STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	A. BUILDING _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELBY HEALTH AND REHABILITATION CENTER	46100 SCHOENHERR RD SHELBY TOWNSHIP, MI 48315

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F0000 SS=	INITIAL COMMENTS Shelby Health And Rehabilitation Center was surveyed for an Abbreviated survey on 11/13/24. Intake: MI00147833. Census= 193.	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 MI00147833. Based on observation, interview, and record review, the facility failed to ensure a comprehensive nursing assessment was completed and timely acute care emergent hospital transfer for one Resident (R901) of three residents reviewed for care, when R901 sustained a fall with head trauma and bleeding while taking anticoagulant medication. Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to assess a change of condition following the fall for R901. A review of R901's medical record revealed, R901 was admitted to the facility on 7/23/23 and	F0684	F684: G (Quality of Care) Element 1: Resident 901 no longer resides in the facility. Unit Manager re-educated on post fall policy & procedure including notifying NP/MD with acute changes. Element 2: All residents in the facility who are on anti-coagulants who sustain a fall have the potential to be impacted by the identified practice. Fall incidents for residents who receive anti-coagulants and have had a fall incident since 11/13/24 have been reviewed with no concerns identified. Like residents will be updated and reviewed daily to ensure compliance. Risk Management checklist procedure has updated to include best practice for initial assessment, notifications and documentation. Element 3: Nurses will be educated on the Risk Management checklist which will ensure a comprehensive nursing assessment was completed and best practice expectations are followed. The Fall Management Guidelines Policy was reviewed and deemed appropriate.	11/27/2024

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

Electronically Signed | 11/21/2024

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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	discharged on 10/08/24 with diagnoses that include Quadriplegia and Atrial fibrillation (AFIB). A review of R901's quarterly Minimum Data Set (MDS) assessment dated 10/01/2024, noted R901 with a moderate impaired cognition, functional limitation in range of motion upper as impairment on one side, and lower extremity (hip, knee, ankle, foot) impairment on both sides. A review of R901's medications noted, Eliquis (blood thinner) 2.5mg (milligram), Give 1 tablet by mouth two times a day for AFIB. Start 7/23/23, end indefinite. Monitor for signs and symptoms of bleeding related to use of anticoagulant medication. Start Date: 02/28/2024. A review of R901's Medication Administration Record (MAR) noted, October 1st-9th, the resident was administered the Eliquis as ordered. Further review of R901's medical record revealed, "10/8/2024 11:21(11:21 AM) Incident Note Text: Observed lying on the floor, on [R901's] right side, in front of [R901's] wheelchair. Call light was not in use, but within reach. Assessed for injuries, with the following noted: bruise noted to right eyelid, superficial scrape to right forearm, 4inch, half-moon, skin tear. NP [Nurse Practitioner] into eval, and assisted with placement of steri strips, to approximate tear. Pressure dressing applied. Resident placed into bed with use of mechanical lift. Bed in lowest position, call light in reach. Resident unable to state how [they] fell, secondary to current mental status, due to UTI (urinary tract infection). Writer spoke with dtr (daughter)... Notified physician notified..." A review of the 24-hour report noted, "10/08/24. 7am-3pm (shift) Cipro (used to treat infections caused by bacteria) uti (urinary tract infection), IM (intramuscular injection) Rocephin (used to treat many kinds of bacterial infections) x1given,		Element 4: DON or designee will complete audits daily on new risk management to ensure residents with a fall incident who is receiving anti-coagulant medications have been accurately assessed. The audit will ensure MD or NP is aware of all assessment observations and such is documented in Risk Management documentation and progress note to ensure all resident change of condition related to the incident have been assessed timely for 4 weeks. Audits will be submitted to QAA for review and will be used to drive further education/training with staff. Element 5: Compliance date: 11/27/24. DON will be responsible for sustained compliance.	

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	fall shift #1, skin tear RLE (right lower extremity), bruising to R (right) eye area, bruising to tongue. neuro checks. 3pm-11pm (shift) blank. 11pm-7am (shift) hospitalized." On 11/13/24 at 11:41 AM, Registered Nurse (RN) "A" was asked about the fall of R901. RN "A" explained they were down on the low 500 hall which was part of her assigned unit and was told that R901 had a fall saying, "The Unit Manager, (UM "C") and two CNAs (Certified Nursing Assistants) had gotten [R901] in bed." RN "A" was asked if R901 was able to explain how they fell. RN "A" stated, "No. [R901] was confused." RN "A" was asked if R901 had any injuries to their head. RN "A" explained R901 had some bruising to their right eyelid and bit their tongue. RN "A" was asked how they monitored R901 after the fall. RN "A" explained, they started Neuro checks (neurological examination, is a series of tests and questions that evaluate the nervous system). On 11/13/24 at 12:39 PM, CNA "D" and CNA "E" were asked if they found R901 on the floor. CNA "D" stated, "No, a resident found [R901] on the floor." CNA "D" and "E" were about the duration of time that R901 on the floor. They were asked the condition of R901 once they observed R901 on the floor. CNA "D" explained, R901 was very confused and kept talking about the wheels on the wheelchair and not answering the questions. CNA "D" and "E" explained this was unlike R901, R901 was more alert, would use their call light, did not try to stand, or get out of their chair without help. On 11/13/24 at 12:46 PM, UM "C" was asked about R901's fall. UM "C" stated when they entered R901's room, R901 was in an awkward position by the mechanical chair. UM "C" stated, "(R901) wasn't speaking right and wouldn't say			

