

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2025
NAME OF PROVIDER OR SUPPLIER  Qualicare Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  695 E Grand Blvd Detroit, MI 48207	

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.  (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

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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	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 2561232. Based on interview and record review the facility failed to timely and appropriately assess a new onset leg pain for one Resident (R901) of three residents reviewed for quality of care, resulting in R901 experiencing prolonged signs and symptoms of severe pain with subsequent hospitalization to address the pain. Findings include: On 7/23/25 at 12:52 p.m. the complainant was contacted regarding the allegations reported to the state agency. The complainant said on 7/7/25 approximately at 2:45 p.m., R901 could be heard screaming through the hall while receiving care. The hip area was observed by the complainant who stated, It looked like a bone was sticking out of the upper thigh. R901 was crying, screaming, and did not want the area touched. The nurse aid said the resident was complaining of pain to her right leg all weekend. The residents barely ate and didn't want to get out of bed. R901 told the complainant, I fell. The complainant also said they asked the day shift nurse to send the resident to the hospital and the nurse said an x-ray was needed before sending the resident out to the hospital. The nurse manager attempted to look at the leg, but the resident would not allow it and guarded the leg. The complainant said R901 was not sent out to the hospital until approximately 12:00 a.m. The hospital concluded that the resident had a hip fracture and required surgery. Review of the electronic medical record documented R901 was initially admitted into the facility on [DATE] and readmitted on [DATE]. R901 was discharged from facility to the hospital on 7/8/25 with diagnoses that included displaced fracture of upper right femur (7/6/25), neuropathy, non-Hodgkin lymphoma and Leukemia, stage 4. According to the quarterly Minimum Data Set assessment dated [DATE], R901 was cognitively intact (BIMS-15) and required partial/moderate one-person assistance with self-care and mobility. Review of Pain care plan dated 11/22/24 documented the following: Focus: (R901) at risk for pain and has chronic pain related to Leukemia, history of Non-Hodgkin's leg lymphoma Date Initiated: 11/22/2024. Goal: Will not have an interruption in normal activities due to pain through the review date. Interventions: Evaluate characteristics of pain on a scale of (SPECIFY 0-10); Observe for pain presence Q (every) shift as needed; Observe/record: resident complaints of pain or requests for pain treatment. Review of the radiology report dated 7/7/25 documented the following: Examination Date: 7/7/2025 20:59 (8:59 pm)- FINDINGS: There is a mildly displaced fracture of the proximal femoral (hip) diaphysis with apex medial angulation. The osseous margins of the fracture appear somewhat moth-eaten. CONCLUSION: Fracture of the proximal femoral diaphysis with imaging features which may suggest underlying lytic lesion/ pathologic fracture. Review of the nurse's progress notes documented the following: -7/5/2025 15:02 (3:02 pm) Nurses Notes Late Entry: Res is laying in bed alert and awake, c/o back pain yelling and crying.-7/6/2025 16:06 (4:06 pm) Nurses Notes Late Entry: Received res lying in bed alert and awake, c/o pain to lower back ,crying but not yelling loudly resident refused to turn she said she can't.-7/7/2025 14:50 (2:50 pm) Nurses Notes: Resident complaints of pain this shift Motrin and 2 Tylenol given for pain. Stat x-ray ordered; tramadol ordered q 6 hours prn for pain.-7/7/2025 14:53 Nurses Notes: Radiology notified of order for stat x-ray right femur.-7/7/2025 23:09 (11:09 pm) Nurses Notes: Rt femoral/hip x-ray performed, awaiting results. Prn pain medication is given for pain relief.-7/7/2025 23:23 (11:23 pm) Nurses Notes: Writer spoke with MD. MD ordered to transfer resident out to hospital. Review of the medication administration notes documented the following:-7/6/2025 20:38 (8:38 pm) eMar -Medication Administration Note: hip pain.-7/6/2025 21:48 (9:48 pm) eMar -Medication Administration Note: PRN Administration was: Ineffective resident states she is still in pain. Follow-up Pain Scale was: 4-7/7/2025 12:06 (12:06 am) eMar -Medication Administration Note: pain med given-7/7/2025 18:01(6:01 pm) eMar -Medication Administration Note: pain in right hip/leg. On 7/24/25 at 9:56 a.m. CENA E was interviewed. CENA E said while visiting R901 at the beginning of the day shift (7am-3:30pm), R901 was complaining of pain to the back and right side of the leg. CENA E was in the room with CENA B and the resident. CENA E said R901 always complained of back pain but not to the leg until that day. CENA B was attempting to give the resident care, but she cried out in pain every time she tried to move the resident On 7/24/25 at 10:15 a. m. the Social Service Director (SSD) C was interviewed and said on 7/7/25 approximately 12:00 p.m., upon arriving to the second floor, R901 could be heard screaming and wailing from the elevator and SSD's office which were in the front hall. The resident's room was in the back hall. CENA B requested SSD C to come to R901's room and look at the right leg. R901 was in severe pain and cried. The CENA B came to SSD C because the nurse was not available and the resident had been in pain all weekend according to CENA R</p>		