

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                 |
| <p>F 0812</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Many</p>                | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: On 1/27/2026 at 9:59 AM, observation of the walk-in cooler found an increased accumulation of black spotted debris on the top surfaces of the hard plastic shelving used to store food product. When asked how often the storage shelves get cleaned, Dietary Manager (DM) F stated they get power washed, but it's been so cold we have not been able to take them outside. On 1/27/2026 at 10:19 AM, an interview with DM F found that the clean utensil bin is cleaned weekly. Observation inside of the bin found an assortment of clean utensils stored among food crumbs and debris. Upon wiping the inside of the bin, it was found to be greasy. DM F stated that they will get it cleaned. On 1/27/2026 at 10:21 AM, an interview with DM F found that the tabletop slicer is used once or so a week to slice meat. When asked what the plastic cover over the slicer meant to kitchen staff, DM F stated that it's to keep the unit clean between uses. Upon removing the plastic cover, observation of the slicer found accumulation of dried meat debris on the backside bottom and top portions of the blade. On 1/27/2026 at 10:30 AM, observation of the back corner of the kitchen found a stand-up floor mixer covered with a plastic bag. An interview with DM F found that they only have one cook who uses the mixer, and that it only gets used about once a month. Observation of the mixer found yellow and white debris caked on the surface of the under arm of the unit. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 1/27/2026 at 10:03 AM, observation of the three door Traulson cooler, in the serving room, found the ambient air thermometer in the back of the unit read 50F. An interview with DM F found that they don't usually keep a lot of products in the cooler. At this time, a container of Tuna Salad and a packet of cream cheese was taken and found to be 47.3F when measured with a rapid read thermometer. An interview with DM F found that she was going to toss the items in the unit. On 1/27/2026 at 11:10 AM, an observation of the C unit nourishment room found a refrigeration unit with an internal temperature of 50F. According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above. or (2) At 5C (41F) or less. On 1/27/2026 at 10:35 AM, observation of the high temperature dish machine data plate found that it requires 160F minimum temperature for the wash water and an initial rinse temperature of 180F from the manifold of the machine. A review of the Dish Machine Log found that staff only track the rinse temperature of the unit. Observation of the dish machine over the course of five loads of dishes found the wash gauge range between 148F-152F. An interview with DM F found that she was (continued on next page)</p> |                                                                                   |                                                 |

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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                   |                                                 |
| <p>F 0812</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Many</p>                | <p>going to reach out to the vendor. On 1/28/2026 at 11:58 AM, observation of the high temperature dish machine, over three racks of dishes, found that the wash gauge was around 140F. According to the 2022 FDA Food Code section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than.(3) For a single tank, conveyor, dual temperature machine, 71oC (160oF).On 1/27/2026 at 11:01 AM, observation of the A and B nourishment room refrigeration unit found the following items: a takeout container of chicken wings with no date to indicate discard, a leftover container of pizza with a receipt dated 1/21/26, and a yogurt container with a best by date of 1/22/26.On 1/28/2026 at 11:48 AM, observation of the walk-in cooler found two containers of whipped topping with a best by date of 1/21/26. Further review found an open package of sliced smoked ham with no date to indicate discard. On 1/28/2026 at 11:12 AM, observation of the Homebound nourishment room found the following items: a container of rice not dated, leftover sub not dated, peanut butter and jelly sandwich not dated. Further review of the unit found a nutritional supplement with manufacturer's directions that state the item is good for 14 days after thaw. An interview with DM F found that she was unaware when the items would have thawed. A record review of the facility provided document entitled Food From Outside Sources, revised 11/12/2021, found that All food brought in is to be checked by the Nurse, Dietary Manager, or Dietitian. It must be placed in a seal container and labeled for the content, the guest's/residents's name and date the food was received, and an expiration date of 3 days after the food was brought in. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .On 1/27/2026 at 11:02 AM, observation of the A and B nourishment room found packed disposable cups stored underneath the wastewater line to the hand sink. On 1/27/2026 at 11:12 AM, observation of the Homebound nourishment room found a package of thickened juices stored underneath the wastewater line to the hand sink. According to the 2022 FDA Food Code section 3-305.11 Food Storage. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:.(2) Where it is not exposed to splash, dust, or other contamination;.According to the 2022 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 -3-306.On 1/27/2026 at 11:10AM, observation of the C unit nourishment room microwave found the unit with bubbled and peeling surfaces on the inside of the unit. Portions of the unit were found with brown and rusted surfaces. According to the 2022 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.On 1/28/2026 at 10:22 AM, observation of the Cardiac nourishment room found that the ice machine drain line was found directly connected to the wastewater line of the sink via a condensate pump. The current set up allows for the potential contamination of ice due to wastewater from the nourishment room sink. