STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414021	A. BUILDING _____ B. WING _____	3/15/2023

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SAMARITAS SENIOR LIVING GRAND RAPIDS LODGE	1950 32ND ST S E GRAND RAPIDS, MI 49508

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F0000 SS=	INITIAL COMMENTS Samaritas Senior Living Grand Rapids Lodge was surveyed for an abbreviated survey on 3/14/23-3/15/23. Intake # MI00134978. Census = 85	F0000		
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00134978. Based on interview, and record review, the facility failed to address an acute change of condition and notify the physician of persistent pain and a decline in ADL (activity of daily living) (getting out of bed) following a fall in 1 of 3 residents (Resident #100) reviewed for quality of care, resulting in a delay in pain interventions and a delay in the diagnosis of left pubic rami (pelvic bone) fracture. Findings include: Review of an "Admission Record" revealed Resident #100 was originally admitted to the facility on 11/2/20, with pertinent diagnoses	F0684	Element 1: Resident #100 has been reviewed to ensure appropriate treatment has been provided and pain interventions are in place. Element 2: Residents that have encountered a fall have the potential to be affected by this deficient practice. A review has been completed of current resident falls in the past 30 days to ensure any change of condition post fall have been identified, escalated to physician, and addressed. Element 3: A review has been completed on the Notification of Change Policy. Licensed facility and contract nurses will be re-educated on identifying change in conditions post fall. Nurses not educated prior to date of compliance will be re-educated prior to the start of their next shift. Element 4: The DON/designee will complete a review on falls for 5 random residents to ensure proper identification of a change in condition weekly for 4 weeks, then biweekly for two months. Results will be forwarded to QAPI for further direction. Any concerns regarding timeliness with reporting change in condition will be addressed immediately and then reported to the Director of Nursing. The Director of Nursing or designee will report results to QAPI	4/12/2023

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

Electronically Signed | 04/04/2023

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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	which included: osteoporosis (condition when bone strength weakens and is susceptible to fracture. It usually affects hip, wrist or spine) and osteoarthritis (breakdown of joint cartilage and underlying bone). Review of a "Minimum Data Set" (MDS) assessment for Resident #100, with a reference date of 2/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #100 was cognitively impaired. Review of the "Functional Status" revealed that Resident #100 was totally dependent and required 2 person assistance for transfers. Review of Resident #100's "Care Plan" that was in place at the time of the fall on 2/18/23 "...INTERVENTIONS: Give analgesic (medication to relieve pain) PRN (as needed) for pain. Resident may complain of pain, stiffness, or weakness, document complaints...Monitor/document/report to MD (medical doctor), PRN s/sx (signs and symptoms) or complications related to osteoporosis: acute fracture, compression fractures...pain, especially back pain...Date Initiated 2/28/22..." In a phone interview on 3/14/23 at 10:58 A.M., Certified Nursing Assistant-Agency (CNA-A) "J" reported the day of Resident #100's fall that it was a very busy day and she was in a hurry. CNA-A "J" reported she had hooked the hoyer sling up to the hoyer lift like she always had, but that during the transfer Resident #100 slid out of the sling and landed on the floor. CNA-A "J" reported that Resident #100 hit the floor hard and that Resident #100 complained of pain with the transfer back into bed and with position changes while in bed, which was a new complaint. In an interview on 3/14/23 at 12:17 P.M., LPN		monthly x3 months and then as directed by the QAPI committee. Audit results will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the committee. The Director of Nursing is responsible for attaining and sustaining overall compliance with this plan of correction.	

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	"F" reported that he was called into Resident #100's room by CNA-A "K" on 2/18/23 due to Resident #100 falling. LPN "F" reported that Resident #100 was on the floor and complained of back pain with ROM (range of motion). LPN "F" reported that he did not perform ROM on Resident #100's left leg due to her known chronic pain in the knee. LPN "F" reported that when they got her back in bed she continued to complain of pain in her middle back and had increased pain when she was rolled on her side. LPN "F" reported that he called the "on-call" person and they said to give her Tylenol (over the counter pain medication), continue to monitor and that they would see her on Monday (2 days later). LPN "F" reported that Resident #100 continued to have pain with any movements in bed, would verbally moan when the HOB (head of bed) was raised, would yell out during repositioning and stated, "...if she wasn't touched she was fine...as long as she wasn't moving she was fine..." LPN "F" reported that Resident #100 normally got out of bed and into her chair for all meals and stated, "...we did not get her up after that...because every time we moved her she would yell in pain...we fed her in bed...she was more comfortable there..." LPN "F" reported that he administered PRN Tylenol that day, but that her routine pain medications (Gabapentin) appeared to be controlling the pain. LPN "F" reported that he did not follow up with the physician later that day or the next day either, because he thought they just wanted Resident #100 monitored until they came in on Monday (2 days later) and stated, "...her complaints of pain were very concerning to me...we limited her movement and kept her in bed...we were very careful with her..." LPN "F" reported that to this day Resident #100 has not been out of her bed and stated, "...we haven't even tried...we don't want her to be uncomfortable...she is still complaining of pain when they (CNA's) change her..."			

