STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235116	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Woods Nursing & Rehabilitation Center	1684 Vulcan St Muskegon, MI 49442

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00145370 Based on interviews and record review, the facility failed to protect a resident's (Resident #5) right to be free from physical abuse from another resident (Resident #4). Findings: Resident #4 (R4) Review of an Admission Record revealed R4 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia with agitation and behavioral disturbances and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for R4, with a reference date of 4/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 7, out of a total possible score of 15, which indicated R4 was severely cognitively impaired. Review of R4's Care Plan revised 4/21/24 revealed, (R4) has the potential for psychosocial distress related to: anticipated dementia progression, expressing sadness / anger / empty feeling over lost roles and status. Wanderguard is in place due to unsafe wandering. Confusion and memory loss present. DX (diagnosis) of depression. Orders for psychotropic medications .Interventions/Tasks . If/when (R4) becomes agitated, attempt to redirect by offering snack or drink. Attempt to engage him in conversation that is meaningful to him . Review of R4's Care Plan revised 4/22/24 revealed, Altered functional mobility and ADL's (Activities of Daily Living) related to generalized weakness, dementia, confusion. Resident can ambulate independently with his wheeled walker, and at a fast pace. Given his dementia being questioned will increase his agitation which can lead him to be combative with cares . Review of R4's Order Summary dated 4/17/24 and April Medication Administration Record revealed, OLANZapine Oral Tablet 5 MG (Zyprexa) Give 1.5 tablet by mouth at bedtime for depression. The medication was administered on 4/18/24 and was discontinued on 4/19/24. (Zyprexa is an antipsychotic medication). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Care Conference dated 4/19/24 with Interdisciplinary Team and R4's Power of Attorney revealed medications, medical condition, and care plan were reviewed. The note reflected R4's behaviors of wandering and exit seeking but did not reflect R4 exhibiting combative/physical aggressive behaviors. The note did not reflect a discussion/rationale for the discontinuation of Zyprexa. (There was no documentation that an additional care conference had been completed prior to R4's transfer on 5/30/24). Review of R4's Behavioral Support Intervention Analysis revealed: 1. Start of Behavioral Log Review-4/17/24 2. End of Behavioral Log Review-4/24/24 3. Type and Number of Behaviors-(R4) has wandering noted daily. He wanders throughout the facility and into other resident's room. He has a wanderguard in place due to unsafe wandering and exit seeking Orders for Zyprexa and Remeron which are used for dx of depression . Indicating R4 was receiving Zyprexa throughout the lookback period. There were no combative behaviors noted. Review of R4's Psychiatric Evaluation dated 4/22/24 revealed, .(R4) is an 85yo (year old) male who is referred for an evaluation and medication management of his dementia with behaviors. He is currently taking Zyprexa 2.5mg nightly .Since being at Lake Woods, he has been exit seeking and wandering .He has been observed slamming doors and throwing his walker .Recommendations .Increase Zyprexa 5mg nightly .Follow up 4 wks (weeks) or sooner if indicated . Review of R4's Electronic Health Record revealed no documentation from the Interdisciplinary Team or provider for the abrupt discontinuation of the Zyprexa on 4/19/24. Review of the FDA guidelines for Zyprexa revealed the medication should not be stopped abruptly and should be done under the supervision of a provider. Review of the National Library of Medicine (NLM) article Olanzapine revealed, .Clinicians should monitor patients while discontinuing olanzapine therapy, as there is a risk of physical withdrawal and rebound symptoms. Hence olanzapine should be tapered gradually . Review of R4's Order Summary dated 4/25/24 revealed, OLANZapine Oral Tablet 5 MG (Zyprexa) Give 0.5 tablet by mouth at bedtime for depression 2.5 MGs of Zyprexa. Review of R4's Interdisciplinary Documentation dated 4/27/2024 written by Social Services (SS) K revealed, (R4) was seen on 4/22/24 by (psychiatric provider) and the IDT (Interdisciplinary Team) reviewed report, PCP (primary care provider) agreed to restart (R4's) Zyprexa. CCC (Clinical Care Coordinator) was informed and medication was restarted. SS (Social Services) will continue to assess, offering support as needed. Review of R4's Electronic Health Record revealed no documentation from the Interdisciplinary Team or provider for restarting Zyprexa at 2.5mg instead of the recommended 5mg from the psychiatric consult on 4/22/24. Review of R4's Health Care Provider Note dated 5/6/24 revealed, .There is no new medical or nursing concerns . Mood is stable, no behavioral issues . and did not reflect and change in R4's behaviors or mood. