STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235706	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 842 Based on interview and record review, the facility neglected to implement interventions to prevent falls for one (Resident #2) of three reviewed for falls resulting in Resident #2 being lowered to the floor and sustaining fractures, hospitalization , and surgery. Findings include: Review of the medical record revealed Resident #2 (R2) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R2 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating she was cognitively intact. The MDS revealed R2 required extensive assistance of two staff members for transfers and ambulation. Review of the ADL (Activities of Daily Living) Self Care Performance Deficit Care Plan initiated 11/6/19, revealed R2 required extensive two-person assistance for transfers and ambulation. Review of the At Risk for Fall Related Injury and Falls Care Plan initiated 11/6/19, revealed encourage (R2) to wear appropriate footwear as needed and encourage (R2) to wear non-skid footwear when out of bed, assist as needed initiated 11/7/19. R2's Care Plans did not indicate she refused to use a gait belt. Review of the Incident and Accident Report dated 1/3/20, revealed at 7:45 AM CNAs (Certified Nursing Assistants) transferring bed to shower chair, guest started feeling weak and was lowered to floor. Sitting on floor back against bed, knees bent, legs to (left) side, c/o (complained of) (left) knee pain. The Incident and Accident Report revealed R2 sustained bilateral distal femur fractures. Review of the POS [REDACTED]. Review of the SBAR (Situation, Background, Appearance, Review) Communication Form dated 1/3/20 revealed guest lowered to floor during a transfer from bed to shower chair, guest legs became weak and required being lowered to floor, now with increased pain to BIL (bilateral) knees .Xray of L (left) knee, and later orders given for xray to R (right) knee. X ray results of L knee show distal femur fracture. Practitioner notified, orders given to transfer to ER for eval and tx (evaluation and treatment). Review of the Radiology Results Report dated 1/3/20, revealed R2's left knee had an acute fracture involving left distal femur with modest displacement. Review of the Physician's Note dated 1/3/20, revealed patient with fall early in the morning onto knees. Patient complaining of left knee pain initially then right knee pain. Patient with previous TKA (total knee arthroplasty/replacement) of her right knee. Patient had a left TKA scheduled until stroke which brought patient here. Patient with some minor swelling and tenderness over site .Patient with weakness, poor gait stability and poor safety awareness. X-ray ordered .Patient with fall, contusion of bilateral knees x-rays performed which showed acute fracture of left distal femur with displacement. Patient sent out to ER for urgent evaluation of this . In an interview on 3/13/20 at 10:41 AM, Certified Nursing Assistant (CNA) D reported when her and CNA E attempted to transfer R2 from bed to the chair, her condition changed and we had to lower her down. CNA D reported R2 never used a gait belt because R2 had refused a gait belt in the past. When asked how R2 was transferred without the use of a gait belt, CNA D stated we held her hand. R2 reported she received education that a gait belt had to be used even if the resident refused. CNA D reported she told the nurse that R2 refused the gait belt. In an interview on 3/13/20 at 1:21 PM, CNA E stated we turned (R2 in bed), had her feet hanging off the bed, asked if she was ready and she said no. We gave her a couple minutes. We were ready to stand her up. Said 1, 2, 3. She didn't really stand up for us. We put her down, gave her a couple minutes and tried again and she wasn't really helping us stand up. We asked her to straighten her legs. She was barely past a 90-degree angle standing up. We were already turning her to get her in the shower chair. The options were for her to stand up or lower to the floor. It wasn't possible to get her on the bed. She wasn't able to stand up. Kept staying my knee, my knee, and slowly lowered her to the floor. When asked how R2 was lowered to the floor, CNA E stated we were both under her arms and we lowered her sitting on her bottom. CNA E reported they were able to pivot R2 during the second transfer attempt. CNA E stated when we started to turn her, that's when she started to get lower and lower and reported R2 first complained of knee pain during the second transfer attempt. CNA E reported a gait belt was not used and R2 was barefoot. When asked why a gait belt was not used, CNA E reported she thought R2's kardex (care guide) indicated she was an extensive one person assist. CNA E reported she thought it was safe to use two people instead of a gait belt. CNA E reported neither her nor CNA D attempted to put a gait belt on R2 that day. CNA E reported she did not hear R2 refuse a gait belt. CNA E stated I now know that any time we transfer, we are to use a gait belt. CNA E reported R2 was barefoot because she didn't have any