minimal difficulty answering questions. R3 reported did not recall recent hospital transfer. Review of the Electronic Medical Record(EMR), dated 4/18/24 to current, reflected readmission with new diagnosis that included displaced spiral fracture of shaft of right femur. (continued on next page)

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	235567	A. Building B. Wing	10/04/2024

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Hillsdale Hospital McGuire and MacRitchie Ltcu	168 South Howell St Hillsdale, MI 49242

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R3 Nurse Progress Note, entered as LATE ENTRY on 4/3/24 at 9:39 p.m., with effective date 3/31/24 at 6:55 p.m., reflected, Responded to CNA[certified nurse aide] call for assistance with Resident mid-shift change. Writer, followed by Day-shift nurse, walked into Resident room to discover Resident holstered upward suspended by arms in sling on sit-to-stand in upright position with bilateral legs bent down toward the floor. For safety, Writer and Day-shift nurse agreed to lower Resident down to the floor due to visible discomfort evidenced by Resident's bilateral arms noted holstered up in sling while suspended in sit-to-stand for greater than 10 minutes. Once lowered to the floor, pillows were placed under Resident for comfort while lying down on the floor until CNA returned with Hoyer lift. When Hoyer lift arrived, Writer, Day-shift nurse, and CNA worked together to place the sling under Resident, carefully lift Resident from the floor, and transfer Resident to the bed. No immediate signs or symptoms of injury were noted after Resident was positioned for safety and comfort while lying in bed. Resident admitted to pain present, stating, I hurt allover. Refused PRN Tylenol offered stating, It doesn't work. Agreeable to waiting for scheduled pain patch replacement. Sling removed; call light placed within reach. Plan of care followed with monitoring continued throughout shift. Note was completed by Licensed Practical Nurse (LPN) N. Review of R3 Nurse Note, dated 4/1/2024 at 1:35 a.m., reflected, Late Entry[4/3/24] Note Text: Responded to CNA report of change noted to Resident skin at right outer thigh. Reddened area appearing bruised noted at right outer thigh. Admits to soreness to touch at the site. Agreeable to ice placed on affected area at the time. Small, reddened area appearing bruised noted to front left knee. Admits to tolerating pain at left knee. Responding well as possible to pain patch replaced as scheduled during this shift AEB uninterrupted sleep continued through the night. POC followed with monitoring continued throughout shift. Note was completed by LPN N. Review of R3 Nurse Progress note, dated 4/3/2024 at 9:39 a.m., reflected, New skin condition. Large bruise noted on lateral right thigh and knee. Right knee swollen [named Medical Director O] notified and XR ordered. ' Note completed by Registered Nurse(RN) D. Review of R3 Nurse Progress Note, dated 4/3/24 at 1:25 PM, reflected, Right femur XR results: Severely displaced spiral fracture of the distal femoral diaphysis. [named MD O] and [named] (guardian) made aware. Resident is being transferred to ER. During an observation and interview on 10/02/24 at 9:55 AM, R3 was self propelling wheelchair down hall and reported was in pain all over and staff had given scheduled pain medications. During an interview on 10/02/24 at 2:54 PM, Medical Director(MD) O reported was unable to recall when he was notified of R3 fall that resulted in right femur fracture on 4/3/24. MD O reported would expect staff to call and notify him of all falls at the time fall. During an interview on 10/02/24 at 3:50 PM, Nurse Manager B reported would expect nurse staff to assess resident post fall including pain and skin and document in progress notes and complete risk management form(Incident/Accident form) at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/2/24 at 4:40 PM, LPN F reported worked 4/1/24 days shift and was told in report about R3 fall from 3/31/24 from the sit-to-stand by RN N. LPN F reported R3 used sit-to-stand 4/1/24 with no more pain than resident usually reported. LPN F reported was under the impression the physician had already been contacted. LPN F reported after fall staff expected to complete fall check list including risk management form(Incident/accident form), along with progress note that includes details of fall and what was done,according to check list, for 24 and 48 hours. LPN F reported after fall staff expected to contact physician and responsible party and document details. During a telephone interview on 10/03/24 at 10:03 AM, RN P reported encouraged staff to use two staff for transfers because R3 and was unsure if anyone told CNA Q who was newer a newer staff. RN P reported CNA Q had transferred R3 on 3/31/24 with 1 person assist with use of sit-to-stand. RN P reported her and night shift nurse entered R3 room about 7:00 p.m. and observed CNA Q attempting to lower R3 to the ground with R3 in a squatted position. The