

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634024	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/16/2025
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NAME OF PROVIDER OR SUPPLIER LAKE ORION NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 585 EAST FLINT STREET LAKE ORION, MI 48362
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F0000 SS=	INITIAL COMMENTS Lake Orion Nursing Center was surveyed for an Abbreviated survey on 6/16/25. Intake(s): MI00153580 Census=88	F0000		
F0689 SS= G	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 Number(s): MI00153580. Based on interview and record review, the facility failed to provide supervision according to the individualized plan of care for one (R801) of three residents reviewed for falls, resulting in an "acute intertrochanteric fracture of the left femur (hip)" and an "acute subdural hematoma (bleeding between the brain and the skull)" that ultimately resulted in the resident's death after R801 was left unsupervised on the toilet and sustained a fall. Findings include: A review of R801's hospital records revealed the following:	F0689	1. Resident R801 no longer resides at the facility 2. A facility wide audit was completed by the Director of Nursing on 6/24/25 to identify other residents assessed to be high risk for fall (i.e., enrolled in the Falling Star Program). Plans of care for these residents were reviewed to ensure toileting and supervision interventions were in place. All residents enrolled in the Falling Star Program were issued a visual alert (star) on their room door and care card was updated. Residents requiring supervision while toileting were cross-checked for compliance with protocol that prohibits staff from leaving residents unattended. 3. The policy "The Falling Star Program" was reviewed and updated to reflect the implementation of a visual alert on the hallway door. 4. Re-Education of all staff: a. As of 6/26/25, all licensed staff nurses and CNAs were re-educated on: • The facility's Falling Star Protocol and expectations. • Supervision requirements during toileting, • The process of direct communication during handoffs. b. Staff were tested post training to ensure comprehension. Competency validation	7/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/30/2025

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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	<p>A discharge summary dated 5/23/25 documented, "Discharge Final Diagnosis: Subdural hematoma...(R801)...presented to hospital on 5/22/2025 s/p (status post) unwitnessed fall at her assisted living facility (nursing home). Pt (patient) unresponsive on arrival and not protecting her airway. Pt intubated in the ED (Emergency Department) and taken for CT (Computed Tomography) imaging. Imaging showed acute subdural hematoma measuring 3.6 cm (centimeters) with mass effect, 2.8 cm midline shift, and subfalcine and uncal herniation (a critical condition where accumulating blood compresses and displaces the brain structure causing herniation). Extensive discussion had with family regarding goals of care and comfort measures elected. Pt compassionately extubated on 5/22/25. Patient condition continued to decline after extubation. (R801) died on 5/24/25 at 9:39..." (It should be noted that R801 died on 5/23/25 at 9:39 per the discharge summary date).</p> <p>A "H&P (history and physical) Trauma" note documented R801 had a CT of the chest/abdomen/pelvis on 5/22/25 which revealed an "acute intertrochanteric fracture of the left femur" and that R801 was "unresponsive on evaluation, absent brainstem reflexes".</p> <p>On 6/16/25, an unannounced, onsite investigation was conducted.</p> <p>A review of R801's clinical record revealed R801 was admitted into the facility on 6/1/23 and discharged to the hospital on 5/22/25 with diagnoses that included: hypovolemic shock (a condition caused by severe loss of blood of fluids), dementia with behavioral disturbances, and psychotic disorder. A</p>		<p>included return demonstrations of supervised toileting protocol.</p> <p>c. Education with Licensed Nurses: Licensed nurses were instructed not to delegate supervision of high-risk residents without confirmed verbal acknowledgment from receiving staff.</p> <p>5. Monitor plan to Ensure Ongoing Compliance:</p> <ul style="list-style-type: none"> • The DON and/or designee will perform daily audits for 30 days. Then 3x/week for 30 days, then weekly for 3 months of all residents identified as Falling Stars to ensure toileting is supervised per care plan. • Results will be logged, reported during daily stand up and QA&A meetings, and used to guide coaching or discipline if deviations are found. • Ongoing re-education for new hires and PRN staff will be required before floor assignment. 		

