STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235245	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brittany Manor	3615 E Ashman St Midland, MI 48642

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 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39056

Based on interview and record review, the facility failed to promptly identify a change in condition and act upon those changes for 1 resident (R4) out of 4 residents reviewed for quality of care, resulting in R4 experiencing unnecessary pain, a delay in evaluation and surgical intervention for a femur fracture.

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: difficulty in walking, muscle wasting and atrophy, need for assistance with personal care, weakness, history of falls prior to admission, and dementia.

Review of R4's Brief Interview for Mental Status (BIMS) dated 11/26/24 revealed a score of 11, out of a total possible score of 15, indicating R4 was moderately cognitively impaired. (Last assessment obtained prior to his fall on 1/12/25.). R4's BIMS dated 1/17/25 revealed a score of 15, indicating R4 was cognitively intact.

During an interview on 01/23/2025 at 11:15 AM, R4 reported that on 1/12/25 he slipped and fell in the bathroom which resulted in him experiencing pain in his right hip. R4 reported he was assisted back to bed following the fall but experienced significant pain with movement stating he was too painful to move. R4 reported that he couldn't get out of bed and remained in his bed until his transfer to the hospital on 1/14/25. R4 reported that he wanted to go (to the hospital) sooner and was unsure of the cause of the delay in transfer.

