STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	254030	A. BUILDING _____ B. WING _____	**6/24/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS MANOR	**13137 NORTH CLIO ROAD CLIO, MI 48420**

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F0000 SS=	INITIAL COMMENTS Maple Woods Manor was surveyed for an Abbreviated Survey exiting on 06/24/2025. Event ID: GGH811 Intake Numbers: MI00153484 and MI00153865 Census: 114	F0000		
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Numbers MI00153484 and MI00153865. Based on interview and record review the facility failed to promptly assess a change in condition for one resident (Resident #501) of two residents reviewed for pain, resulting in a delay in pain treatment and discovery of bilateral femur fractures. Findings include: Resident #501: On 6/20/2025 at 9:45 AM, Resident #501 was observed sleeping in bed and did not appear to be	F0684		

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

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.

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	in any distress. Two CNA (Certified Nursing Assistants) in the room shared the resident is a two person assist and fully dependent on care. On 6/20/2025 at 10:42 AM, Maintenance Director "O" shared the Shower Aide informed her as they were lowering Resident #501 in the bed (via mechanical lift) it tilted forward. She explained the pivot point was too tight which caused the Hoyer to tilt, but they were able to safely lower the resident to the bed. On 6/20/2025 at 11:05 AM, CNA "P" stated she last showered Resident #501 on 5/27/2025 and was assisted by CNA "H." As they were placing the resident back in bed (via mechanical lift) the legs on the machine closed and the lock was not properly functioning. The Hoyer hit CNA "P" in the shoulder and CNA "H" in the leg but the resident was unharmed. On 6/20/2025 at 11:50 AM, Family Member "K" shared during her visit on 6/1/25 she noticed he was rocking back and forth more intensely which indicated he was in pain. She pulled back his covered and observed his left leg was externally rotated and the right leg was extended straight out on the bed. She notified the nurse that she wanted him transferred to the Emergency Room for imaging and further treatment. His nurse completed her assessment, and he displayed pain and winced upon his foot being touched. Family Member "K" continued a CNA noticed his increase in pain and informed her that is why they did not get him up on 6/1/2025. She added the facility has been unable to provide an explanation as to how the bilateral fractures occurred. On 6/20/2025 at approximately 12:15 PM, a review was conducted of Resident #501's medical record and it indicated he admitted to the facility on 1/17/2025 with diagnoses that included,			

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	Anxiety, Heart Failure, Dementia, Hypertension, Schizoaffective Disorder and upon admission back to the facility on 6/5/2025 fracture of right and left femur neck. Resident #501 is fully dependent upon staff to meet all his daily needs. Further review yielded the following: Progress Notes: 5/30/2025 at 05:36: "Called sister with results per sister's request. Sister stated that resident has had ongoing lethargy x 2 days, and she is concerned since he had a mild fever yesterday and was pocketing food ..." 6/6/2025 at 12:48:" Resident readmitted to facility r/t bilateral femoral fractures ..." There were no progress notes or assessments regarding Resident #501 increased pain and externally rotated leg and subsequent transfer to the Emergency Room. Care Plan: " ...Non-ambulatory ...total assist with bathing, monitor for impaired skin integrity...assist of two, heard of bed should be elevated for comfort ...Provide physical assistance to accept nutrition by mouth ...identify sources of discomfort ... (Resident #501) is unable to relay pain symptoms: use FLACC pain scale ..." Skin Assessment: 5/27/25: "Residents skin remains warm, dry and intact. Mucous membranes are moist and pink. Skin turgor age appropriate. No open areas or bruising noted ..." Pain Assessments:			

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	5/27/25 at 20:31: 0 5/27/2025 at 22:29: 0 6/1/2025 at 15:27: 0 (this was the day his leg was discovered to be externally rotated by his sister). May 2025 MAR (Medication Administration Record): Resident #501 received Acetaminophen on 5/29/25 at 1737 and 5/30/25 at 1806 for pain. Resident #501 was not administered any other pain medications outside of these two times in May 2025. Hospital Discharge Records: Imaging: "Acute complete slightly impacted angulated fracture at the right femoral head/neck junction ...suspected acute complete fracture of the left femoral head/neck junction ...acute significantly displaced fracture of both femurs at the head/neck junction ..." Orthopedic Surgery Consult Note: "Patient is 61 year old male presenting with bilateral hip pain. Sister at bedside helping to provide collateral. Reports the past few days she has noticed patient being more uncomfortable ...both extremities are externally rotated, left one appears slightly more shortened compared to the right one ...Appears to have some discomfort with passive motion of his hips ... RLE (right lower extremity): externally rotated ... LLE (left lower extremity): Externally rotated ..."			