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's HCP (Health Care Provider) Visit dated 5/13/24 revealed, .No nursing concerns today . and did not reflect and change in R4's behaviors or mood. Review of R4's Interdisciplinary Documentation dated 5/15/2024 revealed, .(R4's daughter in law) informed writer that (R4) loves to tinker with things and will often attempt to disassemble things. (R4's daughter in law) talked about getting resident a busy board. Writer informed (R4's daughter in law) that she would share this info with the activity department . Review of R4's Interdisciplinary Documentation dated 5/15/2024 revealed, (R4's) roommate scheduled to discharge 5/16; resident is packing all of his belongings in belief that he is also leaving. States he is waiting for his ride. Unable to redirect from being exit seeking this round. Writer contacted son and left voicemail. Review of R4's Care Plan did not reflect R4's family member's recommendation and R4 was not provided a busy board to assist with his restlessness/agitation/wandering behaviors. Review of R4's Interdisciplinary Documentation dated 5/17/2024 revealed, .Resident has been very confused, and not knowing who he was .He was yelling at this nurse, because he was confusing me, I didn't know what he was talking about. His roommate discharged home yesterday, and I feel he's confused about that. No new interventions were implemented despite the identification of a possible psychological stressor. Review of R4's Interdisciplinary Documentation dated 5/18/2024 revealed, resident combative with staff and other residents. Resident hitting staff and throwing items such as walker at staff. Resident fell when throwing walker at CNA (Certified Nursing Assistant) talking to him. When this nurse went to evaluate resident for injuries and find out what happened from resident point of view resident refused to answer or let this nurse assess for injuries. Resident again got combative and yelling at this nurse and CNA in room. DON notified, dr notified. fall paperwork completed by staff nurse and calls completed. A linked note dated 5/20/2024 revealed, resident not combative to other residents. no resident on resident contact. Only resident to staff combative behavior. During an interview via telephone on 08/19/2024 at 3:04 PM, Nursing Home Administrator (NHA) (on leave since 8/11/24) reported she followed up with the nurse that wrote the note on 5/18/24 to ensure there had been no resident to resident abuse. The nurse clarified her documentation with the linked note on 5/20/24. Review of R4's Interdisciplinary Documentation dated 5/18/2024 revealed, Resident observed wandering into other residents rooms. When redirection was attempted by staff, he became combative, swinging his fist, throwing his walker at staff and falling onto buttocks. Writer obtained vital signs, performed pain assessment and assisted resident up onto feet returning walker. Resident educated on entering female residents rooms to which he responded I was going to my car. Resident became agitated and exit seeking, looking for the keys to his car. He removed wander guard (sic) from his ankle and proceeded to attempt to exit facility. On Call physician (name omitted) contacted and notified. New Order for Ativan 0.5 mg q 8 hours prn (every 8 hours as needed) for agitation called to (name omitted) Pharmacy. Daughter in Law (name omitted) contacted and notified of incident and changes. Review of R4's Behavioral Care Log from 4/22/24 through 5/18/24 (documentation completed twice daily) revealed R4 began displaying physical aggression on 5/18/24 which was a change from his documented baseline behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Electronic Health Record revealed a comprehensive assessment and/or medication review was not completed with the Interdisciplinary team, the provider, and the family despite an increase in the number of R4's behaviors, the intensity of his behaviors (physical violence), and his fall. Review of R4's Interdisciplinary Documentation dated 5/19/2024 revealed, Resident awake 0530 (5:30 AM) combative with staff and trying to Hit (initials omitted) when walking by. Very disruptive . Monitor closely. Review of R4's Electronic Health Record did not reflect how staff would monitor R4 more closely (1:1 supervision, increased staffing on unit, 15 minute checks, etc). The care plan did not reflect changes in R4's monitoring. Review of R4's Interdisciplinary Documentation dated 5/19/2024 revealed, Resident came to harbor fire exit door and attempted to kick the door open. Resident was unable to open door. Resident then attempted to come behind nurses station. When this nurse attempted to redirect resident from behind desk resident started throwing hand sanitizer at this nurse. This nurse again attempted to redirect resident and resident started hitting this nurse. DON was called and resident actions reported to RN on terrace. RN on terrace already aware and making calls and arrangements for resident care. Resident made his way back to terrace on his own. Clarified with