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from (continued on next page)</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                   |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. On 1/28/2026 at 12:04 PM, observation of the walk-in cooler found two large zip lock bags, sealed, with ground turkey sausage dated for 1/28. When asked what the sausage was from, DM F stated that they must have saved it from breakfast this morning. When asked if there was a log or tracking for the cooling sausage, DM F stated they don't keep a cooling log. When asked what time the sausage would have started the cooling process, DM F was unsure, but agreed that the item would have started to cool prior to 10:00 AM. At this time, the temperature of the product was taken with a rapid read thermometer and found to be 74.5F. DM F stated she would discard the product. According to the 2022 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3) Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Many</p>                | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility. Findings include: On 1/27/26 at 10:25 AM observation of the kitchen serving room revealed a possible stagnant water line coming from the hand sink area down the wall near the steam tables. An interview with the Maintenance Director (MD) H found that he was unaware of the water line. An interview with the Dietary Manager G found she was unaware of what the water line was for and stated it was not something that kitchen staff use. On 1/27/26 at 1:11 PM observation of the Homebound unit soiled linen room revealed the hopper had brownish yellow water coming from the hot and cold-water fixtures on the over hopper faucet. Further observation found discolored water coming from the hopper sprayer. On 1/27/26 at 1:35 PM observation of the soiled linen room in unit C revealed a sink and hopper fixture with no water flow and possible stagnant water. On 1/27/26 at 1:57 PM observation of soiled utility room (near room [ROOM NUMBER]) revealed water level low in the hopper bowl, indicating infrequent use of the water fixture. When the hopper faucet was turned on the water flow was slow and discolored. The hopper spray was observed with brownish yellow water coming out. On 1/28/26 at 9:08 AM observation of the soiled utility room in the New Center unit found a hopper. An interview with housekeeping manager (HM) G found the hopper was not used. When asked if he had responsibilities for the Water Management Plan (WMP) he indicated he did not. On 1/28/26 at 9:20 AM observation of B unit janitor closet sink noted that the handle for the cold-water side was missing which indicates a possible stagnant water line. On 1/28/26 at 9:32 AM observation of B unit hallway found an inoperable water fountain with possible stagnant water. On 1/28/26 at 9:45 AM observation of B unit soiled utility room found debris in hopper bowl and an inoperable utility sink not allowing for lines to be flushed indicating possible stagnant water. An interview with Certified Nursing Aide (CNA) E indicated the hopper unit was not used by staff. On 1/28/26 at 9:58 AM observation of A unit hallway found an inoperable water fountain with possible stagnant water. On 1/28/26 at 10:11 AM, observation in Homebound unit A hallway found a water line with shut off valve extended through the wall. Interview with HM G found that the water line was for a drinking fountain that had been removed and this water line was shut off. When the valve was opened, the water was collected in a clear plastic cup and found to be milky and discolored. On 1/28/26 at 12:15 PM an interview with MD H indicated that he was in the process of creating a Water Management Program (WMP) binder with documentation that had existed electronically, but much had been lost. Further, he described the following processes related to the WMP: MD H showed the packet of test strips that he uses to monitor for free chlorine. He tests cold water at Point of Use ([NAME]) in resident rooms using WaterWorks? 5-Way Water Check test strips. As the strips do not detect/indicate free chlorine in the 0-0.5 parts per million (ppm) range, the results he was able to detect were consistently 0.5 ppm (the minimum amount detectable by use of the color change test strip). The current testing method is insufficient for the stated control level they are monitoring for (minimum of 0.2 ppm). - MD H described a monthly water flushing procedure, indicating that flushing took place at various points of use including sinks, showers and storage tanks. On 1/28/26 at 2:00 PM An interview with Nursing Home Administrator (NHA) took place to follow up on WMP documentation. When asked for WMP documentation, NHA indicated that MD H would have that information. On 1/28/26 at 1:30 PM an observation of the basement vending/staff lounge area revealed a potentially stagnant water line extension off the line running to a small wall mounted hand sink. Interview with MD H found he was unaware of the water line. A record review of the facility-provided Water Management Program policy, last revised 2/1/24, stated that The facility will implement measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems with a water management (continued on next page)</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>program that is based on nationally accepted standards and will include: An assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread; and measures to prevent the growth of opportunistic waterborne pathogens, and how to monitor them. The assessment will include a description of the building water systems using text and flow diagrams for identification. No such assessment or water systems description with flow diagrams was provided upon request. The policy further states that an effective water management program include: preventing water stagnation. The Water Management Team Meeting Minutes dated 11/13/25 and 12/19/25 section 8 addresses Review and validate flush schedule completion and the box marked is other frequency, explain in minutes section. In 11/13/25 minutes section there is no reference of a flushing schedule. In 12/19/25 minutes section it is stated: sinks are flushed twice a month at low point. No detail is provided about which sinks, fixtures, or dead end piping are flushed.</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                 |
