STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CON	ISTRUCTION	(X3) D/	ATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	À. BUILDIN	\G			LETED
		414021	B. WING			3/15/2	023
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
SAMARITAS	SENIOR LIVING	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION ( RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
F0000	INITIAL COMME	INTS	F0000				
SS=		Living Grand Rapids Lodge was breviated survey on 3/14/23-					
	Intake # MI001349	978.					
	Census = 85						
F0684 SS= G	Quality of care is applies to all treat facility residents. comprehensive at the facility must of treatment and car professional star comprehensive p and the residents This REQUIREM evidenced by: This citation pertait Based on interview facility failed to ad condition and notif pain and a decline living) (getting out 3 residents (Reside of care, resulting in and a delay in the (pelvic bone) fract Findings include: Review of an "Adh Resident #100 was facility on 11/2/20	assessment of a resident, ensure that residents receive the in accordance with idards of practice, the berson-centered care plan, s' choices. IENT is not met as ins to intake #MI00134978. w, and record review, the ldress an acute change of fy the physician of persistent in ADL (activity of daily t of bed) following a fall in 1 of ent #100) reviewed for quality in a delay in pain interventions diagnosis of left pubic rami ure.	F0684	approp pain int Elemen Reside the pote practical current ensure been id address Elemen A revie Notifica Licensa re-educ conditio to date to the s Elemen The DC falls for identifica directio with rep address the Direction	nt #100 has been reviewed to e riate treatment has been provid erventions are in place. It 2: Ints that have encountered a fall ential to be affected by this defice e. A review has been completed resident falls in the past 30 day any change of condition post fa lentified, escalated to physician. Sed. It 3: whas been completed on the tion of Change Policy. ed facility and contract nurses w cated on identifying change in ons post fall. Nurses not educate of compliance will be re-educated tart of their next shift. It 4: DN/designee will complete a rev 5 random residents to ensure p cation of a change in condition v eeks, then biweekly for two mor s will be forwarded to QAPI for fi n. Any concerns regarding time porting change in condition will I sed immediately and then repor ector of Nursing. The Director of g or designee will report results	ed and have cient of s to II have and iII be ed prior ed prior iew on proper veekly ths. urther liness be ted to to QAPI	4/12/2023
LABORATORY	DIRECTOR'S OR PE	ROVIDER/SUPPLIER REPRESENT	ATIVE'S SIGNA	TURE	TITLE	(X6) DA	TE
Electronical	ly 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDING	PLE CON G	STRUCTION		DATE SURVEY PLETED
	414021	B. WING _			3/15/	2023
NAME OF PROVIDER OR SUPPL	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE
SAMARITAS SENIOR LIVING	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 495	508	
PRÉFIX (EACH DEFICIE TAG FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
bone strength we fracture. It usuall osteoarthritis (br underlying bone) Review of a "Min assessment for R date of 2/9/23 rev Mental Status" (I possible score of #100 was cogniti "Functional Statu was totally deper assistance for tra Review of Residu in place at the tin "INTERVENT (medication to re pain. Resident m weakness, docun complaintsMor (medical doctor), or complications fracture, compres back painDate In a phone interv Certified Nursing reported the day a very busy day a "J" reported she I the hoyer lift like the transfer Resident #100 hi #100 complained into bed and with which was a new	aimum Data Set" (MDS) esident #100, with a reference ealed a "Brief Interview for BIMS) score of 8, out of a total 15, which indicated Resident vely impaired. Review of the s" revealed that Resident #100 dent and required 2 person nsfers. ant #100's "Care Plan" that was the of the fall on 2/18/23 (ONS: Give analgesic lieve pain) PRN (as needed) for ty complain of pain, stiffness, or ent itor/document/report to MD PRN s/sx (signs and symptoms) related to osteoporosis: acute sion fracturespain, especially initiated 2/28/22" ew on 3/14/23 at 10:58 A.M., Assistant-Agency (CNA-A) "J" of Resident #100's fall that it was nd she was in a hurry. CNA-A tad hooked the hoyer sling up to she always had, but that during ent #100 slid out of the sling floor. CNA-A "J" reported that the floor hard and that Resident of pain with the transfer back position changes while in bed,		the QAF Audit re such tim has bee committ The Dire attaining	x3 months and then as d Pl committee. sults will be reviewed by ( ne consistent substantial of a achieved as determined ee. ector of Nursing is respon g and sustaining overall of a plan of correction.	QAPI until compliance d by the sible for	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING		STRUCTION		ATE SURVEY LETED
		414021	B. WING _		3/15/2	023	
NAME OF PRO	VIDER OR SUPPLIE	R	STREET ADDRESS, CITY, S			STATE, ZIP CODE	
SAMARITAS	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETIO DATE
	#100's room by Cl Resident #100 wa of back pain with "F" reported that H Resident #100's le pain in the knee. I got her back in be pain in her middle when she was roll reported that he ca they said to give h pain medication), they would see he LPN "F" reported have pain with any verbally moan wh raised, would yell stated, "if she w long as she wasn't "F" reported that H of bed and into he "we did not get I time we moved he fed her in bedsh there" LPN "F" PRN Tylenol that medications (Gabi controlling the pain not follow up with the next day either wanted Resident # in on Monday (2 c complaints of pair mewe limited he bedwe were ver reported that to th been out of her be triedwe don't wa	he was called into Resident NA-A "K" on 2/18/23 due to ling. LPN "F" reported that s on the floor and complained ROM (range of motion). LPN he did not perform ROM on ft leg due to her known chronic .PN "F" reported that when they d she continued to complain of back and had increased pain ed on her side. LPN "F" lled the "on-call" person and the Tylenol (over the counter continue to monitor and that r on Monday (2 days later). that Resident #100 continued to y movements in bed, would en the HOB (head of bed) was out during repositioning and asn't touched she was fineas moving she was fine" LPN Resident #100 normally got out r chair for all meals and stated, her up after thatbecause every r she would yell in painwe e was more comfortable reported that he administered day, but that her routine pain apentin) appeared to be in. LPN "F" reported that he did a the physician later that day or r, because he thought they just f100 monitored until they came lays later) and stated, "her a were very concerning to er movement and kept her in y careful with her" LPN "F" is day Resident #100 has not d and stated, "we haven't even unt her to be uncomfortableshe g of pain when they (CNA's)					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY
