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 _____	09/11/2020

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 1539. Based on observation, interview and record review, the facility failed to justify hospital transfers for 1 residents (# 8) of 10 residents reviewed for infection control/ presumptive and positive for Covid 19. Resulting in the potential for continued medically unnecessary hospital transfers of clinically stable residents. Findings Include: Resident #8 According to the clinical record, Resident #8 (R8) was a [AGE] year old female, admitted to facility on 8/17/20 with [DIAGNOSES REDACTED]. Review of the clinical record reflected R8 was placed on the [MEDICATION NAME] hallway in a private room and was to be in isolation for 14 days per facility protocol for all new admissions. R8 was monitored for signs and symptoms of Covid 19 and found to have none. R8 was tested at the facility for Covid 19 on 8/17/2020 and positive results were returned from the laboratory on 8/18/2020 at 21:45. After results returned positive for Covid 19 R#8 was transferred to hospital on [DATE] based on her positive result. Review of the facility's transfer sheet dated 8/18/2020 at 22:16 reflected the reason for the transfer was positive Covid test. On 09/09/2020 at 2:10 PM, during an interview with Director of Nursing (DON B) she reported the facility does not require residents to be tested for Covid 19 prior to admission. The facility will complete the test for Covid 19 and when a positive result occurred the facility transfers the out as soon as possible. When queried why R8 was transferred to the hospital opposed to the designated HUB, DON B reported they have not sent any residents to the hub as of yet, all residents that have been positive for Covid 19 have been sent to the emergency department at the hospital. When queried if in isolation/quarantine and staff wear all personal protective equipment as observed on the [MEDICATION NAME] unit, what was the justification for R8 to be transferred. DON B reported the facility does not have staff for Covid 19 residents, DON B further reported coordinating transfer with the hub can not be done at night or off hours, therefore residents would have to go to the hospital.
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 realates to intake MI 4143. Based on observation, interview, and record review the facility failed to prevent an accident for one out of five residents (Resident #5) resulting in a fall, skin tears, and a right arm fracture, and the potential for further accidents to occur. Findings Included: Resident #5 (R5): Per the facility face sheet revealed R5 had a [DIAGNOSES REDACTED]. Review of R5's Electronic Medical Record (EMR) revealed that on 2/1/2019 R5 was documented to be 60 inches in height, or 5 feet tall. Review of a Facility Reported Incident (FRI), dated 8/24/2020, revealed that on 8/14/2020 R5 sustained a fall with a fracture. The report revealed it was concluded that R5 have fallen from a syncopal episode (fainted/passed out), and sustained a fracture to her right arm, and skin tears to both of her upper extremities. The report further revealed that upon further investigation Dietary Aid (DA) C had bumped into R5 in the hallway with a food cart causing R5 to lose her balance and fall. The report revealed that during an interview with DM C she later admitted that she bumped into R5 with the food cart, and did not see R5 in the hallway, but felt a bump and upon walking around the food cart found R5 on the floor. The report revealed that DA C was terminated for careless behavior regarding resident safety, and misrepresentation of a material fact. The report revealed the incident occurred due to DA C's height and not having a clear line of visibility. Record review of an X-ray report, dated 8/14/2020, revealed R5 had a proximal humeral fracture (a break of the upper bone of the arm closest to the shoulder) Record review of a care plan, dated 2/1/2019 and titled, (R5) has impaired visual function R/T (related too) wears glasses for visual acuity ., another care plan in place, dated 2/12/2020 for R5 revealed, (R5) .has impaired cognitive function or impaired thought processes R/T dx (diagnosis) of [MEDICAL CONDITION]. In an interview on 9/10/ , at 12:16 AM, DA C stated that she was pushing a cart in the hall that contained resident food trays. DA C said she was pushing the cart from behind and stated that she was 5'4 and the cart was taller than she was. DA C said that she could not see over the cart, nor could she see that R5 was in front of the cart. DA C said she bumped into R5 with the cart, and upon going to the front of the cart she found R5 on the ground. DA C said she reported the incident to a nurse who assessed R5 and sent her to the hospital where it was discovered that she had a broken arm. DA C said R5 was off to the side of the hallway, and said she would usually push the carts off to the side of the hall, so residents could go around her, but stated R5 was on the side of the hallway, and she did not know R5 was there. DA C said R5 should not have been wandering the hallway. DA C said she was told that she was going too fast, and said she was not trained on any certain way to push or pull the cart. DA C said if there was a policy and procedure on the correct was to maneuver the carts, she had never seen it. In an interview on 9/10/2020, at 2:00 PM Dietary Manager (DM) E stated the incident was brought to her attention. DM E said the dietary staff were taught to look on both sides of the cart while pushing it and taught to push the carts and not pull them because it was easier to push them. DM E said there was no facility policy and procedure, nor documented training for the dietary staff on how to safely maneuver the food tray carts throughout the facility. DM E also stated the food carts were taller than the staff. Observation on 9/10/2020, at 2:10 PM, of food tray carts with DM E revealed the carts were on wheels, and approximately 5'5 in height. DM E stated she was 6 ft tall and it was observed that she could not see over the cart. Further observation of the food cart revealed the cart was to tall in height to be able to see over the top of it, with a remaining blind spot in the front of the cart when looking side to side while pushing the cart. In an interview on 9/10/2020, 2:45 PM, Licensed Practical Nurse (LPN) F stated R5 was on the floor by the wall close to the DM office. LPN F said DA C had the food cart pushed a small way in front of R5 and had reported to her that she found R5 on the floor. LPN F said DA C did not report to her that she had bumped into R5 or anything else. LPN F said R5 was independent with ambulation and did not use any assistive devices. LPN F also stated that R5 did have dementia and did wander the hallway all the time, and when she observed R5 on the floor on she was lying on right side. LPN F further stated that R5 did not have a history of falls. LPN F said the dietary staff always pushed the food carts from behind. LPN F said she performed a full assessment on R5, and then sent her to the hospital when she noticed her right arm was distorted. Record review of DM C's Cook Job Description, dated 3/12/2020, revealed no documented requirements for safely maneuvering the food carts throughout the facility. Review of DM C's New Employee Orientation Checklist, dated 3/12/2020, revealed no training on how to safely maneuver the food carts throughout the facility. Review of a Dietary Department Orientation checklist, with a last revision date of June 2016, revealed a blank document. The checklist document did not have DM C's name, signature, nor staff signatures of training. The checklist also revealed no

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) orientation training in regard to safely maneuvering the food carts throughout the facility.