STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235615	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Brighton	1014 E Grand River Brighton, MI 48116

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to intakes: MI00144321 and MI00144496. Based on interview and record review, the facility failed to notify the Licensed Practitioner and Resident Representative regarding an unwitnessed fall for one (R903) of two residents reviewed for accidents. Findings include: Review of complaints reported to the State Agency alleged R903 was found on the floor in the resident's room on 4/23/24 at 5:45 PM and the resident's representative was not informed of the fall, change in condition, and the need for additional pain medication related to right hip pain until 4/25/24 at 10:30 PM as the facility was preparing the resident for transfer to the emergency department. According to the facility's policy titled, Falls Management dated 3/2024: .If a fall occurs the following actions will be taken .RN/LPN (Registered Nurse/Licensed Practical Nurse) at time of fall occurrence .Notify the Licensed Practitioner and the Resident's Representative . Review of the clinical record revealed R903 was admitted into the facility on [DATE] with diagnoses that included pancreatic cancer and was receiving hospice services. According to the Minimum Data Set (MDS) assessment dated [DATE], R903 had moderate cognitive impairment (scored 11/15 on the Brief Interview for Mental Status exam (BIMS); had a history of falls and required partial to moderate assistance with transfers. Further review of the clinical record revealed there was no documentation following the resident's fall on 4/23/24 at 5:45 PM that the physician, resident representative, or nurse manager had been notified of the fall or complaint of hip pain at a level of 10 (with 10 being the highest pain) and need for administration of morphine. On 5/21/24 at 12:57 PM, a phone interview was conducted with Certified Nurse Assistant (CNA D). When asked to recall the events regarding R903's fall, CNA D reported on 5/23/24 around 5:45 PM, while performing last rounds, they entered R903's room and did not immediately see the resident and they thought R903 was out of the room. CNA D reported they found R903 on the floor between the bed and the wall and then notified Register Nurse (RN B). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 12:40 PM, an interview was conducted with RN B who confirmed while performing last rounds prior to shift change on 4/23/24, R903 was found lying on the floor. R903 was transferred back to bed with assistance from CNA D using a blanket. When asked who was notified after R903 was found lying on the floor, RN B confirmed no nurse manager, no physician, no family representative was made aware of the incident. Furthermore, RN B reported the oncoming shift nurse (RN E) was not informed of R903 being found on the floor just prior to shift change. When asked why not, RN B reported they were handling two admissions and reported to the other nurse on those residents. RN B stated when a resident is found on the ground and there is no obvious injury, and vitals are stable, it did not warrant an escalation of notification. On 5/21/24 at 1:40 PM, An interview was conducted with the Director of Nursing (DON). When asked when they were notified R903 was found on the floor, the DON reported they were not notified until 4/26/24 via a text message from the afternoon Unit Manager. The DON acknowledged and reported RN B should have notified the nurse manager, physician, and residents' representative.

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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 0689 Level of Harm - Minimal harm or potential for 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** 49083 This citation pertains to intakes: MI00144321 and MI00144496 Based on interview and record review, the facility failed to ensure timely and adequate assessment and investigation into an unwitnessed fall for one resident (R903)of two residents reviewed for falls, resulting in a delay of post-fall policy practices which included increased monitoring, initiate an investigation which delayed identification of an acute hip fracture resulting in transfer to the hospital for further evaluation and escalation of care, and increased pain. Findings include: Review of the complaints reported to the State Agency (SA) alleged R903 was found on the floor in the resident's room on 4/23/24 at 5:45 PM and the resident's representative was not informed of the fall, change in condition, and the need for additional pain medication related to right hip pain until 4/25/24 at 10:30 PM as the facility was preparing for to transfer the resident to the emergency department. Review of the clinical record revealed R903 was admitted into the facility on [DATE] with diagnoses that included pancreatic cancer and was receiving hospice services. According to the Minimum Data Set (MDS) assessment dated [DATE], R903 had moderate cognitive impairment (scored 11/15 on the Brief Interview for Mental Status exam (BIMS); had a history of falls and required partial to moderate assistance with transfers. An interview with Registered Nurse (RN B) acknowledged that on 4/23/24 at 5:45, R903 was found on the floor in the resident's room. RN B denied initiating an incident report and confirmed the fall was not reported to the physician, nurse manger, personal representative or the assigned RN (RN C) for the next shift. On 5/21/24 at 12:45 PM, a telephone interview with RN C confirmed Nurse B did not report R903 was found on the floor prior to start of the next shift. The Medication Administration Record (MAR) revealed R903 was medicated with morphine on 4/23/24 at 7:49 PM for severe hip pain, not relieved by relaxation. R903 rated the pain at 10 out of 10 (10 being the highest pain score). When inquired if severe pain in the hip rated 10/10 indicated a change in condition and should the physician have been notified, RN C confirmed R903 previous pain assessment was not reviewed. RN C replied the physician was not contacted, and medicated with the morphine because there was an order already in place. The physician and family representative were not informed. Review of the facilities policy title; Pain Management dated 5/2024 documented: .Licensed Nursing may notify the Health Care Provider of any new development of pain, change in pain, change in condition that could potentially cause pain . On 4/24/24 at 12:47 documentation revealed R903 .was having some right hip pain with movement, thisam <sic> . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 8:02 AM, RN A administered morphine for moderate/severe pain, c/o (complained of) right hip pain. Further clinical record review revealed RN A on 4/25/24 at 12:08, documented R903 was having moderate/severe pain, moaning, guarding with movement, Dr (Doctor) made aware. A STAT X-ray was ordered. On 4/25/24 at 10:46 PM, an x-ray revealed right hip femoral fracture. The facility transferred R903 to the hospital for further evaluation and escalation of care. On 5/21/24 at 1:40 PM, an interview was conducted with the Director of Nursing (DON). The DON confirmed the Post Fall IDT (Interdisciplinary Team) was not conducted until 4/29/24. A record review of R903's Care Plan initiated on 3/5/24 was not amended reflecting the fall and did not establish new Goals or Interventions. The care plan was not revised until 4/29/24, Reason: Discharge. The DON further revealed that the responsible party was not notified R903 was found on the floor until 4/26/24 via a text message from the afternoon Unit Manager. The DON acknowledged a fall investigation should've been initiated and the care plan should've been updated on 4/23/24 when R903 was found on the floor. The DON acknowledged RN B should have notified the nurse manager, physician, and residents' representative. Review of the facility's policy titled; Falls Management dated 3/2024 documented: .If a fall occurs the following actions will be taken .RN/LPN at time of fall occurrence .Evaluate the resident including initial neurological check, pain, ROM (range of motion), skin, joints, extremities vital signs .Evaluate the resident each shift for 72 hours .Notify the Licensed Practitioner and the Resident's Representative . Complete an incident report in risk management. This report includes the circumstances surrounding the fall, devices in use, full body observation for injury, pain, range of motion, and neuro checks as needed .The nurse at the time of fall with [sic] review and update the resident's fall plan of care with a new intervention .