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	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brittany Manor	3615 East Ashman Street 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2656241 and #2658212.Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a staff person, for two of three residents (Resident #100 and Resident #101) reviewed for abuse, resulting in the need for emergency medical attention and admission to the hospital for R100. Findings: Resident #100 (R100)Review of an admission Record revealed R100 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnosis of dementia. Review of R100's Plan of Care reflected that R100 was independent with walking, bed mobility, feeding herself with set-up assistance, and transferring between surfaces. During an interview on 11/06/25 at 9:37 AM, R100 stated that in the past, staff shoved her and that it made her mad. Review of an admission Record revealed R101 was a [AGE] year-old male, admitted to the facility on [DATE] with pertinent diagnoses of dementia. Review of video and audio footage, provided by the Administrator, showed the following events that occurred on 10/20/25 at 2:50 AM:-R100 and R101 walked in the hallway, appeared calm, and spoke to no one. -Certified Nurse Aide (CNA) A sat in the hallway and the view of CNA A was partially obstructed by equipment. No other staff were visible on the video footage. -R100 entered a room (room [ROOM NUMBER]) that did not belong to her. CNA A called out for R100, got up from the chair, and entered room [ROOM NUMBER].-CNA A came back into the hallway, alone after a few seconds and yelled God in a frustrated voice. CNA A put on her shoes and went back toward room [ROOM NUMBER].-As CNA A entered room [ROOM NUMBER], R101 walked into the doorway behind CNA A. CNA A turned partially around and faced R101, extended the right arm and shoved R101, on the shoulder, and caused R101 to stumble backwards in the hallway. -CNA A entered room [ROOM NUMBER]. Nothing was heard while CNA A and R100 were in the room together, i.e. no yelling, no instruction by CNA A for R100 to leave the room, no sounds of a physical scuffle, and no calls for help by CNA A.-R100 stepped into the doorway, with her back to the hall, and was propelled across the hallway, hitting the back of her head on the wall across from room [ROOM NUMBER]. A thud was heard on the video/audio recording as R100 hit the wall. CNA A stood in the doorway of room [ROOM NUMBER].-R100 was sent to the emergency room and treated for an open and bleeding cut to the back of her head that required sutures and for a large hematoma (bruise) to her buttock. The 4 cm (centimeter) hematoma to R100's right buttock showed underlying bleeding and R100 was admitted to the hospital for two days to monitoring for bleeding. During an interview on 11/06/25 at 10:07 AM, the Administrator stated that CNA A was fired for her failure to follow the facilities abuse policy and procedure and for the inappropriate physical contact with R100 that caused injury and for shoving R101. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the re-education of staff regarding recognizing staff burn-out, behavior management, and the abuse policy and procedure. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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