STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Nursing and Rehab	3011 N Center Rd Flint, MI 48506

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 This Citation pertains to Intake Number MI00146446. Based on interview and record review, the facility failed to ensure that a complete nursing assessment was done after a condition change (a fall at the facility on 7/2/24) for one resident (Resident #101) of 3 residents reviewed for assessing/monitoring after a change in condition (a decline in therapy due to increased pain), resulting in incomplete nursing and physician documentation, and delayed hospitalization with a CT (Computed Tomography). Findings Include: Resident #101: Review of the Face Sheet, Nurse Practitioner and Nursing and Physician note's dated 7/1/24 through 7/12/24, emergency room and Hospital notes dated 7/12/24 through 7/14/24, care plans dated 6/24, and MDS (nursing assessment tool) dated 7/24, revealed Resident #101 was [AGE] years-old, alert and able to make his own medical decisions, admitted (last admission) to the facility on [DATE], after a fall at home with several fractures and post surgical repair of spine. The resident was a fall risk and required assistance with transfers at the facility. The resident's diagnosis included, chronic stage 5 end stage kidney disease and on Hemodialysis, heart disease, stroke, diabetes, morbid obesity, high blood pressure, T-11 and T-12 fracture with routine healing, spinal fusion, major depression and anxiety. Review of the residents facility Pain Care Plan dated 6/27/24, stated report nonverbal expressions of pain such as moaning, striking out, grimacing, crying, thrashing, change in breathing, etc. Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective. Review of the facility Accident/Incident Report dated 7/2/24, revealed Resident #101 got up from his bed by himself and fell next to his bed. The facility documented no injuries at the time. Due to complaint's of pain in the hip area, the facility had an x-ray done on 7/3/24. Review of the facility's X-ray report dated 7/3/24, stated Multiple views of the left hip and pelvis show normal alignment without acute fractures or dislocations. Hospital Notes: (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital emergency room notes dated 7/12/24, stated Presented to the ED (emergency department) for evaluation after a fall 1 week ago, complain of left hip pain, left chest pain, the patient (Resident #101) is status post T9-L1 fusion, C6-7 fusion on June 3, 2024 (back spinal surgery); currently wearing TLSO (a abdominal hard brace), LT (left) hip x-ray, LT femur x-ray were negative for any acute abnormalities, CT cervical spine, lumbar spine without contrast, CT chest for any acute abnormalities, CT cervical spine (neck area), thoracic spine (chest area), lumbar spine without contrast, CT chest abdomen and pelvis with contrast ordered; reported comminuted, mildly displaced fracture of the left inferior and superior pubic rami. Nondisplaced left sacral fracture, small left pelvic abductor and adductor hematoma (bruise like), small bilateral pleural effusion with compressive atelectasis of lower lobe (lower lung). The resident had multiple fractures and pneumonia. Review of the facility nursing note's dated 7/2/24 through 7/12/24, revealed pain medication was given and stated, pain relieved with pain medication. No complete pain assessment (per facility policy) after the resident fell (change in condition) was documented. During a phone interview done on 8/26/24 at 10:15 a.m., Physician, MD D stated I talked to patient (Resident #101); the x-ray (done on 7/3/24) came back negative. I don't know if his previous falls at home fractured his pelvis; he had a knee and back brace on. The x-ray may not of been able to pick up the fractures in pelvis. X-ray can miss fractures. During an interview done on 8/26/24 at 11:51 a.m., Occupational Therapist/OT F stated He (Physician D) came in the gym because the (Family Member of Resident #101) wanted another x-ray done (after the x-ray done on 7/3/24). He wanted to know why she was asking for that. I told him of his increased pain. Review of the physician notes dated 7/4/24 through 712/24, revealed no documentation from Physician D regarding an increase of pain in left lip area and a change in condition, nor of what OT F had informed him of. During an interview done on 8/26/24 at 10:29 a.m., with Director of Rehab Services, OTA E stated His fall was on 7/2/24 at 4:45 a.m. A couple of days later we did an x-ray hip and pelvis (No acute fx or dislocation of left hip pelvis). Therapy informed me that (Family Member of Resident #101) would transfer him in his room; to bathroom to bed and to chair, she called for EMS for transport (Family Member called the ambulance herself for a transfer to the hospital due to increased pain). After he fell on [DATE], his pain assessment dated [DATE], said pain over last 5 days was 7 (using 0 to 10 pain scale). He had therapy on 7/2/24 (day he fell), bed mobility, transfer with mod assistance, bike for 15 minutes. His pain level for this PT secession was not documented. On 7/4/24, OT (Occupational Therapist F) saw him. (OT F's) response was that the pt (Resident #101) increased pain to lower left extremity, nursing aware, due to decline required increased assist with daily needs and Hoyer for transfer. Attempt from sit to stand with complaints of significant pain with nursing and IDT (Interdisciplinary Team) aware, OT with decision to seize standing until IDT can further assess Hoyer (mechanical lift) to be used for transfers. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 8/26/24 at 11:51 a.m., Occupational Therapist/OT F On 7/4 (7/4/24), I said (to Resident #101), lets get up for therapy, when he went to sit up he acted like he was having increased difficulty, he was having increased pain, moderate to max pain; then I put his brace on and once we sat him up the brace pain did not subside. It usually does. I laid him back down and I told the nurse (unable to recall nurse and did not document incident) his pain seems to be worse. I then went and got a PTA (Physical Therapy Assistant) and asked her if she thought he was different (I don't see him regularly). She and I stood him up and at that point he couldn't bear weight because of his legs and his pain; he was complaining of pain. They (the facility transport man) wanted to know how to transfer him to dialysis. Then I put Hoyer for transfer. If we say a max of 2, it means a Hoyer for staff. On 7/4/24, he was made a Hoyer by OT due to decline in therapy. Review of the facility resident's nursing notes dated 7/4/24, had no complete nursing pain assessment per the facility Pain policy. Also there was no documentation of OT F informing nursing of increased pain and decline in ability to participate in therapy secession. Review of the facility nursing Pain Interview assessment dated [DATE] (the day of the fall), revealed the last page (verbal descriptor scale, indicators of pain and frequency of indicator of pain) was not filled out. It was documented on the pain assessment that the resident did have pain in the last 5 days, on occasion and it interfered with day-to-day activities. Review of the facility Pain Level Summary dated 6/27/24 through 7/12/24, revealed from 7/2/24 (day of fall) through 7/12/24, the resident had x 8 #5's, x 5 #6's, x 5 #7's, and x 1 #8 pain levels documented (using a 0 to 10 pain scale). Review of the facility electronic medication administration sheets dated July, 2024, revealed the resident received Gabapentin 300 mg daily (for pain), no documentation of indicators for pain (crying, gasping, moaning), facial expressions, body movements/postures or frequency of pain. Review of the facility Pain Assessment policy dated 1/24, stated Pain management is a multidisciplinary care process that includes: Assessing the potential for pain, addressing the underlying causes of the pain, developing and implementing approaches to pain management, conduct a comprehensive pain assessment whenever there is a significant change in condition, and when there is onset of new or worsening of existing pain. Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain. During the comprehensive pain assessment gather the following information: Intensity, descriptors, pattern, location and radiation, frequency, timing and duration, impact and factors that exacerbate the pain.