STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235706	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at Lansing West	12200 Broadbent Lansing, MI 48917

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** 46954 This citation pertains to intake MI00150279. Based on interview and record review, the facility failed to prevent a fall for one (Resident #150) of three reviewed for accidents, resulting in a fall with bilateral femur fractures when Resident #150 fell from her bed. Findings include: Resident #150 (R150) Review of the medical record reflected R150 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included dementia, senile degeneration of brain, right femur pathological fracture, and left femur pathological fracture. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/24, reflected R150 scored 7 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R150 no longer resided in the facility. Review of R150's Care Plan revealed R150 was a two person assist with the use of a Hoyer for transfers and ambulated via wheelchair with staff assist. Review of a Nurses Note dated 7/22/2024 at 7:28 PM revealed Guest (R150) was observed on floor next to bed .with head towards foot of bed. Bed was noted to be in elevated position. Guest not able to state how incident occurred r/t (related to) cognitive impairment. Guest c/o (complained of) pain to LUE (left upper extremity), and left knee. Guest not able to provide pain details r/t (related to) cognitive impairment. Rounding provider at facility in to evaluate guest at time of incident, and unable to assess guest for injury r/t positioning and c/o pain .and potential injury r/t height of bed at time of fall. Review of an Incident Report dated 7/22/24 confirmed that R150's bed was in an elevated height position at the time of her fall out of bed. Review of R150's Fall Care Plan revealed an intervention added on 7/23/24 which stated Bed to be in lowest position at all times unless performing cares. Bed remote to be out of patient reach due to cognitive inability to safely position bed. (continued on next page)

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	Review of a Nurses Note dated 2/1/25 at 6:56 AM revealed Guest (R150) had had an unwitnessed fall upon shift change. She was found in the opposite side of her bed hollowed [sic] for help . Called 911 to send guest out due to fall generalized pain. Resident states that she has intense pain on Left knee and lower limb and back .transferred to [NAME] Hospital at 7 AM . Review of an Incident Report dated 2/1/25 stated guest (R150) observed on the floor with her head at the foot of her bed with head slightly under and her hands holding the side of the bed. The incident happened upon shift change. Both caregivers who happened to be close to the guest's room upon overhearing guest called for help. The fall was unwitnessed .guest voiced to be in severe pain .guest stated that she was trying to go to the bathroom . The immediate action taken section of the Incident report stated, resident transferred to hospital .Ct scan and x-rays of bilateral lower extremities showed pathological fractures to bilateral femurs . resident underwent surgical repair .discipline provided to CENA (certified nursing assistant) as bed was waist level after cares provided .physician documentation and orthopedic review indicated pathological fractures that likely [were] caused [by] the fall when resident attempted to stand out of bed. The same incident report revealed an investigation for the fall that occurred on 2/1/25. The investigation revealed R150 was interviewed prior to being transferred out to the hospital and R150 stated that she was attempting to stand up and walk to the bathroom. She reported that she stood up, immediately went down, and was in pain. R150's room was evaluated post fall, and her bed was noted at a waist level height and the bed controller was attached to the headboard. Director of Nursing (DON) B interviewed LPN E and CNA F on 2/3/25 who stated that they observed R150 on the floor calling for help. They reported that the call light was on the floor at the head of the bed and that R150's bed was waist high. The investigation report indicated that CNA H was interviewed and stated that she performed care on R150 at approximately 5:15 AM. CNA H reported that she left the bed at waist level position upon completion of care. CNA H was educated that the bed was to be in the lowest position possible, and at the time of the fall the bed was noted to be at waist level. Review of the After Visit Summary from R150's hospitalization revealed the following (R150) female was admitted to the trauma service following a fall that resulted in bilateral (left and right) femur fractures. Upon evaluation, it was determined that she required surgical intervention. Orthopedic surgery was consulted, and the patient underwent an open reduction internal fixation (ORIF) procedure using a . rod for stabilization of the fractures .Although the decision was made to proceed with surgery initially, post-operative discussions led to the conclusion that the focus should shift to comfort measures only, in alignment with the family's wishes. Throughout her hospital stay, [R150'S] pain was well-managed, and efforts were made to ensure her comfort during recovery .Despite her surgical intervention, the overarching goal was to honor her and her family's preferences regarding end-of-life care. The medical team provided education and support for transitioning to hospice care, emphasizing the importance of quality of life during this time . Further review of the After Visit Notes from the hospital revealed R150 sustained bilateral supracondylar fractures of the femur. According to the National Library of Medicine, this classification of fracture is most commonly causes by a high impact trauma to the bone. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/20/25 at 10:38 AM, Certified Nursing Assistant (CNA) D reported having familiarity with R150 and the fall that occurred on 2/1/25. CNA D stated that she was walking down the hallway when she overheard R150 calling out for a doctor. When CNA D entered the room, she observed R150 on the floor of her room next to her bed. R150 had obvious deformity of both legs. CNA D stated that the height of the bed was waist level, confirming that the bed was not in the lowest position per the plan of care. In an interview on 2/20/25 at 11:30 AM, Licensed Practical Nurse (LPN) E stated that she was working the day of R150's fall on 2/1/25. LPN E indicated that she observed R150 on the floor next to her bed with obvious deformity to both legs. LPN E stated that R150's bed was up pretty high confirming that the height of the bed was not low, per the care plan. In an interview on 2/20/25 at12:47 PM, CNA H reported that she was working the night shift when R150 sustained the fall on 2/1/25. CNA H stated that she had completed care on R150 at 5:15 AM, and before exiting the room, did not ensure that R150's bed was in the low position like it should have been. CNA H confirmed that she had received education regarding the bed height after R150's fall. In an interview on 2/20/25 at 1:27 PM Registered Nurse (RN) C stated that she was working the morning that R150 sustained the fall out of bed. RN C stated that she had entered the room of R150 and observed her on the floor next to her bed. RN C reported that the height of the bed was high and not in the low position per the care plan. Review of a Social Services reevaluation dated 2/7/25 reflected R150 had experienced trauma from a nursing care setting and stated, resident fell out of bed, [family member] stated that this was traumatic for the resident. Review of the Physician orders for R150 reviewed a new order dated 2/6/25, after readmission, for oral solution Morphine 0.25 milliliters every four hours for pain. In an interview on 2/20/25 at 1:21 PM, RN G stated that R150 had increased pain after the readmission to the facility, especially with activities of daily living and with repositioning. In an interview on 2/20/25 at 2:16 PM, DON B stated she was contacted the morning of R150's fall. Staff reported R150 was found on the floor after calling out for help and presented with pain and obvious deformity on bilateral lower extremities. DON B interviewed staff and concluded that the plan of care was not followed when the CNA did not ensure that R150's bed was low before exiting the room. DON B confirmed that the CNA received a disciplinary action and education.