During an interview on 01/23/2025 at 12:05 PM , Family Member/Emergency Contact (FMEC) C reported that R4 sustained a fall on Sunday 1/12/25 and his wife went to the facility to assess his condition. FMEC C reported that at that time he was in bed and was reporting pain. FMEC C stated that R4 just stayed in bed because he couldn't do anything else and reported as long as he was not moved and remained in bed his pain was manageable. FMEC C reported that it wasn't until Tuesday (1/14/25) that they determined he needed to be evaluated in the emergency department to identify the root cause of his pain/change in condition. FMEC C reported he met R4 at the hospital where he was in shock to find out the extent of R4's injuries and the number of fractures sustained from the fall as well as the need for immediate surgical intervention and was concerned with the delay in his transfer to the hospital with the significant injuries.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Brittany Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3615 E Ashman St Midland, MI 48642	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R4's Incident Report dated 1/12/25 revealed, This was at the beginning of shift he was in bed watching tv. I passed his meds and he took them with no issues. Moments later he put his call light on and before we was able to answer it I heard him at his doorway and when I turned around and noticed him standing with urinal in hand he lost his balance and landed on his right side, no head injuries or any other injuries noted during shift. He was really confused and stated that he was going to bathroom .Notes: 1/13/2025 Resident seems really confused UA (urinalysis) collected to rule out possible UTI (urinary tract infection). 1/13/2025 (no time documented) F/u (follow up) to resident fall on 1/12/25. Therapy attempted to screen this day post fall and resident refused due to new onset of pain .Noted resident is not bearing weight on the right leg. Increased ADL assistance provided. PA (physician assistant) notified and new order obtained for Xray of rt (right) femur/hip for dx (diagnosis): hip pain. Resident has 0/10 pain at rest, non- pharmalogical (sic) pain interventions in place. (Company name omitted) notified of new orders for Xray and will be completed within 24 hours . Confirming the facility was aware that the resident was experiencing pain with movement and had a change of condition of (inability to bear weight on right leg and altered mental status). The resident was not sent to the emergency department despite the change of condition both physically and cognitively and the knowledge that an xray could not be immediately obtained. Review of R4's Post Fall Evaluation dated 1/12/25 revealed, Confused a&o x 1-2 (alert and oriented to person, place, time, situation is x4) .unknown baseline but was told by other staff members that he's normally not that confused (indicating a change in R4's mental status) .he lost his balance and landing sitting up at the right side. He didn't hit his head and denied any pain or discomfort .monitoring throughout shift . Review of R4's Resident At Risk dated 1/13/25 revealed, .Action Taken: Assessed head to toe, rom (range of motion), v/s (vital signs), more confusion ua completed. There was no documentation revealing the outcome of the range of motion assessment despite documentation that R4 was no longer able to bear weight on his right leg and had pain with movement. Review of R4's Order Details dated 1/13/25 at 5:39 PM revealed, X-Ray for right femur/hip DX: Hip Pain. Review of R4's Electronic Medical Record revealed no documentation that the x-ray could not be completed or that the physician was notified of the delay in treatment. Review of R4's Occupational Therapy Missed Visit Details dated 1/13/25 revealed, Pt (patient) unable to be seen today due to having a fall this morning and having right hip pain. Pt unable to stand following fall and 2PA (2 person assist). Nursing addressing . Review of R4's Interdisciplinary Team note dated 1/13/25 revealed, Fall 1/12/25 @ 7:15pm .Resident currently on PT/OT case (physical therapy/occupational therapy) load and when OT approached for treatment that day, he stated he could not participate r/t (related to) too much pain in his right LE (lower extremity/leg), nursing notified of change. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Brittany Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 3615 E Ashman St Midland, MI 48642	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R4's Occupational Therapy Treatment Encounter Note dated 1/14/25 revealed, .nursing stated that awaiting xray to come in for stat (immediate) order . Review of R4's Provider Progress Note dated 1/14/25 . Patient had a fall yesterday morning landing on his right hip. He has been unable to weight bear since the fall. Xray was ordered yesterday but has not been done yet. Pain is getting worse as he is requiring being turned q 2 hours for (sic) prevent pressure areas. Discussed with nursing for patient to be sent out for xray and evaluation as if xray is negative, then why can he not weight bear. Nursing will notify Primary care . Extremities .Positive pain noted of the right hip/thigh with any movement . Currently unable to bear weight on right LE . Confirming a delay in obtaining the xray. Review of R4's Pain Summary revealed pain scores of 0/10 indicating no pain. Important to note R4 stated he did not experience pain at rest, only with movement. Review of R4's Electronic Medical Record revealed no comprehensive physical assessments or comprehensive pain assessments following the fall assessment to identify the quality of pain (sharp, dull, achy), aggravating factors (movement), the physical appearance of the injured leg, his cognitive status (had the confusion resolved or continued), or the results of his urinalysis. Review of R4's Tasks for lying to sitting, sitting to standing, and toileting from the time of the fall on 1/12/25-1/14/25 revealed R4 was no longer performing these tasks as he had before and either required a significant change in assistance or did not perform the task. Review of R4's Nurses Note dated 1/14/2025 at 09:02 AM revealed, Resident is c/o pain to left and right hip. Resident has had recent fall and fell on right hip. EMS notified to transfer resident to (name omitted) hospital for evaluation. Son notified of transfer. Review of R4's Nurses Note dated 1/14/2025 at 9:16 AM revealed the ambulance arrived to transport R4 to the emergency department at that time. Approximately 38 hours from the time of the fall. Review of R4's Emergency Department Progress Note dated 1/14/2025 1:26 PM revealed, . presents to the (name omitted) emergency department via EMS (emergency medical services/ambulance) for evaluation following a fall which occurred 2 days prior to arrival . The patient is a resident at [NAME] Manor and reports he had a mechanical fall in the bathroom on the evening of 1/12 .He was helped back to bed and was not ambulatory from that time. He had right hip tenderness which was aggravated by any kind of movement . Imaging studies revealed a right intertrochanteric femur fracture, right inferior pubic ramus fracture, possible sacral insufficiency fracture, and small right retroperitoneal hematoma .Right lower extremity shortened and externally rotated (physical deformity in his right leg) . Review of R4's hospital Tertiary Trauma Survey (trauma provider consultation) dated 1/15/2025 revealed, . Extremities: Neurovascular intact bilaterally, 2+ pulses bilateral radial bilateral DP pulses, external rotation of the right lower extremity that is slightly shortened. Pain over the right hip on palpation. Plan: Right intertrochanteric femur fracture Right inferior pubic ramus fracture (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Possible acute sacral insufficiency fracture Right retroperitoneal hematoma -Hemoglobin 7.6 from 7.9 from 8.2 Acute blood loss anemia -Likely related to #1 and #2 . Confirming a physical change in R4's right leg from the injury identified by a second provider. During an interview via email on 1/23/2025 at 3:37 PM, Director of Nursing (DON) was asked for documentation of additional monitoring/assessments regarding R4's injury and/or mental status change based on the note monitoring throughout shift on the Post Fall Evaluation dated 1/12/25. DON replied There was a provider who saw him on 1/14 and then he was sent out d/t the pain. There were interventions that she did nonpharmalogically r/t the pain that day- relaxation, positioning and rest- noted on 1/13. Confirming additional monitoring/assessments had not been completed. DON was asked to provide documentation as to why the x-ray was not completed and/or physician notified it could not be completed on 1/13/25. DON stated, The xray was ordered but he went out the hospital and it was done there. There was no documentation provided for the rationale of the delay of the xray or physician notification. During an interview via email on 1/23/2025 at 7:00 PM, DON stated, per our conversation we discussed nurses making a fall progress note every shift for three days, however per our policy there is just to be an assessment done for 72 hrs and doesn't indicate the frequency. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Assessing the characteristics of pain allows you to understand the type of pain, its pattern, and the types of interventions that bring relief .Quality: People use a variety of words to describe the quality of their pain (e.g., pain, ache). Ask patients to describe their discomfort using their own words whenever possible; then use these words consistently to obtain an accurate report. For example, say, Tell me what your discomfort feels like. What do you call it? The patient may describe the pain as aching, crushing, throbbing, sharp, or dull. If the patient reports the pain as dull, ask if it is still dull or if it has changed when you return to assess the patient's pain . Aggravating and precipitating factors: Various factors or conditions bring on or make pain worse. Ask a patient to describe activities that cause or aggravate pain, such as physical movement, positions, drinking coffee or alcohol, urination, swallowing, eating food, or psychological stress. Also ask them to demonstrate actions that cause a painful response, such as coughing or turning a certain way .Behavioral effects: When a patient has pain, assess verbalization, vocal response, facial and body movements, and social interaction. A verbal report of pain is a vital part of assessment. You need to be willing to listen and understand. When a patient is unable to communicate pain, it is especially important for you to be alert for behaviors that indicate it (Box 44.9). [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1141-1143). Elsevier Health Sciences. Kindle Edition.