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	what happened, R901 was really confused. UM "C" stated, "I went out to get a first aid kit to treat the skin tear." UM "C" further explained RN "A" was given the report and took over from there with Nurse Practitioner (NP) "B". UM "C" explained they went back out to the nursing station to start the orders to send R901 out to the hospital. After NP "B" and RN "A" exited the resident's room, orders were to start neuro checks and not send the resident to the hospital. On 11/13/24 at 12:55 PM, NP "B" was asked about the fall and the reason R901 was not sent out to the hospital after a head injury. NP "B" refer to their progress note and explained she may have not known about the head injuries because she did not reference them in her note. NP "B" was asked about the procedure for transferring residents to a higher level of care who are prescribed anticoagulant medications, had an unwitnessed fall, with a visible bruise on the head. NP "B" explained, it all depends on her assessment and if there is a new onset mental status change. NP "B" was asked how that can be determined for R901 when she had confusion prior to the fall. NP "B" explained her assessment after the fall was R901 was "stable." A review of R901 hospital records dated 10/8/24 at 18:41 (6:41 PM) noted, "Medical Decision-Making including ED (emergency department) Course and Interventions Assessment: [R901] ... presents to the ER (emergency room) after a seizure... Later in the afternoon [R901] had a witnessed seizure and therefore EMS was called. Upon arrival to the ER the patient was postictal appearing with decreased responsiveness and not following commands. [R901] had clearly bitten [R901's] tongue as [R901] had blood in the mouth and lacerations on the tongue. [R901] does take Eliquis and therefore a level 2 trauma was activated in the setting of fall earlier in the day with seizures now and evidence of trauma,			

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	concern for intracranial abnormality. [R901] was evaluated via ATLS (Advanced Trauma Life Support) protocol, and the trauma service was contacted ... Shortly after arrival to the ER the patient had another witnessed seizure in the resuscitation area. [R901] was treated with IM (intramuscular) Ativan after which the seizure resolved after approximately 1 minute. After the second seizure [R901] did not return to [R901's] baseline and was having sonorous respirations. During the second seizure [R901] appeared to have bitten [R901's] tongue again as [R901] had more blood in the mouth. The decision was made to intubate the patient for airway protection in the setting of recurrent seizures and unresponsiveness ..." Further review of R901's medical record pictures revealed, a large deep blood-filled gash on limb, swollen lip, and visible blood indentation of R901's teeth their tongue. On 11/13/24 at 1:30 PM, the Director of Nursing (DON) was asked about the facility's procedure following an unwitnessed fall of a resident on anticoagulants that has a visible head injury. The DON explained to start neuro checks are first, and if anything changes 911 is called. On 11/13/24 at 2:19 PM, the Nursing Home Administrator (NHA) was asked if R901 had any falls within the last six months. The NHA, responded via email "No- This is [R901's] only fall ever at the facility." On 11/14/24 at 3:09 PM, Interested Party (IP) explained on 10/08/24, they called the facility to speak with nursing staff because they had a message for [R901] and spoke with [RN "A"]. IP explained [RN "A"] stated, "I was just looking up your number, [R901] had a fall." The IP explained RN "A" stated R901 bit their tongue,			

