

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
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 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3051101. Based on interview and record review, the facility failed to ensure emergency Physician services were provided in a timely manner for one resident (R101) of three residents reviewed for a change of condition. Findings include: On 7/9/2026 at 8:46 AM, Family Member C was interviewed and said that R101 had a fall with head injury on 4/11/2026 at the facility and wasn't sent to hospital until 10 hours later once a doctor responded to the nurse's call. Record review of R101's Progress note dated 4/10/2026 at 23:57 revealed, Resident was observed sitting on the floor in her room and bleeding from the skin tear she sustained from falling at her left eyebrow. Resident stated that she was trying to get up to sit on the floor and she stated that she was trying to go to the bathroom. She was put back in bed and offered bedpan. Dry pressure dressing was applied to her left eyebrow and the bleeding stopped. She is alert and oriented X2, disoriented to situation with occasional periods of forgetfulness. Vital signs at time of fall was BP 182/91, temp 97.2f, pulse 88, resp 16, SpO2 93% room air, and pain 5. tylenol was given for pain, Blood pressure started trending down to 164/78, 132/69. Attending (sic) physician (Medical Doctor D) was notified via paging, daughter (Family Member C) was notified and she came to stay with her mum at 0100 am, and on call manager (manager) notified via voicemail. Neuro checks initiated, awaiting further orders. Resident was frequently (sic) offered bedpan and reminded of using her call light for assistance. She is in bed and in no acute distress at this time. Will continue with plan of care. According to the [NAME] Scale (0-10), a pain level of 5 is indicative of moderate pain. Record review of R101's progress note dated 4/11/2026 revealed, Writer received report that resident experienced (sic) a fall overnight. The midnight nurse was unable to reach (sic) the oncall physician, and follow up was endorsed (sic) to the day nurse. Following the fall, the resident was placed in the activity room for close monitoring. The resident family arrived and transported the resident back to her room, stating the resident does not like being in the activity room. Writer informed the family that the placement was for safety and observation following the fall. A second family member later approached the nurse station, appearing (sic) upset and requesting information regarding the next steps in resident care. Writer explained that contact had been attempted with the in call physician, and that further actions would be determined once a response was received. The family then became increasingly agitated, expressing concern that someone should have been called earlier, and that the resident may have sustained a concussion. Writer reassured the family that the resident condition was (sic) being monitored and that appropriate steps were being taken to ensure her care. On call finally reached out to writer, examined resident and ordered to send resident out to r/o concussion and possibly get stitches. Writer informed family of the doctor orders, and the ETA time for pick up. Writer continued to provide (sic) care per care plan for pt until transportation showed up. On 7/9/2026 Licensed Practical Nurse (LPN) B was interviewed and said the on-call doctor did not respond to LPN A during the midnight shift. LPN B further said she (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 235177	Facility ID: 235177 If continuation sheet Page 1 of 2

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed R101 around 7 AM and paged Medical Doctor D and received a response around 11:00 AM when the provider ordered the resident to the hospital. LPN B stated, Usually the on-call physician responds in around 20 minutes. On 7/9/2026 LPN A was interviewed and said she assessed R101 after the fall on 4/11/2026 at around 1:00 AM. LPN A said she notified Medical Doctor D but did not get a response. LPN A stated, The doctor is supposed to respond in 20-30 minutes to give us instructions. The doctor did not respond by shift change so I gave my report to the oncoming nurse. On 7/9/2026 at 2:00 PM, Medical Doctor D was telephoned for an interview. There was no response by survey exit. Review of R101's Electronic Health Record revealed she was admitted to the facility on [DATE] and sent to the hospital on 4/11/2026 with diagnoses that included Encounter for surgical aftercare following surgery on the circulatory system, Repeated Falls, and Ataxic gait. Review of R101's physician orders revealed, Clopidogrel Bisulfate Tablet 75 mg (blood thinner), Aspirin Oral Tablet Chewable 81 mg (blood thinner). Review of R101's transfer order dated 4/11/2026 at 11:38 AM revealed, Transfer to Emergency department. Review of R101's care plan revealed, (R101) is at risk for abnormal bleeding/bruising R/T (related to) medication use. Antiplatelet, post-surgical. Date initiated 3/28/2026. Interventions observe and report to physician PRN s/sx (sign symptoms) of complications lethargy, bruising, sudden changes in mental status. Date initiated 3/28/2026. On 7/9/2026 at 2:15 PM, the Director of Nursing (DON) was interviewed and said the expectation is for the on-call doctor to respond to the nurse within 20 minutes. If the on-call doctor does not respond, then the nurse should call the medical director. The DON said that at the time of R101's fall the attending doctor, and medical director was Medical Doctor D. The DON further said since Medical Doctor D was both the attending and facility medical director for R101 there were no other medical doctors for the nurses to notify. Review of the facility's policy titled, Physician Services revised 3/12/2025 revealed in part. All residents shall be provided with emergency and/or alternative physician care. 6. Emergency physician care is available to all residents. A. if the resident's attending physician is not available when an emergency occurs, the covering physician on call must be contacted. B. the facility maintains a listing of physicians, alternate physicians, and their phone numbers. Each attending physician will provide the facility with this contact information for his or her coverage group.		