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	Hospital Course: "This is 61 year old male with bilateral femoral neck fractures status post unknown mechanisms. Patient is nonambulatory at baseline and does not assist with transfers. Medicine was consulted for medical management. Thorough discussion and shared decision making with the patients family occurred and ultimate decision for nonoperative management was reached ..." Facility Investigation Conclusion: " ...during investigations with staff and residents, abuse, neglect or misappropriation was not identified. Based on interviews and record reviews it can be concluded that these injuries present at subacute and may be a result of previous injury and/or pathological in nature ..." On 6/20/2025 at 12:25 PM, Nurse "E" reported there was nothing communicated in report regarding increased pain for Resident #501. CNA "S" alerted her in the evening that she needed to assess Resident #501 but before she was not able to make it to the his room, his sister came to get her. Nurse "E" shared Resident #501's left leg had slipped off the pillow and resembled the shape of a frog leg. His sister asked why his leg was externally rotated when, from her observation it did not appear to be externally rotated. Nurse "E" slid her hand under his heel, and he winced and said "ohhh ohhh." From there, their on-call practitioners were contacted and orders were provided to send him out. Nurse "E" was asked why there was no documentation regarding her assessment of resident. She reported she did not complete a progress note or the transfer documentation as she was extremely busy. She stated she knows that it was required of her and the DON (Director of			

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	Nursing) asked her a few times to complete the necessary documentation and she failed to do so. On 6/20/2025 at 1:10 PM, an interview was conducted with East Unit Clinical Care Coordinator "C" regarding Resident #501. She reported she was alerted that Monday that he went out to the hospital and was not aware his leg was externally rotated. Resident #501 is a mechanical lift and fully dependent on staff to meet their needs. She expressed he has always rocked back and forth but they had various levels on intensity. If his rocking was harder paced that would indicate a need for further assessment. On 6/20/2025 at 1:30 PM, CNA "H" stated Resident #501 does not move his legs and it takes two staff to care for him due to his stature. She stated she does not recall any reports from the 3rd shift regarding an increase in pain. She added he did rock back and forth and his sister indicated that was a sign of pain/discomfort. But the rocking was not consistent. CNA "H" expressed when providing incontinence care he would typically grimace when cleaning his genital area but she was not sure if that was due to him being sensitive or uncomfortable with a woman providing care. On 6/20/2025 at 1:55 PM. Nurse "R" reported Resident #501 rocked back and forth but it was not continuous throughout the day. She stated she noticed it more upon his return from the hospital as he would rock and makes and noise. On 6/20/2025 at 2:30 PM, CNA "S" was interviewed regarding Resident #501. The CNA stated on Saturday (5/31/25) when she arrived to work she noticed he was in increased pain. She noticed it as if they were getting him into his chair and tuning and repositioning him. CNA "S" shared he was grunting more and seemed			

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	uncomfortable. Additionally, she observed the left leg was bent into the right and that is atypical as he does not move his legs. She stated she had never seen him like that and informed the nurse about his increased pain and his leg, but was unsure if an assessment was conducted. CNA "S" reported it was discussed during their shift reports and passed along to 1st and 3rd shift. She said on Sunday evening the 1st shift aide did not get him out of bed due to his increase in pain. She added she heard that after this shower on 5/27/2025 is when the change in condition initially occurred and added that he was sensitive in his genital area during incontinence care. On 6/20/2025 at 4:05 PM, an interview was conducted with CNA "G" regarding Resident #501. Upon her arrival to work on that Tuesday evening (5/27/2025) she was informed in report that he had a shower in the latter part of 1st shift and slept the majority of 2nd shift. As CNA "D" and "N" were providing care to Resident #501's roommate he (Resident #501) woke up and they stated his eyes were rolling to the back of his head, he gritted his teeth, was grimacing and making noises like a horse. This was not his baseline and the aides alerted the nurse who after reviewing his chart stated his behavior was due to his diagnosis but to the aides this was far beyond his regular behaviors. CNA "G" stated she recognized he was in pain, as he was pressing his hands into his groin area and did not want to move them. On 6/20/2025 at 4:25 PM, CNA "N" shared she was providing care to the roommate of Resident #501. While they were doing care Resident #501 began to breathe harshly and she initially thought he was snoring. It sounded abnormal so they checked on him, they attempted to gain his attention, but he was not responding (he would			

