STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235025	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Brook Medical Care Facility	4543 South M-88 Highway Bellaire, MI 49615

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** Based on observation, record review, and interviews, the facility failed to prevent staff to resident abuse for one Resident (#27) of two residents reviewed for abuse. This deficient practice resulted in untreated physical pain and psychosocial harm based on the reasonable person concept.Findings include: Resident #27 (R27)Review of R27's Electronic Medical Record (EMR) indicated R27 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (A progressive disease that destroys memory and other important mental functions), dementia (a general term for a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life) with agitation, anxiety, chronic pain syndrome, abnormalities of gait and mobility, restlessness and agitation. R27 had a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment.The facility failed to recognize R27 was suffering from unrecognized and uncontrolled chronic pain from a prior motor vehicle accident. CNA P and CNA Q placed R27 unnecessary distress by placing hands on R27 in an attempt to control movement and push them down, causing feelings of frustration and unresolved pain based on the reasonable person concept.Per review of a facility reported incident (FRI) on 8/12/25 the FRI documentation stated during review of the security camera footage regarding another incident, two staff members were interacting with R27 who was in their wheelchair in the dining area of the Glacier Hill Household on 7/29/25. It appeared Certified Nursing Assistant (CNA) P attempted to tie R27 to their wheelchair at 8:52 PM with a bath blanket to prevent R27 from rising, with another bath blanket used to tuck around R27's legs and firmly under the thighs in an attempt to prevent R27 from rising from their wheelchair. CNA Q was present at the resident's side as the incident was occurring. Review of security camera footage for 7/29/25 collaborated the FRI information. While viewing the security footage both CNAs were observed exhibiting agitated behaviors with R27 with expansive movement of the CNAs arms and arms resting on their hips or crossed over their bodies with observable jerky movements. On 7/29/25 at 8:50 PM, CNA Q placed their hand on R27's chest prior to the blanket placement and had used observable force to push R27 back into the wheelchair when they lifted themselves from the wheelchair. CNA Q had placed their hands on both shoulders of R27 and used observable force to push R27 down into the wheelchair when they stood up out of their wheelchair on 7/29/25 at 9:04PM.The review of R27's orders did not indicate any order for any type of restraint and R27 was not care planned for any type of restraint.On 9/24/2025 at 9:02 AM, an interview was conducted with the Director of Nursing (DON) regarding the incident on 7/29/25. The DON stated R27 was in the dining room of Glacier Hall in their wheelchair with CNA Q who was making a broccoli salad for themself. R27 was at the bar area right by the front area of the kitchen where R27 had a salty snack that the CNA's wanted R27 to eat, in hopes that R27 would drink water with medications later. The DON verified the care plan did not have a plan of care for restraints. The DON stated both CNAs in question had received training on restraints and abuse prior to this incident. The DON noted the facility's annual abuse education covered restraints, but not specific restraint education. The DON stated after interviewing the CNA who placed the blanket around R27, the CNA (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	did not view the act as a physical restraint. The DON stated CNA Q's body language was clearly agitated with R27 in the security camera footage.On 9/25/2025 at 11:15 AM, an interview was conducted with LPN J regarding R27 since the incident. LPN J felt that the incident although it was not a good thing did lead to the facility finding out more about the resident, so they could accommodate R27 more. LPN J stated that now the facility has a recliner for R27 that can be used in the afternoon. LPN J stated the afternoon is when R27 tends to get antsy in the wheelchair and stand up a little. When staff notice R27's antsy behavior they put R27 in the recliner as the staff learned R27 had a previous motor vehicle collision and may have back and hip pain. LPN J stated the change of position to the recliner seems to help R27 who then gets very calm. LPN J also stated that the scheduled medication has helped change R27's demeanor as well. LPN J stated that R27 is a mover and if R27 can do that safely it's in the resident's best interest. The staff keep an eye on any changes in R27 motoring around the floor and address it. Facility's Plan