		414021	B. WING _		3/15/2	3/15/2023	
NAME OF PROVID		ER			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE
SAMARITAS SE	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950	8		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE
a h d v v v k k v v v v v v v v v v v v v v	t 1:00 P.M. Resider back with the egrees. CNA "G vith lunch. CNA aise the HOB ver vould scream and egshe doesn't would get up into tesident #100 rep ips and stated, " an an interview on tegistered Nurse eceived report at vho indicated tha arlier in the day, ware and did not me. RN "O" reported that she chysician, because vas planning to se ays. RN "O" reported that she chysician, because vas planning to se ays. RN "O" reported that she chysician, because a message, a bortly after that r allen due to impr Resident #100 whe was back in be ported that she go neuro (neurolo) whe was back in be ported that she chysician the afternoon and the two meases and the neuro (neurolo) whe was back in be ported that she chysicient the secure of the assesser.	tion and interview on 3/14/23 lent #100 was lying in bed on HOB at approximately 30 " came in to assist the resident "G" reported that she had to y slow otherwise Resident #100 I stated, "I think she hurt her vant to get upbut before she her chair with no problem" orted that she had pain in her it's really bad" 13/15/23 at 11:00 A.M., (RN) "O" reported that she had the start of shift from LPN "F" t Resident #100 had fallen and that the physician was want anything done at that orted that Resident #100 was ring during repositioning and grimacing and saying is not normal for her" RN "O" lid not follow up with the e she was told that the physician ee Resident #100 in a couple orted that she would have sician if the resident had not able to perform ROM and d ROM on her legs because it she moved or twisted"					

						0(0) 5	
AND PLAN OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	G	ISTRUCTION		ATE SURVEY LETED
		414021	B. WING _			3/15/2	2023
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	TATE, ZIP CC	DE
SAMARITAS	SENIOR LIVING (	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950	18	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	expectation from a know the resident reported that Doctr (DO) "T" was sche 2/20/23, and durin decision to send R for evaluation. Review of "On-Ca "M" dated 2/18/23 textregarding (R- had a fall while tra having back pain. left voicemail in th with further conce received a call bac (Resident #100) sl guided to the floor were checked and pain in her mid bac palpation, but othe comfortable in bed medication provid remember hitting H a report of the fall. Gave orders to pro EIGHT HOURS o Neuro checks ever any worsening of s altered mental stat for discussion and Review of Resider Administration Re indicated in additio Gabapentin (for ch #100 had an order 500mg give 2 table	ny calls that weekendmy a skilled facility is that they and when to call" NP "M" or of Osteopathic Medicine eduled to see Resident #100 on g that visit, DO "T" made the esident #100 out to the hospital and the the esident #100 out to the hospital and the the esident #100 out to the hospital and the esident #100 reporting that she insferring with Hoyer lift and 1357 (1:57 P.M.) - called and he number provided to call back rms. 1400 (2:00 P.M.) - k from (LPN "F") that reported ipped out of the Hoyer and was of during transfer. Her vitals stableshe did report some ck with any movement or rewise denies pain and is 1. She has not had any pain ed at this time. She did not her head. Staff was vague with h, he will look further into this. wide Tylenol now and EVERY ver the weekend, perform y four hours, and call if there is symptoms, change in vitals, or usWill forward to care team follow up on Monday." at #100's Medication cord (MAR) from February on to regularly scheduled tronic pain syndrome), Resident for Acetaminophen Tablet ets by mouth every 8 hours as art date 1/6/23, and had cation a total of 3 times on 2/18/23. Indicating 2/18/23 at 2:28 P.M. for pain					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CON	ISTRUCTION		ATE SURVEY PLETED
		414021	B. WING				
NAME OF PRO	VIDER OR SUPPLIE	R	STREET ADDRESS, CITY,			STATE, ZIP CODE	
SAMARITAS	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950	)8		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	a pain level of 5 o P.M. for a pain lev also an order place from the hospital of transdermal patch h through a patch pl once weekly starti indicates that Resi doses of PRN pain prior to returning : Review of Residen revealed, "Ask Re and Document twa Start Date 01/29/2 Resident #100 had day of the fall, exa pain level. Follow levels were noted from 1-6 pain leve Review of a Facili received on 2/20/2 "On 2/18/23, (R resulted in no exter Physician sent ress report of pain. X-1 fracture of the left bone)" Review of Residen Department Summ Date/Time: 02/20/ patient presents to with concerns of 1 noted to be febrile here but slightly e temperatureGiva	ty Reported Incident (FRI) 22 at 11:33 P.M. revealed, esident #100) had a fall which mral injury. On 2/20/23, ident out to (hospital) due to ay results showed suspected inferior pubic ramus (pelvic nt #100's Emergency nary revealed, "Arrival '2023 2055 (8:55 P.M.)The the emergency department eft hip pain. In route she was She does not have a true fever					

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		414021	B. WING	i			
NAME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CO	DE
SAMARITAS SE	Enior Living (	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508	8	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIEN FULL REGULAT II	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE ( FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETIO DATE	
u		reach out to her for follow- te/Time: 02/21/2023 0116					