Nurse Consultant (NC) D on 08/19/2024 at 3:36 PM the nurse was completing documentation to have R4 transferred to the emergency department. Review of R4's Interdisciplinary Documentation dated 5/19/2024 revealed, Resident reported from prior nurse resident since waking after having given Ativan on prior shift has been more agitated and becoming combative staff, as another resident was walking in the hallway he wheeled toward her and started yelling at her to get away from him, we were able to intervene and keep residents safe, he was yelling at staff to not look at him, do not go near him , he propelled his walker down to the other end of the building, was kicking at fire extinguisher yelling at staff and throwing items. I called NP (Nurse Practitioner name omitted) on call, due to risk of harm to himself and others order given to send to ED (Emergency Department) for evaluation and treatment. Family (Son/POA and daughter in law names omitted) will meet resident at ED, (Nurse Practitioner name omitted) stated they would not have been able to calm him down when he gets this agitated . Indicating R4 was beginning to display aggression towards other residents, not just staff, and staff were no longer able to redirect/deescalate R4. R4 returned from the emergency department with a new order for Zyprexa 5mg. Review of R4's Order Summary dated 5/20/24 revealed, ZyPREXA Oral Tablet 5 MG (Olanzapine) Give 1 tablet by mouth one time a day for Agitation. (The dose that was recommended on 4/22/24 by the psychiatric consultant). Review of the NLM article Olanzapine revealed, .Daily administration of olanzapine leads to reaching the steady-state plasma concentration in about one week . Indicating the increased dose would not reach full efficacy for 1 week. Review of R4's Interdisciplinary Documentation dated 5/21/2024 revealed, .Continues to wander into others rooms, and use their bath rooms (sic) . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Interdisciplinary Documentation dated 5/23/2024 revealed, Resident continues to become combative with staff when redirection is attempted. He wandered into other residents rooms this evening, taking his pants down, urinating and yelling I want everything that belongs to me or a lawsuit will be made. Review of R4's Interdisciplinary Documentation dated 5/24/2024 revealed, Resident agitated this morning, refusing to use his restroom or unit restroom, pushing past writer and entering the room of another resident. Writer attempted to assist resident and redirect out of room. He became combative, striking writer in chest with closed fist. He took his pants off and entered Room (number omitted) and used restroom. He allowed staff to assist in putting his pants back on and went back into room to eat breakfast. After eating his meal, (R4) began banging on the walls of his room . Review of R4's Electronic Health Record revealed that no new care planned interventions and/or comprehensive physical assessments were initiated despite R4 exhibiting new/worsening wandering behaviors (using other resident bathrooms and urinating in resident rooms on 5/21/24, 5/23/24, and 5/24/24). Review of R4's Interdisciplinary Documentation dated 5/24/2024 at 11:00 AM revealed, Writer witnessed resident exiting his room, ambulating without his walker, losing balance and falling onto his knees then laying on floor .Root cause determined to be Increased agitation/restlessness. Antianxiety medication administered causing lethargy. Intervention: Medication review/intervention and Discontinuation of Ativan 0.5mg . R4's antianxiety medication (ativan) was discontinued despite the root cause of the fall being identified as agitation/restlessness. Review of R4's Interdisciplinary Documentation dated 5/24/2024 at 5:30 PM revealed, Resident observed becoming combative with CNA staff when attempting to redirect to his room. Resident then went into another resident's room and laid in bed with him. When attempt was made to assist him out he threw bedside table at staff then exited room, snatched supply holder off the side of medication cart and began to snatch blankets and pillows from other residents. He knocked over walker and began throwing items in reach at staff. Writer unable to redirect at this time as resident is a threat to his own safety as well as others. On call physician (nurse practitioner name omitted) contacted and notified of events and gave verbal order to start Ativan 0. 5mg PRN. DON contacted and notified. Review of R4's Interdisciplinary Documentation dated 5/24/2024 at 5:45 PM revealed, (R4) refused dinner tray and ambulated to dining room asking to be served. When tray was presented to him, he refused again. He then went into maintenance closet and took off all of his clothing, becoming combative with staff when attempting to redirect him. After being escorted to be toileted, resident ambulated to the Harbor unit, entering resident's rooms and taking their belongings. He again, became combative when redirection was attempted. When told that this was not his room, he responded It is now. After being escorted back to unit, resident wandered into other resident's rooms for approximately an hour. He then allowed staff to assist him into bed . