

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/04/2025
NAME OF PROVIDER OR SUPPLIER  Hartford Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  6700 W Outer Dr Detroit, MI 48235	

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 1227387 and 1227390. Based on interview and record review the facility failed to implement fall prevention interventions for one (R101) of three residents reviewed for accidents, hazards, and adequate supervision, resulting in multiple falls with the potential for injuries. Findings include: This citation pertains to intakes 1227387 and 1227390. Based on interview and record review the facility failed to implement fall prevention interventions for one (R101) of three residents reviewed for accidents, hazards, and adequate supervision, resulting in multiple falls with and without injury. Findings include: On 8/4/25 at 10:30 a.m. R101 was contacted via telephone regarding the allegations reported to the state agency. R101 said they experienced several falls when trying to get something off the floor, when needing to go to the bathroom independently, and after putting on and waiting for the call light to be answered. R101 said the nurses put the resident at the nurse's station all day because of the multiple falls, I tried to get whatever fell off the floor and the nurses took too long to help me, so I did it myself and fell. I hurt my head, my shoulders, legs and back. Review of the clinical record documented R101 was admitted into the facility on 2/2/25 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Parkinson's disease, and history of falling. R101 was discharged to another facility and no longer resides at the facility. According to the quarterly Minimum Data Set assessment dated [DATE], R101 was cognitively intact (BIMS-13), and required one person assistance with activities of daily living. Review of the Risk for Falls care plan, dated 2/2/25 documented: R101 is at risk for falls related to injury and falls related to: history of falls, hemiparesis, impaired cognition, decreased transfer and locomotion mobility. Goal: Will be free from injury and related to falls through the review date. Interventions: Keep the residents' environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position. 2/2/25 Staff to ensure that all items are in reach and accessible (i.e. remote control, cell phone, water cup, books, ink pens, etc.). 2/20/25 Put the call light within reach and encourage him/her to use it for assistance as needed. 2/2/25 Staff to locate a different room, closer to the nurse's station. 5/30/25 Review of the following Incident and Accident reports documented in part for following falls: -2/3/25 16:00- Incident Description: .In room, observed resident lying on floor, on the right side, near the bed. I was reaching for my call light and the end table moved and I rolled out of bed. Immediate Action taken: . Resident complained of pain in right shoulder. -2/18/25 12:09- Incident Description: . Observed resident on floor in bathroom in room with back against the wall facing the toilet. Resident stated trying to grab onto the rail with the weak hand and slid onto the floor. No injury observed. -2/20/25 00:00- Incident Description: The resident was observed on the floor unwitnessed on the left side. No injuries observed. There was no statement from resident about the fall. -2/26/25 05:55- Incident Description: CNA observed resident on the floor in room. observed laying on back in front of the wheelchair. Resident stated trying to get call light off the floor. No injury observed. -3/13/25 00:00- Incident Description: The resident was observed in the bedroom on buttocks and pillow near the bedroom door trying to get remote control. No injury observed. -3/26/25 00:00- Incident Description: Observed resident on buttocks on the floor in front of the wheelchair. The Resident was trying to get remote off floor. No injury observed. -5/17/25 14:00- Incident Description: Called in the room due to the patient's fall and bruising around the eye. Resident was trying to get the bed remote on the side of the bed. -5/29/25 15:45- Incident Description: Resident was observed sitting on buttocks. Resident said was trying to go to the bathroom. No injury observed. -6/10/25 11:15- Incident Description: The resident was observed on the floor on side of the bed on buttocks trying to obtain eyeglasses. No injury observed. On 8/4/25 at 4:25 p.m. CENA A was interviewed and queried about implementing interventions to residents that are at risk for falls. CENA A said the aides are supposed to ask the resident or look in the resident's chart to know their status. Any changes to the resident are reported to the nurse so the care guide can be updated. The aides are supposed to read the care guide to know if the resident has fall precautions. A lot of the time, residents drop their call lights and remotes on the floor. But if the rounds are done regularly or call lights answered, then residents would probably not fall. On 8/4/25 at 4:40 p.m. the Director of Nursing (DON) was interviewed. The DON said the resident was reviewed in Fall Risk meetings and recalled the number of times the resident (R101) fell and would be better to be close to the nurse's station. The reason for the residents' falls were identified. We tried to put frequently used items within reach. Nursing staff are supposed to check on residents at least every two</p>		