| <p>F 0921</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Many</p>                | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation and interview the facility failed to maintain general cleanliness and repair of the premises. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting all residents. Findings include: On 1/27/26 starting at 1:17 PM, an environmental tour was conducted in the homebound unit with the following observations: The faucet in resident room [ROOM NUMBER] was observed with only a pencil thin stream of hot water when in use. The faucet was loose to mount and was able to be moved around. The shower room found eight razors stacked on the sink basin. Further observation revealed spots of black accumulation on underside of the shower bed mat, and a wet washcloth on the floor. An observation of the janitor closet revealed that a chemical pre-dispensing system was in place and that staff leave the faucet on when not in use. This set up puts undue back pressure on the faucets internal atmospheric vacuum breaker (AVB) of which will ruin the integrity of the mechanism. On 1/27/26 starting at 1:20 PM, an individual tour was conducted in the C unit and found the following observations: The tub room revealed a toilet loose to mount on the floor, and unattached to the floor caulk. The shower room found a brown smear on the underside of the shower bed mat as well as an accumulation of moisture and black spots on the shower bed plastic surface. On 1/28/26 starting at 8:24 AM, a tour of the laundry department was conducted with Housekeeping Manager (HM) G with the following observations: Clean sorting bins, used to transport clean linen from the washers to the dryers, revealed a layer of excess debris under the inside support floor (used to help bring linen near the top of the bin). Debris included packaged cookies, plastic wrappers, used gloves, a metal hanger, and dirty socks and gloves. Observations of the laundry bulk storage room revealed two of four lights inoperable and one light unshielded. Further observation found numerous tiles loose on the floor. On 1/28/26 starting at 9:00 AM, a tour of the New Center unit was conducted with HM G with the following observations: The nursing supply storage closet was found with a liquid nebulizer product stored in a box on the floor. Buildup of dust and debris was observed on the floor under and around the shelving unit. The clean utility closet revealed a buildup of dust, straws, and gloves on the floor under the storage unit. Observation of the spa revealed a brown smear on a shower chair. When asked, HM G stated it looked like a bowel movement and that Certified Nursing Aides (CNAs) are responsible for cleaning shared equipment in shower room. Further observation found lint balls and a loose screw near the drain of the shower. An observation of the janitor closet found the mop sink faucet left on leaving undue pressure on the faucet's internal AVB. The nourishment room revealed a package of napkins stored beneath the sink with visible brown and black wastewater on the packaging. The Campus Martius enrichment center revealed food crumbs beneath the chair cushion. Additionally, a green lounge chair was observed to have a red stain on the back edge of the cushion and backrest. On 1/28/26 starting at 9:28 AM, a tour of the Homebound B unit was conducted with HM G with the following observations: Observation of the janitor closet found the mop sink faucet left on leaving undue pressure on the faucets internal AVB. Shower room two revealed four broken and crumbled two by two-inch floor tiles at the entrance of the shower room. [NAME] smear marks were observed on the shower bed mat, along with dried white crumbs and pooled water in the crease of the mat. The exhaust air vent was visibly soiled with an accumulation of dust. Additional observations found an accumulation of dust and debris along the perimeter and corners of shower room. An observation of shower room one found the shower curtain hanging low and touching the floor, with black residue along the bottom portion of the curtain. Further observations found an accumulation of debris along the perimeter and corners of the shower room. The soiled utility room revealed a hand sink fixture with a crack in the back leaking heavily when turned on. The storage closet on unit B revealed an accumulation of debris on the floor including dust, dirt, razors, and used gloves. On 1/28/26 starting at (continued on next page)</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