SS=G H A § re P re a T T B re T T B R R fr fr fr fr fr fr fr fr fr fr fr fr fr	Accidents. The fa (483.25(d)(1) The emains as free of cossible; and §4 eceives adequa issistance devic his REQUIREM (videnced by: This citation pertar Based on observate eview, the facility esidents (Residen azards, resulting all and sustaining racture. Tindings include: Review of an "Adu tesident #100 was acility on 11/2/20 (hich included: og one strength weat racture. It usually steoarthritis (deg Review of a "Mini ssessment for Re- ate of 2/9/23 reve fantal Status" (B1) ossible score of 1	ision/Devices §483.25(d) acility must ensure that - he resident environment of accident hazards as is 83.25(d)(2)Each resident te supervision and tes to prevent accidents. IENT is not met as ins to intake #MI00134978. ion, interview, and record (failed to safely transfer 1 of 3 t #100) reviewed for accident in Resident #100's avoidable a left rami (pelvic bone) mission Record" revealed s originally admitted to the b, with pertinent diagnoses steoporosis (condition when kens and is susceptible to affects hip, wrist or spine) and enerative joint disease). imum Data Set" (MDS) sident #100, with a reference caled a "Brief Interview for IMS) score of 8, out of a total 5, which indicated Resident ely impaired. Review of the	F0689	appropicurrent Elemen Residei transfer review J utilize a transfer and kar Elemen A revier lift polic Nursing use of r e-educate re-educate re-educate two mo QAPI for regardii address the Dire Nursing wonthly the QAI	nt #100 has been reviewed to riate transfer status is reflected plan of care and kardex. t 2: Ints that utilize a mechanical lift is have the potential to be affer has been completed on reside mechanical lift to ensure pro- status is reflected in their pla dex. t 3: w has been completed on the y. g staff will be re-educated on the mechanical lifts. Nursing staff ed prior to date of compliance tated prior to the start of their the start of their bafely on residents, then biweed in the sure mechanical lift sare bafely on residents, then biweed or further direction. Any conce ng mechanical lift transfers will sed immediately and then report for the start of Nursing. The Director g or designee will report result x 3 months and then as direct PI committee. soults will be reviewed by QAF ne consistent substantial com an achieved as determined by	d in the t for ected. A ents that per n of care transfer he proper not re- will be next shift. dents a leing kly for d to rms II be orted to of s to QAPI ted by PI until pliance the e for	4/12/2023

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY PLETED
		414021	B. WING	B. WING			2023
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA		
AMARITAS	SENIOR LIVING	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I JIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE ( FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETIC DATE
		" revealed that Resident #100 lent and required 2 person sfers.		with thi	s plan of correction.		
	in place at the tim ADL (activities of related to cognitiv weakness/debility 11/12/20INTER Dependent mecha 2 staff assist. Date transfer interventi and revealed, "TR mechanical hoyer						
	received on 2/20/2 "On 2/18/23, (R resulted in no exte Physician sent res report of pain. X-r fracture of the left bone) INVESTI identified at the tin Practical Nurse (L provider (Nurse P orders were given Osteopathic Medin notified on Monda was monitored po neurological checl the time(Resider while she was bein 7:11am, (Register (Resident #100) h Resident was not a hurt but said yes w	ty Reported Incident (FRI) 12 at 11:33 P.M. revealed, esident #100) had a fall which rnal injury. On 2/20/23, ident out to (hospital) due to ay results showed suspected inferior pubic ramus (hip GATION:No injury was ne of the fall. (Licensed PN) "F") reported fall to on call ractitioner (NP) "M"). No new .Per (NP "M") (Doctor of cine (DO) "U") would be yy (2/20/23). (Resident #100) st fall with Vital signs and cs. No concerns were noted at tt #100) slid out of the hoyer ng transferredOn 2/19/23 at ed Nurse (RN) "O") noted that ad pain with repositioning. able to state where exactly she /hen asked if her lower back asked if legs hurt. No swelling rmal findings at that time. Will					

STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION		ATE SURVEY PLETED
		414021	B. WING			3/15/2023	
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE
SAMARITAS S	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE
	limits). She compl repositioning of he however, resident Scheduled pain me it was effective in around 3:58pmp resident post fall a #100) to be sent of perform x-ray due lower back. On 2/ 11:30pmhospita #100) had a suspe- pubic ramusOn 2/ #100) had a suspe- pubic ramusOn 2/ #100) had returned as the fracture just (emergency room) In an interview on of Nursing (DON) fell on 2/18/23 duu knowledgeable ab reported that Reside safe to transfer in body sling, as long stated, "now (Ref for the full body si expectations for st In a phone intervia Certified Nursing reported the day o a very busy day ar "J" reported she he the transfer Reside and landed on the Resident #100 hit stayed with the resi get Licensed Pract "J" reported that L along with other C	1 report showed that (Resident cted fracture of the left inferior 2/21/23 at 3:16am(Resident d to facility with no new orders, t needed to heal per ER ) provider" 3/14/23 at 5:01 P.M., Director o reported that Resident #100 e to staff not being out the use of a hoyer. DON dent #100 should have been the U shaped sling or the full g as it was hooked up right and esident #100) was care planned ling just to simplify the					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CON	ISTRUCTION		PATE SURVEY
		414021	B. WING			_ 3/15/2023	
NAME OF PRC	VIDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE
SAMARITAS	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950	8		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	reported that Resi with the transfer in changes while in I complaint. CNAA her a couple days #100's injury due CNA-A "J" come discuss the incider and CNA-A "K" r to observe, were b determined that C sling up wrong. C told that she was straps prior to hoc lift and stated, " that wayno one even know she was slingI am still co "J" reported that th facility had given #100 used the hoy specific sling and type of hoyer that thereas an agenc our for yourself] care planI didn't was very unorgan she had only work because she had c stated, "after tha not comfortable w In a phone intervit CNA-A "K" repor with Resident #10 CNA-A "K" repor was lifted up, she and fell on the flo stated, "(CNA-A strapsI didn't no started sliding out	ag to do the transfer. CNA-A "J" dent #100 complained of pain nto bed and with position bed, which was a new A "J" reported that DON called later to inform of Resident to the fall and requested that in to the facility to further nt. CNA-A "J" reported that she reenacted that scenario for DON oriefly educated, and it was NA-A "J" had hooked the hoyer NA-A "J" had hooked the hoyer NA-A "J" reported that she was supposed to criss-crossed the leg sking the sling onto the hoyer I had no ideaI always did it had ever corrected meI didn't as supposed to have a full body onfused to this day" CNA-A he sheet of paper that the her only indicated that Resident er lift, but did not specify a stated, "I had never used the the facility had until I worked ey CNA you have to figure it I don't know how to look at the . know anything about herit ized" CNA-A "J" reported that ted in the facility 2 or 3 shifts, alled off several times and tt I canceled all my shiftsI was vorking there" ew on 3/14/23 at 11:24 A.M., rted that she assisted CNA-A "J" 00's hoyer transfer on 2/18/23. rted that when Resident #100 slipped right out of the sling or, landing on her bottom and A "J") didn't cross the leg tice until (Resident #100) of the slingit happened so C" reported that it was her one					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		PATE SURVEY	