of Correction:For resident R27 the resident's care plan has been reviewed. There is no order present for a physical restraint, the resident demonstrates motor agitation at times especially in the late evening. A physician order for physical therapy evaluation and treatment was ordered in conjunction with another diagnosis this resident has. A discussion with the physician resulted in an occupational therapy evaluation and treatment for potential seating needs related to comfort has been initiated effective 8/15/25. The resident is offered individualized items to touch or interact with during times of increased motor agitation. The resident finds comfort in the kitchen/dining area related to her past history of home making. The resident will be able to maneuver her wheelchair in the cleared dining area during the evening when she has increased motor agitation. Items can be placed on the tabletops for R27 to interact with decreasing R27's anger or frustration by being sat in one place. The pressure alarm will remain on R27's wheelchair for safety to alert the staff of the resident's attempts to rise so that staff can intervene for her safety.For all residents, the Director of Nursing or designee will complete a random review of resident interactions utilizing the security camera system. Looking specifically for staff interaction with residents. This will occur at various times of the day and night on all the households. This review of the security camera system will be completed by 8/27/25. Residents on each household will be surveyed by the social services department to ask about interactions with staff asking if the residents' needs are being met, if they feel that there are any issues related to abuse, mistreatment, or neglect. This survey will be completed by 8/29/25. Any concerns noted of abuse, mistreatment, or neglect in review of the camera footage or in response to the survey will be immediately reported to the Director of Nursing and Administrator for immediate action.A quality assurance study will be initiated utilizing the results of the in-person survey and any results of concern noted on the random review of the security camera footage. This review will be completed by 9/5/25. The in-person survey asking about issues relating to abuse, mistreatment, or neglect will be repeated in September of 2025 and a second random review of camera footage on each household looking for concerns related to abuse, mistreatment, or neglect will be completed and documented as a quality assurance study by 9/30/25. If any concerns regarding abuse, mistreatment, or neglect are documented the in-person survey and review of the security camera system will continue until both survey results indicate no identified concerns with abuse, mistreatment, or neglect.The Director of Nursing reviewed and revised the Facility Restraint policy to include definitions of physical restraints, chemical restraints, and mechanical restraints. All nursing staff receive education regarding restraint use, the Facility policy and State and Federal regulation. All staff will receive training on the Facility policy and on abuse reporting and requirements and protecting residents from abuse. This will be accomplished by 9/1/25.Past Non-Compliance accepted as of 9/12/25 for the facility.

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F 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to provide adequate supervision per the plan of care during functional transfers and mealtimes for two Residents (#38 and #106) of eight residents reviewed for accident hazards and supervision. This deficient practice resulted in actual harm when Resident #38 experienced a fall with fracture and head contusion. Findings include: Resident #38 (R38) Review of R38's face sheet, revealed original admission to the facility on 5/2/25 with medical diagnoses including diabetes mellitus, hypertension, muscle weakness, and gout. Review of R38's Minimum Data Set (MDS) assessment dated [DATE], revealed in section GG, Functional abilities and goals; toileting hygiene, dependent on staff, and sit to stand and toilet transfer, supervision or touching assistance. Review of a pocket care plan, dated 7/3/25, revealed R38 required a one person assist with a gait belt for transfer, SBA [stand-by assistance] for room ambulation, and wheelchair use in the hallway with assistance. On 9/23/25 at 2:35 PM, an interview was conducted with R38 who was resting in her bed and was asked if she had a fall and replied, Yes. R38 was unable to give any details of the fall or when the fall had occurred. Review on R38's incident and accident report, dated 7/3/25 at 6:16 PM, read in part, .Incident Description: Nursing description: Staff assisting resident to restroom with walker. Bathroom door open, with door touching resident bed and resident wheelchair positioned next to the wall outside the