STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235623	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royalton Manor, L L C	288 Peace Blvd St Joseph, MI 49085

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 0684 Level of Harm - 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** 46999 This citation pertains to intake #MI00147013 Based on observations, interview, and record review the facility failed to provide prompt medical care after a fall for 1 (Resident #100) of 4 residents reviewed for falls resulting in Resident #100 experiencing significant pain, suffering, and a delay in emergent care after a fall with fracture. Findings include: Resident #100 Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: age-related osteoporosis (disease that causes the bones to become weak and more likely to break), alzheimer's disease (disease that causes loss of cognitive abilities), fracture of pelvis, and falls. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 7/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #100 was unable to complete the assessment. Section E of the MDS revealed Resident #100 did not reject care during the assessment period. Section GG revealed Resident #100 ambulated up to 50' with supervision and no device. Review of a Care Plan for Resident #100, with a reference date of 7/10/23, revealed a focus/goal/interventions of: Focus: (Resident #100) is at risk for fall related injury and falls R/T (related to) hx (history) of multiple falls .Goal: Will be free from injury related falls .Interventions: Encourage resident to be out in common area when seen ambulating .redirect resident with activity when beginning to wander . Review of an Incident Report for Resident #100 with a reference date of 9/16/24 revealed at 8:00pm, the resident had a witnessed fall during which she landed on her bottom. A section titled Injuries Observed at Time of Incident revealed no injuries observed at time of incident. Review of a Change of Condition Evaluation for Resident #100, written by LPN E on 9/17/24 at 12:48am, a section titled Signs and Symptoms Identified revealed: fall, pain, trauma .right leg is turned outward and shorter than left leg significantly . (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: 235623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Royalton Manor, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 288 Peace Blvd St Joseph, MI 49085	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Pain Scale report for Resident #100 revealed the resident's pain level was assessed as an 8 out of 10 by LPN E on 9/17/24 at 1:08am. Review of Resident #100's medical record revealed no Change of Condition Evaluation, or post fall assessment completed by RN D for the resident's fall on 9/16/24. Review of Resident #100's physician's orders revealed an order for a two view right hip x-ray was entered by LPN E at 12:28am. Review of a Radiology Report for Resident #100 with a reference date and time of 9/17/24 at 1:03am revealed: Findings: there is an acute communicated right femoral intertrochanteric fracture (hip fracture) . In an interview, Emergency Medical Technician (EMT) G reported he cared for Resident #100 as she was transported to the local acute care hospital on 9/17/24 at approximately 1:15am. EMT G reported Resident #100 yelled out in pain with any movement and had an obvious shortening and rotation of her right leg. Review of a History and Physical report for Resident #100 with a reference date of 9/17/24, from a local emergency room , revealed Extremities: Exam of right lower extremity reveals diffuse tenderness (widespread pain) with any hip movement, shortening and external rotation of the leg . Review of a Physician Discharge Summary for Resident #100, from a local acute care hospital, with a reference date of 9/20/24, revealed a summary of hospital stay: .femur fracture with intramedullary nailing (surgical repair) on 9/17/24 . During an observation on 10/2/24 at 3:49pm, Resident #100 sat in the community room in a wheelchair, wore a hospital gown, grimaced and furrowed her brow, as she rubbed her right upper thigh. In an interview on 10/3/24, at 9:18am, Registered Nurse (RN) D reported she was the nurse who responded when Resident #100 fell on [DATE] at 8:00pm. RN D reported Resident #100 was lying on her right side in the hallway near her room. When queried about assessing Resident #100 for injuries while she was on the floor, RN D stated At that time I didn't do an assessment. I wanted to get her off the floor. RN D reported she and 2 Certified Nursing Assistants (CNAs) lifted Resident #100 into a wheelchair and then transferred her to bed. RN D reported she assessed Resident #100 as she laid in bed and at that time, noticed Resident #100's right foot had an outward rotation which was an indication of a potential fracture. When further queried, RN D reported she did not pursue getting an order to transport Resident #100 to the hospital because she thought it was protocol to get an x-ray first. RN D reported she could not recall if she informed the provider of Resident #100's outward leg rotation. In an interview on 10/3/24 at 12:37pm, Certified Nursing Assistant (CNA) M she responded when Resident #100 fell on [DATE]. CNA M described Resident #100 as hysterical, yelling Ow repeatedly as she laid on the floor. CNA M reported she, RN D, and another CNA assisted Resident #100 to standing but the resident could not bear weight on her right leg and was ultimately transferred to a wheelchair. CNA M reported Resident #100 grimaced and pointed to her right leg as she sat in the wheelchair. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 10/3/24 at 2:57pm, Certified Nursing Assistant (CNA) K reported Resident #100 complained of hip pain immediately after her fall on 9/16/24. CNA K reported prior to the fall, Resident #100 could walk without assistance but after the fall, the resident could not bear weight on her right leg. CNA K reported Resident #100 struggled to verbally express herself due to her dementia, but in the hours after her fall, she appeared painful, refused to allow anyone to touch her, guarded her leg, and repeatedly said I fell , I fell . In an interview on 10/3/24, at 8:50am, Licensed Practical Nurse (LPN) E reported on 9/16/24 a few hours after the fall, RN D asked LPN E to come take a look at Resident #100 and at that time, RN D also asked if she should call a provider to inquire about getting an x-ray for the resident. LPN E reported when she assessed Resident #100, the resident was complaining of pain in her right leg, had a shortening and rotation of her right leg, and could not tolerate passive range of motion to the extremity. LPN E reported a resident who fell should never be moved prior to the completion of a thorough assessment for injury and that a failure to properly assess the resident could result in lack of identification of injuries and the development of complications. LPN E reported Resident #100 should have gone to the hospital immediately after her fall. In an interview on 10/3/24 at 11:15am (RN) C reported a full assessment should be completed immediately after a resident fall, prior to moving the resident. If the resident was painful or has a gross anomaly such as foot rotation or shortening of a leg, the physician should be contacted immediately, and the resident should be sent to the emergency room for further evaluation. In an interview on 10/3/24 at 2:19pm, Director of Nursing (DON) B reported a post fall assessment should be completed by the nurse prior to moving a resident who had fallen. The post fall assessment should include taking vital signs, assessing for pain, performing range of motion, checking pedal pulses, visual inspection for physical injuries. Upon completion of the assessment, the nurse should then report the findings to the primary care provider and take the action of the provider as directed. In an interview on 10/3/24 at 8:34am, Family Member (FM)/Durable Power of Attorney (DPOA) I for Resident #100 reported he received notification of the resident's fall on 9/16/24 at approximately midnight. When queried about his wishes for Resident #100 regarding hospitalization , FM I reported he wanted Resident #100 to be transported to the emergency room for evaluation if she fell and appeared to have an injury. FM I reported he believed it would have been in Resident #100's best interest to go to the hospital at the time of the fall. FM I reported Resident #100 had intense pain prior to the surgical repair of the hip fracture that she suffered during the fall on 9/16/24. In an interview on 9/17/24 at 2:35pm, Medical Director (MD) F reported a resident who had a rotation or shortening of a leg after a fall should be transported to the emergency room immediately because those were signs of a serious injury.