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Interdisciplinary Documentation written by SS K revealed, On 5/24/24 writer observed (R4) in the hallway with only a shirt on. As writer was walking towards (R4), staff approached him attempting to redirect him back to his room. Resident was agitated and aggressive with staff and writer. (R4) entered another male resident's room and refused to leave. As staff attempted to assist resident with putting a brief and pants on, (R4) continued to be aggressive with them .(R4) has had an increase in aggressive behaviors. Writer did speak with resident's daughter in law (name omitted) this morning, updating her on possible psych placement . Writer will seek psych placement for (R4). Review of R4's Interdisciplinary Documentation dated 5/25/24 revealed, About 6:30 am this morning, the CNA's observed resident walking down the hall way toward the fish bowl with his walker and no pants or pull up on, stated he needed the bathroom, CNA attempted to redirect resident in the right direction and he punched her in the face, causing a bruise near her left eye. Resident became very combative, kicking swinging his arms and cursing . Review of R4's Electronic Health Record revealed there were no new care planned interventions initiated or increased supervision for R4 to protect other residents despite increased agitation/restlessness, a fall, an escalation of behaviors to resident physical contact/getting into bed with another resident, and a physical assault on a staff member resulting in a bruised left eye. SS K documented the need to seek inpatient psychiatric services on 5/24/24 and the licensed nurse documented a concern to R4's safety as well as others (resident and staff) safety on 5/25/24. Review of R4's Interdisciplinary Documentation dated 5/25/2024 revealed, .(Nurse Practitioner name omitted) would like us to try to get urine from resident to dip . indicating a concern that R4 was exhibiting symptoms of a urinary tract infection. There were no Interdisciplinary Documentation or other progress notes completed on 5/26/24. Review of R4's Interdisciplinary Documentation dated 5/28/2024 revealed, (R5) stated that this resident punched him in his eye the day prior (5/27/24). Stated that he didn't say anything because he was embarrassed . There were no other notes documented on 5/28/24. Review of R4's Interdisciplinary Documentation dated 5/29/2024 revealed, Resident continues wandering into others rooms and attempting to exit facility through emergency doors. PRN Ativan administered for restlessness effective for only an hour .Resident difficult to redirect as he becomes combative with staff. R5's room was changed following the physical assault by his roommate (R4). There was no additional action taken by the facility to protect all residents and to prevent a possible reoccurrence prior to his transfer to the inpatient psychiatric hospital on 5/30/24 at approximately 12:00 PM. Review of R4's Petition for mental Health Treatment dated/signed 5/29/24 by SS K revealed, .History of being combative, physically and verbally aggressive with others. (R4) has confusion, short and long term memory loss present. DX (Diagnosis) of Dementia with behavioral disturbances and agitation .(R4) punched a staff member in the eye which resulted in her having a black eye. He has been delusional, combative, aggressive, throwing things at others, climbing in bed with others (sic) residents. SS K documented that she would seek psychiatric placement for R4 on 5/24/24 in an Interdisciplinary Documentation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5 (R5) Review of an Admission Record revealed R5 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: mild cognitive impairment, weakness, anxiety, and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for R5, with a reference date of 4/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 8, out of a total possible score of 15, which indicated R5 was moderately cognitively impaired. Review of R5's Skin assessment dated [DATE] revealed, While administering resident his mighty shake, writer observed that resident had dark red bruising under his under his right eye. Writer saw resident an hour prior to assist him in toileting and did not see bruising to eye. When asked what happened he responded, (R4) punched me yesterday, I didn't say anything because I was embarrassed . Review of the Witness Statement written by Licensed Practical Nurse (LPN) O dated 5/28/24 revealed, While administering (R5) his mighty shake, writer observed that he had bruising his r (right) eye. When asked what happened, he stated, (R4) punched me. I did not witness this incident. (R5) states that it happened last night. Review of the Witness Statement written by CNA L dated 5/28/24 revealed, I did not finish anything. I was just finishing my break. Review of the Witness Statement written by CNA M dated 5/28/24 revealed, I was doing care on a resident and did not witness the incident. Review of the Witness Statement written by CNA N (no date) revealed, Did not witness anything. Review of the Witness Statements indicated insufficient staff available to provide appropriate supervision for a resident with known increased behaviors. Review of the Facility Reported Incident (FRI) investigation revealed: .