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	During an observation and interview on 3/14/23 at 1:00 P.M. Resident #100 was lying in bed on her back with the HOB at approximately 30 degrees. CNA "G" came in to assist the resident with lunch. CNA "G" reported that she had to raise the HOB very slow otherwise Resident #100 would scream and stated, "...I think she hurt her leg...she doesn't want to get up...but before she would get up into her chair with no problem..." Resident #100 reported that she had pain in her hips and stated, "...it's really bad..." In an interview on 3/15/23 at 11:00 A.M., Registered Nurse (RN) "O" reported that she had received report at the start of shift from LPN "F" who indicated that Resident #100 had fallen earlier in the day, and that the physician was aware and did not want anything done at that time. RN "O" reported that Resident #100 was uncomfortable during during repositioning and stated, "...she was grimacing and saying ouch...and that was not normal for her..." RN "O" reported that she did not follow up with the physician, because she was told that the physician was planning to see Resident #100 in a couple days. RN "O" reported that she would have contacted the physician if the resident had increased pain or not able to perform ROM and stated, "...I focused ROM on her legs because it was painful when she moved or twisted..." In an interview on 3/15/23 at 12:32 P.M., Nurse Practitioner (NP) "M" reported that she had received a secure text from the facility on 2/18/22 in the afternoon and she called back but had to leave a message, and then LPN "F" called back shortly after that reporting that Resident #100 had fallen due to improper use of the hoyer lift, that (Resident #100) was having back pain, but that she was back in bed and comfortable. NP "M" reported that she gave instructions to LPN "F" to do neuro (neurological) checks and call us back if Resident #100 was not improving and stated,			

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"...we did not get any calls that weekend...my expectation from a skilled facility is that they know the resident and when to call..." NP "M" reported that Doctor of Osteopathic Medicine (DO) "T" was scheduled to see Resident #100 on 2/20/23, and during that visit, DO "T" made the decision to send Resident #100 out to the hospital for evaluation.

Review of "On-Call Communication" from NP "M" dated 2/18/23 revealed, "Received a secure text...regarding (Resident #100) reporting that she had a fall while transferring with Hoyer lift and having back pain. 1357 (1:57 P.M.) - called and left voicemail in the number provided to call back with further concerns. 1400 (2:00 P.M.) - received a call back from (LPN "F") that reported (Resident #100) slipped out of the Hoyer and was guided to the floor during transfer. Her vitals were checked and stable ...she did report some pain in her mid back with any movement or palpation, but otherwise denies pain and is comfortable in bed. She has not had any pain medication provided at this time. She did not remember hitting her head. Staff was vague with a report of the fall, he will look further into this. Gave orders to provide Tylenol now and EVERY EIGHT HOURS over the weekend, perform Neuro checks every four hours, and call if there is any worsening of symptoms, change in vitals, or altered mental status...Will forward to care team for discussion and follow up on Monday."

Review of Resident #100's Medication Administration Record (MAR) from February indicated in addition to regularly scheduled Gabapentin (for chronic pain syndrome), Resident #100 had an order for Acetaminophen Tablet 500mg give 2 tablets by mouth every 8 hours as needed for pain, start date 1/6/23, and had received the medication a total of 3 times following her fall on 2/18/23. Indicating administration on 2/18/23 at 2:28 P.M. for pain

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	level of 7 out of 10, on 2/21/23 at 12:40 P.M. for a pain level of 5 out of 10, and on 2/27/23 at 6:09 P.M. for a pain level of 5 out of 10. There was also an order placed after Resident #100 returned from the hospital on 2/21/22 for Buprenorphine transdermal patch (pain medication administered through a patch placed on the skin) to be applied once weekly starting on 2/22/23. This record indicates that Resident #100 received only 2 doses of PRN pain medication after her fall and prior to returning from the hospital on 2/21/23. Review of Resident #100's MAR from February revealed, "Ask Resident if they are having pain and Document two times a day for evaluation. Start Date 01/29/2023." The record indicated that Resident #100 had 0/10 pain level up until the day of the fall, except for 2/6/23 indicated 2/10 pain level. Following the fall on 2/18/23 pain levels were noted in 14 of 20 evaluations, ranging from 1-6 pain level. Review of a Facility Reported Incident (FRI) received on 2/20/22 at 11:33 P.M. revealed, "...On 2/18/23, (Resident #100) had a fall which resulted in no external injury. On 2/20/23, Physician sent resident out to (hospital) due to report of pain. X-ray results showed suspected fracture of the left inferior pubic ramus (pelvic bone)..." Review of Resident #100's Emergency Department Summary revealed, "...Arrival Date/Time: 02/20/2023 2055 (8:55 P.M.)...The patient presents to the emergency department with concerns of left hip pain. In route she was noted to be febrile...She does not have a true fever here but slightly elevated body temperature...Given the fall with mild left-sided greater trochanteric (upper leg/hip) tenderness, x-ray left hip was obtained...Pelvic x-ray however does show a pubic rami fracture...No surgery is			

