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	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron Woods Nursing Center	1395 South Huron Road 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 - 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** This Citation Pertains to Intake Number MI00153102. Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures to ensure safe transfer utilizing a mechanical lift (device to move a dependent individual from one surface to another) and ensure planned interventions were in place for fall prevention, for one resident (#701) of three residents reviewed, resulting in Resident #701 experiencing a fall during a mechanical lift transfer resulting in an intraventricular hemorrhage (IVH- bleeding into the ventricles of the brain). Findings include: Resident #701 Review of intake documentation revealed a concern that Resident #701 had a fall with head injury while being transferred with a mechanical lift. The intake detailed that the facility did not identify a root cause of the fall/accident and did not report the fall with severe injury to the State Agency. Per the Intake, Resident #701's health had declined since the occurrence, and they are not communicating and making eye contact as they did prior to falling from the mechanical lift. (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 - Actual harm Residents Affected - Few	An interview was conducted with Confidential Witness G on 5/21/25 at 8:52 AM. When queried regarding Resident #701, Witness G stated, (Resident #701) had a week ago Monday not yesterday but a week ago Monday while being transferred with the Hoyer (mechanical) lift and had a laceration on their head. Witness G revealed they believed the incident/fall should have been reported to the State Agency via a Facility Reported Incident (FRI). When queried how Resident #701 fell while being transferred in a Hoyer lift, Witness G revealed the facility did not clearly identify the root cause of the fall. Witness G disclosed the facility initially specified that (Resident #701) had slippery clothing on and that they moved in the Hoyer, rolled, and slipped up and out of the sling. Witness G stated, Unless (Resident #701) defied gravity, I don't know how that would happen. Witness G then stated, (Resident #701's) got dementia. They are on Ativan (controlled medication commonly used to treat anxiety) and doesn't fight. I know (Resident #701) wasn't squirming around in there (mechanical lift) but even if I was in a Hoyer lift and tried to do that (roll and slip up and out of the sling), it would be very difficult. Witness G then stated, The next day, (the facility) stated, We think that maybe we need to do some extra training with (staff) and that maybe the people that were using the lift weren't trained properly. Witness G stated, That doesn't sound good either. That indicates that they're not properly training people. Witness G revealed the next day the facility was back to the slipping out part. Witness G verbalized they were told that Resident #701 started to roll (in the sling) and with their slippery clothing, they slipped up and out of the Hoyer sling. Witness G stated the staff member wasn't able to get over there to save (Resident #701) from falling out. Witness G verbalized it did not make sense as the Hoyer sling cradles the Resident and it would have been very difficult for the Resident to fall out. When asked about the Resident's care following the fall, Witness G revealed a CT (diagnostic test to used to visualized soft tissues and organs in the body) was completed because Resident #701 was complaining of severe pain in their neck and head. When queried regarding the CT results, Witness G replied, It did show an intracranial hemorrhage in the frontal lobe which is where the laceration is on the forehead. Witness G was asked if Resident #701 had a change in mental status following the fall and replied, (Resident #701) has Alzheimer's so obviously it's hard to do a neuro exam unless you know their baseline but (Resident #701's) not operating at their baseline. When queried what changes were identified from the Resident's baseline, Witness G replied, Before the fall, (Resident #701) was able to you know interact with us and make eye contact. They would kind of sing along to some songs that they knew from the past and things such as that. Witness G continued, (Resident #701) is not making eye contact anymore and when you try to feed (the Resident) now, they are not interested or doesn't understand. With further inquiry, Witness G revealed there was really no interaction from Resident #701 at all now. Witness G then stated, (Resident #701's) forehead took the impact of the fall and verbalized that, as someone who has used a Hoyer lift as part of their job, they could not understand how a Resident could fall headfirst out of the sling if the Resident was properly positioned, and lift was being utilized appropriately. Witness G disclosed Resident #701 was receiving Hospice services and stated, I know (Resident #701) doesn't have a great quality of