(R5) reported that the cause of the bruising was due to his roommate making contact with his eye. (R5) provided several different timelines throughout interviews stating this happened the day prior, the night prior and then in the last interview a few weeks ago which would have been well before observed bruising and his first initial statements. However, (R5) has been consistent in reporting the cause of the bruising . To maintain (R5's) safety and the safety of others (R5) was offered and accepted a different room. This created a private room for (R4) which mitigated risk to others and met (R5's) preference not to room with (R4) as well as to be in a bed 1 position .(Confirming no other action was taken by the facility to protect the residents to prevent a possible reoccurrence besides R5's room change despite R4's ongoing/increasing wandering in the facility.) Coordination with (R4's) family to obtain history and best care plan were recent with revisions on 4/21/24 . (Confirming R4's care plan had not been updated with R4's increased behaviors.) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conclusion: The allegation cannot be verified or refuted due to there being no reliable witnesses at the time of the incident that caused bruising to (R5's) eye. (R5) is not a reliable historian however based on circumstantial observations including (R5's) statement, despite inconsistent timelines, new onset bruising to his right eye and observations of (R4's) increased agitation it is reasonable to conclude that an interaction took place between (R4) and (R5) that resulted in (R5) obtaining a bruise . Further review of the facility investigation revealed, .(R4) had worsening combative behaviors that were increasingly difficult to redirect. Health care provider recommended inpatient psych for medication management and resident was subsequently admitted . (Confirming the facility was aware of R4's increasing physically aggressive/assaultive behaviors and staffs difficulty/inability to redirect the resident.) Review of an email received on 08/16/2024 at 4:43 PM from the facility revealed, Zyprexa was restarted on 4/25/24 per psych provider (names omitted.) Psych consult recommendation made to increase Zyprexa was reviewed by (Nurse Practitioner name omitted) & IDT, declined increase at that time. Zyprexa increased from 2.5mg to 5mg on 5/21/24 due to increase in behaviors. Transferred to (inpatient psychiatric facility) on 5/30-6/14/24. During an interview via telephone on 08/19/2024 at 3:04 PM, NHA confirmed that R4's Care Plan had not been updated with new intervention since 4/21/24 and no other interventions had been implemented. NHA reported she had not been notified of R4 laying in another residents bed. During an interview on 08/19/2024 at 3:21 PM, SS K and DON could not provide documentation from the Interdisciplinary team and provider regarding the abrupt stopping of Zyprexa on 4/19/24 or a rationale from the provider, Interdisciplinary team, and family related to continuing/restarting Zyprexa at 2.5mg instead of the recommended 5mg by the psychiatric consultant on 4/25/24. SS K reported if she had spoken with R4's family/responsible party she would have documented it (in the Interdisciplinary Documentation). NC D reviewed R4's Electronic Health Record and confirmed there was no documentation related to the above concerns available. Review of the facility policy Abuse Prevention Overview last revised March 2019 revealed, .Prevention .2. The facility will provide supervision of staff and residents to the extent possible .3. The facility will provide a qualitative and quantitative analysis of incident accident reports. 4. The facility will develop care plans, which include interventions for behaviorally challenged residents. Respond and Identify .The facility will identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur . Protect-1. the facility will provide resident protection as indicated while an investigation is in progress as outlined in the policy for resident protection during an abuse investigation, including .*Increased supervision of the alleged victim and residents . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the National Library of Medicine (NLM) article Olanzapine revealed, .Daily administration of olanzapine leads to reaching the steady-state plasma concentration in about one week .Clinicians should monitor patients while discontinuing olanzapine therapy, as there is a risk of physical withdrawal and rebound symptoms. Hence olanzapine should be tapered gradually . [NAME] K, Saadabadi A. Olanzapine. [Updated 2023 [DATE]]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK532903/