		414021	B. WING				3/15/2023	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, ST	ATE, ZIP CO	ZIP CODE	
SAMARITAS	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950	8			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
	"I did not get an anythingno weld	rking at the facility and stated, y trainingno help with coming or nothingno one even dI had to figure things out						
	"F" reported that if there were 2 agen and stated, "I we been here twice' called into Reside LPN "F" reported floor and complai (range of motion) not perform ROM to her known chro reported that where continued to comp and had increased her side. LPN "F" call" person and ti continue to monit on Monday (2 day there are a lot of a facility and they d that he educated ti afterwards about to Resident #100 due being limp. LPN ' the agency CNA'ss (direct care-givers care, and that CN, checked the Kard the type of hoyer to During an observa at 1:00 P.M. Reside her back with the degrees. CNA "G with lunch. CNA	a 3/14/23 at 12:17 P.M., LPN the day that Resident #100 fell cy CNA's working on the hall as told that one of them had " LPN "F" reported that he was nt #100's room by CNA-A "K". that Resident #100 was on the ned of back pain with ROM . LPN "F" reported that he did to n Resident #100's left leg due onic pain in the knee. LPN "F" n they got her back in bed she plain of pain in her middle back pain when she was rolled on reported that he called the "on- hey said to give her Tylenol, or and that they would see her /s later). LPN "F" reported that gency CNA's working in the lo not know the residents, and he agency CNA's involved using a full body hoyer pad for e to her weight and her body 'F" reported that he reminded e to check the resident's Kardex s care guide) prior to providing A-A "J" told him that she had ex and that it did not indicate sling that the resident required. Ation and interview on 3/14/23 dent #100 was lying in bed on HOB at approximately 30 " came in to assist the resident "G" reported that she had to y slow otherwise Resident #100						

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		414021	B. WING _			3/15/2	023
	VIDER OR SUPPLIE	P			STREET ADDRESS, CITY, STATE		
						, 217 00	DE
SAMARITAS	SENIOR LIVING (	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (I RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	would get up into I Resident #100 repo hips and stated, " In an interview on "Q" reported that F	3/14/23 at 3:32 P.M., CNA Resident #100 used to get up in					
	the time. In an interview on Practitioner (NP) " received a secure t in the afternoon an leave a message, a shortly after that, r had fallen due to in that she was having back in bed and co that she gave instru 2 hours neuro (neu back if Resident # stated, "we did n expectation from a know the resident # stated, "we did n expectation from a know the resident # 2/20/23, and DO "" time to send Resid evaluation due to t having. Review of "On-Ca "M" dated 2/18/23 textregarding (Re had a fall while tra having back pain. left voicemail in th with further concer received a call bac (Resident #100) shi	and now she is in bed all of 3/15/23 at 12:32 P.M., Nurse M" reported that she had ext from the facility on 2/18/22 d she called back but had to nd then LPN "F" called back eporting that Resident #100 mproper use of the hoyer lift, g back pain, but that she was mfortable. NP "M" reported actions to LPN "F" to do every trological) checks and call us 100 was not improving and ot get any callsmy skilled facility is that they and when to call" NP "M" or of Osteopathic Medicine sduled to see Resident #100 on T" made the decision at that ent #100 out to the hospital for he amount of pain she was Il Communication" from NP revealed, "Received a secure esident #100) reporting that she nsferring with Hoyer lift and 1357 (1:57 P.M.) - called and the number provided to call back trns. 1400 (2:00 P.M.) - k from (LPN "F") that reported ipped out of the Hoyer and was during transfer. Her vitals					

		i					
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G			ATE SURVEY PLETED
		414021	B. WING _			3/15/2	2023
NAME OF PRO	VIDER OR SUPPLIE	R	•		STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
SAMARITAS	SENIOR LIVING (	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950	8	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	pain in her mid bac palpation, but othe comfortable in bed medication provide a report of the fall, into this. Gave ord every eight hours of Neuro checks ever any worsening of s altered mental stat for discussion and Review of Resider Administration Re indicated in additio Gabapentin (for ch #100 had an order 500mg give 2 table needed for pain, st the medication a to fall on 2/18/23 at 12:44 of 10, and on 2/27/ of 5 out of 10. Alss patch (pain medica patch placed on the starting on 2/22/23 Resident #100 had Review of Resider revealed, "Ask Res and Document two Start Date 01/29/24 Resident #100 had day of the fall, exc pain level. Followi	nt #100's MAR from February sident if they are having pain o times a day for evaluation. 023." And indicated that 0/10 pain level up until the ept for 2/6/23 indicated 2/10 ing the fall on 2/18/23 pain in 14 of 20 evaluations, ranging					

-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) D COMF	ATE SURVEY PLETED	
		414021	B. WING			3/15/2023	
NAME OF PRO	VIDER OR SUPPLIE	ER		STREET ADDR	ESS, CITY, STATE, ZIP CC	DDE	
SAMARITAS	SENIOR LIVING	GRAND RAPIDS LODGE		1950 32ND S GRAND RAP	T S E IDS, MI 49508		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORRECTIVE ACTIC REFERENCED TO	F CORRECTION (EACH IN SHOULD BE CROSS- THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F0726	Department Summ "Arrival Date/T P.M.)The patient department with c route she was noted have a true fever h temperatureGive greater trochanter ray left hip was of does show a public bone)No surger to her for follow-t 02/21/2023 0116	```	F0726	Element 1:		4/12/2023	