life. They are 87 (years old) and have Alzheimer's, have for several years, but I don't want the reason they pass (die) to be something traumatic and due to negligence. Witness G stated, I don't want someone else to get hurt. That's the fear that I have. When queried regarding the laceration Resident #701 received when they fell, Witness F revealed a facility nurse had put steri-strips (thin, adhesive bandages used to cover small cuts to keep the skin closed) on the laceration but it had continued to bleed so the Hospice nurse came to the facility and applied a pressure dressing. When asked to clarify if they were saying steri-strips were not holding the wound edges together, Witness F confirmed. Witness F indicated the most appropriate treatment for the laceration would have been evaluation in the Emergency Department (ED) and sutures. When asked if there was any additional information related to the fall they wanted to discuss, Witness F reiterated they were concerned that the facility had not been able to provide a clear explanation of how the fall occurred and indicated they felt there was either a lack or investigation or transparency. Witness F stated, (Resident #701's) not doing well. There was a notable decline following the fall and reiterated they were concerned for other residents who resided in the facility and required a Hoyer lift for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review revealed Resident #701 was admitted to the facility on [DATE] with diagnoses which included dementia with other behavioral disturbance, weakness, depression, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired, had one sided impaired Range of Motion (ROM) in their upper and lower extremities, and was dependent upon staff to complete all Activities of Daily Living (ADLs). The MDS further detailed the Resident displayed no behaviors. Resident #701 was receiving Hospice Services related to their diagnosis of dementia. A comparative review of Resident #701's admission MDS assessment dated [DATE] revealed the Resident had no impairments in ROM at that time. On 5/21/25 at 11:18 AM, Resident #701 was observed sitting alone in their room in a Broda chair (high back, reclining wheelchair with side cushions for positioning and a one-piece solid leg/footrest) with their eyes partially closed. A dark-colored scabbed and red area, approximately 3 inches long by half an inch wide was present on the left side of the Resident's forehead. The leg/footrests were down, and the Resident was holding a doll. When spoke to, Resident #701 did not respond verbally or non-verbally. The Resident's bed was the first bed, closest to the hallway in a shared, two-person room. Their bed was positioned against the wall of the room with the top of the bed (pillows) away from the door and towards the window and other resident area of the room. An overbed table was positioned over the bed and a dresser was next to the door towards the bottom of the bed on the wall with the hallway door. At 11:21 AM on 5/21/25, an interview was completed with Licensed Practical Nurse (LPN) A and Registered Nurse (RN) F. When queried regarding the large, scabbed area on Resident #701's forehead, RN F revealed they were orientating with LPN A and had recently started at the facility. LPN A was asked what happened to Resident #701's forehead and hesitantly responded that Resident #701 had a fall. When queried regarding the fall, LPN A replied, I wasn't there. Would you like to talk to the DON (Director of Nursing)? When queried regarding the Resident sitting in the Broda chair in their room and lack of response, LPN A replied, (Resident #701) has been up since 6 (6:00 AM) or 7 (7:00 AM) and indicated the Resident is most likely tired. An interview was completed with Certified Nursing Assistant (CNA) H on 5/21/25 at 11:26 AM. When queried if they were Resident #701's assigned CNA, CNA H confirmed they were. CNA H was then queried regarding the scabbed area on Resident #701's forehead and replied that the area was from a fall. When queried, CNA H revealed they were not working when the fall occurred and stated, (CNA I) and (CNA J) were. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	At 11:30 AM on 5/21/25, an interview was conducted with CNA I. When queried regarding Resident #701's fall, CNA I confirmed they were working and stated, We had (Resident #701) in the shower sling (mesh, quick dry sling frequently used to shower dependent individuals). When asked if they had given the Resident a shower, CNA I replied, (Resident #701) is assigned one (shower sling). CNA I then stated, Me and the other (CNA) didn't even have (Resident #701) that day. We just do it as a team and do all the Hoyer's together. When asked what they meant, CNA I replied, The first two people who aren't busy get all the lift resident's back in bed. CNA I revealed they will start at one end of the hall and move their way down until all the residents are back in bed. When asked if Resident #701 usually becomes combative and/or anxious while being transferred with the Hoyer lift, CNA I