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #: MI00146179 Based on observation, interview, and record review, the facility failed to ensure adequate supervision for 1 of 12 residents (Resident #1) reviewed for safety, resulting in R1 left unsupervised outside. Findings: During an observation on 08/15/2024 at 7:25 AM, the front entrance/main entrance of the facility had 2 sets of doors. The first set of doors was unlocked, the second set of doors required a code to enter. There was a doorbell attached to the wall. Resident #1 (R1) Review of an Admission Record revealed R1 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, heart failure, and stage 4 kidney disease. Review of a Minimum Data Set (MDS) assessment for R1, with a reference date of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 6, out of a total possible score of 15, which indicated R1 was severely cognitively impaired. Review of R1's Assessment for Outdoor Independence dated 7/13/24 revealed, (R1) is alert and oriented X2 BIMS score is 6/15 indicating cognitive impairment. Resident self propels in her wheelchair and is able to transfer as a 2 assist. She has cognitive or physical impairments which could impede on her independent safety. Outdoor independence is not recommended at this time. Review of R1's Fall assessment dated [DATE] revealed, Resident is A&OX2. Resident gets short of breath easily and has poor balance she is a two assist with ambulation and transfers and 1 assist with bed mobility. Review of R1's Interdisciplinary Documentation dated 7/11/24 revealed, Per (day center) (R1) will be getting picked up for the day center M/W/F (Monday, Wednesday, and Friday) starting Friday 7/12. Schedule will be as follows: Mon PU (pick up) 9:20am DO (drop off) 3:40pm Weds PU 8:45am DO 1:40pm Fri PU 9:50am DO 2pm. (continued on next page)

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	235116	A. Building B. Wing	08/19/2024

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Lake Woods Nursing & Rehabilitation Center	1684 Vulcan St Muskegon, MI 49442

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Interdisciplinary Documentation dated 7/18/24 revealed, (R1) is a recent admission to the facility. She is [AGE] years old. She is alert and oriented x's 2-3. She scores 6 on the BIMS. She is able to communicate her needs and use her call light .She is able to transfer with one staff assistance. She has vascular wounds on her bilateral great toes which cause her some discomfort when bearing weight. She is able to propel her w/c (wheelchair) .She is at risk for falls r/t (related to) diabetic neuropathy and pain in her feet, blindness in one eye, and psychotropic medication use .She states she has pain in her neck, and her feet .(R1) is frequently incontinent. She has diuretic medication as ordered which may contribute to urge incontinence. She wears absorbent briefs . Indicating R1 required staff assistance with ADLs (Activities of Daily Living). Review of R1's Interdisciplinary Documentation dated 7/19/24 revealed, Resident had blood sugar drop to 72 and was symptomatic. Resident was given snacks and assisted to bed. (Provider name omitted) notified and aware blood sugar eval to be assessed. Per [NAME] & [NAME]/Fundamentals of Nursing, symptomatic hypoglycemia (low blood sugar) can result in diaphoresis, shakiness, confusion, loss of consciousness. Indicating R1 required nursing supervision to ensure adequate blood sugar levels and interventions to treat hypoglycemia. Review of R1's Interdisciplinary Documentation dated 7/22/24 revealed, This writer helped (R1) outside today at 9:20am when a (day center) bus was at (the attached assisted living) picking up residents for the day center, after a call was made from (day center) stating that they were outside ready for pick ups. I let the dispatcher know (R1) was being wheeled outside and would be ready. This writer saw (day center) bus pull into the parking lot and around to where (R1) was sitting. A few hours later 11:50ish am, (Registered Nurse/RN C) came wheeling (R1) inside and stated that (day center) never picked her up for the day center. (R1) reported to the nurse that her scalp was hot and that she had been sitting in the sun for a while. A call was made to (day center). (Director of Nursing) was notified. Review of a Witness Statement dated 7/31/24 written by Infection Prevention Manager (IPM) I revealed, Unaware resident was unattended outside. Brought to my attention that (day center) bus did not pick up resident for clinic visit. Resident previously observed just before bus arrival sitting outside with activities present sitting at front entrance benches. Resident was assessed by nursing at bedside and had no skin related issues. Review of R1's Short Term Care Plan-Sun Burn dated 7/22/24 revealed it was initiated due to out in sun for 3 hrs (hours). Sun burn (check) skin/scalp . Review of a Witness Statement dated 8/1/24 written by Certified Nursing Assistant (CNA) E revealed, I seen (R1) outdoors, waiting for her bus ride to an appt. (appointment) as well as other residents. The bus pulled up and did not get out to get her. And kept going but I didn't or wasn't aware she was getting picked up. Review of a Witness Statement dated 8/1/24 written by CNA G revealed, I (CNA G) was at fishbowl (receptionist desk) when I observed (R1) going outside to be picked up by (day center) around 9 am. After finishing my rounds and going back up to the fishbowl she was still outside. The statement did not reflect that CNA G went outside to determine if R1 required assistance back into the building and/or her needs were met (toileting, hydration, nutrition, pain, etc.) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Witness Statement dated 8/1/24 written by Administrative Assistant-Assisted Living (AAAL) F revealed, I was at the fishbowl when the (day center) man called and said he was here to pick the residents up at the (assisted living) and MRM B asked him was he getting (R1) and he said yes after they get on the bus but he just kept driving off instead of pulling up to the nursing home and getting her. Review of a Witness Statement dated 7/31/24 written by Activity Aide (AA) H revealed, I arrived at (name of facility) (sic) at 9:30 am, I observed (R1) sitting by flower boxes. I said hello, she smiled and waved, I went inside to clock in . The statement did not reflect that AA H made additional observations of R1 following the interaction. Review of a Witness Statement dated 7/31/24 written by AA J revealed, I do not recall there being an incident. Indicating Activity Staff were not present with R1 while she was outside. Review of a Witness Statement (no date) written by Medical Records Manager (MRM) B revealed, On 7/22 (R1) was schedule for (day center). (Day center) called stating they were outside to pick up residents from the (assisted living) and (name of facility) (sic). I then told them I was wheeling (R1) outside for pick up. I saw the bus pull around the parking lot and park in front of (R1). After that I went off to a meeting. Around 11:50 AM (RN C) came in wheeling (R1) stating she had not been picked up by (day center). Instead had been left outside with Activity Staff .(Director of Nursing) was notified. During an interview on 08/19/2024 at 12:39 PM, MRM B reported that on 7/22/24 the day center van was at the attached assisted living picking up residents and wanted R1 outside. MRM B reported she wheeled R1 outside the front doors and observed the day center bus pull up. MRM B reported she was on her way to a meeting and did not observe the day center bus driver assist R1 onto the bus. MRM B reported she was notified by Registered Nurse (RN) C that R1 was never picked up and had been outside during that time. MRM B confirmed that there was a code required to enter the building at the second set of front entrance doors. If a staff member wasn't in the fishbowl (reception area enclosed with glass), a doorbell could be utilized to alert staff. MRM B reported R1 did not have access to a call light outside and was unsure if R1 had a personal cellphone. Review of R1's Inventory of Personal Effects revealed no cell phone listed. Confirming R1 did not have a personal cell phone available for use. Review of the investigative notes and witness statements revealed no Witness Statement completed by RN C. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/19/2024 at 1:14 PM, RN C reported she was aware that R1 had been taken outside at approximately 9:30 AM on 7/22/24 to be picked up by the day center. RN C reported she left the facility for her lunch but did not recall visualizing R1 at that time. RN C reported when she returned from lunch around 12:30 (PM) she noticed R1 by the flag pole outside of the main entrance of the facility. RN C reported she went up to R1 and asked (day center) didn't pick you up? to which R1 replied no and reported she was getting really warm and her scalp was warm. RN C reported R1 had been outside for about 3 hours. RN C reported she asked R1 why she didn't ask for assistance back into the building and reported that R1 was not very vocal and didn't want to inconvenience anyone. RN C confirmed that when she visualized R1 she was alone and did not have staff supervision. RN C confirmed that R1 could self-propel in her wheelchair but was not sure she would be able to open the front doors independently or find the doorbell. RN C reported she immediately notified management of the incident but was not asked to complete a witness statement. Review of the Facility Reported Incident (FRI) investigation revealed, .Investigation: (day center) program administrator reported to the Administrator that she was made aware resident (and day center participant) (R1) waited outside for period of time while awaiting transportation and asked if a facility reported event had been entered. Due to this allegation an investigation was initiated .Date and time of two-hour report:: 7/31/24 at 4:45 PM .Immediate Action: On 7/22/24 the resident was assisted back inside the facility by a licensed nurse. (R1) explained that she had been outside waiting for the (day center) transport to take her to the day center as planned, however the bus did not pick her up. A skin assessment was completed by a licensed nurse as (R1) stated her scalp was warm and she had erythema (redness) to her scalp but no raided, or open areas . Ambulatory Status: Extensive Assist with Walker Locomotion Status: Independent and requires one Assist to Propel Wheelchair at times . BIMS: 06/15, indicating severe cognitive impairment . Alleged Victim Interview: (R1) was able to verbalize her thoughts/feelings at the time of the missed transportation. (R1) expressed that she was frustrated (day center) did not pick her up, as this had been an ongoing issue. It is (R1's) pattern to go to the day center with (name omitted) and this is something she wanted to do. She was frustrated that she (was) waiting a long time for the bus and it did not come . Investigation Summary .