STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235395	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND HEALTH CARE CENTER-THREE RIVERS	**517 S ERIE ST THREE RIVERS, MI 49093**

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 -** Minimal harm or potential for 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** This citation pertains to MI 385. Based on observation, interview and record review the facility failed to provide supervision to prevent falls for one (#7) of three residents with multiple falls resulting in a fractured nose, multiple lacerations, abrasions and a decline in condition. Findings include: On 7/28/2020 at 4:38 pm, Family H was interviewed via phone. Family H was concerned that the facility absolutely would not use alarms to help prevent multiple falls with injuries even if it might be better for R7. I was told it was facility policy, they said. No exceptions. According to electronic care plans, Resident #7 (R7) was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the quarterly Minimum Data Set (MDS-resident assessment), dated 5/1/2020, reflected that R7 had severe cognitive impairment; sometimes was understood and understood others; was independent with bed mobility, transfers and walking, required the assist of one staff for dressing, toileting and hygiene; was continent of bowel; was dependent on one staff for bathing; and could feed himself after set-up. A review of R7's care plan for fall risk included the following interventions to minimize the risks of falls and/or injuries prior to 7/20: Assist with chair placement for meals in hallway and for rest breaks, encourage and assist with taking naps in bed between meals, evaluate medications as needed, furniture in room arranged so chair and bed are side by side, have commonly used articles within easy reach, keep bedside chair free of items, including pillows, perimeter mattress, provide assist to transfer and ambulate as needed, refer to therapy as needed, reinforce need to call for assistance. On 7/28/20 at approximately 9:45 AM, R7 was observed to be clean and well-groomed, scooting himself around his room while seated in a high-back wheelchair. A perimeter mattress was observed on his bed. On 7/29/2020 at 10:50 AM, Director of Nurses (DON) B was interviewed via phone about R7's recent falls as follows: On 6/16/20 at 5:55 PM, R7 was seated in the hallway, eating dinner. He stood up, lost his balance and fell on his bottom with his legs out in front of him. He had been restless and agitated before dinner, and was taken to his room to lie down. DON B reported the new intervention to offer rest periods, but this intervention did not appear on the care plan. The intervention to encourage and assist with taking naps in bed between meals was initiated 11/19/18. On 7/7/20 at 5:00 AM, R7 was observed on the floor with his head partially under the sink in his bathroom. R7 was still able to be up independently. Blood was observed on the floor. R7 wouldn't answer questions, but did squeeze the nurse's hand when asked. He was last observed in bed about 15 minutes earlier, and the room was dark. R7 was evaluated at the emergency department, and returned with an abrasion to the right temple, a skin tear to the right elbow and tenderness of the right lateral ribs on exam (fracture was not confirmed). Use of a night light, a flat call light and assisting R7 to get up and ready for the day if he is awake at last rounds on night shift were added to the care plan. On 7/9/20 at 9:48 PM, R7 was observed seated on his bed and rocked forwards as if to rise, but fell on his face on the floor. He had removed his grippy sox. R7 was sent to the emergency department and diagnosed with [REDACTED]. The hospital history and physical, dated 7/10/20, relates that the facility nurse saw R7 stand in a bent-over position, lose his balance and fall forward. R7 discharged back to the facility on [DATE] with a fractured nose, skin tears on both elbows and an abrasion near the right eyebrow. New interventions were a low bed, scoot chair (low-to-the-ground wheelchair with reclining back) instead of the high-backed wheelchair and frequent checks (nurse parks her medication cart by R7's door to do extra monitoring). Frequent checks and the scoot chair were added to the care plan, but checking to see that R7 was wearing appropriate footwear did not. On 7/30/2020 at 9:35 AM, DON B corrected the interventions from the 7/9/2020 fall to keeping the door to R7's room open despite infection control guidelines for potential Covid infection. On 7/12/2020 at 1:50 PM, a loud noise was heard and R7 was observed on the floor of his room. He was last seen 15 minutes earlier. R7 was send to the emergency department, and returned with skin tears to his elbows and a [MEDICAL CONDITION]. New interventions were frequent checks, take R7 for a walk when restless and keep the door of his room open for observation. On 7/30/2020 at 9:35 AM, DON B corrected the interventions from the 7/12/2020 fall to removing the unused bed so R7 has more room. A review of the MDS for significant change in condition, dated 7/16/2020, reflected that R7's condition had declined as followed: R7 was showing signs of increased depression; required the extensive assist of two staff for transfers; extensive assist of one staff for bed mobility, toileting and hygiene; had to be fed; now required a wheelchair to get around; had poor balance and trunk stability; had begun to hold food in his mouth, and had an insidious weight loss of nine pounds since 1/3/2020.

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.