| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235658 | A. Building<br>B. Wing | 02/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Regency at Bluffs Park | 355 Huronview Blvd<br>Ann Arbor, MI 48103 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the care plan for one (R200) of three residents reviewed. Findings include:A review of the clinical record revealed R200 was admitted into the facility on [DATE] with diagnoses that included: hypotension, muscle wasting and atrophy, malaise and Liver cell carcinoma. According to the Minimum Data Set (MDS) assessment dated [DATE], R200 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). Review of Section GG: Functional Limitation in Range of Motion revealed the following:Lower extremity (hip, knee, ankle, foot)-impairment on one side. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support-substantial/maximal assistance. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed-substantial/maximal assistanceToilet transfer: The ability to get on and off a toilet or commode-dependent. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space-dependentA review of the Incident report for R200, dated 11/15/2025, revealed the following:Nursing Description: Resident was ambulating with CNA (certified nursing assistant) to the restroom when he fell flat on his back while transferring to the bathroom. CNA said (she) witnessed the fall, she said he fell backwards and went unconscious. Writer was immediately called, resident was lying on the floor on his back. He started responding, vitals were stable.Resident Description: Resident unable to give description. Level of Pain: PAINAD (Pain Assessment in Advanced Dementia-a pain scale used by caregivers to measure pain in residents with severe dementia or cognitive impairment): 7.Breathing: 1 (Score), (Detail)Occasional Labored Breathing. Short Period of Hyperventilation.Negative Vocalization: 1, Occasional Moan or Groan. Low Level of Speech with a Negative Quality.Facial Expression: 2, Facial Grimacing. Body Language: 2, Rigid, Fists, Clenched, Knees Pulled up or Pushing Away Striking Out.Consolability: 1, Distracted or Reassured by Voice or Touch.Level of Consciousness: Lethargic (Drowsy).Injuries Report Post Incident: Injury Type-Fracture, Injury Location-Top of Scalp.Notes: subdural hematoma, skull fracture, brain compression.Predisposing Physiological Factors: Weakness/Fainted.Predisposing Situation Factors: Ambulating with Assist, Other-ambulating with nursing.A review of the Summary for Failure to follow residents care plan, revealed In-depth analysis how the deficiency occurred: On 11/15/2025 resident (initials redacted-R200) call light was on, CNA (initials redacted-CNA B) answered the light, and he requested to be taken to the restroom to have a bowel movement. CNA ( B) preceded to assist the resident out of bed and walked him to the restroom using the walker and standby assist, a gait belt wasn't used. The CNA (CNA B) turned away to open the door to the bathroom when the CNA (CNA B) heard what sounded like the door hitting a trash can. When the CNA (CNA B) turned back around, she observed the resident on the floor positioned on his back with loss of consciousness. Resident care plan stated resident requires substantial/maximal assistance with two helpers and the use of rolling walker with<br><br>(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: 235658 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/20/2026 |
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| NAME OF PROVIDER OR SUPPLIER Regency at Bluffs Park | | STREET ADDRESS, CITY, STATE, ZIP CODE 355 Huronview Blvd Ann Arbor, MI 48103 | |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | therapy only. The resident was sent to (hospital name redacted) Hospital where right parietal and temporal skull fracture, left occipital condyle fracture, and minor frontotemporal contusions were identified. Interview with therapy regarding residents abilities and rationale for nursing not being able to ambulate resident since he was able to walk. Was on OT (occupational therapy) & PT (physical therapy) services with focus on strengthening, balance, ADLs (activities of daily living), transfer and gait training. Had poor strength and balance. Required Max (maximum) assist for transfer along with increased time for processing and verbal cues for hand placement and proper tech (technique). Attempted gait training, using RW (rolling walker) and max assist. Required verbal and tactile cues for tech for safety and balance. Status was ambulation with therapy only d/t (due to) the assist level and needed cues for safety and tech. Transfer status for staff was sit to stand lift (device used to assist with transferring residents with balance/strength deficits) for safety as cont (continued) with poor strength and balance.A review of R200's Therapy to Nursing Communication, dated for 10/28/25 revealed Ambulatory Status: Substantial/Maximal (assistance), Rolling Walker, In Therapy Only.Transfers: 2 assist, sit to stand lift, substantial/maximal.Comments: Fall RiskA review of R200's Kardex revealed the following: Safety.Provide assistive devices as needed: sit to stand lift for transfers with wc (wheelchair) for ambulation.Transferring.Transfer: Resident requires