(R1) was outside awaiting transport were interviewed related to their observations of (R1) and her pickup. (R1) was noted to be outside awaiting transport, not in any distress, and provided oversight by staff coming and going from the facility and outside for various reasons. (R1) was noted to be on the sidewalk just beyond the front doors. She did not request for a staff member to bring her inside, until nurse (RN C) offered, and she accepted . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R1) was visible to staff the duration of time she was outside. She was sitting at/near the flower boxes just outside the front doors which can be seen by the DON (Director of Nursing) office as well as the reception desk. Multiple staff members come and go from those doors during those times. Both staff and resident families were outside with other residents and noted that (R1) was not in distress, able to ask assistance should she need it and did when she did not want to wait any longer. Staff nurse (RN C) assisted (R1) back inside. (R1's) care plan was reviewed and indicates that she enjoys sitting outside in the warm weather. She is alert and oriented and able to make her needs known, while verbalizing her preferences. She is able to self-propel short distances in her wheelchair. When she was ready to come back inside, she verbalized it to the nurse and was assisted back in .Facility staff justifiably believed (R1) was successfully picked up and could not have predicted that the (day center) driver did not load her into the transport vehicle and take her to the day center . During an interview via telephone with Interim Nursing Home Administrator (INHA), DON, and Nurse Consultant (NC) D present on 08/19/2024 at 3:04 PM, NHA (on leave since 8/11/24) reported that the incident on 7/22/24 was not investigated/reported until 7/31/24 because staff had not notified her of the event. NHA reported the day center notified her of the incident on 7/31/24 after R1's responsible party filed a grievance with the day center regarding the bus driver leaving R1 and immediately started an investigation. NHA reported she was unable to connect with RN C to obtain her witness statement. NHA was asked to provide documentation that R1 was assessed and/or was offered to be brought inside between the observation of AA H and RN C and confirmed that there was no documentation to verify that R1 had been assessed and that her needs were met and confirmed that she was unable to identify any facility staff members that assessed R1 and/or offered to bring R1 inside during that time period. NHA reported that R1's care plan revealed that she enjoyed sitting outside in the warm weather but was not aware of the Assessment for Outdoor Independence that indicated that outdoor independence was not recommended. NHA reported she spoke with R1's responsible party and was told that R1 doesn't want to bother anybody the I'm fine kind of thing. NHA reported that R1 was observed by multiple staff while she was outside and was able to make her needs known/request to be brought inside (despite the lack of a call light system and cell phone to communicate her needs and/or notify staff of an emergency, staff assessment/communication with R1, and R1's behavior of not wanting to ask for assistance bother anybody.) During an interview on 08/19/2024 at 12:52 PM, DON and INHA reported there were no policies for transportation/resident hand off but reported the expectation would be for staff to stay with a resident until they visualized the resident on the transport bus. INHA reported that staff education regarding resident transportation was initiated following the incident. Review of the staff education Outdoor Independence and Transportation revealed, OUTDOOR INDEPENDENCE *Nurses stations and the fish bowl have an updated list of residents deemed capable of outdoor independence *Residents not on this list should never be unsupervised outside *Residents must sign out before going outside (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TRANSPORATION TO (day center) PROCESS *(Day center) dispatch will notify the facility when they arrive to pick up a resident *If the resident is to be transported, (Name of Facility) staff will assist the resident to the transportation vehicle for a handoff *Residents deemed not capable of outdoor independence should wait inside for transport and staff assistance.