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	needed. They will reach out to her for follow-up...Discharge Date/Time: 02/21/2023 0116 (12:16 A.M.)..."			
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 #MI00134978. Based on observation, interview, and record review, the facility failed to safely transfer 1 of 3 residents (Resident #100) reviewed for accident hazards, resulting in Resident #100's avoidable fall and sustaining a left rami (pelvic bone) fracture. Findings include: Review of an "Admission Record" revealed Resident #100 was originally admitted to the facility on 11/2/20, with pertinent diagnoses which included: osteoporosis (condition when bone strength weakens and is susceptible to fracture. It usually affects hip, wrist or spine) and osteoarthritis (degenerative joint disease). Review of a "Minimum Data Set" (MDS) assessment for Resident #100, with a reference date of 2/9/23 revealed a "Brief Interview for Mental Status" (BIMS) score of 8, out of a total possible score of 15, which indicated Resident #100 was cognitively impaired. Review of the	F0689	Element 1: Resident #100 has been reviewed to ensure appropriate transfer status is reflected in the current plan of care and kardex. Element 2: Residents that utilize a mechanical lift for transfers have the potential to be affected. A review has been completed on residents that utilize a mechanical lift to ensure proper transfer status is reflected in their plan of care and kardex. Element 3: A review has been completed on the transfer lift policy. Nursing staff will be re-educated on the proper use of mechanical lifts. Nursing staff not re-educated prior to date of compliance will be re-educated prior to the start of their next shift. Element 4: The DON/designee will review 5 residents a week to ensure mechanical lifts are being used safely on residents, then biweekly for two months. Results will be forwarded to QAPI for further direction. Any concerns regarding mechanical lift transfers will be addressed immediately and then reported to the Director of Nursing. The Director of Nursing or designee will report results to QAPI monthly x3 months and then as directed by the QAPI committee. Audit results will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the committee. The Director of Nursing is responsible for attaining and sustaining overall compliance	4/12/2023

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	"Functional Status" revealed that Resident #100 was totally dependent and required 2 person assistance for transfers. Review of Resident #100's "Care Plan" that was in place at the time of the fall on 2/18/23 "...has ADL (activities of daily living) self-care deficit related to cognitive impairment, weakness/debility...Date initiated 11/12/20...INTERVENTIONS:...TRANSFER: Dependent mechanical full body lift (hoyer) with 2 staff assist. Date Initiated: 11/12/2020." The transfer intervention was revised on 03/01/2023 and revealed, "TRANSFER: Dependent mechanical hoyer lift with 2 staff assist. Recommended to use full body sling." Review of a Facility Reported Incident (FRI) received on 2/20/22 at 11:33 P.M. revealed, "...On 2/18/23, (Resident #100) had a fall which resulted in no external injury. On 2/20/23, Physician sent resident out to (hospital) due to report of pain. X-ray results showed suspected fracture of the left inferior pubic ramus (hip bone)... INVESTIGATION:...No injury was identified at the time of the fall. (Licensed Practical Nurse (LPN) "F") reported fall to on call provider (Nurse Practitioner (NP) "M"). No new orders were given. Per (NP "M") (Doctor of Osteopathic Medicine (DO) "U") would be notified on Monday (2/20/23). (Resident #100) was monitored post fall with Vital signs and neurological checks. No concerns were noted at the time...(Resident #100) slid out of the hoyer while she was being transferred...On 2/19/23 at 7:11am, (Registered Nurse (RN) "O") noted that (Resident #100) had pain with repositioning. Resident was not able to state where exactly she hurt but said yes when asked if her lower back hurt and yes when asked if legs hurt. No swelling noted or any abnormal findings at that time. Will continue to monitor. On 2/19/23 at 1:34pm, (LPN "F"), ...noted that she stayed in bed for the shift (7		with this plan of correction.	

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	-3)...Neuro checks were WNL (within normal limits). She complained of pain during repositioning of her left knee and mid back, however, resident has history of chronic pain. Scheduled pain medication was administered and it was effective in relieving pain...On 2/20/23 around 3:58pm...physician came in to assess resident post fall and placed orders for (Resident #100) to be sent out to (emergency department) to perform x-ray due to continued discomfort in her lower back. On 2/20/23 around 11:30pm...hospital report showed that (Resident #100) had a suspected fracture of the left inferior pubic ramus...On 2/21/23 at 3:16am...(Resident #100) had returned to facility with no new orders, as the fracture just needed to heal per ER (emergency room) provider..." In an interview on 3/14/23 at 5:01 P.M., Director of Nursing (DON) reported that Resident #100 fell on 2/18/23 due to staff not being knowledgeable about the use of a hoyer. DON reported that Resident #100 should have been safe to transfer in the U shaped sling or the full body sling, as long as it was hooked up right and stated, "...now (Resident #100) was care planned for the full body sling just to simplify the expectations for staff..." In a phone interview on 3/14/23 at 10:58 A.M., Certified Nursing Assistant-Agency (CNA-A) "J" reported the day of Resident #100's fall that it was a very busy day and she was in a hurry. CNA-A "J" reported she had hooked the hoyer sling up to the hoyer lift like she always had, but that during the transfer Resident #100 slid out of the sling and landed on the floor. CNA-A "J" reported that Resident #100 hit the floor hard, and that she stayed with the resident while CNA-A "K" left to get Licensed Practical Nurse (LPN) "F". CNA-A "J" reported that LPN "F" came into the room, along with other CNA's, and we got her back into bed, and LPN "F" told me that I had used the			