replied, No. When asked what happened, CNA I revealed they were transferring the Resident from their chair to the bed. CNA I stated, (Resident #701) sat up and went out the left side of the sling. (Resident #701's) head hit the metal bar leg on the Hoyer. When queried if that was how the Resident got the laceration on their forehead, CNA I replied, Yes. When asked how Resident #701 fell out of the side of the Hoyer sling, CNA I attempted to describe the incident detailing the Resident landed directly on the front of the head. When asked about the Resident's reaction to the fall, CNA I responded that the fall was traumatizing for everyone involved. Incident and Accident as well as any investigation documentation pertaining to Resident #701's fall was requested from the facility Administrator at 11:35 AM on 5/21/25. An observation of the Hoyer lift that was utilized during Resident #701's transfer occurred on 5/21/25 at 12:00 PM with the DON, CNA I and CNA K in the conference room. The mechanical lift was an Invacare 450 model battery powered lift with attached Reliant scale (body weight scale). The sling that hung over the lift was a blue mesh style sling with a purple edge. The mechanical lift had a single bar hanger with hooks for the sling to attach. The lift functioned with the controller and there were no obvious mechanical faults observed. When asked what occurred when Resident #701 fell while being transferred, CNA J verbalized they were behind the base and using the electronic controller and CNA I was on the right side of the Resident who was suspended in the in the sling during the transfer. CNA I stated, (Resident #701) leaned to the side and fell out the side gap of the sling to the floor. When asked how the Resident was able to fall out of the side of the sling, CNA I stated, (Resident #701) started to sing and to lean and then fell out. When queried, both CNA I and CNA J confirmed the sling present on the mechanical lift was the same type and size sling used when Resident #701 fell during the transfer. A demonstration of how Resident #701 fell from the lift was provided by the staff at this time. The staff proceeded to attach the sling to the hanger and the DON got into the sling. The sling was noted to be in a sitting, not reclined position. The DON demonstrated they were able to fit through the side gap of the sling. The DON then stated, May be related to the sling attachments and indicated the model of mechanical lift used (Invacare 450). When asked what they meant, the DON pointed out that the model lift has a single hanger rod where there is minimal distance between the sling hook points on the bar enabling the bar to swivel and tip easily. A demonstration by sitting in the sling was completed. With no staff guidance on the sling/individual in the sling, the individual in the sling was able to purposefully position their body to move through the side gap of the sling. Due to the characteristic swivel and tilt motions of the mechanical lift hanger, once the momentum of the body began, without a staff member intervening, guiding and stopping them, the individual was able to tip and subsequently fall from the sling. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON revealed the mechanical lift was removed from use after the fall. When asked if they were saying there was a mechanical malfunction with the lift, the DON replied, No and revealed they felt that once Resident #701 started to tip sideways in the sling, they were unable to prevent the fall because they could not physically stop themselves and the hanger bar part of the mechanical lift allowed the sling to tip sideways. The DON verbalized the other mechanical lifts in the facility were different models which were less tippy due to having a larger hanger and more space between the sling hooks. An observation of the other mechanical lifts in the facility was completed at this time with the DON. The other mechanical lift model is the facility was an Invacare 650 mechanical lift. The DON stated, The CNAs prefer these (model 650 mechanical lift) over the other one (model 450 mechanical lift). When asked why the CNA staff preferred the 650 model over the 450 model, the DON revealed it was because they liked the way the sling attached to the lift hanger as it has three-point connection and is more stable. A facility policy/procedure pertaining to mechanical lift and sling use was requested from the facility Administrator on 5/21/25 at 12:45 PM. At 1:00 PM on 5/21/25, the DON entered the conference room and stated the facility did not have a policy/procedure for mechanical lift and sling use. With further inquiry, the DON stated, We use the manufacturers guide. When asked if the staff who utilize the lift have access to the manufactures guide/owners manual, the DON indicated they do not. The DON then stated that staff have a check off competency completed by the regional nurse educator for lift use when they are hired. Review of Resident #701's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #701) has altered functional mobility and ADLs related to