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	had a bruise on the eyelid, and a small skin tear that they were treating. IP stated, "I didn't understand why [R901] was not being sent out to the hospital, because no one saw [R901] fall. [R901] is paralyzed and would not be able to put [their] arms out to brace during the fall." The IP explained it was obvious R901 had hit their head and needed to go to the hospital. When the family friend went into the room, R901 was lying in bed, their tongue was swollen so badly, R 901 had difficulty eating any food. IP further explained R901 was able to drink the milkshake the family friend brought in. A review of R901's progress notes revealed the following: "10/8/2024 14:41 (2:00 PM) Nursing - Infection Note Cipro continues for tx (treatment) of UTI. No adverse reactions noted. No hematuria or dysuria. Increased confusion noted. NP notified, new order noted for Rocephin 1G IM x 1. Administered at 12pm, right deltoid. Awaiting culture results. Resident is needing assistance with feeding at this time. Extra fluids offered frequently. Neuro checks continue, with previous fall this am." "10/8/2024 14:44 (2:44 PM) Incident Note Text: Med review, new order noted for Rocephin (used to treat bacterial infections) 1G (gram) IM (intramuscular injection) x (time) 1. Administered at 12p (12:00 PM), rt (right) deltoid. Neuro checks in progress and remain within normal limits for resident." "10/8/2024 15:52 (3:52 PM) Progress Note Date of Service: 2024-10-08 Visit Type: Progress Note Transition of Care: Details: Chief Complain confusion, UTI, fall ... Patient seen and examined per nursing staff request post fall from electric wheelchair. Patient has a laceration to [their] left			

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	lower leg and abrasion to the right forearm. Patient has had recent confusion and restlessness with a positive urine dip and started on Cipro has been sent to lab for culture and sensitivity ... Fall from non-moving wheelchair ... Unobserved fall ...patient sustained laceration to left lower leg and right forearm. Laceration cleansed and Steri-Strips applied with nursing ... patient started on Cipro patient continues to have confusion IM Rocephin one-time ordered ... [NP "B"]." "10/8/2024 16:17 (4:17 PM) Nursing Progress Note Text: Upon assessment, tongue noted to be swollen with a bite mark noted to right side of tongue, secondary to fall this am. [RN "A"]." A review of R901's progress notes did not reveal a reference by NP "B" of R901's head and tongue injury. Further review of R901's progress notes revealed the following: "10/8/2024 18:09 (6:09 PM) Nursing Progress Note Text: Writer notified by CNA, that resident was having seizure activity. Writer witnessed resident to be having involuntary movements. Writer noted [R901] to be gasping for air, and blood coming from [R901] mouth, secondary to biting [R901's] tongue. Responsive to sternal rub, but agonal breathing noted. 911 phoned ... EMS arrived at 5:40, one dose of Narcan administered. Transferred to (name of hospital) via EMS..." "10/8/2024 17:56 (5:56 PM)... Summary for Providers Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were: Altered mental status Falls Seizure At the time of evaluation resident/patient ... Primary Diagnosis is: Relevant medical history is: CHF (congestive heart failure) Diabetes Chronic Renal Failure/ESRD. Code Status: Adv Directive: Full			

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	Cardiopulmonary Resuscitation (CPR). Advance directives are: Resident/Patient had the following medications changes in the past week: Cipro/Rocephin. Resident/Patient is on anticoagulant other than warfarin: Yes ... Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Increased confusion (e.g. disorientation). Functional Status Evaluation: Fall ... Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Seizure. Nursing observations, evaluation, and recommendations are: ... A. Recommendations: IM dose of Rocephin x1, continue with neuro checks, monitor mental status ..." "10/9/2024 11:04 Nursing - Progress Note Text: IDT (Interdisciplinary Care Team) met to review fall on 10/8/24 at 1030. Nurse reports that resident was sitting in room for 15 minutes before being, summoned to room to observe resident on the floor in room lying on her right side with her back facing the door and feet pointed toward the head of her bed, resident could not describe how she got from her electric wheelchair to the floor. Resident had recent change in condition on 10/6/24. Staff used mechanical lift to put resident in bed for assessment, nurse observed redness to face more so over right eyelid, left lower leg laceration, and right forearm scrape, first aid rendered to skin sites and neuro checks initiated and wnl (within normal limits), nurse notified DON, provider, and family. Care plan reviewed and updated medication review. Resident was sent out to the hospital." A review of R901's death certificate noted they died four days later. Cause of death Traumatic			

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	Subdural Hematoma, significant conditions: Oral Anticoagulant therapy, new onset Seizures, Manner of death accident, date of injury 10/08/24, fall, at living facility. A of the facility policy titled, "Fall Management Guidelines" dated 12/13/23, revealed, POLICY OVERVIEW: The purpose of this policy is to provide guidelines to assist with fall risk identification and fall management of residents in the facility... POST-FALL EVALUATION: If a resident has just fallen or is observed on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities prior to moving the resident. Complete a neurological evaluation using the Neurocheck Evaluation Form when a resident: Has a witnessed fall when the resident has hit their head. Has an unwitnessed fall when a head injury may be suspected or is unknown. After the completion of the initial neurological evaluation with vital signs, continue the evaluations every 30 minutes X 2, every hour x 4, every 4 hours x 6, then every shift x for a total of 3 days..." The facility's policy did not address unwitnessed falls with residents that are on anticoagulant medication			