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	wrong type of sling to do the transfer. CNA-A "J" reported that Resident #100 complained of pain with the transfer into bed and with position changes while in bed, which was a new complaint. CNA-A "J" reported that DON called her a couple days later to inform of Resident #100's injury due to the fall and requested that CNA-A "J" come in to the facility to further discuss the incident. CNA-A "J" reported that she and CNA-A "K" reenacted that scenario for DON to observe, were briefly educated, and it was determined that CNA-A "J" had hooked the hoyer sling up wrong. CNA-A "J" reported that she was told that she was supposed to criss-crossed the leg straps prior to hooking the sling onto the hoyer lift and stated, "...I had no idea...I always did it that way...no one had ever corrected me...I didn't even know she was supposed to have a full body sling...I am still confused to this day..." CNA-A "J" reported that the sheet of paper that the facility had given her only indicated that Resident #100 used the hoyer lift, but did not specify a specific sling and stated, "...I had never used the type of hoyer that the facility had until I worked there...as an agency CNA you have to figure it our for yourself...I don't know how to look at the care plan...I didn't know anything about her...it was very unorganized..." CNA-A "J" reported that she had only worked in the facility 2 or 3 shifts, because she had called off several times and stated, "...after that I canceled all my shifts...I was not comfortable working there..." In a phone interview on 3/14/23 at 11:24 A.M., CNA-A "K" reported that she assisted CNA-A "J" with Resident #100's hoyer transfer on 2/18/23. CNA-A "K" reported that when Resident #100 was lifted up, she slipped right out of the sling and fell on the floor, landing on her bottom and stated, "...(CNA-A "J") didn't cross the leg straps...I didn't notice until (Resident #100) started sliding out of the sling...it happened so fast..." CNA-A "K" reported that it was her one			

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and only time working at the facility and stated, "...I did not get any training...no help with anything...no welcoming or nothing...no one even showed me around...I had to figure things out myself..."

In an interview on 3/14/23 at 12:17 P.M., LPN "F" reported that the day that Resident #100 fell there were 2 agency CNA's working on the hall and stated, "...I was told that one of them had been here twice..." LPN "F" reported that he was called into Resident #100's room by CNA-A "K". LPN "F" reported that Resident #100 was on the floor and complained of back pain with ROM (range of motion). LPN "F" reported that he did not perform ROM on Resident #100's left leg due to her known chronic pain in the knee. LPN "F" reported that when they got her back in bed she continued to complain of pain in her middle back and had increased pain when she was rolled on her side. LPN "F" reported that he called the "on-call" person and they said to give her Tylenol, continue to monitor and that they would see her on Monday (2 days later). LPN "F" reported that there are a lot of agency CNA's working in the facility and they do not know the residents, and that he educated the agency CNA's involved afterwards about using a full body hoyer pad for Resident #100 due to her weight and her body being limp. LPN "F" reported that he reminded the agency CNA's to check the resident's Kardex (direct care-givers care guide) prior to providing care, and that CNA-A "J" told him that she had checked the Kardex and that it did not indicate the type of hoyer sling that the resident required.

During an observation and interview on 3/14/23 at 1:00 P.M. Resident #100 was lying in bed on her back with the HOB at approximately 30 degrees. CNA "G" came in to assist the resident with lunch. CNA "G" reported that she had to raise the HOB very slow otherwise Resident #100 will scream and stated, "...I think she hurt her

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	leg...she doesn't want to get up...but before she would get up into her chair with no problem..." Resident #100 reported that she had pain in her hips and stated, "...it's really bad..." In an interview on 3/14/23 at 3:32 P.M., CNA "Q" reported that Resident #100 used to get up in her chair everyday and now she is in bed all of the time. In an interview on 3/15/23 at 12:32 P.M., Nurse Practitioner (NP) "M" reported that she had received a secure text from the facility on 2/18/22 in the afternoon and she called back but had to leave a message, and then LPN "F" called back shortly after that, reporting that Resident #100 had fallen due to improper use of the hoyer lift, that she was having back pain, but that she was back in bed and comfortable. NP "M" reported that she gave instructions to LPN "F" to do every 2 hours neuro (neurological) checks and call us back if Resident #100 was not improving and stated, "...we did not get any calls ...my expectation from a skilled facility is that they know the resident and when to call..." NP "M" reported that Doctor of Osteopathic Medicine (DO) "T" was scheduled to see Resident #100 on 2/20/23, and DO "T" made the decision at that time to send Resident #100 out to the hospital for evaluation due to the amount of pain she was having. Review of "On-Call Communication" from NP "M" dated 2/18/23 revealed, "Received a secure text...regarding (Resident #100) reporting that she had a fall while transferring with Hoyer lift and having back pain. 1357 (1:57 P.M.) - called and left voicemail in the number provided to call back with further concerns. 1400 (2:00 P.M.) - received a call back from (LPN "F") that reported (Resident #100) slipped out of the Hoyer and was guided to the floor during transfer. Her vitals			