SS= D	Services The fac nursing staff with competencies an nursing and rela resident safety a highest practical psychosocial we determined by re- individual plans number, acuity a resident populat facility assessme §483.35(a)(3) Th licensed nurses competencies an care for resident through resident described in the Providing care in assessing, evalu implementing re responding to re Proficiency of nu-	sing Staff §483.35 Nursing cility must have sufficient in the appropriate and skills sets to provide ted services to assure and attain or maintain the ble physical, mental, and ell-being of each resident, as asident assessments and of care and considering the and diagnoses of the facility's ion in accordance with the ent required at §483.70(e). the facility must ensure that have the specific ad skill sets necessary to as 'needs, as identified assessments, and plan of care. §483.35(a)(4) includes but is not limited to iating, planning and sident's needs. §483.35(c) urse aides. The facility must the aides are able to mpetency in skills and	F0/20	Resident #100 has be appropriate transfer st current care plan and Element 2: Residents that utilize a transfers have the pot review has been computilize a mechanical lift transfer status is refler and kardex. Element 3: A review has been con competency evaluatio policy. Current facility and ag be re-educated on the mechanical lifts. Any f	a mechanical lift for ential to be affected. A bleted on residents that t to ensure proper cted in their plan of care mpleted on the n policy and transfer lift ency nursing staff will proper use of acility or agency nursing prior to compliance date for to the start of their II review records of 6 ency nursing staff at records of		

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		414021	B. WING _			3/15/2	2023
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CO	DE
SAMARITAS	SENIOR LIVING (	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 49508	i	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT IN	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTIOI RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	needs, as identifi assessments, an care. This REQUIREM evidenced by: This citation pertai Based on interview facility failed to en staff possess the con necessary to provide residents (Resident and hazards, result avoidable fall, and bone) fracture. Findings include: Review of a Facilit received on 2/20/2 "On 2/18/23, (Ref resulted in no exter Physician sent resi report of pain. X-ra fracture of the left bone) INVESTIC identified at the tim slid out of the hoyod transferredOn 2/ Nurse (RN) "O") n pain with repositio 3:58pmphysiciar fall and placed ord sent out to (emerga ray due to continue back. On 2/20/23 a report showed that	ssary to care for residents' ed through resident d described in the plan of ENT is not met as ins to intake #MI00134978. A, and record review, the isure that all working nursing ompetencies and skill sets de safe transfers for 1 of 3 t #100) reviewed for accidents ing in Resident #100's sustaining a left rami (pelvic ty Reported Incident (FRI) 2 at 11:33 P.M. revealed, esident #100) had a fall which rnal injury. On 2/20/23, dent out to (hospital) due to ay results showed suspected inferior pubic ramus (hip GATION:No injury was ne of the fall(Resident #100) had ningOn 2/20/23 around a came in to assess resident post ers for (Resident #100) to be ency department) to perform x- ed discomfort in her lower tround 11:30pmhospital (Resident #100) had a of the left inferior pubic		weeks, monthly forward concerr will be a reporte Directo results as direc Audit re such tir has bee commit The Dir attainin	Audits will be done weekly f biweekly for the next 4 week y for the next 2 months. Resu- led to QAPI for further directions regarding mechanical lift tr addressed immediately and ti d to the Director of Nursing. T r of Nursing or designee will to to QAPI monthly x3 months a cted by the QAPI committee. esults will be reviewed by QA ne consistent substantial con en achieved as determined by tee. rector of Nursing is responsib g and sustaining overall com s plan of correction.	s, and lits will be on. Any ansfers hen The report and then PI until npliance y the le for	

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DEAN OF CORRECTION UMBER: 414021		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			DATE SURVEY PLETED 2023
NAME OF PRO	ER GRAND RAPIDS LODGE	STREET ADDRESS, CITY, 1950 32ND ST S E GRAND RAPIDS, MI 495					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E :FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	reported the day of a very busy day an "J" reported she h the hoyer lift like the transfer Resid and landed on the LPN "F" came int CNA's, and we go "F" told me that I sling to do the tran the Director of Nu couple days later injury due to the f "J" come in to the incident. CNA-A A "K" reenacted t observe, were brid determined that C sling up wrong. C told that she was s straps prior to hoo lift and stated, " that wayno one even know she was slingI am still co "J" reported that t facility had given #100 used the hoy specific sling and type of hoyer that thereas an agenc our for yourself] care planI didn't was very unorgan she had only work because she had c stated, "after tha not comfortable w	Assistant-Agency (CNA-A) "J" f Resident #100's fall that it was nd she was in a hurry. CNA-A ad hooked the hoyer sling up to she always had, but that during ent #100 slid out of the sling floor. CNA-A "J" reported that o the room, along with other t the back into bed, and LPN had used the wrong type of nsfer. CNA-A "J" reported that trying (DON) called her a to inform of Resident #100's all and requested that CNA-A facility to further discuss the "J" reported that she and CNA- hat scenario for DON to effly educated, and it was NA-A "J" had hooked the hoyer NA-A "J" had hooked the hoyer NA-A "J" reported that she was supposed to criss-crossed the leg whing the sling onto the hoyer I had no idea I always did it had ever corrected meI didn't is supposed to have a full body onfused to this day" CNA-A he sheet of paper that the her only indicated that Resident rer lift, but did not specify a stated, "I had never used the the facility had until I worked ty CNA you have to figure it I don't know how to look at the know anything about herit ized" CNA-A "J" reported that ted in the facility 2 or 3 shifts, alled off several times and tt I canceled all my shiftsI was vorking there" ew on 3/14/23 at 11:24 A.M.,					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	STRUCTION		ATE SURVEY PLETED	