substantial/maximal assistance with two helps, sit to stand lift.Toileting.Toilet Transfer: Resident requires substantial/maximal assistance with (one, two) helper(s).A review of R200's Care Plan Report revealed the following:(Name redacted) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): Impaired Balance, Date initiated 10/27/2025.Interventions: AMBULATION/WALKING: Resident requires substantial/maximal assistance with rolling walker in therapy only with (one, two) helper(s), Date initiated 10/30/2025.Interventions: Transfer: Resident requires substantial/maximal assistance with two helps, sit to stand lift, Date initiated 10/30/2025.Interventions: TOILET TRANSFER: Resident requires substantial/maximal assistance with (one, two) helper(s), Date initiated 10/30/2025.On 2/20/2026 at 1:56 PM, during a telephone interview with CNA B, it was reported that on the morning of 11/15/25, she had gotten R200 up out of bed and attempted to get him to the bathroom with a walker and grippy socks only (no gait belt or other assistive devices were used), R200 was in a standing position, and CNA B reached to open the bathroom door, she heard a loud sound, turned back around and saw R200 on the floor, R200 was not responding initially. CNA B stepped out in the hallway to get a nurse and CNA G was on her way into the room at that time. Once CNA G had arrived R200 had started to regain consciousness. LPN C entered the room, took residents vital signs, an ambulance was called and the resident was sent out to the hospital. CNA B reported being aware that the Kardex should be used to determine the level of assistance a resident requires. When asked if she had checked the Kardex for R200 she reported that she had not because she had taken care of him before and didn't think to check. CNA B reported that after this incident she received education related to safe transfers, gait belt use and following care plans but did not receive any formal discipline.On 2/20/2026 2:46 PM, during a telephone interview with LPN D (a floor nurse that had provided care for R200 in the past), it was reported that R200 walked with nursing staff (x2) with assistance and a walker. LPN D reported that R200 could get up to the walker fine with 2 people next to him but needed more assistance getting off the toilet due to his height. When asked what nursing staff should use to determine the level of assistance a resident requires, LPN D reported they use to use the ADL book but now look at the Kardex. On 2/20/2026 at 12:55 PM, during an interview with Director of Nursing, it was reported that R200 fell while being ambulated to the bathroom with a gait belt and walker (the DON later corrected this statement to indicate that a gait belt was not used), he fell backwards<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Regency at Bluffs Park | | STREET ADDRESS, CITY, STATE, ZIP CODE 355 Huronview Blvd Ann Arbor, MI 48103 | |

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| F 0656<br>Level of Harm - Minimal harm or potential for actual harm<br>Residents Affected - Few | as the CNA was opening the bathroom door, she yelled for the nurse, CNA told the nurse that resident had been unconscious but was awake when the nurse arrived, he was sent out to the hospital where they did imaging that revealed he had a skull fracture and a brain bleed. DON reported that nursing staff should refer to the Care plan or Kardex to determine what level of assistance a resident requires and that through the facilities investigation it was determined that the care plan was not followed and the resident should not have been ambulating with nursing staff due to weakness and immobility. DON reported that through their interviews it was determined that R200 had ambulated with nursing staff prior to this incident and that there was a walker at his bedside.Review of R200's Death Certificate revealed the following:date of death : November 30, 2025. Immediate cause of death: Complications of blunt force head trauma and Fall. Date of injury: 11/15/2025. Time of Injury: 0645 on or aboutDescribe how injury occurred: The decedent fell from standing height. Place of Injury: Nursing HomeA review of the facilities policy titled Fall Management, documented in part Residents identified at risk for falls will have an initial plan of care developed to meet each resident's needs. Interventions should be related to the risk factors as well as incorporating resident choice to help minimize the risk of a fall. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent a fall for one (R200) of three residents reviewed, resulting in major injury.Findings include:A review of the clinical record revealed R200 was admitted into the facility on [DATE] with diagnoses that included: hypotension, muscle wasting and atrophy, malaise and Liver cell carcinoma. According to the Minimum Data Set (MDS) assessment dated [DATE], R200 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). Review of Section GG: Functional Limitation in Range of Motion revealed the following:Lower extremity (hip, knee, ankle, foot)-impairment on one side. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed and with no back support-substantial/maximal assistance. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed-substantial/maximal assistanceToilet transfer: The ability to get on and off a toilet or commode-dependent. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space-dependentA review of the Incident report for R200, dated [DATE], revealed the following:Nursing Description: Resident was ambulating with CNA (certified nursing assistant) to the restroom when he fell flat on his back while transferring to the bathroom. CNA said (she) witnessed the fall, she said he fell backwards and went unconscious. Writer was immediately called, resident was lying on the floor on his back. He started responding, vitals were stable.Resident Description: Resident unable to give description. Level of Pain: PAINAD (Pain Assessment in Advanced Dementia-a pain scale used by caregivers to measure pain in residents with severe dementia or cognitive impairment): 7. Breathing: 1 (Score), (Detail)Occasional Labored Breathing. Short Period of Hyperventilation. Negative Vocalization: 1, Occasional Moan or Groan. Low Level of Speech with a Negative Quality. Facial Expression: 2, Facial Grimacing. Body Language: 2, Rigid, Fists, Clenched, Knees Pulled up or Pushing Away Striking OutConsolability: 1, Distracted or Reassured by Voice or Touch. Level of Consciousness: Lethargic (Drowsy). Injuries Report Post Incident: Injury Type-Fracture, Injury Location-Top of ScalpNotes: subdural hematoma, skull fracture, brain compression. Predisposing Physiological Factors: Weakness/Fainted. Predisposing Situation Factors: Ambulating with Assist, Other-ambulating with nursingA review of the facilities Summary for Failure to follow residents care plan, revealed In-depth analysis how the deficiency occurred: On [DATE] resident (initials redacted-R200) call light was on, CNA (initials redacted-CNA B) answered the light, and he requested to be taken to the restroom to have a bowel movement. CNA ( B) preceded to assist the resident out of bed and walked him to the restroom using the walker and standby assist, a gait belt wasn't used. The CNA (CNA B) turned away to open the door to the bathroom when the CNA (CNA B) heard what sounded like the door hitting a trash can. When the CNA (CNA B) turned back around, she observed the resident on the floor positioned on his back with loss of consciousness. Resident care plan stated resident requires substantial/maximal assistance with two helpers and the use of rolling walker with therapy only. The resident was sent to (hospital name redacted) Hospital where right parietal and temporal skull fracture, left occipital condyle fracture, and minor frontotemporal contusions were identified. Interview with therapy regarding residents abilities and rationale for nursing not being able to ambulate resident since he was able to walk. Was on OT (occupational therapy) & PT (physical therapy) services with focus on strengthening, balance, ADLs (activities of daily living), transfer and gait training. Had poor strength and balance. Required Max (maximum) assist for transfer along with increased time for processing and verbal cues for hand placement and proper tech (technique). Attempted gait training, using RW (rolling walker) and max assist. Required<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | verbal and tactile cues for tech for safety and balance. Status was ambulation with therapy only d/t (due to) the assist level and needed cues for safety and tech. Transfer status for staff was sit to stand lift (device used to assist with transferring residents with balance/strength deficits) for safety as cont (continued) with poor strength and balance.A review of R200's Therapy to Nursing Communication, dated for [DATE] revealed Ambulatory Status: Substantial/Maximal (assistance), Rolling Walker, In Therapy Only.Transfers: 2 assist, sit to stand lift, substantial/maximal.Comments: Fall RiskA review of R200's Physical Therapy PT Evaluation and Plan of Treatment, dated [DATE], revealed the following:Reason for Referral: Patient exhibits exacerbation of decrease in strength, decease in transfers, reduced balance and decreased neuromotor control indicating the need for PT to promote safety. awareness, minimize falls, improve dynamic balance and enhance rehab potential. Strength/Manual Muscle Testing: Lower extremity, RLE (right lower extremity)=2+/5, LLE (left lower extremity)=2+/5. Functional Assessment: Transfers=Max/2 Sit to Stand=Max/2A review of R200's Physical Therapy Treatment Encounter Note, dated [DATE], documented in part patient co (complains of) dizziness BP (blood pressure) in standing 77/39 and in sitting 89/49, returned patient back to his bed and nursing has been notified.A review of R200's Physical Therapy Discharge summary, dated [DATE]-[DATE], revealed the following:Dynamic Standing: Baseline ([DATE]) Poor (stands with Mod A (moderate assistance) and minimally reaches ipsilaterally, unable to cross midline), Previous ([DATE]) Poor+ (stands with Min A and reached ipsilaterally, unable to weight shift). Distance Level Surfaces (ambulation): Baseline ([DATE]) 0 feet, Previous ([DATE]) 20 feet Max/2A review of R200's Occupational Therapy, Therapy Progress Report, dated [DATE]-[DATE], revealed the following: Toileting: Baseline ([DATE]) Max/2, Previous ([DATE]) Max/2, Current ([DATE]) Max/2.Review of R200's Occupational Therapy Treatment Encounter Note, dated [DATE], revealed the following: Functional Skills Assessment-Activities of Daily Living/Self Care-Toileting-Max/2. Functional Skills Assessment-Mobility During ADLs-Functional Mobility During ADLs=Max/2A review of R200's Kardex revealed the following: Safety.Provide assistive devices as needed: sit to stand lift for transfers with wc (wheelchair) for ambulationTransferring.Transfer: Resident requires substantial/maximal assistance with two helps, sit to stand lift Toileting.Toilet Transfer: Resident requires substantial/maximal assistance with (one, two) helper(s)A review of R200's Care Plan Report revealed the following:(Name redacted) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): Impaired Balance, Date initiated [DATE]. Interventions: AMBULATION/WALKING: Resident requires substantial/maximal assistance with rolling walker in therapy only with (one, two) helper(s), Date initiated [DATE]. Interventions: Transfer: Resident requires substantial/maximal assistance with two helps, sit to stand lift, Date initiated [DATE]. Interventions: TOILET TRANSFER: Resident requires substantial/maximal assistance with (one, two) helper(s), Date initiated [DATE].A review of Skilled Nursing Facility Progress Note-completed by the facilities Nurse Practitioner, dated [DATE], documented in part He (R200) says he feels weak, legs are weak and go out on him a lot.Assessment: 1. Physical deconditioning, 2. Dizziness, 3. Lightheadedness, 4. Generalized weakness.Medical Plan of Care: Generalized weakness with gait instability Physical Deconditioning-Continue PT/OT while at SAR (subacute rehab), He will need Home Care upon discharge from SAR; Dizziness, lightheadedness-Encourage increase po (oral) fluid intake, Counseled patient on need to reposition slowly.A review of Skilled Nursing Facility Progress Note-completed by the facilities Nurse Practitioner, dated [DATE], documented in part Assessment: 1. Dysuria, 2. Increased urinary frequency, 3. Dizziness, 4. Lightheadedness, 5. Generalized weakness, 6. Physical deconditioning .Medical Plan of Care: Generalized weakness with gait instability Physical Deconditioning-Continue PT/OT while at SAR, He will need Home Care upon discharge from SAR; Dizziness,<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | lightheadedness-Encourage increase po fluid intake, Counseled patient on need to reposition slowly.A review of R200's progress notes revealed the following: On [DATE] at 07:54. Nurses Notes, Late Entry: Note Text: Resident was sent out to the hospital via ambulance accompanied by HVA (initials for ambulance company) due to a fall with injury. Vitals were stable, resident was lethargic and disorient(ed). Pupils were non reactive to light bilaterally, resident fall backwards on the floor, he hit his head and went unconscious for a moment. Responsible party and on call MD was notified. On [DATE] at 13:45. Change In Condition, Change In Condition Symptoms: AMS (altered mental status), more confusion. Current Vital Signs: BP 111/57 resp (respirations)18. Pulse 77.temp 97.4. O2 94.Nursing Action Taken: vital signs, contact Md, assessment. Practitioner Notification and Recommendations: order labs cbc (Complete blood count) with diff (differential), BMP (Basic metabolic panel) and UA C&S (urinalysis with culture and sensitivity).On [DATE] at 11:55 Behavior Note, Note Text: writer received call from patient's (family member redacted) that patient reported to have call light on for hours. Writer went up to patient's room, call light not on, CNA and Nurse right outside patient's room report patient's light has not been on for any extended time today. Call light in place, patient resting comfortable and not soiled. Visited with patient who reported to have had call light on for awhile. Call light monitoring has been initiated. Patient did not have any needs not met when visiting.On [DATE] at 09:35 Nurses Notes. Note Text: orthostatic blood pressures per MD one time only. 135/68 laying 80hr, 16resp, 97.9 temp, 94%. sitting 87/40, 96 hr, 19rsp 97.9 temp 94%standing 109/87, 91hr, 95%, 20resp.On [DATE] at 1:56 PM, during a telephone interview with CNA B, it was reported that on the morning of [DATE], she had gotten R200 up out of bed and attempted to get him to the bathroom with a walker and grippy socks only (no gait belt or other assistive devices were used), R200 was in a standing position, and CNA B reached to open the bathroom door, she heard a loud sound, turned back around and saw R200 on the floor, R200 was not responding initially. CNA B stepped out in the hallway to get a nurse and CNA G was on her way into the room at that time. Once CNA G had arrived R200 had started to regain consciousness. LPN C entered the room, took residents vital signs, an ambulance was called and the resident was sent out to the hospital. CNA B reported being aware that the Kardex should be used to determine the level of assistance a resident requires. When asked if she had checked the Kardex for R200 she reported that she had not because she had taken care of him before and didn't think to check. CNA B reported that after this incident she received education related to safe transfers, gait belt use and following care plans but did not receive any formal discipline. On [DATE] at 11:45 AM, during a telephone interview