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	were checked and stable ...she did report some pain in her mid back with any movement or palpation, but otherwise denies pain and is comfortable in bed. She has not had any pain medication provided at this time. She did not remember hitting her head. Staff was vague with a report of the fall, he (LPN "F")will look further into this. Gave orders to provide Tylenol now and every eight hours over the weekend, perform Neuro checks every four hours, and call if there is any worsening of symptoms, change in vitals, or altered mental status...Will forward to care team for discussion and follow up on Monday." Review of Resident #100's Medication Administration Record (MAR) from February indicated in addition to regularly scheduled Gabapentin (for chronic pain syndrome), Resident #100 had an order for Acetaminophen Tablet 500mg give 2 tablets by mouth every 8 hours as needed for pain, start date 1/6/23, and received the medication a total of 3 times following her fall on 2/18/23. Indicating administration on 2/18/23 at 2:28 P.M. for pain level of 7 out of 10, on 2/21/23 at 12:40 P.M. for a pain level of 5 out of 10, and on 2/27/23 at 6:09 P.M. for a pain level of 5 out of 10. Also Buprenorphine transdermal patch (pain medication administered through a patch placed on the skin) applied once weekly starting on 2/22/23. This record indicates that Resident #100 received only 2 doses of pain medication after her fall and prior to returning from the hospital on 2/21/23. Review of Resident #100's MAR from February revealed, "Ask Resident if they are having pain and Document two times a day for evaluation. Start Date 01/29/2023." And indicated that Resident #100 had 0/10 pain level up until the day of the fall, except for 2/6/23 indicated 2/10 pain level. Following the fall on 2/18/23 pain levels were noted in 14 of 20 evaluations, ranging from 1-6 pain level.			

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	Review of Resident #100's Emergency Department Summary dated 2/21/22 revealed, "...Arrival Date/Time: 02/20/2023 2055 (8:55 P.M.)...The patient presents to the emergency department with concerns of left hip pain. In route she was noted to be febrile...She does not have a true fever here but slightly elevated body temperature...Given the fall with mild left-sided greater trochanteric (upper leg/hip) tenderness, x-ray left hip was obtained...Pelvic x-ray however does show a pubic rami fracture (pelvic bone)...No surgery is needed. They will reach out to her for follow-up...Discharge Date/Time: 02/21/2023 0116 (12:16 A.M.)..."			
F0726 SS= D	Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and	F0726	Element 1: Resident #100 has been reviewed to ensure appropriate transfer status is reflected in the current care plan and kardex. Element 2: Residents that utilize a mechanical lift for transfers have the potential to be affected. A review has been completed on residents that utilize a mechanical lift to ensure proper transfer status is reflected in their plan of care and kardex. Element 3: A review has been completed on the competency evaluation policy and transfer lift policy. Current facility and agency nursing staff will be re-educated on the proper use of mechanical lifts. Any facility or agency nursing staff not re-educated prior to compliance date will be re-educated prior to the start of their next shift. Element 4: The DON/designee will review records of 6 random facility and agency nursing staff members to ensure that records of competency evaluation are present and	4/12/2023

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	techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00134978. Based on interview, and record review, the facility failed to ensure that all working nursing staff possess the competencies and skill sets necessary to provide safe transfers for 1 of 3 residents (Resident #100) reviewed for accidents and hazards, resulting in Resident #100's avoidable fall, and sustaining a left rami (pelvic bone) fracture. Findings include: Review of a Facility Reported Incident (FRI) received on 2/20/22 at 11:33 P.M. revealed, "...On 2/18/23, (Resident #100) had a fall which resulted in no external injury. On 2/20/23, Physician sent resident out to (hospital) due to report of pain. X-ray results showed suspected fracture of the left inferior pubic ramus (hip bone)... INVESTIGATION:...No injury was identified at the time of the fall...(Resident #100) slid out of the hoyer while she was being transferred...On 2/19/23 at 7:11am, (Registered Nurse (RN) "O") noted that (Resident #100) had pain with repositioning...On 2/20/23 around 3:58pm...physician came in to assess resident post fall and placed orders for (Resident #100) to be sent out to (emergency department) to perform x-ray due to continued discomfort in her lower back. On 2/20/23 around 11:30pm...hospital report showed that (Resident #100) had a suspected fracture of the left inferior pubic ramus..."		current. Audits will be done weekly for 4 weeks, biweekly for the next 4 weeks, and monthly for the next 2 months. Results will be forwarded to QAPI for further direction. Any concerns regarding mechanical lift transfers will be addressed immediately and then reported to the Director of Nursing. The Director of Nursing or designee will report results to QAPI monthly x3 months and then as directed by the QAPI committee. Audit results will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the committee. The Director of Nursing is responsible for attaining and sustaining overall compliance with this plan of correction.	