		414021	B. WING				3/15/2023	
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	ZIP CODE	
SAMARITAS	SENIOR LIVING	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4950			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
	with Resident #10 CNA-A "K" report was lifted up, she and fell on the floo stated, "(CNA-A strapsI didn't no started sliding out fast" CNA-A "K and only time wor "I did not get an anythingno weld showed me around myself" In an interview on "F" reported that there were 2 agen- and stated, "I wa been here twice' called into Reside LPN "F" reported floor and complai (range of motion). a lot of agency CP they do not know educated the agen about using a full #100 due to her w LPN "F" reported CNA's to check th givers care guide) that CNA-A "J" tt Kardex and that it hoyer sling that th In an interview on reported that Resis staff not being km hoyer. DON repon have been safe to the full body sling	ted that she assisted CNA-A "J" O's hoyer transfer on 2/18/23. ted that when Resident #100 slipped right out of the sling or, landing on her bottom and A "J") didn't cross the leg tice until (Resident #100) of the slingit happened so " reported that it was her one king at the facility and stated, y trainingno help with soming or nothingno one even dI had to figure things out a 3/14/23 at 12:17 P.M., LPN he day that Resident #100 fell cy CNA's working on the hall st told that one of them had ' LPN "F" reported that he was nt #100's room by CNA-A "K". that Resident #100 was on the ned of back pain with ROM LPN "F" reported that here are JA's working in the facility and the residents, and that he cy CNA's involved afterwards body hoyer pad for Resident eight and her body being limp. that he reminded the agency te resident's Kardex (direct care- prior to providing care, and old him that she had checked the did not indicate the type of e resident required. a 3/14/23 at 5:01 P.M., DON dent #100 fell on 2/18/23 due to owledgeable about the use of a ted that Resident #100 should transfer in the U shaped sling or a, as long as it was hooked up ow (Resident #100) was care						

						() (A) D	
AND PLAN OF (	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	G	ISTRUCTION		ATE SURVEY LETED
		414021	B. WING			3/15/2	2023
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CC	DE
SAMARITAS	SENIOR LIVING (	GRAND RAPIDS LODGE			1950 32ND ST S E		
					GRAND RAPIDS, MI 49508		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	planned for the ful expectations for sta	l body sling just to simplify the aff"					
	"Q" reported that F her chair everyday the time. CNA "Q' new full hire CNA "(CNA "R") will timethe CNA's th trainingas long a and familiar with t month" In an interview on reported that since #100, the facility n complete additiona lifts with their agen their next shift. DO Director of Nursin, ensuring that it is of In an interview on "V" reported that s the past 2 weeks, v P.M. that day, and residents that inclu "V" reported that s had not ever receivs from the facility at hoyer lifts. CNA-A first day I was han the shower days ar transferthe facilit am doing" In an interview on reported that the he did not receive it p written hoyer lift e	3/14/23 at 3:32 P.M., CNA Resident #100 used to get up in and now she is in bed all of 'reported that she is training a (CNA "R") today and stated, not be on her own for a long hat the facility hire get a lot of s they need to feel comfortable he facilitysometimes a 3/14/23 at 3:46 P.M., DON the incident with Resident tow requires that agency al education related to hoyer ney, or with the facility prior to DN reported that Assistant g (ADON) is responsible for lone. 03/14/23 at 3:19 P.M., CNA-A she had worked 2-3 shifts over with her shift beginning at 2:30 was assigned a group of ded Resident #100. CNA-A she worked for an agency and red education or orientation nd/or her agency related to A "V" stated, "on my very ded a sheet of paper that tells of how they (residents) ty assumes that I know what I 3/14/23 at 4:00 P.M., ADON over education for those that rior to 3/11/23, consists of ducation and someone on the most important parts of					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 414021	À. BUILDIN	NG	STRUCTION	(X3) DAT COMPLE <b>3/15/202</b>	
	VIDER OR SUPPLIE	GRAND RAPIDS LODGE			STREET ADDRESS, CITY, STATE 1950 32ND ST S E GRAND RAPIDS, MI 49508	, ZIP CODE	3
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	oss- 🛛 (	(X5) COMPLETIC DATE
F0842 SS= D	related to hoyer lift that day, after this CNA-A "V". ADO (SCH) "H" handed CNA-A "V" and h that she had receiv that she had receiv "I" was not a CN competent to educ complete hoyer lift "V" did not receiv starting the shift th Review of Residen Department Summ "Arrival Date/Ti P.M.)The patien department Summ "Arrival Date/Ti P.M.)The patien department with c route she was note have a true fever h temperatureGive greater trochanteri ray left hip was of does show a public Resident Record §483.20(f)(5) Re information that i public. (ii) The fa information that i agent only in acd under which the disclose the info the facility itself i §483.70(i) Media accordance with standards and p maintain medicat that are- (i) Com	ht #100's Emergency hary dated 2/21/22 revealed, me: 02/20/2023 2055 (8:55 t presents to the emergency oncerns of left hip pain. In ed to be febrileShe does not tere but slightly elevated body en the fall with mild left-sided to (upper leg/hip) tenderness, x- btainedPelvic x-ray however	F0842	Elemen Resider potentia comple assess care pro Elemen A revier Assess License on the p assess to date	nt #102 no longer resides in the t 2: ints that are at risk for falls have al to be affected. A review has b ted to ensure accuracy in fall ment documentation and the pla operly reflects the residents' stat t 3: w has been completed on the Fa ment policy. id nursing staff have been re-ed oroper completion of the fall ment. Any nurse not re-educated of compliance will be re-educated tart of their next shift.	the een in of ius. all Risk ucated d prior	4/12/2023

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		414021	B. WING			3/15/2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	TATE, ZIP CO	DE
SAMARITAS	SENIOR LIVING	GRAND RAPIDS LODGE	1950 32ND ST S E GRAND RAPIDS, MI			9508	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE
	contained in the regardless of the the records, exci- the individual, or where permitted Required by Law payment, or hea permitted by and 164.506; (iv) For reporting of abus violence, health and administrative enforcement pur purposes, resea medical examine avert a serious th permitted by and 164.512. §483.7 safeguard medic loss, destruction §483.70(i)(4) Me retained for- (i) T by State law; or of discharge whe State law; or (iii) resident reaches §483.70(i)(5) Th- contain- (i) Suffic the resident; (ii) . assessments; (iii care and service of any preadmiss review evaluation conducted by the nurse's, and othe progress notes; a	o confidential all information resident's records, a form or storage method of ept when release is- (i) To their resident representative by applicable law; (ii) <i>x</i> ; (iii) For treatment, lth care operations, as i in compliance with 45 CFR public health activities, se, neglect, or domestic oversight activities, judicial <i>y</i> e proceedings, law poses, organ donation rch purposes, or to coroners, ers, funeral directors, and to hreat to health or safety as i in compliance with 45 CFR 0(i)(3) The facility must al record information against , or unauthorized use. edical records must be 'he period of time required (ii) Five years from the date en there is no requirement in For a minor, 3 years after a is legal age under State law. e medical record must cient information to identify A record of the resident's i) The comprehensive plan of s provided; (iv) The results sion screening and resident ns and determinations e State; (v) Physicia's, er licensed professional's and (vi) Laboratory, her diagnostic services ed under §483.50. IENT is not met as		charts t risk ass care we weeks. further inaccur will be a reporte Director results as direc Audit re such tin has bee commit The Dir attainin	DN/designee will review 4 re o ensure proper completion sessment is reflected in the beekly times 4 weeks then bit Results will be forwarded t direction. Any concerns reg acy in fall assessment docu addressed immediately and d to the Director of Nursing, r of Nursing or designee will to QAPI monthly x2 months ted by the QAPI committee soults will be reviewed by Q, ne consistent substantial co en achieved as determined tee. ector of Nursing is responsi g and sustaining overall cor s plan of correction.	of the fall plan of weekly for 4 o QAPI for arding imentation then The I report and then API until ompliance by the ible for	

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 414021	À. BUILDING		COMP	
SAMARITAS SENIOR LIVING GRAND RAPIDS LODGE				1950 32ND S	, , ,	UE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORRECTIVE ACTIC REFERENCED TC	DF CORRECTION (EACH DN SHOULD BE CROSS- ) THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	Based on interview failed to maintain a medical record, ind resident (Resident for accident hazard inadequate fall inte inaccurate fall risk Findings include: Review of an "Adr Resident #102 was facility on 10/27/2: which included: Ai dementia. Review of Residen indicated falls on 1 11/13/22 (fall with with major injury). Review of Residen dated 1/19/23 reve or greater, the residen HIGH RISK for po protocol should be documented on the (past 3 months): N The assessment da "9". In an interview on	<ul> <li>and record review the facility a complete and accurate</li> <li>cluding assessments for 1</li> <li>#102) of 3 residents reviewed</li> <li>ls, resulting in the potential for reventions in place due to assessment.</li> <li>nission Record" revealed originally admitted to the 2, with pertinent diagnoses</li> <li>lzheimer's disease and</li> <li>t #102's "Fall Reports"</li> <li>1/3/22 (fall with major injury), no injury), and 2/28/23 (fall</li> <li>t #102's "Fall Risk Evaluation"</li> <li>aled, "If the total score is 10</li> <li>lent should be considered at tential falls. Prevention initiated immediately and care plan2. History of falls o falls in the past 3 months"</li> <li>ta resulted in a fall risk score of</li> <li>3/15/23 at 12:49 P.M.,</li> </ul>				
	#102's fall assessm have indicated that 3 months. DON re data is meant to tri revise care plan int Resident #102's fal	g (DON) reported that Resident ent was inaccurate and should she had 2 falls in the previous ported that the fall assessment gger staff to develop and or erventions, and although l assessment was inaccurate, een reviewed and revised.				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 414021		Á. BUILDI	TIPLE CONSTRUCTION		DATE SURVEY MPLETED 5/2023
	1	GRAND RAPIDS LODGE	ID	1950 32ND GRAND RA	ORESS, CITY, STATE, ZIP ( ST S E PIDS, MI 49508 OF CORRECTION (EACH	CODE (X5)
PRÉFIX TAG	(EACH DEFICIEN FULL REGULA	ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	PREFIX TAG	CORRECTIVE ACTI REFERENCED T	ION SHOULD BE CROSS- O THE APPROPRIATE FICIENCY)	COMPLÉTION DATE
F0940 SS= D	Requirements A implement, and r program for all n individuals provide contractual arrar consistent with th must determine fit training necessa assessment as a Training topics n limited to- This REQUIREM evidenced by: This citation perta Based on interview facility failed to m program for agence in the facility to er of 3 residents (Res accidents and haza #100's avoidable ff (pelvic bone) fract Findings include: In a phone interview facility failed Nursing reported the day o that it was a very ff hurry. CNA-A "J" hoyer sling up to t had, but that durin slid out of the slin, CNA-A "J" report had used the wron transfer. CNA-A " Nursing (DON) ca	ments §483.95 Training facility must develop, maintain an effective training ew and existing staff; ding services under a ogement; and volunteers, neir expected roles. A facility the amount and types of ry based on a facility specified at § 483.70(e). nust include but are not IENT is not met as ins to intake #MI00134978. v, and record review, the aintain an effective training y staff consistent with their role issure the safety of resident in 1 sident #100) reviewed for trds, resulting in Resident all, and sustaining a left rami ure. ew on 3/14/23 at 10:58 A.M., Assistant-Agency (CNA-A) "J" f Resident #100's fall (2/18/23) busy day and she was in a reported she had hooked the he hoyer lift like she always g the transfer Resident #100 g and landed on the floor. ed that LPN "F" told me that I g type of sling to do the J" reported that the Director of illed her a couple days later to t #100's injury due to the fall	F0940	appropriate transfer current care plan and Element 2: Residents that utilize transfers have the por review has been con utilize a mechanical transfer status is refl and kardex. Element 3: A review has been c competency evaluati policy. Current facility and a be re-educated on th mechanical lifts. Any staff not re-educated will be re-educated p next shift. New agency staff will to facility policies and start of their first shift Element 4: The DON/designee w random facility and a members to ensure f competency evaluati current. Audits will be weeks, biweekly for t monthly for the next forwarded to QAPI for concerns regarding r will be addressed im reported to the Direct Director of Nursing of results to QAPI mon as directed by the Qu Audit results will be r	e a mechanical lift for otential to be affected. A npleted on residents that lift to ensure proper ected in their plan of car ompleted on the ion policy and transfer lift agency nursing staff will be proper use of r facility or agency nursing d prior to compliance date orior to the start of their II be provided orientation d expectation prior to the t assignment. will review records of 6 agency nursing staff that records of ion are present and e done weekly for 4 the next 4 weeks, and 2 months. Results will b or further direction. Any mechanical lift transfers imediately and then stor of Nursing. The or designee will report thly x3 months and then	t re it e e

