

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Regency at Lansing West		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2740541. Based on interview and record review, the facility failed to prevent a fall for 1 (R1) of three reviewed. Findings include: Review of the complaint received by the State Agency revealed [R1] had a fall on 12/26/25. [R1] was in her bedroom, and the tech [Certified Nursing Assistant (CNA)] got her up from her bed and left her standing on her own and went around to the bathroom and [R1] fell on her arm and leg. Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included history of falling, fracture of humerus, and joint replacement surgery. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/25 revealed R1 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Discharge MDS with an ARD of 1/30/26 revealed R1 had one fall without injury since admission/prior assessment. Review of the Functional Ability Deficit care plan initiated 12/13/25 revealed an intervention dated 12/15/25 that revealed R1 requires touching assistance with one helper and 2ww [2-wheel walker] for ambulation/walking. Review of the Nurses Note dated 12/26/25 and authored by Licensed Practical Nurse (LPN) D revealed guest attempted to transfer from bed to walker. Guest observed on the floor at the foot of the bed .complained of mild [pain] near incision site on shoulder. Guest encouraged to use call light for assistance with ambulation. Review of a second Nurses Note dated 12/26/25 revealed Guest observed on the floor by nursing staff. Guest stated I was trying to get to my walker .Guest educated on safety measures and to request assistance with ambulation. Review of the fall Incident Report dated 12/26/25 revealed R1 had an unwitnessed fall and was observed on the floor at the foot of the bed. The resident description of the event revealed Resident stated that she was ambulating to the bathroom, using her walker with CNA present and she lost her balance. In a telephone interview on 3/5/26 at 3:13 PM, LPN D reported on 12/26/25 a code purple was called to R1's room and by the time she arrived at the room, R1 was on the floor at the foot of her bed. In an interview on 3/5/26 at approximately 3:45 PM, RN F reported R1 was a touch assist with ambulation which meant a gait belt should be used and touching/guiding assistance was needed. RN F reported she did not witness R1's fall. In a telephone interview on 3/5/26 at 4:10 PM, CNA E reported they came in at the tail end of R1's fall and saw the other aide lowering her [R1] to the floor. CNA E reported there was a walker, but they had it to the side of them with a hand on the walker, but not really using it. CNA E reported a gait belt was not being used. Attempts were made to contact CNA C via telephone on 3/5/26 at 2:46 PM and 4:25 PM without success. On 3/5/26 at 4:28 PM, Director of Nursing (DON) B reported CNA C was on leave. In an interview on 3/5/26 at 4:45 PM, DON B reporting touching assistance required staff to touch, guide, and maneuver the resident while using a gait belt. DON B reported CNA C assisted R1 to a standing position and then left R1 standing while CNA C went into the bathroom to get things ready. R1 then fell. DON B reported according to R1's care plan, staff should not have left R1 standing alone and that R1 required touching assistance with one helper and a 2-wheeled walker.</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2740541. Based on interview and record review, the facility failed to maintain accurate medical records for 1 (R1) of three reviewed. Findings include: Review of the complaint received by the State Agency revealed [R1] had a fall on 12/26/25. [R1] was in her bedroom, and the tech [Certified Nursing Assistant (CNA)] got her up from her bed and left her standing on her own and went around to the bathroom and [R1] fell on her arm and leg. [Name of Registered Nurse (RN) F] wrote in the medical report that [R1] got up on her own out of bed and fell on her own. The report was falsified and [R1] fell due to the tech not providing [R1] with support. Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included history of falling, fracture of humerus, and joint replacement surgery. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/25 revealed R1 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The Discharge MDS with an ARD of 1/30/26 revealed R1 had one fall without injury since admission/prior assessment. Review of the Nurses Note dated 12/26/25 and authored by Licensed Practical Nurse (LPN) D revealed guest attempted to transfer from bed to walker. Guest observed on the floor at the foot of the bed .complained of mild [pain] near incision site on shoulder. Guest encouraged to use call light for assistance with ambulation. Review of a second Nurses Note dated 12/26/25 revealed Guest observed on the floor by nursing staff. Guest stated I was trying to get to my walker .Guest educated on safety measures and to request assistance with ambulation. Review of the fall Incident Report dated 12/26/25 and completed by LPN D revealed the report was Privileged and Confidential-Not part of the Medical Record. The incident report revealed R1 had an unwitnessed fall and was observed on the floor at the foot of the bed. The resident description of the event revealed Resident stated that she was ambulating to the bathroom, using her walker with CNA present and she lost her balance. In a telephone interview on 3/5/26 at 3:13 PM, LPN D reported on 12/26/25 a code purple was called to R1's room and by the time she arrived at the room, R1 was on the floor at the foot of her bed. When asked about the discrepancies in the incident report and medical record and whether staff was with R1, LPN D reported there were mixed stories as to how R1 fell. In an interview on 3/5/26 at approximately 3:45 PM, RN F reported she did not witness R1's fall. When asked about the discrepancies in the documentation, RN F reported there was a lot of confusion as to what happened. In a telephone interview on 3/5/26 at 4:10 PM, CNA E reported they came in at the tail end of R1's fall and saw the other aide lowering her to the floor. CNA E reported there was a walker, but they had it to the side of them with a hand on the walker, but not really using it. CNA E reported a gait belt was not being used. Attempts were made to contact CNA C via telephone on 3/5/26 at 2:46 PM and 4:25 PM without success. On 3/5/26 at 4:28 PM, Director of Nursing (DON) B reported CNA C was on leave. In an interview on 3/5/26 at 4:45 PM, when asked about the documentation discrepancies surrounding R1's fall, DON B reported there was some confusion with what occurred. DON B reported she interviewed CNA C and CNA C reported she assisted R1 to a standing position, left R1 standing while CNA C went into the bathroom to get things ready, and then R1 fell. R1's medical record did not accurately reflect the incident as it occurred.</p>		