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	In a phone interview on 3/14/23 at 10:58 A.M., Certified Nursing Assistant-Agency (CNA-A) "J" reported the day of Resident #100's fall that it was a very busy day and she was in a hurry. CNA-A "J" reported she had hooked the hoyer sling up to the hoyer lift like she always had, but that during the transfer Resident #100 slid out of the sling and landed on the floor. CNA-A "J" reported that LPN "F" came into the room, along with other CNA's, and we got her back into bed, and LPN "F" told me that I had used the wrong type of sling to do the transfer. CNA-A "J" reported that the Director of Nursing (DON) called her a couple days later to inform of Resident #100's injury due to the fall and requested that CNA-A "J" come in to the facility to further discuss the incident. CNA-A "J" reported that she and CNA-A "K" reenacted that scenario for DON to observe, were briefly educated, and it was determined that CNA-A "J" had hooked the hoyer sling up wrong. CNA-A "J" reported that she was told that she was supposed to criss-crossed the leg straps prior to hooking the sling onto the hoyer lift and stated, "...I had no idea...I always did it that way...no one had ever corrected me...I didn't even know she was supposed to have a full body sling...I am still confused to this day..." CNA-A "J" reported that the sheet of paper that the facility had given her only indicated that Resident #100 used the hoyer lift, but did not specify a specific sling and stated, "...I had never used the type of hoyer that the facility had until I worked there...as an agency CNA you have to figure it our for yourself...I don't know how to look at the care plan...I didn't know anything about her...it was very unorganized..." CNA-A "J" reported that she had only worked in the facility 2 or 3 shifts, because she had called off several times and stated, "...after that I canceled all my shifts...I was not comfortable working there..." In a phone interview on 3/14/23 at 11:24 A.M.,			

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	CNA-A "K" reported that she assisted CNA-A "J" with Resident #100's hoyer transfer on 2/18/23. CNA-A "K" reported that when Resident #100 was lifted up, she slipped right out of the sling and fell on the floor, landing on her bottom and stated, "...(CNA-A "J") didn't cross the leg straps...I didn't notice until (Resident #100) started sliding out of the sling...it happened so fast..." CNA-A "K" reported that it was her one and only time working at the facility and stated, "...I did not get any training...no help with anything...no welcoming or nothing...no one even showed me around...I had to figure things out myself..." In an interview on 3/14/23 at 12:17 P.M., LPN "F" reported that the day that Resident #100 fell there were 2 agency CNA's working on the hall and stated, "...I was told that one of them had been here twice..." LPN "F" reported that he was called into Resident #100's room by CNA-A "K". LPN "F" reported that Resident #100 was on the floor and complained of back pain with ROM (range of motion). LPN "F" reported that there are a lot of agency CNA's working in the facility and they do not know the residents, and that he educated the agency CNA's involved afterwards about using a full body hoyer pad for Resident #100 due to her weight and her body being limp. LPN "F" reported that he reminded the agency CNA's to check the resident's Kardex (direct care-givers care guide) prior to providing care, and that CNA-A "J" told him that she had checked the Kardex and that it did not indicate the type of hoyer sling that the resident required. In an interview on 3/14/23 at 5:01 P.M., DON reported that Resident #100 fell on 2/18/23 due to staff not being knowledgeable about the use of a hoyer. DON reported that Resident #100 should have been safe to transfer in the U shaped sling or the full body sling, as long as it was hooked up right and stated, "...now (Resident #100) was care			

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planned for the full body sling just to simplify the expectations for staff..."

In an interview on 3/14/23 at 3:32 P.M., CNA "Q" reported that Resident #100 used to get up in her chair everyday and now she is in bed all of the time. CNA "Q" reported that she is training a new full hire CNA (CNA "R") today and stated, "...(CNA "R") will not be on her own for a long time...the CNA's that the facility hire get a lot of training...as long as they need to feel comfortable and familiar with the facility...sometimes a month..."

In an interview on 3/14/23 at 3:46 P.M., DON reported that since the incident with Resident #100, the facility now requires that agency complete additional education related to hoyer lifts with their agency, or with the facility prior to their next shift. DON reported that Assistant Director of Nursing (ADON) is responsible for ensuring that it is done.

In an interview on 03/14/23 at 3:19 P.M., CNA-A "V" reported that she had worked 2-3 shifts over the past 2 weeks, with her shift beginning at 2:30 P.M. that day, and was assigned a group of residents that included Resident #100. CNA-A "V" reported that she worked for an agency and had not ever received education or orientation from the facility and/or her agency related to hoyer lifts. CNA-A "V" stated, "...on my very first day I was handed a sheet of paper that tells the shower days and how they (residents) transfer...the facility assumes that I know what I am doing..."

In an interview on 3/14/23 at 4:00 P.M., ADON reported that the hoyer education for those that did not receive it prior to 3/11/23, consists of written hoyer lift education and someone reviewing with them the most important parts of

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	the materials, and that CNA-A "V's" education related to hoyer lifts and slings was completed on that day, after this surveyor had interviewed CNA-A "V". ADON reported that Scheduler (SCH) "H" handed out the hoyer education to CNA-A "V" and had her sign a form indicating that she had received it. ADON reported that SCH "H" was not a CNA or a nurse, and was not competent to educate someone on how to complete hoyer lifts. ADON reported that CNA-A "V" did not receive the education prior to her starting the shift that day. Review of Resident #100's Emergency Department Summary dated 2/21/22 revealed, "...Arrival Date/Time: 02/20/2023 2055 (8:55 P.M.)...The patient presents to the emergency department with concerns of left hip pain. In route she was noted to be febrile...She does not have a true fever here but slightly elevated body temperature...Given the fall with mild left-sided greater trochanteric (upper leg/hip) tenderness, x-ray left hip was obtained...Pelvic x-ray however does show a pubic rami fracture..."			
F0842 SS= D	Resident Records - Identifiable Informatio §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The	F0842	Element 1: Resident #102 no longer resides in the facility. Element 2: Residents that are at risk for falls have the potential to be affected. A review has been completed to ensure accuracy in fall assessment documentation and the plan of care properly reflects the residents' status. Element 3: A review has been completed on the Fall Risk Assessment policy. Licensed nursing staff have been re-educated on the proper completion of the fall assessment. Any nurse not re-educated prior to date of compliance will be re-educated prior to the start of their next shift. Element 4:	4/12/2023