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	LIA (X2) MULTIPLE CONS A. BUILDING		STRUCTION		(X3) DATE SURVEY COMPLETED	
		414021	B. WING			3/15/2023		
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DDE	
SAMARITAS	SENIOR LIVING	GRAND RAPIDS LODGE	1950 32ND ST S E GRAND RAPIDS, MI 4			8		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIOI DATE	
	facility to further of reported that she as scenario for DON educated, and it w had hooked the hoy reported that she v to criss-crossed th sling onto the hoy ideaI always did corrected meI di supposed to have a confused to this di the sheet of paper only indicated tha lift, but did not sp "I had never use facility had until I CNA you have to don't know how to know anything ab unorganized" CI only worked in the she had called off "after that I can comfortable work? In a phone intervity CNA-A "K" repor with Resident #10 CNA-A "K" repor was lifted up, she and fell on the flow stated, "(CNA-A "K and only time wor "I did not get an anythingno welc	CNA-A "J" come in to the discuss the incident. CNA-A "J" and CNA-A "K" reenacted that to observe, were briefly as determined that CNA-A "J" yer sling up wrong. CNA-A "J" vas told that she was supposed e leg straps prior to hooking the er lift and stated, "I had no it that wayno one had ever dn't even know she was a full body slingI am still ay" CNA-A "J" reported that that the facility had given her t Resident #100 used the hoyer ecify a specific sling and stated, d the type of hoyer that the worked thereas an agency figure it our for yourselfI o look at the care planI didn't out herit was very NA-A "J" reported that she had e facility 2 or 3 shifts, because several times and stated, eled all my shiftsI was not ing there" ew on 3/14/23 at 11:24 A.M., ted that she assisted CNA-A "J" 0's hoyer transfer on 2/18/23. ted that when Resident #100 slipped right out of the sling or, landing on her bottom and A "J") didn't cross the leg tice until (Resident #100) of the slingit happened so ." reported that it was her one king at the facility and stated, y trainingno help with coming or nothingno one even dI had to figure things out		attainin	tee. ector of Nursing is responsi g and sustaining overall cor s plan of correction.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 414021	À. BUILDIN	G	ISTRUCTION		DATE SURVEY PLETED 2023
	NAME OF PROVIDER OR SUPPLIER SAMARITAS SENIOR LIVING GRAND RAPIDS LODGE			STREET ADDRESS, CITY, S 1950 32ND ST S E GRAND RAPIDS, MI 4950			DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULE FERENCED TO THE APPF DEFICIENCY)	D BE CROSS-	(X5) COMPLETIO DATE
	there were 2 agen and stated, "I was been here twice called into Reside LPN "F" reported floor and complai (range of motion) a lot of agency CP they do not know educated the agen about using a full #100 due to her w LPN "F" reported CNA's to check th givers care guide) that CNA-A "J" to Kardex and that it hoyer sling that th Review of CNA " Testing" dated 9/J that she was empl "J" reported havin with hoyer lifts. In an interview or CNA Recruiter (A "J" had been empj hiring CNA's, the written competent which consists of comfortable they "I" reported that th type of demonstra competency and s for anythingwe trained and tested agency CNA's are	the day that Resident #100 fell cy CNA's working on the hall as told that one of them had "LPN "F" reported that he was int #100's room by CNA-A "K". that Resident #100 was on the ned of back pain with ROM . LPN "F" reported that there are NA's working in the facility and the residents, and that he cy CNA's involved afterwards body hoyer pad for Resident reight and her body being limp. that he reminded the agency her resident's Kardex (direct care- prior to providing care, and old him that she had checked the did not indicate the type of her resident required. J's" Clinical Competency 12/22 provided by the Agency oyed by, indicated that CNA-A ag "advanced-level experience" A 3/14/23 at 11:55 A.M., Agency ACR) "I" reported that CNA-A loyed by the agency and upon y are required to complete a cy test and also a skills checklist the CNA indicating how are with specific skill sets. ACR he agency does not require any titons or observations to ensure tated, "not for transfers, not would hope that they have been by the state" ACR "I" e facilities require the CNA's to ion and others assume that ready to go when they walk in "I" reported that CNA "J" had					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G			ATE SURVEY LETED
		414021	B. WING _			3/15/2	2023
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY	, STATE, ZIP CC	DDE
SAMARITAS	GRAND RAPIDS LODGE			1950 32ND ST S E GRAND RAPIDS, MI 4	9508		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX CORRECTIVE ACTION SHOULD		D BE CROSS-	(X5) COMPLETION DATE
	completed the necessary competencies that the agency had required.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		414021	B. WING _			3/15/2	2023
NAME OF PRO	R			STREET ADDRESS, CITY, STATI	, ZIP CO	DE	
SAMARITAS	GRAND RAPIDS LODGE		1950 32ND ST S E GRAND RAPIDS, MI 49508				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (EACH RRECTIVE ACTION SHOULD BE CROSS EFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
starting the shift that day.							
	Registered Nurse difficult to managestated, "it's a pro- without knowing t	3/15/23 at 11:00 A.M., (RN) "O" reported that it was e with all the agency staff and oblem that the CNA's come in hese residentsand I am so meone to oversee us"					
	"P" reported that t need more training and don't know wl educationthey do check everything t	3/15/23 at 12:25 P.M., CNA he CNA's from the agencies g and stated, "they come in hat they are doingno on't ask for helpI have to hey doso I have my residents "P" reported that there is y CNA's working.					