dementia with behavioral and psychological symptoms . (Initiated: 12/1/24; Revised: 12/2/24). The care plan included the intervention, Transfer: Mechanical Lift-Follow guide for sling type and loop attachment (Initiated: 12/2/24). A form entitled, Mechanical Lift Guidance dated 12/2/24 was scanned into Resident #701's EMR. The form specified the Resident was a full mechanical lift using a mesh full body, medium violet edge sling. The sling loop attachments were Upper: Green and Lower: Purple Review of documentation in Resident #701's EMR revealed the following: - 5/12/25 at 1:15 PM: Fall Management (assessment) . Cognitive / Behavior Status: 1. Has the residents Behavior changed in the previous 90 days? No. 2. Have the following behaviors been displayed in the previous 90 days: Restlessness, lethargy, resists care, does not follow or understand direction . No . Summary . STCP (Short Term Care Plan) initiated for latent injury due to recent fall . is assessed as a fall risk r/t (related to) dementia. - 5/12/25at 1:30 PM: Skin Assessment . Face . Open Wound . Length: 3.5 cm (centimeters) . Width: .5 cm . Depth: .3 cm . Assessment Notes: Resident was lying in bed during this assessment and tolerated movement of limbs. Wound noted to L (left) forehead above eyebrow measuring as stated above. Wound washed with NS and patted dry, x 6 steri-strips were applied with edges well approximated . Abrasion without bruising noted to L (left) forearm-cleansed with warm water and air dried, abrasion with scant bruising noted to L (left) chin, cleansed with warm water and air dried. No other injury was observed . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 5/12/25 at 2:39 PM: Interdisciplinary Documentation . at 1315 (1:15 PM) (Certified Nursing Assistant- CNA) called nurse to room, patient on floor laying on left side. Staff stated (Resident#701) slide out of sling during transfer using the mechanical lift. 2 (CNAs) were present. Laceration by left eye, six steri-strips applied. Notified doctor, (Family Member C) notified. when asked if we could send to ER for exam. (Family Member C) refused stated to monitor (Resident) here. Neuros initiated DON (Director of Nursing). hospice aware. X-rays ordered. Hospice nurse here at this time. Doctor called at this time, new orders for pain medications . Note was authored by Licensed Practical [LPN] Nurse A - 5/12/25 at 3:21 PM: This writer spoke with (Family Member C) . regrading incident and wishes for resident to not seek immediate medical attention. Education provided on risks that could result in death if treatment is not perused. (Family Member C) stated he understood and that he would like to proceed with x-rays in house and in-house monitoring. It was explained that even STAT x-rays could take 24 hours to be completed. He said he does not want (Resident #701) sent to the hospital as that is a 'harsh environment' and he did not want to make any 'rash decisions'. Witness C stated 'I would like for (Resident #701) to be comfortable, please just keep them there. HCP (Health Care Provider) notified of (Family Member C) wishes. Hospice nurse arrived and new orders obtained for comfort and any expected pain that (Resident) may experience . STAT x-rays ordered . Wound head dressed with 6 steri-strips applied to left side of forehead by IP (Infection Prevention) nurse. Hospice applied pressure dressing as head continued to bleed . - 5/13/25 at 8:37 AM: Interdisciplinary Documentation . (DON) contacted x-ray services. X-ray services stated that the order is visualized and due to a technical delay within the region the plan is to arrive to compete the ordered x-rays between 11a and noon today. - 5/13/25 at 9:40 AM: Medical Professional Note . Late Entry . Seen and evaluated today for an acute visit. Patient had a fall yesterday from the hoyer (mechanical lift) . Unable to obtain any information from (Resident #701). X-rays are pending, laceration to the left forehead with intact steri strips . Patient is on hospice . - 5/13/25 at 11:50 AM: Interdisciplinary Documentation . x-rays completed on resident, awaiting results. - 5/13/25 at 17:00 PM: Interdisciplinary Documentation . HCP aware of x-ray results, (DON) spoke with (Family Member C) over the phone to review results of x-rays and (Family Member C) is choosing not to pursue with suggested CT brain. (Family Member C) is aware of potential outcome . - 5/14/25 at 9:45 PM: Interdisciplinary Documentation .Call placed to (Family Member C), who stated they and (Family Member E) would like to have a CT of the head on an outpatient basis. Coordination of care call made to (DON) who will call (Family Member C) in the morning - 5/15/25 at 7:51 AM: Interdisciplinary Documentation . (DON) spoke with (Family Member C) and a conference call was had with (other family), Medical Director and (DON). A CT brain without contrast will be ordered for today and completed outpatient as requested by family. Family stated they are requesting the CT of the brain to make a determination if the family members should prepare for the resident passing sooner rather