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	facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physicia's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:		The DON/designee will review 4 resident charts to ensure proper completion of the fall risk assessment is reflected in the plan of care weekly times 4 weeks then biweekly for 4 weeks. Results will be forwarded to QAPI for further direction. Any concerns regarding inaccuracy in fall assessment documentation will be addressed immediately and then reported to the Director of Nursing. The Director of Nursing or designee will report results to QAPI monthly x2 months and then as directed by the QAPI committee. Audit results will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the committee. The Director of Nursing is responsible for attaining and sustaining overall compliance with this plan of correction.	

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Based on interview and record review the facility failed to maintain a complete and accurate medical record, including assessments for 1 resident (Resident #102) of 3 residents reviewed for accident hazards, resulting in the potential for inadequate fall interventions in place due to inaccurate fall risk assessment.

Findings include:

Review of an "Admission Record" revealed Resident #102 was originally admitted to the facility on 10/27/22, with pertinent diagnoses which included: Alzheimer's disease and dementia.

Review of Resident #102's "Fall Reports" indicated falls on 11/3/22 (fall with major injury), 11/13/22 (fall with no injury), and 2/28/23 (fall with major injury).

Review of Resident #102's "Fall Risk Evaluation" dated 1/19/23 revealed, "...If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. Prevention protocol should be initiated immediately and documented on the care plan...2. History of falls (past 3 months): No falls in the past 3 months..." The assessment data resulted in a fall risk score of "9".

In an interview on 3/15/23 at 12:49 P.M., Director of Nursing (DON) reported that Resident #102's fall assessment was inaccurate and should have indicated that she had 2 falls in the previous 3 months. DON reported that the fall assessment data is meant to trigger staff to develop and or revise care plan interventions, and although Resident #102's fall assessment was inaccurate, the care plan had been reviewed and revised.

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	414021	A. BUILDING _____ B. WING _____	3/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAS SENIOR LIVING GRAND RAPIDS LODGE	1950 32ND ST S E GRAND RAPIDS, MI 49508

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F0940 SS= D	Training Requirements §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00134978. Based on interview, and record review, the facility failed to maintain an effective training program for agency staff consistent with their role in the facility to ensure the safety of resident in 1 of 3 residents (Resident #100) reviewed for accidents and hazards, resulting in Resident #100's avoidable fall, and sustaining a left rami (pelvic bone) fracture. Findings include: In a phone interview on 3/14/23 at 10:58 A.M., Certified Nursing Assistant-Agency (CNA-A) "J" reported the day of Resident #100's fall (2/18/23) that it was a very busy day and she was in a hurry. CNA-A "J" reported she had hooked the hoyer sling up to the hoyer lift like she always had, but that during the transfer Resident #100 slid out of the sling and landed on the floor. CNA-A "J" reported that LPN "F" told me that I had used the wrong type of sling to do the transfer. CNA-A "J" reported that the Director of Nursing (DON) called her a couple days later to inform of Resident #100's injury due to the fall	F0940	Element 1: Resident #100 has been reviewed to ensure appropriate transfer status is reflected in the current care plan and kardex. Element 2: Residents that utilize a mechanical lift for transfers have the potential to be affected. A review has been completed on residents that utilize a mechanical lift to ensure proper transfer status is reflected in their plan of care and kardex. Element 3: A review has been completed on the competency evaluation policy and transfer lift policy. Current facility and agency nursing staff will be re-educated on the proper use of mechanical lifts. Any facility or agency nursing staff not re-educated prior to compliance date will be re-educated prior to the start of their next shift. New agency staff will be provided orientation to facility policies and expectation prior to the start of their first shift assignment. Element 4: The DON/designee will review records of 6 random facility and agency nursing staff members to ensure that records of competency evaluation are present and current. Audits will be done weekly for 4 weeks, biweekly for the next 4 weeks, and monthly for the next 2 months. Results will be forwarded to QAPI for further direction. Any concerns regarding mechanical lift transfers will be addressed immediately and then reported to the Director of Nursing. The Director of Nursing or designee will report results to QAPI monthly x3 months and then as directed by the QAPI committee. Audit results will be reviewed by QAPI until such time consistent substantial compliance has been achieved as determined by the	4/12/2023

