STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235492	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheffield Manor Nursing & Rehab Center	15311 Schaefer Rd Detroit, MI 48227

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 34208 This citation pertains to intake MI00148780. Based on observation, interview, and record review, the facility failed to ensure (1) safe positioning in a geri-chair, (2) implement appropriate interventions to prevent falls from a geri-chair, and (3) implement appropriate post-fall interventions for one resident (R303) of three residents reviewed for falls, resulting in a fall causing a laceration to the forehead and transfer to the emergency room for imaging studies. Findings include: A complaint received by the State Agency alleged the resident fell and sustained an injury. On 12/17/24 at 11:39 AM, R303 was observed in their room with their eyes closed making some slightly restless movements with their arms and hands. An attempt to get R303's attention by speaking to them was not ackowledged by R303. At the bedside, a geri-chair was observed with two large, thick cushions in the seat. The cushions were made of a shiny black material that appeared slippery and were approimately six and eight inches thick. A review of R303's clinical record revealed they most recently readmitted to the facility on [DATE] and begun hospice services. R303's diagnoses included: protein calorie malnutrition, traumatic subdural hemorrhage, dementia, duslusional disorder, failure to thrive, and seizures. R303's most recent completed Minimum Data Set (MDS) assessment revealed they had severely impaired cognition and needed substantial/maximal assistance for most activities of daily living including transferring and needed partial/moderate assistance for rolling their body from left to right. R303's most recent re-admission nursing assessment dated [DATE] was reviewed and indicated they were At Risk for falls. A review of R303's Kardex (care guide) was conducted and did not indicate R303 used a geri-chair. R303's progress notes were reviewed and revealed the following: A note entered into the record by Nurse 'A' dated 12/5/24 at 11:43 AM indicated R303 was discovered on the floor near their geri-chair with their positioning pillow and a sheet near them with a laceration above their right eye. (continued on next page)

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.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A note entered into thre record by Nurse 'B' dated 12/6/24 at 9:20 AM indicated the resident had a fall on 12/5/24 resulting in a laceration above their right eye and they (Nurse 'B') transferred R303 to the emergency room per the Nurse Practitioner's order. At that time, R303's care plans were reviewed and did not include any care plans for the use of a geri-chair and/or positioning cushions, or any care plans with interventions for falls at the time the fall occurred on 12/5/24. A review of a facility provided incident report completed by Nurse 'A' indicated the following: R303 resident slid out of the their geri-chair, they were oriented to person, there were no predisposing environmental factors that contributed to the accident, there were no predisposing situation factors that contributed to the accident, and listed confusion, impaired memory, and gait imbalance as predisposing physiological factors to the accident. A review of a facility provided document titled, Post Fall Evaluation last revised July 2014 was reviewed and read, Factors observed at time of fall .Equipment malfunction (specify): Extra padding on gerichair .Were there any changes in the resident's normal routine? (a box marked 'yes') If yes, explain: Res (resident) has a new gerichair cushion, will adjust to sit lower while resident utilizes it . A second review of R303's care plans for falls was conducted and revealed the first fall care plan for R303 was implemented on 12/6/24 by MDS Nurse 'C', the day after the actual fall. The focus read, (R303) is at risk for fall related injury and falls R/T (related to): Confusion, Decondition, Fear of Falling .hx (history) of falls . The interventions on the plan included the following: anticipate the resident's needs, assess the fall risk level, do not leave resident unattended in bathroom, education resident/family/caregivers about safety, appropriate footwear, observe for fatigue and offer rest, obtain labs, provide activities, call light in reach, and revieweing information on past falls to determine root cause. It was noted the care plan did not include any interventions about the geri-chair, the cushions, or increased supervision. On 12/17/24 at 2:04 PM, a phone call was placed for an interview to Nurse 'A', and a voicemail was left, however; the call was not returned. On 12/17/24 at 2:06 PM, a phone call was placed to Nurse 'B' and a voicemail was left, however; the call was not returned. On 12/17/24 at 2:15 PM, an interview was conducted with the facility's Director of Nursing. They were asked how the resident fell from the geri-chair and said they slipped out of the chair because of the very thick cushions that were in the chair at the time. They were then asked why R303 did not have any care plans for falls prior to the fall and said they were going to locate them, however; no evidence of an active fall care plan prior to 12/6/24 was provided by the end of the survey. Finally, the DON was asked why none of the current care plan interventions implemented on 12/6/24 addressed the use of the geri-chair and the cushions and they had no response, but indicated their understanding the care planned interventions in place were not all appropriate for R303 in light of the root cause of the fall on 12/5/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided policy titled, Fall Management revised 9/22/23 was conducted and read, The facility will identify hazards and resident risk foactors and implement interventions to minimize falls and risk of injury related to falls .When a fall occurs .4. The licensed nurse will complete: .Review and or revise care plan and link to the resident kardex (care guide) .