bathroom. Resident took a few steps with her slippers on. CNA (certified nurse aide) and resident state her foot got tangled in the wheelchair and she fell to floor, hitting head on bathroom door frame/door. Resident description: Resident states she was walking to bathroom, lost her balance and fell on the floor. Denies pain and discomfort to back of head. Did rate lower back pain 7 out of 10. Review of progress note, dated 7/3/25 at 7:00 PM, read in part, Staff assisting resident to restroom with walker. Bathroom door open, with door touching resident bed and resident wheelchair positioned next to the wall outside the bathroom. Resident took a few steps with her slippers on. CNA and resident state her footgot (sic) tangled in the wheelchair wheel and she fell to the floor hitting head on the bathroom door frame/door.resident does have a contusion to back of her head and a small bruise area to left elbow noted. Review of progress note, dated 7/5/25 at 6:31 PM, read in part, .TOP OF LEFT FOOT IS BRUISED, RESIDENT BELIEVES IT IS FROM FALL. Review of progress note, dated 7/5/25 at 9:12 PM, read in part, resident being monitored for recent fall.resident left foot top does have bruising to base of 2nd toe and top of foot, bilateral feet are slightly swollen.the bruise area is sensitive to touch will continue to monitor. Review of radiology report, dated 7/8/25 at 4:24 PM, read in part, .Conclusion: Possible acute (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	non-displaced fracture at medial base of 3rd proximal phalanx (toe). Consider more sensitive imaging evaluation with CT (computer tomography) as clinically directed. Review of CT scan, dated 7/17/25 at 12:37 PM, read in part, .History: X-ray LT (left) foot possible third toe FX (fracture).Findings.Intra-articular fracture at the medial base of 3rd digit proximal phalanx, involving the MTP (metatarsophalangeal, a bone in the toes of the foot that is connected between the metatarsal bones [in the foot] and the phalanges [toes]) joint, with valgus alignment (a condition where the foot deviates outward, causing the heel to turn out and the toes to rotate outwards, leading to abnormal weight distribution and an abnormal appearance) at the 3rd MTP.Impression: 1. Intra-articular fracture at the medial base of 3rd digit proximal phalanx, involving the MTP joint, with valgus alignment at the 3rd MTP. On 9/24/25 at 3:23 PM, an interview was conducted with Registered Nurse (RN) O who was asked about R38's fall and how R38 transferred and replied, (R38) transfers with one staff from her wheelchair with a gait belt around her to allow staff to assist with the transfer. RN O was asked if a gait belt was used on 7/3/25 when R38 fell in her bathroom and replied, I am not sure. (R38) hit her foot on the bottom of the wheelchair and stumbled and then fell. RN O was asked for the witness statements. RN O was asked if R38 had a care plan for how she transfers and fall risk interventions and replied, She should. I think I put on in place when she was admitted in May. RN O stated that she thinks everyone is a fall risk, R38 had a potential for falls, and that R38 did not ambulate by herself that she was a one staff assist for transfers with a gait belt. Review of witness statement from CNA N, dated 7/3/25, read in part, .Approx. (approximately) 6:10 PM I grabbed her pants to stand up from her wheelchair, lost balance forward to walker I caught her. Stood her up. Regained balance. I asked if she was ok. She said yes. Ok, let's head into the bathroom. I turned to get out of her way. When facing back to her she was on her way down. I noticed her foot was caught on her wheelchair wheel. On 9/25/25 at 9:00 AM, an interview was conducted with RN A in lieu of the Director of Nursing (DON), who confirmed R38 did not have a care plan for how they transferred or have fall risk interventions until 27 days after falling and sustaining a fracture and head contusion. RN A confirmed on 6/2/25 R38 transferred with one staff assist and a gait belt. RN A stated it was unclear if a gait belt was used on 7/3/25 when R38 fell and should have been included in the incident and accident report and the witness statement. On 9/25/25 at 10:30 AM, an interview was conducted with CNA N who confirmed her witness statement regarding R38's fall. CNA N stated she turned her back on R38 to get out of her way and noticed R38 was off balance, then grabbed R38's pants and not the gait belt because R38 was a 'bigger lady'. CNA N stated R38 was a standby assist of one with a gait belt. CNA N confirmed she should have used the gait belt but thought she would have been able to assist her better by grabbing R38's pants. Review of R38's care plan, dated 5/2/25, read in part, .Focus: The resident has an ADL (activities of daily living) self-care performance deficit.ensure that resident has her equipment 4 wheeled walker and