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	<p>review of a Minimum Data Set (MDS) assessment dated 3/16/25 revealed R801 had intact cognition, no behaviors, required supervision or touching assistance for toilet transfers, and did not have any falls during the assessment period.</p> <p>A review of R801's progress notes from 3/2025 through 5/2025 revealed the following:</p> <p>On 3/26/25 R801 was observed on the floor on the right side of her bed. R801 reported she "slipped while sitting up on the side of her bed and then reaching for her shoes to put on" to prepare for a shower.</p> <p>On 4/15/25, R801 was observed sitting on the floor mat next to the bed. R801 reported she was trying to reach the wash basin and the wheelchair and slid off the bed. R801 was encouraged to use the call light for assistance.</p> <p>On 4/25/25, R801 was observed on the floor. R801 reported she leaned forward to reach for the wheelchair that was placed by the window. It was documented R801 attempted to self transfer to wheelchair, was a 1 person assist for transfers, but had poor safety awareness and often attempted to transfer independently. It was documented R801's call light was activated at the time of the fall, but R801 did not wait for assistance.</p> <p>On 5/10/25 at 5:00 AM, R801 was observed on the floor in her room. R801 said she wanted to get to the bathroom and said she did not fall, but sat on the floor mat to prevent herself from falling. The call light was within reach and activated, but R801 did not wait for help. R801 was encouraged to use the</p>			

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	<p>call light for assistance.</p> <p>On 5/10/25 at 2:50 PM, R801 was observed on the floor a second time and said she was trying to go to the bathroom and fell and hit her head on the floor. R801 had a hematoma on the left side of her forehead and was transferred to the hospital in accordance with the physician's orders. R801 returned to the facility at 10:26 PM the same day.</p> <p>On 5/10/25 at 11:35 PM, R801 was observed on the floor a third time, approximately one hour after returning to the facility from the hospital. R801 reported she did not know what happened and safety checks every hour were implemented for the next 24 hours.</p> <p>On 5/11/25 at 1:50 AM, R801 was observed on the floor for the fourth time within less than 24 hours. R801 reported she was trying to get cream to put on herself. However the Certified Nursing Assistant (CNA) had already put the cream on "a few minutes ago".</p> <p>On 5/11/25 at 9:30 AM, R801 was observed on the floor by the nurse's station with her wheelchair in front of her. R801 was referred for physical therapy.</p> <p>On 5/17/25 at 11:15 AM. R801 was observed attempting to self transfer from bed and was placed on one to one supervision. At 11:22 PM, while at the nurse's station, R801 told the nurse she saw a "gorilla in her room who almost hit her in the head". At 4:25 PM, R801 was observed on the toilet in her room. R801 reported she transferred herself from the bed to the wheelchair and to the toilet and said she "forgot" to activate the call light. It was</p>				

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	<p>documented that the CNA waited with R801 until she was finished using the toilet and then provided assistance.</p> <p>On 5/19/25 at 10:13 AM, R801 was observed in her wheelchair. R801 reported she transferred herself and took herself to the bathroom and reported she "forgot" to use the call light. It was noted R801 refused to wear non-slip socks.</p> <p>On 5/19/25, R801 took herself to the bathroom and the nurse reminded her to use the call light. R801 said she did not have time to wait.</p> <p>A review of a progress note dated 5/22/25 at 2:41 PM documented as a late entry (on 5/23/25 at 8:33 AM) by Licensed Practical Nurse (LPN) 'A' revealed, "Writer called in room by 2N (2 North Unit) nurse stating that resident (R801) was on the floor in the bathroom. Writer went in to assess resident and observed resident positioned on laying on her back positioned between wall and toilet. Resident assessed and noted to have left temple with large hematoma and c/o (complained of) pain to her L (left) hip. Resident was assisted back to bed via 2 person manual lift...NP (Nurse Practitioner) present at facility and called to assess. Orders were placed for STAT (right away) X-ray to left hip...Neuro checks initiated..."</p> <p>A review of a progress note dated 5/22/25 at 3:03 PM documented by LPN 'D' revealed, "Writer called room for reports of resident on floor in bathroom. Res (resident) positioned on buttocks leaning backwards against toilet seat, positioned between wall and toilet. left temple with large hematoma. Reports pain to left hip. Pain with attempts to perform ROM</p>			