than later. HCP here to evaluate resident. Hospice has also been updated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 5/15/25 at 7:55 AM: Medical Professional Note . Seen and evaluated today for an acute visit . had a fall on day before yesterday from the Hoyer lift . Discussed with the nurse and family and updated and will have (Resident) go for a CT scan for the brain to rule of ICH . - 5/15/25 at 12:46 PM: Interdisciplinary Documentation . (Resident#701) had Roxanol (narcotic pain medication for severe pain) at 0730 this am with noted pain relief. At 1000 (Resident #701) was observed holding the back of the left side of their neck and facial grimacing. Roxanol could not be administered until 1130. This nurse spoke with family in building and spoke with (Family Member C) over the phone . spoke with hospice. New orders for Ativan (controlled antianxiety medication) 0.5 mg milligrams) every 4 hrs. prn (as needed) and Roxanol 0.25 ml (milliliters) every 2 hrs prn . - 5/15/25 at 10:15 PM: Interdisciplinary Documentation . Spoke with (Family Member C) to report results of today's CT head examination. Resident has intracranial bleed. The provider called the facility and asked the registered nurse to call (Witness C) to determine any further treatment. (Witness C) does not want any surgery for resident . - 5/19/25 at 12:24 PM: Interdisciplinary Documentation . Late Entry . Resident observed holding steri-strips from forehead in hand. Wound is well approximated with no drainage . Review of diagnostic imaging results in Resident #701's EMR revealed the following: - 5/13/25 at 1:51 PM: X-Ray of the Skull, 2 Views . Findings . Ill defined intracranial lucency noted over bilateral fronto-parietal regions, more pronounced on left . Intracranial Compartment . lucency is projected within the cranial vault and not clearly confined to soft tissues - may represent intracranial air . Impression: 1. Ill-defined intracranial lucency over bilateral fronto-parietal regions (frontal and parietal lobes of brain), greater on the left side- concerning for intracranial air (air in brain) in the clinical context of trauma, suggest CT scan . - 5/15/25 at 4:14 PM: CT Brain/Head w/o (without) contrast . Indication: Trauma. Intracranial hemorrhage . Findings: There is intracranial hemorrhage in the dependent occipital hors of the lateral ventricles (fluid filled area of the brain which contains cerebral spinal fluid) . Soft tissue swelling about the left extracranial (outside the skull) frontal region . Postinfarct encephalomalacia (brain tissue softening or loss which can develop days to middle brain lobe) . Impression: 1. There is intraventricular hemorrhage (bleeding in the ventricles of the brain) in the occipital (posterior -back) hors of the lateral ventricles as seen bilaterally (blood will often collect in the dependent area of the ventricles - the occipital horns when an individual is flat or recumbent) . Review of Hospice documentation in Resident #701's EMR revealed a RN PRN (as needed) Hospice Visit note dated 5/12/25 at 2:31 PM. The note detailed, Reason for PRN Visit: Pt (Patient) fell from sling today and has a large laceration . Approx. 6 in. (inch) laceration above left eye. Indicate Functional/Safety Assessment Findings: Pt fell out of Hoyer . Narrative: Received call from facility reporting that patient had fallen and requesting nurse visit. Patient was lying in bed with steri strips on left side of forehead. There was a small trickle of blood that was draining down into right eye (sic). Gauze dressing applied and covered with gauze wrap for a pressure dressing . No other complaints other than head hurting on left side . (Family Member Witness C) notified and didn't want (Resident #701) taken to hospital . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/21/25 at 1:30 PM, an interview was attempted to be completed with Resident #701's family member Witness C. A voicemail message with a return phone number was left. An interview was completed with Therapy Director Occupational Therapist (OT) K on 5/21/25 at 2:00 PM. When queried regarding Therapy Staff evaluation for mechanical lift devices including slings, OT K stated, I just eval for the slings based on (resident) weight. When asked if Therapy trains staff regarding mechanical lift use and procedures, OT K indicated they do not and stated, The nursing educator does the training. OT K was then queried regarding Resident #701's fall from the mechanical lift and indicated they were aware of the fall. When queried regarding Resident #701's ability to sit up independently and support themselves, OT K revealed Resident #701 does not really have any core strength and is not able to support themselves. On 5/21/25 at 3:00 PM, an interview was completed with the facility Administrator. When asked why the facility did not report Resident #701's fall from the Hoyer lift which resulted in severe injury, the Administrator stated, We reviewed it and it was not an injury of unknown origin. On 5/21/25 at 3:45 PM, an interview was completed with the DON. When queried why there