quad cane. R38's care plan lacked any indications for how to transfer and interventions for prevention of falls. R38's care plan was not updated for fall interventions until 7/30/25 which was 27 days after her fall with a fracture and head contusion. Review of R38's fall risk assessment, dated 6/1/25, revealed a score of 19 which indicated R38 was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at risk for falls. The fall risk assessment indicated a score of 10 or greater, constituted high-risk for falls. Review of policy titled, Falls Risk Policy and Procedure, dated 9/2025, read in part, Standard: The facility will ensure that the Resident environment remains as free of accident hazards as is possible and that each Resident receives adequate supervision and assistive devices to prevent accidents.Procedure: The facility will identify Residents at risk for falls and implement procedures to prevent accidents/falls and update Care Plans to incorporate interventions. Protocol(s): 1. A Fall Risk Assessment will be completed upon admission / readmission, quarterly, or upon significant change in the electronic medical record. The Fall Risk Assessment includes the use of the Morse Falls Risk Scale completed in the EMR (point click care). 2. If the Resident is assessed to be at Moderate or High Risk for falls the following shall be implemented per the nursing staff.Update the computerized care plan.The fall interventions are imbedded into the ADL [activities of daily living] Care Plan. Review of policy titled, Falls Risk Policy and Procedure, dated 9/2025, read in part, Standard: The facility will ensure that the Resident environment remains as free of accident hazards as is possible and that each Resident receives adequate supervision and assistive devices to prevent accidents.Procedure: The facility will identify Residents at risk for falls and implement procedures to prevent accidents/falls and update Care Plans to incorporate interventions.3. Resident Falls Fall or Found on Floor #1:.C. Investigation: 1. Review incident report, interview staff and review documentation.G. Review Care Plan / Revise Care Plan. Resident #106 (R106) Review of R106's EMR revealed initial admission to the facility on 9/17/25 with diagnoses including fracture of the lumbosacral spine and pelvis, dementia, and dysphagia (difficulty swallowing). Review of R106's EMR revealed a Health Status Note, dated 9/18/25 at 11:36 AM, that read, in part: .While eating bkfst [breakfast] resident was noted to be pocketing (the act of storing food or liquid in the mouth, typically in the cheeks or on the roof of the mouth, instead of swallowing it promptly) her waffle and scrambled eggs. Resident given oatmeal and continued to pocket. Orders entered for ST [speech therapy] evaluation. Review of R106's Speech Therapy Evaluation, dated 9/18/25, read, in part: How often does the patient require supervision/assistance at mealtime d/t [due to] swallow safety? = 91-100% of the time. .What modified diet is recommended for the patient to swallow solids safely? = Pureed Review of R106's EMR revealed a diet order, initiated 9/22/25, which read, Pureed texture, regular consistency, follow swallow precautions on her care plan. On 9/24/2025 at 8:49 AM, R106 was observed eating breakfast in the common dining area. No clinical staff were observed in the vicinity of the dining room. R106's meal ticket was placed on the table next to her and read, in part, follow swallow precautions on her care plan. Review of R106's care plan revealed the following nutritional goal, initiated 9/22/25: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Safe swallow free from clinical s/sx [signs and symptoms] of aspiration. Resident will have no choking episodes through the review date. The following intervention was initiated on 9/22/25: .Supervision during all oral intake*Sit upright for all oral intake (including snacks & meds [medications])*Remain upright for @ least 30 minutes following meals*Take small bites & sips*Eat/drink slowly, taking a break after each bite/sip*Swallow @ [at] least 2 times per bite of food/sip of liquid*Alternate bites of food w/ [with] sips of liquids (remind her to sip liquids between bites) *Check of pocketing*. On 9/24/2025 at 2:58 PM, an interview was conducted with Speech Language Pathologist (SLP) L who confirmed she was treating R106 for a swallowing dysfunction. SLP L stated R106 was downgraded to a level II (pureed) diet due to concerns of pocketing which could lead to choking and aspiration. SLP L confirmed she recommended R106 receive supervision with all oral intake in the event R106 required cues for things like pacing, taking small bites, and monitoring for pocketing in order to decrease the risk for aspiration. When SLP L was asked her expectation for supervision, she responded the resident should be in a common area and within the line of