three staff lowered R3 to the ground and R3's right leg was tucked under left leg and RN P was unable to recall who disconnected or how, when sit-to-stand straps were disconnected. RN P reported LPN N completed assessment. LPN P reported was not in room when R3 was transferred back to bed. RN P reported management provided staff education after R3 fall that included sit-to-stand training, fall process including to follow Post Fall Checklist that included assessment, notify physician, house manager, responsible party, document in EMR assessment including pain, location, when, how, who notified, new orders, and add order for every shift charting for 48 hours. Review of R3 Hospital History and Physical(H&P), dated 4/3/24, reflected chief complaint was leg pain. The document reflected, History of Present Illness .She presents here, transferred from [named facility Hospital] for RIGHT femoral fracture s/p a reported fall at the SNF .[named R3] reportedly lives at [named facility]; she is wheelchair/bed-bound at baseline requiring multiple people to assist with transfers to and from her chair/bed, but she reportedly fell out of bed 2-3 days ago. She was brought to the [named local] ER earlier today where it was discovered that she had suffered a RIGHT femoral fracture and was thus transferred to our ER. Per the ED physician, she arrived in no acute distress and hemodynamically stable (apart from tachycardia), saturating well on room air; patient's presentation was suspicious for potential thrombotic/embolic process due to evidence that the extended femoral fracture had not been reduced, thus patient was pan scanned with a CT chest revealing evidence concerning for multiple bilateral pulmonary emboli . Continued review of the H&P reflected, Physical exam: Marked swelling to right proximal lower extremity, with obvious shortening and deformity .Bruising and ecchymosis present on the lateral aspect of the RIGHT lower extremity extending from the hip/upper thigh through the knee .Plan .heparin infusion . closed displaced spiral fracture of diaphysis of RIGHT femur, acute blood loss anemia .Trauma services will follow along during admission for management of Bucks Traction and further collaboration with Orthopedic surgery. Due to diagnosis of PE, [named](ortho surgery) reports he will fix patient once appropriate . Review of R3 Hospital Trauma Evaluation, dated 4/3/24, reflected R3 arrived at 5:19 p.m. by Emergency Medical Services. Continued review of evaluation reflected R3 received 2 units packed red blood cells in emergency room for Hemoglobin of 7.5. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Hospital Operative Report, dated 4/9/24, reflected R3 had Open Reduction Internal Fixation periprosthetic right Femur fracture. Continued review of the report reflected, Indications for procedure: The patient is a [AGE] year old female was found to have right periprosthetic femoral shaft fracture. She was diagnosed with bilateral pulmonary emboli. We attempted to do her surgery 5 days ago but she was not cleared by pulmonology or the medical team. We boarded her for open reduction internal fixation today after clearance . During a telephone interview on 10/03/24 at 11:35 AM, Licensed Practical Nurse (LPN) N reported was just coming in for night shift on 3/31/24 and finishing up shift report with day nurse RN P when heard R3 call light and call for help. LPN N reported entered R3's room and observed R3 was on sit-to-stand yelling in agony, help me and crying with lift belt around chest, under arms, suspended. LPN N stated, visual you can't unsee. LPN N reported R3 feet were not on the lift platform and there was no strap behind R3 legs. LPN N reported R3 left knee was out of the machine but bent with foot off platform and right knee was bent with foot partially off side of platform and was unable to recall if R3 had shoes on. LPN N reported both her and RN P had to reposition R3 legs away from the machine to lower R3 to the floor. LPN N reported R3 did not appear to have any new indication of pain. LPN N reported did not consider R3 incident as fall because she was lowered to the floor and did not complete fall checklist or contact physician for that reason. LNP N reported around 3:00 am CNA staff reported R3's knee, just didn't look right. LPN N reported completed assessment and reported R3 right knee was swollen, red and warm to touch and applied. LPN N reported was contacted 4/1/24 by Nurse Manager B about R3 fall from sit-to-stand and advised to completed fall report after reporting what took place. LPN N report completed Fall Incident/Accident report next shift worked on 4/3/24 along with late progress notes. LPN N reported NHA A and Nurse Manager both contacted her about the incident and asked several questions but never asked if the sit-to-stand leg strap was in place even though she had told them R3 knees were going in different directions. Review of R3 Physician orders, dated 3/11/24, reflected, Skilled note/night skilled charting Q shift every day and night shift