with LPN C, it was reported that she was the nurse assigned to R200 for the 11/14 to [DATE] shift. LPN C reported that she had seen R200 around 5:30 AM to give him his meds and he was alert and oriented at that time. LPN C was called to R200's room around 6 AM by the CNA, she grabbed the vital signs machine and when she arrived to his room he was observed on the floor, flat on his back, near the end of his bed and in front of his dresser. Upon her arrival R200 was speaking but was out of it, requesting to get back in bed and asking for his wife. LPN C reported that she told R200 that she couldn't get him back in bed at that time, his vital signs were stable, eyes were dilated, and he could squeeze her hands. LPN C reported that she stayed with the resident until paramedics arrived, which she estimated to be approximately 15-20 minutes from the time of his fall. LPN C denied being aware of R200 recently experiencing any dizziness or low blood pressure. LPN C believed that R200 was a one person assist at the time of his fall and used the urinal at night unless he needed to have a bowel movement.On [DATE] at 2:46 PM, during a telephone interview with LPN D (a floor nurse that had provided care for R200 in the past), it was reported that R200 walked with nursing staff (x2) with assistance and a walker. LPN D reported that R200 could<br><br>(continued on next page) |

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| F 0689<br>Level of Harm - Actual harm<br>Residents Affected - Few | get up to the walker fine with 2 people next to him but needed more assistance getting off the toilet due to his height. When asked what nursing staff should use to determine the level of assistance a resident requires, LPN D reported they use to use the ADL book but now look at the Kardex. When asked why she had completed a set of orthostatic vital signs on R200, she reported not being sure but thought the doctor could have ordered them because the resident felt dizzy after therapy. When asked what she had done with the results she was unsure but reported she probably followed up with the doctor. When asked if she knew what the criteria was for the results to be considered positive, she reported not remembering. On [DATE] at 12:55 PM, during an interview with Director of Nursing, it was reported that R200 fell while being ambulated to the bathroom with a gait belt and walker (after reviewed the PNC that she had completed the DON later corrected this statement to indicate that a gait belt was not used), he fell backwards as the CNA was opening the bathroom door, she yelled for the nurse, CNA told the nurse that resident had been unconscious but was awake when the nurse arrived, he was sent out to the hospital where they did imaging that revealed he had a skull fracture and a brain bleed. DON reported that nursing staff should refer to the Care plan or Kardex to determine what level of assistance a resident requires and that through the facilities investigation it was determined that the care plan was not followed and the resident should not have been ambulating with nursing staff due to weakness and immobility. DON reported that through their interviews it was determined that R200 had ambulated with nursing staff prior to this incident and that there was a walker at his bedside. When asked if she knew why a set of orthostatic vital signs were completed on [DATE], she reported that she did not and would let me know if she was able to determine that (no additional information was provided prior to survey exit). When asked if any new interventions were put in place for residents dizziness, lightheadedness and hypotension, DON reported that she would let me know if she found any documentation of new interventions (no additional information was provided prior to survey exit). When asked what the expectation was for gait belt use, DON reported that a gait belt should be used for all transfers for anyone that requires any level of assistance.Review of R200's Death Certificate revealed the following: date of death : [DATE]. Immediate cause of death: Complications of blunt force head trauma and FallDate of injury: [DATE], Time of Injury: 0645 on or about, Describe how injury occurred: The decedent fell from standing height, Place of Injury: Nursing Home.A review of the facilities policy titled Fall Management, documented in part Residents identified at risk for falls will have an initial plan of care developed to meet each resident's needs. Interventions should be related to the risk factors as well as incorporating resident choice to help minimize the risk of a fall.A review of the facilities policy titled Routine Resident Care, documented in part Staff members should observe the following safety precautions with all residents.Gait belts are used for transfers and ambulation, as indicated.R200's care plan, Kardex and Therapy to Nursing Communication sheet indicated resident should have been ambulated by therapy only. The resident was ambulated by a single (non-therapy) staff member without a gait belt or use of sit to stand, despite documentation that resident had experienced lightheadedness/dizziness, episodes of hypotension and required substantial/maximal assistance which resulted in major injury (multiple skull fractures and brain bleed). |