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	03/27/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to proved dignified care and services for two facility residents (R10 and R34). Findings: Resident #10 (R10) Review of an Admission Record revealed R10 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: tracheostomy, diabetes mellitus with diabetic neuropathy, kidney disease, and heart disease. Review of a Minimum Data Set (MDS) assessment for R10, with a reference date of 2/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated R10 was moderately cognitively impaired. Review of R10's Care Plan revealed R10 required the use of a mechanical lift and the assistance of 2 staff members to transfer from his bed to his wheelchair. During an observation and interview on 03/26/25 at 08:48 AM, R10 pressed his call light and reported that he was ready to get up and into his wheelchair for the day. R10 reported that it frequently took greater than 30 minutes to have his call light answered and wait times were worse on 3rd shift. The following observations were made while in the hallway outside of R10's room: At 08:52 AM a Certified Nurse Aide (CNA) M entered R10's room, turned off his call light, and reported she had to assist another resident and stated, I'll come back. From 08:53 AM-09:14 AM R10's call light was inactive, and no staff entered his room. At 09:14 AM R10 initiated his call light. At 09:16 AM a housekeeping staff member entered his room to identify his needs. The housekeeping staff member exited his room and notified CNA M that R10 required assistance. The call light remained active. (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 03/27/2025
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 09:19 AM CNA M entered R10's room, turned off his call light, and left the room to assist a resident in a different room. At 09:21 AM CNA M entered R10's room, stated she had to go get a sling (for the mechanical lift) and I'll be back. R10's call light remained inactive. At 09:24 AM CNA M brought a mechanical lift sling to R10's room and exited his room. R10's call light remained inactive. At 09:26 AM this surveyor entered R10's room and observed R10 visibly upset (shaking his head and scowling). R10 reported staff would frequently shut his call light off and exit his room which caused feelings of frustration. At 09:31 AM R10 initiated his call light. At 09:32 AM a CNA entered R10's room and assisted R10 (44 minutes from the initial call light activation). During an interview on 03/27/25 at 12:00 PM, Nursing Home Administrator (NHA) reported the expectation is that a staff member will leave the call light on until the residents' needs are met. Review of the facility policy Call Lights last revised 3/12/25 revealed, Policy-Call lights will be placed within the resident's reach and answered in a timely manner .Responding to a Call Light .3. Go to the location of the call light, and turn off the light if you are able to meet the resident request . 31771 R34 Review of the Electronic Medical Record (EMR) Admission Record reflected R34 originally admitted to the facility 2/25/25 and has current pertinent diagnoses of Feeding Difficulties and Need for Assistance with Personal Care. The Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the Resident was mildly cognitively impaired. Section GG (titled Functional Abilities and Goals) of this MDS revealed R34 required Substantial /maximal assistance with eating and that a Helper does more than half the effort. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 11:53 AM lunch service was observed to be progress in the North Hall Dining Room. Initially present were three residents at one table, two residents at another, and two residents sitting at tables by themselves. All residents except one resident, (R34) sitting by herself, were eating. R34 reported she has not received her meal yet. At 12:00 PM a female resident was pushed by a staff member to sit at the table with R34. This new resident was immediately provided a meal tray that was set up by the staff. A male resident in a power wheelchair then arrived at a nearby table and was immediately provided a meal. At 12:04 PM a staff member provided coffee and an orange-colored drink to the resident sitting at the table with R34. R34 did not have any beverages. At 12:06 PM a staff member asked R34 if she was done eating and ready to return to her room. R34 reported she had not received her meal yet and the staff member told her she would let someone know. At 12:08 PM a staff member brought a covered tray and set it before R34 telling her she would be back with a clothing protector. While the staff member was away R34 