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	and requested that CNA-A "J" come in to the facility to further discuss the incident. CNA-A "J" reported that she and CNA-A "K" reenacted that scenario for DON to observe, were briefly educated, and it was determined that CNA-A "J" had hooked the hoyer sling up wrong. CNA-A "J" reported that she was told that she was supposed to criss-crossed the leg straps prior to hooking the sling onto the hoyer lift and stated, "...I had no idea...I always did it that way...no one had ever corrected me...I didn't even know she was supposed to have a full body sling...I am still confused to this day..." CNA-A "J" reported that the sheet of paper that the facility had given her only indicated that Resident #100 used the hoyer lift, but did not specify a specific sling and stated, "...I had never used the type of hoyer that the facility had until I worked there...as an agency CNA you have to figure it our for yourself...I don't know how to look at the care plan...I didn't know anything about her...it was very unorganized..." CNA-A "J" reported that she had only worked in the facility 2 or 3 shifts, because she had called off several times and stated, "...after that I canceled all my shifts...I was not comfortable working there..." In a phone interview on 3/14/23 at 11:24 A.M., CNA-A "K" reported that she assisted CNA-A "J" with Resident #100's hoyer transfer on 2/18/23. CNA-A "K" reported that when Resident #100 was lifted up, she slipped right out of the sling and fell on the floor, landing on her bottom and stated, "...(CNA-A "J") didn't cross the leg straps...I didn't notice until (Resident #100) started sliding out of the sling...it happened so fast..." CNA-A "K" reported that it was her one and only time working at the facility and stated, "...I did not get any training...no help with anything...no welcoming or nothing...no one even showed me around...I had to figure things out myself..."		committee. The Director of Nursing is responsible for attaining and sustaining overall compliance with this plan of correction.	

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	In an interview on 3/14/23 at 12:17 P.M., LPN "F" reported that the day that Resident #100 fell there were 2 agency CNA's working on the hall and stated, "...I was told that one of them had been here twice..." LPN "F" reported that he was called into Resident #100's room by CNA-A "K". LPN "F" reported that Resident #100 was on the floor and complained of back pain with ROM (range of motion). LPN "F" reported that there are a lot of agency CNA's working in the facility and they do not know the residents, and that he educated the agency CNA's involved afterwards about using a full body hoyer pad for Resident #100 due to her weight and her body being limp. LPN "F" reported that he reminded the agency CNA's to check the resident's Kardex (direct care-givers care guide) prior to providing care, and that CNA-A "J" told him that she had checked the Kardex and that it did not indicate the type of hoyer sling that the resident required. Review of CNA "J's" Clinical Competency Testing" dated 9/12/22 provided by the Agency that she was employed by, indicated that CNA-A "J" reported having "advanced-level experience" with hoyer lifts. In an interview on 3/14/23 at 11:55 A.M., Agency CNA Recruiter (ACR) "I" reported that CNA-A "J" had been employed by the agency and upon hiring CNA's, they are required to complete a written competency test and also a skills checklist which consists of the CNA indicating how comfortable they are with specific skill sets. ACR "I" reported that the agency does not require any type of demonstrations or observations to ensure competency and stated, "...not for transfers, not for anything...we would hope that they have been trained and tested by the state..." ACR "I" reported that some facilities require the CNA's to attend an orientation and others assume that agency CNA's are ready to go when they walk in the facility. ACR "I" reported that CNA "J" had			

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completed the necessary competencies that the agency had required.

In an interview on 03/14/23 at 3:19 P.M., CNA-A "V" reported that she had worked 2-3 shifts over the past 2 weeks, with her shift beginning at 2:30 P.M. that day, and was assigned a group of residents that included Resident #100. CNA-A "V" reported that she worked for an agency and had not ever received education or orientation from the facility and/or her agency related to hoyer lifts. CNA-A "V" stated, "...on my very first day I was handed a sheet of paper that tells the shower days and how they (residents) transfer...the facility assumes that I know what I am doing..."

In an interview on 3/14/23 at 3:46 P.M., DON reported that since the incident with Resident #100, the facility now requires that agency complete additional education related to hoyer lifts with their agency, or with the facility prior to their next shift. DON reported that Assistant Director of Nursing (ADON) is responsible for ensuring that it is done.

In an interview on 3/14/23 at 4:00 P.M., ADON reported that the hoyer education for those that did not receive it prior to 3/11/23, consists of written hoyer lift education and someone reviewing with them the most important parts of the materials, and that CNA-A "V's" education related to hoyer lifts and slings was completed on that day, after this surveyor had interviewed CNA-A "V". ADON reported that Scheduler (SCH) "H" handed out the hoyer education to CNA-A "V" and had her sign a form indicating that she had received it. ADON reported that SCH "H" was not a CNA or a nurse, and was not competent to educate someone on how to complete hoyer lifts. ADON reported that CNA-A "V" did not receive the education prior to her

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	starting the shift that day. In an interview on 3/15/23 at 11:00 A.M., Registered Nurse (RN) "O" reported that it was difficult to manage with all the agency staff and stated, "...it's a problem that the CNA's come in without knowing these residents...and I am so busy...we need someone to oversee us..." In an interview on 3/15/23 at 12:25 P.M., CNA "P" reported that the CNA's from the agencies need more training and stated, "...they come in and don't know what they are doing...no education...they don't ask for help...I have to check everything they do...so I have my residents and theirs..." CNA "P" reported that there is always new agency CNA's working.			