for skilled. During an interview on 10/03/24 at 1:40 PM, RN D reported observed R3 had very large bruise right lateral knee to hip that was dark purple in color on 4/3/24 and notified Medical Director O who ordered Xrays. RN D reported was the first time seeing that bruise and the only thing that could possible be from was fall 3/31/24. RN D reported was told by radiology staff R3 right femur fracture was seen at bedside. RN D reported to physician and R3 sent to emergency room . RN D reported management provided fall education after incident. During an interview on 10/04/24 at 9:00 AM, CNA R reported was a casual employee and knows if residents have changes or what care needs are by verbal report and asking the nurse. CNA R reported was unsure if they use Kardex. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 11:53 AM, Nurse Manager B reported would expect staff to follow facility fall policy and checklist that included assessment, notify physician/responsible party, maybe nurse manager/NHA A, implement new interventions, complete risk management form(incident/accident report), document every shift for 48 hours in Nurse Progress note. Nurse Manager B reported every shift Nurse Progress Notes should include details of assessment, pain, skin, resident reports, interventions in place, and any changes and notify physician with any changes. Nurse Manager B reported was notified of R3 fall incident from 3/31/24 on 4/1/24 during morning huddle when told R3 had to be assisted off the floor post Sara lift transfer. Nurse Manager B reported she contacted Medical Director O at that time and notified of incident. Nurse Manager B reported placed call to LPN N(night shift staff at time of fall) and discussed R3 fall incident from 3/31/24 and was told LPN N did not complete fall check list because she did not consider incident a fall and provided staff education that R3 incident was a fall because it was an unplanned changed in elevation and a risk management form needed to be completed. Nurse Manager B verified LPN N completed documentation 4/3/24 and was unable to say why every shift Nurse Progress Notes that included detailed assessment were not completed 4/1/24 and 4/2/24. Nurse Manager B reported on 4/1/24 R3 was changed to hoyer lift related to R3 not tolerating sit-to-stand well. Nurse Manager B reported expected staff to follow Care Plan and Kardex interventions and reported R3 fall was not reported to the State of Michigan because they knew bruise and fracture were related to fall. Nurse Manager B reported was unable to locate Lift education for CNA Q, RN P or LPN N prior to R3 staff assisted fall from sit-to-stand lift on 3/31/24.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 34705 Based on interview and record review the facility failed to ensure the nursing staff was evaluated for appropriate competencies and skill sets resulting in the potential for residents of the facility to be unable to maintain the highest practicable physical, mental, and psychosocial well-being and the potential for decreased resident safety for all residents who resided in the facility. Findings include: NHA A provided one Incident Accident Report for R3 on 10/02/24 at 1:55 PM, dated 4/3/24 at 8:25 p.m. Review of the report titled, Fall During Staff Assist, reflected, Incident Description .In response to CNA[Certified Nurse Aide] call for assistance the Resident Writer walked into Resident room followed by Day-shift nurse to discover Resident suspended by arms in sling on sit-to-stand in upright position with bilateral legs bend to the downwards. Continued review of the incident report reflected, Reported by CNA, Resident let go of sit-to-stand bar during transfer, knees together and bent over to one side. The report reflected R3 responsible party was notified 4/3/24(three days after fall), and physician was notified 4/1/24(12 hours after fall). The report included summary of investigation completed by Nurse Manager B. The reported included, Deficiencies: Education for CNAs and reporting, Education thinking things are normal passing on as abnormal, Understanding of what need reported by agency staff During an interview on 10/04/24 at 9:50 AM Human Resource Staff (HR) reported Certified Nurse Aide(CNA) Q was hired 11/2023 and did not have Nurse Assistance Competency completed until 4/1/24 including mechanical lifts(after R3 fall during staff assisted transfer with mechanical lift on 3/31/24). HR Q reported Licensed Practical Nurse (LPN) N was hired 3/5/24 through 6/1/24 and did not have evidence of completed Competency Checklist in file. HR Q reported Registered Nurse (RN) P most recent mechanical lift training was 1/2023(greater than 1 year prior to R3 fall during staff assisted transfer with mechanical lift). During an interview on 10/04/24 at 11:53 AM, Nurse Manager B reported Nurse Manager B reported was unable to locate Lift education for CNA Q, Registered Nurse (RN) P or Licensed Practical Nurse (LPN) N prior to R3 staff assisted fall from sit-to-stand lift on 3/31/24.