reported she finally got her meal. R34 reported her meal was still covered because she requires assistance with eating. R34 reported the food usually isn't hot enough. R34 reported she has asked staff to reheat her food and stated, they won't do it. When asked if staff have actually told her that before R34 nodded her head yes. At 12:15 PM the staff member returned with a clothing protector and began assisting R34 with her meal. At 12:18 PM the staff member left R34 to assist other residents who had finished their meals and were wanting to leave the Dining Room. At 12:20 PM the staff member returned to the table with R34 and resumed assisting her with her meal. On 3/26/25 at 12:20 PM, R34 was sitting at a table by herself in the North Hall Dining Room. It was observed that R34 had a device attached to her right hand that held a fork allowing her to feed herself. R34 reported that the food was cold again and she had asked for tomato soup. R34 reported that after her lunch the previous day she was not taken back to her room for an hour and that it hurt her bottom on which there was a sore. During an interview conducted 3/27/25 at 8:01 AM the North Unit Manager (UM) K reported that the nurses are responsible for making sure the meal trays are dispensed to the residents. UM K reported the Dining Room is served first then the residents who take their meals in their rooms. UM K was informed of the observation of delayed meal service for R34 on 3/25/25 and that the Resident reported the food was usually cold. UM K was also informed that R34 reported an extended wait to return to her room after the meal and that this prolonged wait caused the Resident discomfort. UM K did not offer any comments or additional information.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) accurately document administration of controlled substances and 2.) ensure narcotic medications were administered following the physician order for 4 residents (Residents #23, #74, #84, and #10), reviewed for controlled substances, resulting in medication errors. Findings: Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: generalized anxiety disorder. Review of R23's Order Summary dated 3/5/25 revealed, diazePAM (Valium) Oral Solution 5 MG/5ML .Give 4 ml via PEG-Tube two times a day for ANTIANXIETY AGENTS. To be administered at 8:00 AM and 9:00 PM. Review of R23's Controlled Substance Proof of Use form revealed 1 dose of diazepam was administered on 3/7/25 at 9:45 AM. R23's 9:00 PM dose of diazepam was not documented as dispensed. Review of R23's March Medication Administration Record revealed both doses of R23's diazepam was documented as administered on 3/7/25. Review of R23's Electronic Medical Record revealed no documentation for the withholding of R23's even dose of diazepam on 3/7/25. Resident #74 (R74) Review of an Admission Record revealed R74 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety disorder. Review of R74's Order Summary dated 3/4/25 revealed, Ativan Oral Tablet 0.5 MG (Lorazepam) *Controlled Drug* Give 0.5 tablet by mouth every 6 hours as needed for Anxiety for 14 Days. Review of R74's Controlled Substance Proof of Use form revealed: *On 3/5/25 at 8:00 PM a dose of Ativan was dispensed. *On 3/7/25 at 9:00 PM a dose of Ativan was dispensed. *On 3/16/25 at 8:00 PM a dose of Ativan was dispensed. Review of R74's March Medication Administration Record revealed no documentation that R74's Ativan was administered on 3/5/25, 3/7/25, or 3/16/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #84 (R84) Review of an Admission Record revealed R84 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety disorder. Review of R84's Order Summary dated 3/11/25 revealed, LORazepam (Ativan) Tablet 0.5 MG *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for Anxiety until 03/19/2025 23:59 (11:59 PM). Review of R84's Controlled Substance Proof of Use form revealed: *On 3/16/25 at 9:00 PM a dose of Ativan was dispensed. *On 3/20/25 at 3:00 AM a dose of Ativan was dispensed. *On 3/20/25 at 8:00 PM a dose of Ativan was dispensed. Review of R84's March Medication Administration Record revealed no documentation that R84's Ativan was administered on 3/16/25, or on 3/20/25 at 3:00 AM and 8:00 PM. Review of R84's Electronic Medical Record revealed no documentation of an order for Ativan dated 3/20/25. Resident #10 (R10) Review of an Admission Record revealed R10 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetic neuropathy. Review of R10's Order Summary dated 1/24/24 revealed, Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug* Give 1 tablet by mouth two times a day for pain. To be administered at 8:00 AM and 8:00 PM. Review of R10's Controlled Substance Proof of Use form revealed 1 dose of Norco was dispensed on 3/8/25 at 8:39 AM. Review of R10's March Medication Administration Record revealed both the 8:00 AM and 8:00 PM doses of Norco were administered. During an interview on 3/27/25 at 1:20 PM, Director of Nursing (DON) confirmed the above medication errors/discrepancies and reported medication error reports were generated and 1:1 education as provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The National Coordinating Council for Medication Error Reporting and Prevention (2021) defines a medication error as any preventable event that may cause inappropriate medication use or jeopardize patient safety. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/or failing to administer a medication. Preventing medication errors is essential. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 639). Elsevier Health Sciences. Kindle Edition.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on observation, interview, and record review, the facility failed to ensure food and beverages were enjoyable for three facility Residents (R34, R59, and R41) out of 19 residents reviewed. Findings: R34 Review of the Electronic Medical Record (EMR) Admission Record reflected R34 originally admitted to the facility 2/25/25 and has current pertinent diagnoses of Feeding Difficulties and Need for Assistance with Personal Care. The Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the Resident was mildly cognitively impair. Section GG (titled Functional Abilities and Goals) of this MDS revealed R34 required Substantial /maximal assistance with eating and that a Helper does more than half the effort. On 3/25/25 at 11:53 AM lunch service was observed to be in progress in the North Hall Dining Room. Initially present were three residents at one table, two residents at another, and two residents sitting at tables by themselves. All residents except one resident, (R34) sitting by herself, were eating. R34 reported she has not received her meal yet. At 12:00 PM a female resident was pushed by a staff member to sit at the table with R34. This new resident was immediately provided a meal tray that was set up by the staff. A male resident in a power wheelchair then arrived at a nearby table and was immediately provided a meal. At 12:04 PM a staff member provided coffee and an orange-colored drink to the resident sitting at the table with R34. R34 did not have any beverages. At 12:06 PM a staff member asked R34 if she was done eating and ready to return to her room. R34 reported she had not received her meal yet and the staff member told her she would let someone know. At 12:08 a staff member brought a covered tray and set it before R34 telling her she would be back with a clothing protector. While the staff member was away R34 reported she finally got her meal. R34 reported her meal was still covered because she requires assistance with eating. R34 reported the food usually isn't hot enough. R34 reported she has asked staff to reheat her food and stated, they won't do it. When asked if staff have actually told her that before R34 nodded her head yes. At 12:15 PM the staff member returned with a clothing protector and began assisting R34 with her meal. At 12:18 PM the staff member left R34 to assist other residents who had finished their meals and were wanting to leave the Dining Room. At 12:20 PM the staff member returned to the table with R34 and resumed assisting her with her meal. On 3/26/25 at 12:20 PM R34 was sitting at a table by herself in the North Hall Dining Room. It was observed that R34 had a device attached to her right hand that held a fork allowing her to feed herself. R34 reported that the food was cold again and she had asked for tomato soup. R59 Review of the medical record reflected R59 admitted to the facility 2/26/25 with pertinent diagnoses that included Protein Calorie Malnutrition and Muscle Wasting Atrophy. The MDS dated [DATE] reflected a BIMS score of 12 out of 15 which indicated the Resident was mildly cognitively impaired. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 3:13 PM an interview was conducted with R59 in her room. R59 reported she eats her meals in the North Dining Room about half of the time and the rest in her room. R59 reported the food is always cold. R59 reported the coffee is cool. R59 stated It's not their (staff's) fault R59 indicated the staff are busy and I don't know how you would keep food warm on a tray all the way to the room. On 3/26/25 at 12:17 PM in the room of R59 the R59 reported that the temperature of her lunch was better today but indicated it was still not warm enough. R59 again reported, it's not their fault. During an interview conducted 3/27/25 at 8:01 AM the North Unit Manager (UM) K reported that the nurses are responsible for making sure the meal trays are dispensed to the residents. UM K reported the Dining Room is served first then the residents who take their meals in their rooms. UM K was informed of the observation of delayed meal service for R34 on 3/25/25 and that the Resident reported the food was usually cold. UM K was informed of the two interviews with R59 that the food was cold and that the Resident had stated that it was not the fault of the staff. UM K stated that R59 is very forgiving. UM K did not offer any additional comments or information 29073 Resident #41 (R41) Review of an Admission Record reflected R41 originally admitted to the facility on [DATE] with diagnoses that included paraplegia, depression, anxiety and moderate to severe protein-calorie malnutrition. R41 was their own responsible party. During an interview on 3/25/2025 at 2:05 PM, R41 reported that they were bored with the food, the meals are not very hot and the coffee that is served at the facility is very cold. R41 said they resort to a [delivery service] to bring hot coffee, and despite the delivery distance, the coffee is still hotter than the coffee served at the facility. During an observation of the lunch service on 3/26/2025 at 12:16 PM, an insulated cart containing meal trays was delivered to the unit where R41 lived. R41's tray was the last tray to be delivered and was intercepted at 12:31 PM (15 minutes after the insulated cart was delivered to the unit) by the surveyor to test for palatability and temperature. Staff were instructed to obtain a new meal for R41 at this time. During an observation on 3/26/25 at 12:18 PM, Dietary Manager (DM) C confirmed the temperature of the coffee in the covered mug on R41's meal tray was 109 degrees Fahrenheit. The turkey served with the meal was 126 degrees Fahrenheit, green beans were 133 degrees Fahrenheit, and stuffing was 144 degrees Fahrenheit. DM C said when the food was plated in the kitchen, and the appropriate holding temperatures were maintained. DM C reported that the coffee was poured an hour prior to the temperature observation and the temperature loss is when the food leaves the kitchen and goes onto the unit, Certified Nurse Aides (CNA's) can't deliver the trays right away. DM C said that staff often have to remind to keep the insulated cart doors closed during delivery of meal trays to help maintain palatable temperatures. (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 3/26/25 at 1:31 PM, R41 reported a notable an improvement in the taste and temperature of the meal and coffee because the staff had to get a fresh tray after the surveyor used the meal originally intended for them to test temperatures. R41 said they enjoyed the meal very much and ate every last bite.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review the facility failed to maintain a complete and accurate medical record for 5 residents (R2, R69, R73, R76 & R88) out of 19 residents reviewed. Findings: Resident #88 (R88) Review of a closed clinical record for a Death investigation during the annual recertification survey revealed R88 originally admitted to the facility on [DATE] with a cognitive communication deficit, aphasia (inability to speak), a history of aspiration (inhalation of particulate into the lungs), and received nutrition through a feeding tube. Review of a Nurses Note dated 1/28/2025 at 2:20 AM reflected (R88) passed away at 1:51 AM 1/28/2025. Daughter (name), PA (physician assistant), DON (Director of Nursing), & Funeral home notified per daughter's request. Progress notes leading up to R88's death were reviewed and revealed the following: Review of a Change in Condition note dated 1/22/2025 at 10:10 AM revealed (R88) moaning on and off all night, per CNA (Certified Nurse Aide). (R88) moaning a few times today with grimacing on her face. A CBC (complete blood count), CMP (comprehensive metabolic panel) and an abdominal x-ray were ordered at this time. Review of a Nurses Note dated 1/23/2025 at 8:55 AM, indicated R88 was sent to the Emergency Department for a CT (computerized tomography) scan to rule out ileus (inability of the intestine to contract normally to remove waste out of the body)/possible obstruction (bowel obstruction). R88 returned to the facility on [DATE] at 5:00 PM with a diagnosed Urinary Tract Infection (UTI) and an order to administer an antibiotic. Review of a Nurses Note dated 1/25/2025 at 10:31 AM reflected R88 was moaning during a transfer. Vital signs indicated R88's respirations (breaths per minute) was 24, heart rate was 150 beats per minute and oxygen saturation (SaO2) was 79% (on room air, normal SaO2 is between 95-100%). The nurse administered supplemental oxygen and after speaking to R88's daughter, obtained an order for oral Roxanol (a highly concentrated solution of the narcotic analgesic morphine sulfate). The note indicated R88's vital signs returned to normal with the supplemental oxygen in place at 2 liters (2L). Review of a Nurses Note dated 1/26/2025 at 12:30 PM, R88's daughter came to visit and provided information regarding funeral home. Review of a Dietary Note dated 1/27/2025 at 12:14 PM reflected R88's daughter was informed .prior formula now available. Order placed this date for 2Cal HN (a high-calorie, high-protein nutritional supplement designed for individuals who require increased caloric and protein intake.) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Nurses Note dated 1/27/2025 at 5:50 PM (8 hours before R88 passed away) reflected R88's daughter was given an update on R88's status which was stable. The note indicated (R88's) son in law came to visit (R88) and stated he thought she looked better then (sic) she did over the weekend. Review of a Nurses Note dated 1/27/2025 at 10:54 PM reflected (R88) currently grimacing/moaning. PRN (as needed) morphine administered, she also has a low grade fever of 99.1. Patient has some pulmonary edema at auscultation of the lungs, PA notified and directed order for a CXR (chest x-ray) stat (right away). Patient was repositioned HOB (head of bed) @ (at) 45 degrees, cool towel applied on forehead for LGF (low grade fever). Supplemental O2 (oxygen) @ 2L, Patient stat (sic) @ 90%. Will continue to monitor for any acute change of condition. The note does not indicate R88's daughter was notified of the change in condition and new order for a chest x-ray. During an interview on 3/26/2025 at 4:26 PM, Licensed Practical Nurse (LPN) L reported she was the nurse on duty at the time R88 passed away and had spoken to R88's daughter during the shift, before R88 passed away. LPN L said that R88's death was not entirely unexpected, but no one expected her to pass away that night, it was a shock on 1/28/2025. LPN L said that she was very concerned about R88's lung sounds which sounded nasty with a lot of fluid. LPN L said she notified the physician and got an order for a chest x-ray and indicated she and CNA's were checking on R88 at least every 30-45 minutes, vital signs were measured with every check. LPN L said she did not ask for R88 to be sent to the hospital because R88's daughter did not want R88 to go back to the hospital after having just been there a few days prior. LPN L said she thought she documented a full physical assessment or change in condition on 1/28/2025. LPN L said she would have written vital signs down on a piece of paper, but did not know where they would be in the electronic health record if she didn't add them. Review of O2 Sats Summary & Blood Pressure Summary reflected the last oxygen saturation & blood pressure was recorded on 1/27/25 at 7:09 AM. A Temperature Summary indicated the last temperature taken was on 1/27/25 at 9:23 PM. Review of the entire Electronic Medical Record (EMR) did not reflect a full physical assessment, or recent vital signs had been recorded after LPN L assumed care for R88 on 1/27/2025 and before she passed away on 1/28/2025. No indication R88 had been placed on comfort care with death anticipated was documented. The progress notes do not indicate R88's daughter did not want R88 sent to the hospital was documented. During an interview on 3/27/2025 at 9:45 AM, the DON reported that the facility had not investigated R88's death because it was not unexpected. The DON said that R88's daughter did not want R88 sent to the hospital again, the morphine was added for comfort, and the tube feeding formula was changed because R88's daughter thought it would be less irritating to R88's digestive system. The DON reviewed R88's clinical record and reported she did not see documentation to support the clinical decision making, physical assessments and vital sign monitoring leading up to R88's death. Resident #69 (R69) Review of an Admission Record reflected R69 admitted to the facility with diagnosis that included acute respiratory failure with hypoxia and a need for assistance with personal care. R69 was their own responsible party. (continued on next page)

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 03/27/2025