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	<p>(range of motion). Resident was assisted back to bed via 2 person manual lift...NP present at facility and called to assess...Resident reports that she had been seated on toilet and had 'tried to get my wheelchair' and 'slipped off' toilet. CNA assigned to resident was in 2 West hallway where a majority of residents are assigned, providing care. Was unaware that resident was on the toilet..."</p> <p>A review of a progress note dated 5/22/25 at 4:35 PM documented by LPN 'D' revealed, "Writer called room for reports of res (resident) lethargic. Observed in bed, not responding to verbal or tactile stimuli. Diaphoretic (excessive sweating). BP (blood pressure) 200/88. 911 called and notified need to transfer to (hospital)..."</p> <p>A review of an investigation conducted by the facility revealed the following:</p> <p>An "Investigation Summary" that was also submitted to the State Agency (SA) noted, "On the afternoon of 5/22/25, (R801) was placed on toilet by assigned nurse, (LPN 'A'). Resident was within reach of call light, and able to utilize. (LPN 'A') reported that she had exited room to request that CNA assist with toileting. A short time later it was reported that light was observed to be turned on. Nursing, upon entering room observed (R801) on the floor in the bathroom; nurse proceeded to request assistance of additional nursing staff to assist with assessment and transfer. Three nurses entered room; (LPN 'A'), (LPN 'B') and (LPN 'D'). At that time (R801) was yelling out, in discomfort, holding left hip/sacrum area, reporting pain to area. (NP 'E') was at desk and was notified of concerns with left hip</p>			

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	<p>pain and likelihood of fracture, prior to attempting anticipated transfer to bed. Verbal orders obtained to perform STAT X-ray to area...Upon assessment a large hematoma was noted to be developing to left forehead/temple. (R801) reported to have been insisting she 'didn't hit my head'. Nurse Practitioner was then called in to assess the injury...ordered Neuro checks per facility policy for head injuries. Nurses continued neuro checks as ordered, although later in afternoon, during an assessment it was noted that (R801) became unresponsive; pupils dilated. 911 was called and sent to hospital. Later determined that resident had sustained a hip fracture and a subdural hematoma; it was reported by hospital that resident had been vented and then placed on comfort care, and passed away...Written statements of involved parties were taken, cameras were surveyed at time of incident. Residents fall interventions were reviewed. Fall care plan in place and approaches were appropriate. It was noted that (R801) was a Falling Star (a facility program for residents at high risk for falls) due to having sustained a recent increase in impulsive behavior and fall trend in weeks leading up to incident; Part of Falling Star policy involved not leaving a resident unattended on toilet. (LPN 'A') insisted that she had observed (CNA 'C') in hallway and asked her to assist with care of resident. (LPN 'A') reported that she would have remained with resident if she had felt that (CNA 'C') was not going to perform delegated task. Management, during watching the cameras noted that interaction with (CNA 'C'), was not observed to have transpired. Bathroom light was seen for 8 minutes before staff entered room, at which time (R801) has sustained the reported fall...Upon investigation, it was determined</p>				

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	<p>involved staff were aware of the facility's star protocol and that (R801) was determined to be a falling star. As a result of this investigation (LPN 'A')s contract with (facility name) was terminated. (CNA 'C')...was also terminated..."</p> <p>A review of R801's care plans revealed the following:</p> <p>A "Cognitive Loss/Dementia" care plan initiated on 12/27/24 that read, "Resident has a memory/recall problem r/t (related to) dementia".</p> <p>A "Falls" care plan initiated on 2/19/18 and edited on 5/22/25 that read, "Resident at risk for falling r/t decreased mobility, keeps door closed for privacy causing staff difficulty visualizing attempts to self transfer; takes medications that can cause falls; falls hx (history); debility from recent hospital stay". The care plan noted multiple interventions initiated on 5/14/25 (after R801 had five falls within 24 hours between 5/10/25 and 5/11/25) that included: "Falling star protocol".</p> <p>A review of the facility's policy and procedure for "Falling Star Protocol" revealed, in part, the following, "Purpose...To identify residents who are at high risk for falls and provide visual awareness to all employees at (facility), so that they can participate as a team in an effort to prevent falls from occurring and reduce the risk for injury. All staff are educated on the falling star program...Procedure...Staff must remain in attendance of resident while toileting, either in the bathroom with the resident or just outside the door..."</p> <p>Further review of R801's clinical record</p>				

