STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235592	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron Woods Nursing Center	1395 S Huron Rd Kawkawlin, MI 48631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 This citation pertains to Intake Number MI00150598. Based on observation, interview and record review, the facility failed to prevent repeated falls for one resident (Resident #101) of 4 sampled residents, resulting in Resident #101 sustaining repeated falls from her wheelchair, Findings include: Resident #101: In an observation and interview on 3/5/2025 at 8:10 AM, Resident #101 was seated up in the resident's room in a wheelchair with the footrest in place. Resident #101 was asked about a fall in February 2025. The Resident stated that yes, she fell from her wheelchair and went to the hospital. Record review of Resident #101's Minimum Data Set (MDS), a quarterly assessment dated [DATE] revealed an elderly female with a Brief Interview of Mental Status (BIMS) of 14 out of 15- indicating cognitively intact. Section I- Active diagnoses included: Medically complex conditions, diabetes, hemiparesis, seizure disorder, anxiety, depression, ischemic cardiomyopathy, dysphagia, insomnia. Section G- Functional Abilities: Dependent, helper does all of the effort, resident does none of the effort to complete the activity. Dependent for toileting hygiene, shower/bath. Maximum assist helper does more than half of the effort for: upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, and rolling left and right. Record review of Resident #101's accident/incident reports revealed 3 separate falls had occurred since 01/01/2025: On 1/7/2025 Resident #101 was observed lying face down on the floor by staff in the resident's room. On 2/17/2025 Resident #101 was observed laying on her right side on the floor by staff in the resident's room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/2025 Resident #101's roommate heard the resident fall but did not see the event and yelled out for help. Nursing staff heard the roommate yelling and responded to the room to find Resident #101 lying face down on the floor. Record review of Resident #101's care plans, pages 1-46, revealed care plans for: -Altered Mobility and ADL's Fall Risk Management- encourage non-skid footwear, personal items within reach, Floor mat next to bed while resident is in bed as tolerated, soft touch call light 4/19/2023. Wheelchair seat to have a decreased rear of the seat to assist with comfort as well as fall prevention 6/3/2023. Reacher provided to resident with education to use call light, Dycem applied to side table to place phone and glasses on 2/17/2025, basket for loose items added to tray table. Encourage to be in highly visible areas when up in wheelchair 2/20/2025, encourage curtain to be pulled back when cares are not being performed, date initiated: 4/17/2023, Revision on: 2/20/2025. 'Risk for Falls or Injury' interventions dated 2023: - Assist rails, Call light: resident is able to utilize the call light for assistance, Document resident response to interventions, prn. Examine internal and external risk factors upon admission and post fall as noted on the fall risk assessment tool. Examine the resident's diagnosis and orders and assess the ability to ambulate and bear weight- provide direction to staff via care card. MDS review of the relationship of fall risk and medication side effects, prn. Post- Fall review room for environmental factors/re-act situations prn to assist with development of cause specific interventions, neurological checks prn. Review and modify environmental factors as indicated. Review medications with potential side effects that could contribute to gait disturbance-care plan risk vs benefit prn. See ADL plan of care for fall risk interventions. With history of exit seeking and mobility independence apply interventions as indicated and reassess prn. Interventions Date initiated 4/19/2023. -Adaptive Equipment: wheelchair, full mechanical lift revision date. Assess orthostatic hypotension prn (as needed), Assess postural alignment prn, evaluate side effects of thromboprophylaxis therapy, i.e., itching, bruising, petechiae, hematuria, coffee ground emesis, increased bleeding from injury, black tarry stool; consult health care practitioner as indicated by evaluation date initiated 7/25/2023. There where no interventions for monitoring or increased supervision of Resident #101. Record review of the facility's 'Accident/Incident Report Fall Management' policy, dated 6/2018, revealed it is the policy of the facility to complete an accident incident report for unexplained bruises or abrasions; accidents or incidents where there is injury or the potential to result in injury; falls . (6.) It is recognized that not all falls can be prevented, the facility will utilize applicable elements of the systemic process of assessment, intervention, and monitoring to minimize fall risk and injury (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 030/5/2025 at 10:30 AM, former roommate, Resident #105 stated it was after supper around 8:30-9:00 PM, when she heard a loud crash. Resident #105 stated that she was trying to talk to (Resident #101), but she did not respond, so she pushed the call light. No, Resident #101 was not choking when she fell over. The curtain was pulled between them, so she could not see what actually happened. Resident #105 stated that there was no response from staff. It seemed like forever, so she started to scream for help. It felt like it took them 30 to 40 minutes to get into the room. Finally, 3 staff members came running in and they found Resident #101 on the floor. Resident #105 stated that she guessed Resident #101 went face first to the floor, busted her lip and was bleeding from her nose and mouth. The staff called 911 and they took Resident #101 away around 9:30 PM by ambulance to the hospital. In an interview on 030/5/25 at 11:43 AM, Resident #101 was seated up in wheelchair in room with her black glasses on. Resident #101 recalled the fall, and the roommate calling for help, while she was on the floor. Resident #101 stated that she was reaching for something and just fell out headfirst from her wheelchair. Resident #101 stated that she did get hurt and that staff did come after 45 minutes to help her, while she was on the floor. The roommate was yelling, and she didn't know what happened.