sight of clinical staff. On 9/25/2025 at 8:56 AM, R106 was again observed eating breakfast in the dining room with no staff supervision. On 09/25/2025 at 9:21 AM, an interview was conducted with Certified Nursing Assistance (CNA) M regarding R106's nutritional needs. CNA M stated R106 required a pureed diet due to a history of pocketing food. When asked if R106 required a specific level of oversight, CNA M stated R106 should eat in common areas so staff could, keep an eye on her, but did not require direct supervision. On 9/25/25 at 11:45 AM, an interview was conducted with Clinical Care Coordinator (CCC) H regarding her expectations from clinical staff if a resident required supervision for a specific activity of daily living or functional task. CCC H stated supervision would require visual contact with the resident. CCC H understood the choking and aspiration risk as a result of not providing the recommended level of assistance for R106 during mealtimes. Review of the facility policy titled, Fall Risk Policy and Procedure, revised 0/2025, read, in part: The facility will ensure that the Resident environment remains as free of accident hazards as is possible and that each Resident receives adequate supervision and assistive devices to prevent accidents.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a restraint assessment, physician's order, risk-associated education, consent, and medical justification for the use of a pommel cushion were in place for one Resident (#100) of one resident reviewed for restraints. Findings include: Resident #100 (R100)On 9/23/25 at 1:51 PM, R100 was observed in a wheelchair sitting on a pommel cushion (a cushion with a large raised, center protuberance on the front of the cushion). R100 said the pommel cushion prevented her from picking things up if something falls on the floor because it kept her from being able to lean forward in her wheelchair.The electronic medical record (EMR) for R100 documented admission to the facility on [DATE] with a primary diagnosis of cerebral infarction (stroke). R100 also had an activated Durable Power of Attorney designated in the EMR (DPOA - a designated individual to handle medical decisions). The EMR did not include a physician's order for a pommel cushion, and there was no documentation identifying the medical symptom for which the pommel cushion was to be utilized for. The EMR did not contain an assessment for the use of the pommel cushion or a consent with potential identified risks associated with the use of a pommel cushion. There was no evidence the DPOA was informed of potential risks and benefits associated with the use of the pommel cushion and no consent was able to be located in the EMR. During an interview on 9/24/2025 at 12:24 PM, Certified Nurse Aide (CNA) B said the pommel cushion prevented R100 from standing independently from the wheelchair and was also utilized to prevent R100 from leaning forward and potentially falling from the wheelchair. CNA B confirmed R100 was unable to independently remove the pommel cushion from the wheelchair. The Occupational Therapist (OT) C was interviewed on 9/24/25 at 12:54 PM. OT C said R100 did not have positioning concerns in the wheelchair. When asked why R100 had a pommel cushion, OT C said the pommel cushion was implemented to prevent R100 from falling forward from the wheelchair. When asked if R100 could stand from the wheelchair with the pommel cushion in place, OT C said the resident could stand with assistance from therapists during skilled therapy sessions but was unable to do so with nursing.The Director of Nursing (DON) was not available during the survey on 9/24/2025. The Administrator (NHA) said Registered Nurse (RN) A would be the acting DON for the duration of survey. RN A was interviewed on 9/24/25 at 1:30 PM. RN A was asked if a restraint assessment was completed for the use of the pommel cushion for R100. RN A reviewed the EMR of R100 and said, I do not see one. RN A said a physician's order was required to utilize a restraint, and a restraint assessment and a signed consent [by the DPOA] were required. When asked why the pommel cushion was being used, RN A reviewed the EMR of R100 and said she did not know why the pommel cushion was put in place. RN A suggested Clinical Care Coordinator (CCC) D, the nurse who managed the unit where R100 resided, may have completed a restraint assessment. On 9/24/2025 at 1:36 PM, CCC D was interviewed regarding R100. When asked if any restraint assessments were completed for the resident, CCC D replied, I know she has a pommel cushion. CCC D indicated there was previous discussion regarding the pommel cushion potentially being a restraint, but no restraint assessment was completed. CCC D was asked if the pommel cushion prevented R100 from leaning forward to get items from the floor as she was doing prior to placement of the pommel cushion. CCC