STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634030	A. BUILDING _____ B. WING _____	2/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS AT ROCHESTER HILLS REHAB & NURSING CTR	1480 WALTON BLVD ROCHESTER HILLS, MI 48309

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F0000 SS=	INITIAL COMMENTS The Springs at Rochester Hills Rehab and Nursing Center was surveyed for an Abbreviated survey on 2/26/25. Intakes: MI00149853, MI00148599, MI00149000 Census = 73	F0000		
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00149000 Based on interview and record review the facility failed to fully investigate two falls to determine the root cause, ensure correct interventions were in place for one (R804) of two residents reviewed for falls/accidents. Findings include: A complaint was filed with the State Agency (SA) that reported R804 was transferred from the facility to the hospital emergency room (ER) on/or about 12/13/24 due to low blood pressure. At the hospital it was determined the resident had multiple fractures to both their right and left femur. The complainant further noted that the injury/falls were not reported to the hospital ER upon admission. A Facility Reported Incident (FRI) was submitted	F0689	1.Resident 804 no longer resides in the facility. 2.All Residents that are categorized as “High Risk for Falls” based on their most recent fall assessment, or residents that have sustained a fall in the last 30 days, have the potential to be affected by the alleged deficient practice. By 3/7/2025 these identified residents will have their fall Care Plan reviewed by the Clinical IDT team to ensure appropriate fall interventions were in place and updated as needed. Any resident that has sustained a fall in the last 30 days will have their chart reviewed to ensure an IDT RCA along with a complete physical assessment of the resident has been completed and documented. 3.By 3/7/2025 the DON/designee will provide the following to all Clinical IDT members and licensed nurses: a.Fall Investigation Education with specific attention on determining and documenting the root cause of fall. b.Fall Prevention Education with specific attention on implementation of appropriate interventions.	3/7/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2025

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.

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	to the SA that noted on 12/16/24 the facility was made aware that upon admission to the ER the resident was found to have bilateral femur fractures. The facility addressed the concern as an injury of unknown origin. A review of R804's Clinical Record revealed the resident was initially admitted to the facility on 3/2/23 with diagnoses that included: infection and inflammation reaction due to left knee prosthesis, infection of left knee, vascular dementia and Type II diabetes. A review of the residents Minimum Data Set (MDS- dated 10/23/24) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14/15 (cognitively intact cognition). Continued review of R804's clinical record revealed, in part, the following: Fall Risk Assessment (9/20/24): "R804 ...Mobility: Confined to chair ...Balance: Not able to attempt without physical help ...Score: 20 ...Scores ...A resident who scores a 10 or higher is at high risk ...". Radiology (10/30/24): " ...Procedure: Knee 1 or 2 views ...Findings: the left knee demonstrates no acute fracture. 2. However, abnormal appearance to the bony cortex involving the visualized distal femur. Recommend femur radiographs ...". *It should be noted that no addition recommended femur radiographs were noted to have been completed. General Progress Note (12/6/24): "Resident fall was attended. CNA (certified nursing assistant) stated resident was being transferred when the resident slid down between shower chair and bed. Resident stated she was getting in the shower chair when she lost her footing and slid down, and CNA helped her to the floor ...Physician		4.DON/designee will review 5 residents with sustained falls to ensure that a root cause analysis has been completed and documented with immediate implementation of post-fall intervention along with a complete physical assessment of the resident 5 days per week x 4 weeks, then monthly thereafter for 3 months, or until substantial compliance has been maintained. Results will be presented monthly at QAPI meeting for committee review. DON will be responsible for assuring substantial compliance is attained through this plan of correction by 3/7/2025 and for sustained compliance thereafter.	

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	notified and order for x-ray ...". Radiology (12/6/24): " ...Procedure: Knee 1 or 2 views ...Interpretation ...Findings: No acute fracture ...Conclusion: No acute osseous abnormality ...Recommend close interval follow-up if symptoms continue to persist or progress to exclude subtle or occult fracture which may be more apparent on follow-up evaluation ...". *It should be noted that there were no documents that indicated any other X-rays were completed as recommended. Post Fall Evaluation (12/6/24): " ...R804 ...Pain Level: 0 ...is there a previous history of fall (Yes) ...Describe position if listed ...being transferred ...Care plan intervention to put in place at time of incident: RESIDENT IS TO BE AMBULATED WITH 2 PERSON ASSIST (emphasis added) ...". Kardex: "Activities of Daily Living (ADLs) ...Bed Mobility: extensive assist times 1 ...Transfers: Dependent x1 person assist ...Safety ...Non-skid socks when transferring ...". Interdisciplinary Team Note (12/9/24) "IDT met to discuss recent fall, interventions to wear non-skid socks when transferring." *It should be noted that there was no additional documentation that noted the resident needed additional two person assist. General Progress Note (12/10/24): "Late Entry ...Resident was lowered to the floor by care staff at 6:30 during attempted transfer from her bed to her wheelchair. During transfer, resident grabbed onto her wheelchair and her leg got caught underneath it, causing the CNAs to have to lower her to the floor. Resident was unable to provide any assistance as she is unable to bear weight due to decreased mobility. Resident does not have and <sic> injuries and her pain has been managed			