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	look at the staff typically). Upon closer observation his eyes were rolled into the back of his head and when they tried to touch him he had a visceral reaction. He clenched his body, and he was breathing like they had never heard him do before. The noises he made were not normal either and it appeared he is was in "agony." When they touched him, he began to cry and yelped out. CNA "N" alerted the nurse to his change and she completed a chart review and vitals. Upon her assessment she stated he has these movement due to his diagnosis, the CNA reported what they observed was not his baseline nor his typical movements. On 6/20/2025 at 4:50 PM, an interview was conducted with CNA "D" regarding Resident #501. She reported on the night of 5/27/2025 they were providing care to another resident and heard Resident #501 make an odd noise. When they pulled the curtain back, they saw Resident #501's eyes were rolling in the back of his head which lasted a few minutes. They were calling his name but he did not turn his head toward them like he normally would. He was pressing his body into the bed in a jerking movement. CNA "D" reported this was atypical of him. They did alert the nurse to this, but she attributed it to his current diagnosis set. On 6/23/2025 at 11:05 AM, Therapy Director "J" reported Resident #501 was fully dependent upon staff for his daily care. When he admitted to the facility he was fully dependent with max assist and that did not change during his stay at the facility. She added they did range of motion with his arms which they did see improvements with but they were completing the range of motion not him. Therapy did not work with his legs but looking at the notes there would not have been any gains made.			

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	On 6/23/2025 at 12:30 PM, Nurse "I" reported she did pick up 3rd shift a few weeks ago and recalled the aides reporting Resident #501 seemed to be in more pain than usual. She stated he was rocking back/forth and puffing his lips out and blowing. Nurse "I" shared she had never worked with him before and after chart review found his diagnoses that attributed to his rocking and blowing. Nurse "I" was asked if she administered pain medications and she stated she did not, as after he was repositioned, he appeared more comfortable. Nurse "I" stated she did not complete a progress note but added it on the 24-hour nurse report form. It can be noted from the investigation that it was discovered Resident #501 has an increase in pain and change in condition on the night of 5/27/25. Multiple staff indicated he was visibly uncomfortable and in increased pain days prior to his sister observing his leg being externally rotated. This information was relayed to nursing staff but there was no subsequent nursing progress notes or assessments which led to his delay in treatment and recognizing the change in condition. On 6/23/2025 at 5:20 PM, the Administrator and DON (Director of Nursing) shared Resident #501 was transported to the hospital for pain on 6/1/2025. They were not aware of his fractures until 6/4/25 and that is when the investigation began. They concluded from their investigation Resident #501 did not have a change in condition that would have alerted the staff to complete additional assessments. He was transferred to the hospital at the behest of his responsible party. The DON and Administrator were informed Resident #501 did have a change in condition the night of 5/27/2025 and continued until his sister recognized his externally rotated leg five days later.			

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	They reported they were unaware he had a change in condition as staff did not report it to them during their investigation. It can be noted an aide did mention in her statement she noticed his leg was turned oddly but there was no further follow-up regarding this statement. 6/24/2025 at 12:20 PM, Medical Director "BB" was asked if he received notification from the facility regarding increased pain and behaviors outside of the norm for Resident #501 on the night of 5/27/2025 or morning of 5/28/202, he stated he did not. Medical Director "BB" was informed the resident began to display increased pain that continued throughout the week and abnormal behaviors. He reported he was not made aware of this. Review was conducted of the facility policy entitled, "Change in Resident Condition Physician /Family Notification," revised March 2021. The policy stated, " ...To ensure provision of the necessary care and services to meet the highest practicable physical, mental and psychosocial well being of each resident ... The resident has a significant change in physical, mental, or psychosocial status i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications ...". On 6/24/2025 at 9:37 AM, the Administrator reported the facility does not have a policy for pain.			