D said, yes - It keeps [R100] in an upright position and keeps her from falling forward onto her face. When asked why an assessment wasn't completed if there was a concern about the pommel cushion potentially restraining R100, CCC D said a restraint assessment was not completed because she didn't think it was a restraint. When asked the definition of a restraint, CCC D replied, Something that keeps them from doing something they can normally do. CCC D said the pommel cushion did not require a physician's order because R100 was working with therapy. The policy Restraint Policy dated as effective 8/2025 read, in part: .Residents shall be provided an environment that is restraint-free, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unless a restraint is necessary to treat a medical symptom.A physician's order is required. a physical restraint shall be used only after the interdisciplinary team in conjunction with the physician, has performed an assessment .A restraint is defined by the Centers for Medicare and Medicaid Services (CMS) as follows: A restraint is any manual method, physical or mechanical device, material, or equipment that is attached to or near the resident's body that the individual cannot remove easily, and that restricts freedom of movement, normal access to one's body, or normal activities of daily living.4. The family or responsible party will be notified of the need for restraints. 5. Prior to application of the physical restraint, informed consent using the Physical Restraint Consent is to be obtained from the resident and/or responsible party. The clinical risk factors are to be explained, as well as the decision-maker's / residents right to refuse the restraint. 6. A Physical Restraint Consent must be signed by the family / responsible party for each type of restraint and each episode of restraint.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to complete and update a comprehensive care plan for one resident (Resident #38) of twenty residents reviewed for care plans. Findings include:Resident #38 (R38)Review of R38's face sheet, dated 9/24/25, revealed original admission to the facility on 5/2/25 with medical diagnoses including diabetes mellitus, hypertension, muscle weakness, and gout. Review of R38's Minimum Data Set (MDS) assessment, dated 6/20/25, revealed in section GG, Functional abilities and goals, toileting hygiene, dependent on staff, and sit to stand and toilet transfer, supervision or touching assistance. On 9/23/25 at 2:35 PM, an interview was conducted with R38 who was resting in her bed and was asked if she had a fall and replied, Yes. R38 was unable to give any details of the fall or when the fall had occurred. Review on R38's incident and accident report, dated 7/3/25 at 6:16 PM, read in part, .Incident Description: Nursing description: Staff assisting resident to restroom with walker. Bathroom door open, with door touching resident bed and resident wheelchair positioned next to the wall outside the bathroom. Resident took a few steps with her slippers on. CNA (certified nurse aide) and resident state her foot got tangled in the wheelchair and she fell to floor hitting head on bathroom door frame/door. Resident description: Resident states she was walking to bathroom, lost her balance and fell on the floor. Denies pain and discomfort to back of head. Did rate lower back pain 7 out of 10. Review of R38's care plan, dated 5/2025, read in part, .Focus: Resident request to sleep in a reclining chair states unable to tolerate use of bed.Interventions/Task: Obtain a reclining chair by family that will suit resident.Focus: Resident sleeps only in reclining chair requesting furniture removal Bed removal.Focus: The resident has an ADL (activities of daily living) self-care performance deficit.ensure that resident has her equipment 4 wheeled walker and quad cane. R38's care plan lacked any interventions for prevention of falls. R38's care plan was not updated for fall interventions until 7/30/25 which was 27 days after her fall with a fracture and head contusion. R38's care plan was not updated after her fall to reflect her current use of a bed. Review of R38's fall risk assessments revealed the following: - On 5/2/25 an admission fall risk assessment with a score of 11, which indicated R38 was at risk for falls. The fall risk assessment indicated a score 10 or greater constituted high-risk for falls. - On 6/1/25 a reentry fall risk assessment revealed a score of 19. On 9/24/25 at 11:50 AM, an observation was made of R38 resting in her bed and not in a reclining chair. On 9/24/25 at 3:23 PM, an interview was conducted with Registered Nurse (RN) O who was asked if R38 had a care plan for how she transfers and fall interventions and replied, She should. I think I put one in place when she was admitted in May. RN O stated she thinks everyone is a fall risk, R38 had a potential