socks in her room. CNA E reported socks were available, but they were rushing and forgot. When asked if it would have helped if a gait belt and gripper socks were in place, CNA E Stated yes, yes, it definitely would have helped. CNA E reported she received education that gait belts needed to be used for all transfers and gripper socks should be in place. In an interview on 3/13/20 at 11:18 AM, Registered Nurse (RN) F reported she was not told nor aware of R2 refusing a gait belt. RN F reported staff usually used a gait belt when transferring R2. RN F reported when she assessed R2 after being lowered to the floor, R2 was not wearing any footwear, did not have a gait belt in place, and her left knee was swollen. RN F reported R2 was initially only complaining of pain in her left knee, therefore a left knee x-ray was done at the facility. RN F reported R2 then began complaining of right knee pain, but she was transferred to the hospital before the right knee x-ray could be done. Review of the hospital records dated 1/3/20, revealed [AGE] year-old woman with bilateral distal femur fractures after a fall. Patient requires admission to trauma service. The left knee x-ray results dated 1/3/20 revealed Comminuted distal femoral metaphyseal fracture. The right knee x-ray dated 1/3/20 revealed Comminuted distal femoral metaphyseal fracture which appears to extend into the region of the arthroplasty cup. The bilateral hip and femur x-ray dated 1/3/20 revealed Comminuted fractures involving both distal femoral metaphyses. On the RIGHT side fracture line extends into the arthroplasty device. R2's discharge [DIAGNOSES REDACTED]. R2 had surgery on 1/5/20 and 1/7/20. In an interview on 3/13/20 at 2:38 PM, Director of Nursing (DON) B reported R2 was lowered to the floor by two CNAs. DON B reported a gait belt was not used and footwear was not in place. DON B reported the hospital determined the right femur fracture was pathological. When asked about the left, DON B agreed the hospital paperwork did not reflect pathological fracture on the left and reported the nurse at the hospital told her both were pathological. Review of CNA D's Disciplinary Action Record Work Rules dated 1/3/20 and signed 1/6/20, revealed Failed to use a gait belt during a transfer per policy. All CNAs have been trained to properly use gait belts for all transfers. Employee also failed to assure proper footwear was on patient. Review of CNA E's Disciplinary Action Record Work Rules dated 1/3/20 and signed 1/8/20, revealed Failure to use gait belt during a transfer per policy. All CNAs have been trained to use gait belts for all transfers. Employee also failed to assure proper footwear was on patient.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) This citation pertains to MI 842 Based on interview and record review, the facility failed to report an allegation of neglect to the State Agency for one (Resident #2) of three reviewed for abuse/neglect, resulting in Resident #2's improper transfer resulting in a fall with fractures not reported to the state agency and the potential for further allegations to go unreported. Findings include: Review of the medical record revealed Resident #2 (R2) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R2 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating she was cognitively intact. The MDS revealed R2 required extensive assistance of two staff members for transfers and ambulation. 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When asked if the fall was reported as possible neglect, DON B stated no because we deemed that the fractures caused the lowering. she was care planned for two person assist and they were providing two person assist with the transfer. When asked about the failure to use a gait belt or ensure proper footwear, DON B reported it wasn't wheter the gait belt or footwear was used, it was hte inability of R2 to bear weight. In an interview on 3/13/20 at 3:00 PM, when asked why R2's fall was not reported as possible neglect, Nursing Home Administrator (NHA) A and DON B reported it was a pathological fracture. NHA A reported she consulted with corporate and stated everything we got from investigation and interviews, the fracture is what caused her to go down so that's what we used on the basis of her going down. Review of the facility's investigation revealed The incident did not meet the requirements for reporting due to no suspicion of abuse or neglect, staff assistance per care plan and nature of the fracture, which actually caused the lowering to the floor. Review of CNA D's Disciplinary Action Record Work Rules dated 1/3/20 and signed 1/6/20, revealed Failed to use a gait belt during a transfer per policy. All CNAs have been trained to properly use gait belts for all transfers. Employee also failed to assure proper footwear was on patient. Review of CNA E's Disciplinary Action Record Work Rules dated 1/3/20 and signed 1/8/20, revealed Failure to use gait belt during a transfer per policy. All CNAs have been trained to use gait belts for all transfers. Employee also failed to assure proper footwear was on patient.