was not a statement in the facility provided investigation documentation from Resident #701's nurse and/or the nurse who first assessed the Resident, the DON stated, I was the first nurse to respond. When asked what happened, the DON stated, I was walking down the hall and heard a request for help and went in (Resident #701's room). (Resident #701) was on their left side next to the bed. Their left arm was bent and their fist was by their chin. When asked, the DON revealed they were able to see the right side of the Resident. The DON then stated, The Hoyer was away, (Resident #701) wasn't still resting on the Hoyer. The DON was asked where the Resident's legs were and replied, Feet were out of the sling and head looked like they slightly moved it off of the leg of the Hoyer. When to clarify where the Resident's head was, the DON stated, (Resident #701's) head was just inside the legs (of the Hoyer). The DON was asked where the mechanical lift was in the room and replied, The Hoyer was moved back, and the sling was still attached to the Hoyer. (Resident #701) was completely out of the sling. When asked what they meant when they said the sling was still attached to the Hoyer, the DON responded that the sling was connected to the Hoyer lift as though a person was in it but (Resident #701) was completely out of it. When queried if they were saying that the CNA staff moved the Resident and Hoyer lift prior to the nurse responding to the room to assess, the DON replied, They lowered the sling to the ground but didn't do anything else. The DON then stated, They probably lowered it down and got the rest of (Resident #701) out. Guessing they moved it. When asked where Resident #701's Broda chair was positioned in the room, the DON replied, The Broda was moved out of the way. It was aways away. The DON was unable to provide the exact location of the chair when asked. When queried if the legs of the Hoyer lift were apart or together, the DON replied, Not sure. (continued on next page)

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	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron Woods Nursing Center	1395 South Huron Road 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 - Actual harm Residents Affected - Few	The DON was then asked the specific location of the Resident in their room and stated, Right next to the bed. We were able to get around (Resident #701) but not at the side where the bed was. The DON proceeded to draw a picture of the Resident and their room. In the picture, Resident #701 was on the floor directly next to their bed with their body and head parallel to the bed. In the image drawn by the DON, the Resident's body was pointed with their head towards the room window and their feet towards the door. The DON did not include the Resident's overbed table in the drawing. When asked where the overbed table was in the room, the DON replied, Not sure. The DON was then asked who Resident #701's assigned nurse was on the day Resident #701 fell and replied, (LPN A). When queried why the investigation documentation did not include a statement from LPN A and where they were at the time of the transfer and fall, the DON stated, I told (LPN A) we had it. Review of facility-provided investigation documentation for Resident #701's fall during mechanical lift transfer contained the following: - Signed Statement by CNA I dated 5/12/25: We was putting (Resident #701) to bed and I was right next to her in front of the lift and (CNA J) was in the back of the lift controlling it. (Resident #701) leaned forward and fell out the side. - Signed Statement by CNA J dated 5/12/25: I was operating the controls helping (Resident #701) to bed. My coworking was right next to (Resident #701) helping moved the Hoyer. (Resident #701) leaned and slipped between the straps, hitting their head on the Hoyer. - Return Demonstration Mechanical Lift Competency Check Off Sheets for Facility Staff. - Mechanical Lift Guidance Forms dated 5/14/25 for 15 Residents including Resident #701. Resident #701's form specified the Resident was a full mechanical lift using a medium sized, violet edged, Canvas, full body sling. The sling loop attachments were Upper: Green and Lower: Purple. - Typed Summary: Allegation Type: Witnessed Fall with Injury. Event Information: Event occurred on 5/12/25 at approximately 1:15 PM. (CNA I) and (CNA J) were assisting . (Resident #701) to bed . utilizing an Invacare mechanical lift and an Invacare mesh sling . from their Broda chair to their bed . (CNA J) was working the controls at the base of the mechanical lift while (CNA (I) was next to the resident on the residents right side. The bed was on the resident's left side. (CNA I) was guiding the resident from the Broda chair towards the bed as the height of the lift was being adjusted by (CNA J). (CNA I) was on the right side when the resident leaned too far left and slipped out of the mesh sling that was attached to the mechanical lift. It was observed that the resident touched the left side of their forehead to the leg of the mechanical (lift), th[TRUNCATED]