for falls, and R38 did not ambulate by herself. RN O disclosed R38 required the assistance of one staff member and a gait belt for transfers. RN O was asked why R38's care plan was not updated to reflect her current use of a bed and no longer a reclining chair and replied, She has been sleeping in the bed since this last Saturday, and I thought I updated it already. On 9/25/25 at 9:00 AM, an interview was conducted with RN A in lieu of the Director of Nursing (DON), who confirmed R38 did not have a care plan for how to transfer or fall risk interventions until 27 days after falling and sustaining a fracture and head contusion. RN A confirmed on 6/2/25 R38 transferred with one staff assist and a gait belt. RN A stated it was unclear if a gait belt was used on 7/3/25 when R38 fell and should have been included in the incident and accident report and the witness statement. RN A was asked if the residents' care plans should reflect their current needs and replied, Yes, absolutely they should. Review of policy titled, Comprehensive Care Plans, dated 10/2024, read in part, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. Policy Explanation and Compliance Guidelines.3. The comprehensive care plan will describe, at a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235025	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Brook Medical Care Facility	4543 South M-88 Highway Bellaire, MI 49615

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.f. Resident specific interventions that reflect the resident's needs and preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235025	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure use of Enhanced Barrier Precautions (EBP) during high-contact resident care activities, according to current professional guidelines, for one Resident (#2) of two residents reviewed for infection control.Findings include:Resident #2 (R2)Review of R2's Electronic Medical Record (EMR) revealed initial admission to the facility on 8/13/25 with diagnoses including fracture around the right prosthetic knee joint, urinary tract infection, and need for assistance with personal cares. Review of R2's most recent Minimum Data Set (MDS) assessment, dated 8/29/25, revealed R2 required maximum assistance for both lower body dressing and functional transfers. Review of R2's EMR revealed a physician order, initiated 8/13/25, which read: Enhanced Barrier Precautions for foley catheter care and appliance replacement.On 9/24/25 at 9:24 AM, R2 was observed undergoing an extended skilled therapy session in her private room. Physical Therapy Assistant (PTA) F was observed assisting R2 in transfer training between R2's wheelchair and the edge of bed. During the process of the transfers, the clothing of PTA F was observed to be in direct contact with R2's clothing. PTA F was not wearing personal protective equipment (PPE) although EPB signage was posted on the outside of R2's door.On 9/25/25 at 8:58 AM, R2 was observed undergoing an extended skilled therapy session with Certified Occupational Therapy Assistant (COTA) G in her private room. R2 was observed working on lower body dressing tasks with COTA G. During the dressing task, COTA G was observed handling R2's catheter bag and tubing without gloves. COTA G was not wearing PPE for the duration of the session. The EPB signage continued to be posted on the outside of R2's door. On 9/25/25 at 9:14 AM, an interview was conducted with COTA G regarding EPB expectations. COTA G stated she would only be required to don PPE if she was directly changing or emptying R2's catheter. On 9/25/25 at 11:45 AM, an interview was conducted with Clinical Care Coordinator (CCC) H regarding PPE expectations in regard to EPB. CCC H stated PPE should be donned when care is provided that directly involves R2's catheter such as toileting assistance or providing catheter care. CCC H stated gloves are expected to be worn whenever a catheter bag or catheter tubing is handled.Review of guidance by the Center for Disease Control and Prevention (CDC) titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html), released 4/2/25, read, in part: .The use of gown and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise apply, for all nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions Include: Dressing . Transferring .Review of the facility policy titled, Enhanced Barrier Precautions, revised 10/2024, read, in part: [Facility Name] will implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions refer to the use of gloves and gowns for use during high-contact resident care activities for residents with colonized or active MDROs as well as those residents with indwelling devices such as central lines, urinary catheters, and feeding tubes. Gloves will still be worn at all times of direct care and ADLs [activities of daily living] as part of our standard practice and precautions.