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	with scheduled Norco (a pain medication) ...". General Progress Note (12/13/24): " ...Sent to hospital due to BP (blood pressure) 89/50 and confusion ...". A request was made for all IAs (incident/accident) related to R804 falls dated 12/6/24 and 12/10/24. The following IA's were reviewed and documented: Attended Fall (12/6/24-11:41 AM): " R804-Resident fall was attended. CNA stated resident was being transferred when the resident slid down between shower chair and bed ...No injuries ..." (Authored by Nurse "F"). *It should be noted that no additional documents were provided with the IA. In addition, the name of the CNA and any possible interviews with the CNA were not provided. No interview documents with the resident were provided. Attended Fall (12/10/24 - 6:30 AM): "Resident was lowered to the floor by care staff at 6:30 attempt to transfer from her bed to her wheelchair. During transfer resident grabbed onto her wheelchair and her leg got caught underneath it causing the CNAs to have to lower her to the floor. Resident was unable to provide any assistance ...Statements (CNA "I") Per CNA resident was sitting at edge of bed. 2 CNAs attempted to assist resident to the wheelchair ...she (R804) leaned forward and grabbed onto w/c as she stated she was afraid she would fall ...CNAs had to assist her to a sitting position on the floor with one leg in a cross position under her buttock and other leg was straight out in front of her ...". *It should be noted the name of the second CNA was not documented in the IA.			

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	On 2/26/25 at approximately 1:06 PM, an interview was conducted with Nurse "F" regarding R804's fall that occurred on 12/6/24. Nurse "F" reported that a CNA told them that the resident was on the floor. When asked who the CNA was, they noted that they could not recall. When asked why an x-ray was done of the knee only, Nurse "F" reported that they were concerned as to the way the resident was sitting on the floor and when they contacted the doctor, they ordered the x-ray to the knee only. Nurse "F" was asked if they were aware that both the results of the x-rays completed on 10/30/24 and 12/6/24 both recommended follow-up x-rays. Nurse 'F" stated they were not aware and generally that is for the physician to decide. On 2/26/24 at 1:26 PM an interview was conducted with the Director of Nursing (DON). The DON reported they started at the facility in November 2024. The DON was queried as to R804's falls and the hospital report that indicated the resident had multiple femur fractures. The DON explained that they contacted the hospital on or about 12/16/24 to see how the resident was doing, and it was reported to them that the resident had bilateral commuted femur fractures in addition to a diagnosis of sepsis of the Left knee. The DON noted that following the information received by the hospital they reported the concern to the SA as an injury of unknown origin. The DON noted that there was nothing to lead her to believe that the two falls (12/6/24 and 12/10/24) had caused the fractures as the resident did not report any pain after each fall. The DON further reported that they believed the resident was seen by the medical director at the hospital and believed the falls did not cause the fractures. The DON was asked to provide the names of the CNAs involved in both the 12/6/24 and 12/10/24 falls. The DON returned and noted that they thought CNA "J" was the person who transferred R804 on 12/6/24. In addition, they provided a			

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	document that indicated CNA "I" was present on the second fall (12/10/24). There were no documents provided by the end of the survey to identify a second CNA was present on 12/10/24 at the time of the fall. A document was provided that noted CNA "K" accompanied R804 to a scheduled medical appointment on 12/10/24 following the fall. An interview was conducted with CNA "J" on 2/26/25 at approximately 2:20 PM. CNA "J" was asked about the fall involving R804 on 12/6/24. CNA "J" reported that they did not recall being assigned to the resident and had no recollection of the fall. Again, the name of any CNA, including CNA "J" was not included in the investigation documents. On 2/26/25 at approximately 3:15 PM, a phone interview was conducted with Physician/Medical Director "L". Physician "L" was queried as to R804's falls and diagnosis of multiple femur fractures. Physician "L" reported that they believed it was determined that the fractures were the result of deterioration based on the resident's cancer diagnosis and declining health. The physician reported that they would send hospital documentation that noted that was the cause. When asked if it was possible the fractures could have stemmed from the falls, Physician "L" stated that it was possible, but they were not certain. *It should be noted that no additional documents were provided by the physician by the end of the survey. On 2/26/25 at approximately 3:44 PM, a phone call was made to CNA "I". A voice message was left. No return call was made before the end of the Survey. On 2/26/25 at approximately 3:53 PM, a phone interview was conducted with CNA "K". CNA			

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	"K" reported they had been working for the facility for approximately eight years. They were asked if they were familiar with R804 and what occurred on 12/10/24. CNA "K" reported they escorted the resident to an appointment on 12/10/24 pertaining to their knee. They stated the resident was not seen by the physician as they could not get the resident up on the table. When asked how the resident is usually transferred, CNA "K" reported that they always used a Hoyer lift to transfer the resident as the resident was non-weight bearing and fearful of standing up. On 2/26/25 at approximately 4:20 PM an interview was conducted with Physical Therapy Staff (PTS) "M". PTS "M" was asked if they were familiar with R804 and their transfer status. They stated that they were and recalled the resident was fearful of falls and often refused to stand. A document titled "PT Therapy Progress Report" dated 8/28/24 noted the following: " ...Comments: Patient will improve ability to safely transfer to a standing position from sitting in a chair, wheelchair on the side of the bed with substantial/max assist without medical complications ...Pt refuses to stand at this time ...pain in knee ...fear of falling ...Pt is dependent ...". The facility policy titled, "Care and Treatment/Fall Prevention" (7/11/2028) was reviewed and documented, in part: "Policy ...It is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment ...The Director of Nursing/designee will be responsible for tracking resident falls ...will be responsible for ensuring that residents who have been identified at risk ...have all interventions in place ...".			