NAME OF PROVIDER OR SUPPLIER Brittany Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Notification of Medicare Non-Coverage indicated The Effective Date Coverage of Your Current Skilled Services Will End: 11/15/2024. The form describes R69's right to appeal the decision and includes a space for a signature of the recipient of care to indicate the notice was received and understood. The notice was signed by R69's wife and was not dated. During an interview on 3/27/2025 at 9:50 AM, the DON reported that R69 remained in the facility and shared a room with his wife who would often take control of R69's affairs if R69 was asleep or otherwise busy. The DON reviewed R69's EMR and was not able to locate a progress note or business office/administrative note that would indicate the notice was provided to R69 in a timely manner and there was no explanation for why R69 did not sign the notice himself. 39056 Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Major Depressive Disorder. R2 had a guardian. Review of R2's Order Summary dated 2/1/25-2/16/25 revealed, FLUoxetine (Prozac/antidepressant) HCl Oral Tablet 20 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day . Review of R2's Order Summary dated 2/17/25 revealed, FLUoxetine HCl Oral Capsule 10 MG (Fluoxetine HCl) Give 1 capsule by mouth one time a day . Review of R2's Nurses Note dated 2/17/25 revealed, New order to decrease Prozac to 10mg PO qd (by mouth every day). Resident and family informed of order update. Review of R2's Electronic Medical Record revealed no documentation that R2's guardian was involved in and consented to the Gradual Dose Reduction (GDR) of R2's Prozac. Review of R2's Nurses Note dated 3/27/2025 written by Director of Nursing (DON) revealed, F/U (follow up) with resident niece on order to decrease Prozac on 2/17. Niece stated she was notified and had been in agreement with plan. DON explained progress note did not reflect agreement and niece confirmed she understood the rationale and agreed with plan at the time of the change . Resident #73 (R73) Review of an Admission Record revealed R73 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: major depressive disorder. R73 had a Durable Power of Attorney (DPOA) activated. Review of R73's Order Summary dated 7/19/25-2/25/25 revealed, SEROquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 25 mg by mouth at bedtime . Review of R73's Order Summary dated 2/25/25 revealed, SEROquel Oral Tablet 25 MG (Quetiapine Fumarate) Give 12.5 mg by mouth at bedtime . (continued on next page)

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	03/27/2025

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R73's Order Summary dated 2/25/25 revealed, Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 tablet by mouth every 24 hours as needed for Anxiety Only to be given on shower days, 30-60 minutes before the resident showers. Review of R73's Nurses Note dated 2/25/2025 revealed, New Order-Decrease Seroquel to 12.5 mg at bedtime. Ativan 0.25 to be given on shower days only. Give 30-60 minutes before shower .Family Notified . Review of R73's Electronic Medical Record revealed no documentation that R73's DPOA was involved in and consented to the Gradual Dose Reduction (GDR) of R73's seroquel or was provided education on the risk versus benefit of Ativan. Resident #76 (R76) Review of an Admission Record revealed R76 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: paranoid personality disorder. R76 had a guardian. Review of R76's Order Summary revealed ZyPREXA Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime for antipsychotic had been discontinued. Review of R76's Resident At Risk note dated 3/13/25 revealed, Reviewed Clinical Indicator: Resident was seen by psych np (nurse practitioner) on 3/11/25 .Do (sic) to successful GDR of Zyprexa per np will d/c (discontinue), Will continue to observe for changes in mood and behavior. Review of R76's Electronic Medical Record revealed no documentation that R76's guardian had consented to the discontinuation of Zyprexa. During an interview on 3/27/25 at 10:40 AM, DON reported she was unable to contact R76's guardian to confirm they were educated on and participated in his Zyprexa GDR/discontinuation. During an interview on 03/27/25 at 08:36 AM, Nursing Home Administrator (NHA) confirmed the documentation for R2, R73, and R76's GDR's was lacking and did not reflect risk versus benefit education documentation or guardian/POA consent. During an interview on 3/27/25 at 10:40 AM, DON reported R2, R73, and R76's documentation did not support that their guardian/POAs had been educated on the risk versus benefits and consented to the GDR's of the psychotropic medications. DON reported that the expectation for staff was to ensure all elements of documentation were in place which included notification of a recommendation of a change in medication, consenting to medication changes, as well as education to guardian/POAs and/or family members.