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	<p>revealed "Physician's Statement Attesting to Decision Making Capacity" forms from 6/6/23 and 6/12/24 that indicated R801 "does not have the capacity for make informed medical decisions".</p> <p>A review of the camera footage from outside of R801's room on 5/22/25 between 1:26 PM and 2:32 PM revealed R801's call light was activated at 1:26 PM. At 1:37 PM, LPN 'A' entered R801's room and exited at 1:40 PM. At 1:43 PM, R801's bathroom call light was activated. At 1:48 PM, CNA 'C' walked by R801's room, looked at call light, and did not enter. At 1:50 PM, CNA 'C' walked by R801's room and did not answer the call light or enter the room. R801's call light is no longer lit up at 1:51 PM, but nobody was observed to enter the room. At that time, it was explained by the Director of Nursing (DON) that R801 might have turned the call light off herself. At 1:55 PM, LPN 'B' entered R801's room and exited again. LPN 'B' reentered R801's room at 1:56 PM, followed by LPN 'D' and LPN 'A'. Several other staff members were observed to enter the room, including CNA 'C'. NP 'E' entered R801's room at 2:11 PM.</p> <p>On 6/16/25 at 11:33 AM, an interview was attempted with LPN 'A' via the telephone. A message was left, but LPN 'A' was not available for interview prior to the end of the survey.</p> <p>On 6/16/25 at 12:18 PM, an interview was attempted with LPN 'B' via the telephone. LPN 'B' was not available for interview prior to the end of the survey.</p> <p>On 6/16/25 at 12:22 PM, an interview was conducted with CNA 'C' via the telephone.</p>			

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	<p>When queried about what occurred with R801 on 5/22/25, CNA 'C' reported she was not assigned to R801 that day but was assigned to that hallway. R801's assigned CNA had to work on another hallway as well. CNA 'C' reported she did not witness R801's fall or provide any care to the resident. CNA 'C' recalled seeing R801's call light, but was the only person on the hall at the time and there were other call lights going off so she tried to find someone else to help answer it. CNA 'C' reported at some point the call light was no longer activated and she went into another resident's room. When she came out of the other resident's room, someone told her R801 had fallen. When queried about whether anyone asked her to assist R801 in the bathroom, CNA 'C' reported nobody asked her to assist and it was her understanding someone left R801 in the bathroom. CNA 'C' reported she had been assigned to R801 in the past and she was usually "mentally aware" and often self transferred, but after a recent hospitalization R801's mental status seemed "altered" and explained the resident became more anxious and "fixated" on medical issues and other things.</p> <p>On 6/16/25 at 2:17 PM, an interview with the DON was conducted. When queried about R801's fall and what the conclusion of the facility's investigation was, the DON reported R801 was a "frequent faller" and that her "cognition teeters". The DON reported LPN 'A' explained to her that she entered R801's room to answer the call light and assisted her onto the toilet. LPN 'A' left the room and explained to the DON that CNA 'C' was outside of the room and she told CNA 'C' to look for R801's call light and when it was activated to help her off the toilet. The DON</p>			

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	reported when the facility reviewed the camera footage, LPN 'A' was observed leaving the room and CNA 'C' was not outside of the room and LPN 'A' was not observed talking to CNA 'C'. The DON reported LPN 'A' should have stayed in R801's room until she was done using the toilet. The DON further explained that all staff should answer resident's call lights regardless if they were assigned to that resident, especially when it was blinking which indicated they activated the call light in the bathroom.				