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F 0689 Level of Harm - 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 # MI00149549 Based on observation, interview, and record review, the facility failed to ensure a resident was transferred following care planned interventions and standards of practice for 1 resident (Resident #1) out of 4 residents reviewed for accidents and safety, resulting in R1 sustaining a preventable fall with facial bruising and lacerations requiring hospital treatment. Findings: 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: difficulty in walking, muscle wasting and atrophy, and need for assistance with personal care. Review of R1's Brief Interview for Mental Status (BIMS) dated 12/17/24 revealed a score of 12, out of a total possible score of 15, indicating R1 was moderately cognitively impaired. R1 had a fall at the facility on 11/7/24 and 12/30/24 confirming she was a high risk for falls. During an observation on 01/22/2025 at 11:48 AM, R1 was sitting up in a wheelchair in her room and was noted to have yellow/blue/gray bruising around her right eye spreading down to her cheekbone. Review of R1's Physical Therapy Discharge Summary dated 12/20/24 revealed, .Discharge Recommendations: 1 PA (physical assist) for all functional mobility, RW (rolling walker) use while ambulating with staff . Review of R1's Care Plan last revised 12/19/24 revealed, AMBULATION/WALKING: Resident is limited assist x1 with rolling walker . Review of R1's Care Plan last revised 1/14/25 revealed, AMBULATION/WALKING: Resident is limited assist x1 with rolling walker. Walk to and from the bathroom with gait belt and rolling walker . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 01/23/2025 at 9:47 AM, Family Member/Guardian (FMG) A reported that R1 had fallen on 1/13/25 in the early morning. FMG A reported that she met with R1 the day of the fall and R1 reported to her that her bed was broken and moved when they were attempting to transfer her back to bed. FMG A reported that a facility nurse called her to notify her of R1's fall and reported that R1 was leaning towards the right during a transfer and the Certified Nursing Assistant (CNA) lost control resulting in R1 falling and smashed her face on the frame of the bed. FMG A reported that R1 was to be transferred with her walker and a gait belt to be safe and the CNA did not follow her care planned interventions for transfer. FMG A reported she discussed her concerns with R1's bed not locking to a facility nurse and the nurse reported to her that when R1's style of bed was in the lowest position the wheels would not lock which was also confirmed by maintenance staff. FMG A reported the CNA lacked the education/understanding of the mechanics of R1's bed and should have ensured the bed was in a locked position prior to transferring R1. The facility nurse reported to FMG A that R1's fall was preventable, and the CNA should have ensured the bed was locked, a gait belt in place, and her walker utilized during R1's transfer back to bed. Review of R1's Interdisciplinary Note dated 1/13/25 revealed, 1/13/25 @ 2am Resident was being assisted back from the bathroom by CNA and was transferring back into bed when she began leaning and CNA lost control of the transfer and resident fell , hitting her head on the bed frame. Laceration to right side of face, sent to ER (emergency room) for evaluation and returned w/ (with) tests negative .Staff educated to use gait belt and utilize RW (rolling walker) for transfers and ambulation in room. Review of R1's Hospital Record dated 1/13/25 revealed, .The patient is a [AGE] year-old female presents to the ED with fall and skin tear below her right eye .The wound is too close to the eyelid and the skin is too thin for primary closure with sutures or Dermabond. A nonadherent dressing was placed . Review of R1's Post Fall Evaluation dated 1/13/25 revealed, Fall Description Details .Getting back into bed after using the bathroom .w/c (wheelchair) next to bed. CNA assisted resident to standing position-lost balance (and) resident fell .gait belt not in use. Describe initial intervention to prevent future falls: Gait belt to be used during transfers (and) walker-CNA educated . During an interview on 1/23/25 at 9:26 AM, Director of Nursing (DON) confirmed that CNA B did not use a gait belt while transferring R1 which resulted in a fall with a facial laceration. DON reported that due to R1's improper transfer a meeting was scheduled for CNAs for gait belt/transfer education. During an interview via email on 01/23/2025 at 3:37 PM, DON reported that prior to R1's fall, the use of a gait belt was not on R1's care plan because it is a standard of practice. DON stated that due to the statement that the bed moved during the transfer we wanted to cover all bases and just replace the bed. Review of a Disciplinary Action Record for CNA B dated 1/16/25 revealed, Date of Infarction: 1-13-25 .Care plan not being followed. Resident was transferred without a gait belt .(CNA B) stated she helped the resident (R1) off the toilet (and) didn't use gait belt. She stated the bed moved (and) that's why/how the resident moved (and) hit her head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Several methods are used to help a patient ambulate. For those who can bear weight easily provide support at the waist with a gait belt so that the patient's center of gravity remains midline. The belt helps you to stabilize patients if they lose their balance. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 796). Elsevier Health Sciences. Kindle Edition.