| F 0921<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | 10:01 AM, a tour of Homebound A unit was conducted with HM G with the following observations:The janitors closet found a mop sink faucet left on with an AVB as the backflow prevention device under undue back pressure. The shower room found the soap dispenser leaking onto the floor creating a pool of soap. A chunk of donut with chocolate frosting was observed on the shower floor as well as a brown 1 inch smear on the floor. A cookie and wrapper was observed on the floor as well as a damp washcloth hanging on the handrail. The wastewater line that was previously used to drain the drinking fountain in unit A- Homebound was observed open and exposed with no cap. A thick black substance on the inside of the pipe was found. On 1/28/26 at 10:27 AM, an observation of the janitor closet on cardiac unit revealed the mop sink faucet left on leaving undue pressure on the faucets internal AVB. On 1/28/26 at 2:36 PM, an observation of resident room [ROOM NUMBER] revealed the hot water faucet releasing a trickle of hot water when turned on. |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   |                                                 |
| <p>F 0692</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 2720882. Based on observation, interview, and record review the facility failed to pass water in a timely manner to ensure adequate hydration for five residents (R94, R76, R18, R156, and R33) of seven residents reviewed for hydration, resulting in the potential for increased risk for dehydration. Findings include: During the initial screening process on 1/27/2026 between 10:00 a.m. and 2:00 p.m. multiple residents were observed with no water in their rooms or at bedside. These residents are as follows: R94. R94 was observed to be alert and was able to be interviewed. During an interview, R94 said there was no fresh water passed by the staff since about nine P.M. on the midnight shift. R94 pointed to a small, iced tea bottle and stated, I am glad I kept this tea bottle so I can get me some water out of the sink. I don't understand why they have not passed fresh water yet. According to the electronic medical record (EMR), R94 was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and hypertension. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R94 was cognitive intact with a BIMS (brief interview for mental status) score of 14/15. Review of R94 Nutritional/Hydration care plan revised on 1/28/2026 had the following: (R94) has alteration in nutritional and/or hydration status related to dementia and hypertension. R76. R76 was observed alert, lying in bed with an empty white Styrofoam cup on the bedside table not in reach. During an interview, R76 said there was no cold water passed since midnight shift and would like to have a drink of cold water. According to the electronic medical record (EMR), R76 was admitted on [DATE] with diagnoses that included cerebral infarction, hypertension, and venous insufficiency. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R76 was cognitive intact with a BIMS (brief interview for mental status) score of 15/15. Review of R76 Nutritional/Hydration care plan revised on 1/18/2024 had the following: R76 has alteration in nutritional and/or hydration related to diagnoses CVA (Cerebral vascular accident), history of falls, pain, CAD (Carotid artery disease). R18. R18 was observed in room alert and was able to be interviewed. During an interview R18 stated, No one brought in any fresh water at all today (1/27/2026) and I would like to have some cold water. According to the electronic medical record (EMR), R18 was admitted on [DATE] with diagnoses that included hypertension, severe protein-calorie malnutrition, dementia, anemia, type two diabetes mellitus, and cerebral infarction. According to the significant change Minimum Data Set (MDS) assessment dated [DATE] indicated R18 was severely cognitively impaired with a BIMS (brief interview for mental status) score of 03/15. Review of R18 Nutritional/Hydration care plan revised on 12/10/2025 had the following: (R18) has alteration in nutritional and/or hydration related to diagnoses UTI (urinary tract infection), dementia, and prostate cancer. R156. R156 was observed resident lying in bed alert and oriented. During an interview, R156 stated, They (the staff) came in and picked up my water cup I believe at breakfast time and just have not brought anymore fresh water back yet. According to the electronic medical record (EMR), R156 was admitted on [DATE] with diagnoses that included congestive heart failure, chronic respiratory failure, diabetes mellitus type two, and chronic obstructive pulmonary disease. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R156 was cognitively intact with a BIMS (brief interview for mental status) score of 15/15. Review of R156 Nutritional/Hydration care plan revised on 11/29/2025 had the following: (R156) has alteration in nutritional and/or hydration status related to diagnoses H. pylori (a stomach bacteria), hypertension, and morbid obesity. R62. On 1/27/2026 at 1:30 p.m. R62 was observed with no water cup in the room or at bedside. R62 did not want to be interviewed. According to the electronic medical record (EMR), R62 was admitted on [DATE] with diagnoses that included ETOH, Left femur fracture, hypertension, history of falls, Carotid artery disease, and chronic obstructive pulmonary disease. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R62 was cognitively intact (continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
| F 0692<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | with a BIMS (brief interview for mental status) score of 15/15. Review of R62 Nutritional/Hydration care plan revised on 1/22/2026 had the following: (R62) has alteration in nutritional and/or hydration status related to diagnoses of adjustment disorder, BPH and schizophrenia. On 1/27/2026 at approx. 2:00 p.m. the unit's daily assignment was requested and provided. Review of the daily assignment revealed Certified Nursing assistant (CNA) T was R62's R76's, and R18's assigned CNA for the dayshift (7:00 a.m. thru 3:00 p.m.). On 1/27/2026 at 3:00 p.m. CNA T was interviewed regarding providing water to the residents. CNA T acknowledged that water had not been passed but was going to pass water later. CNA T stated, the residents should have had water at the start of the shift at 7:00 a.m. On 1/27/2026 at 4:16 p.m. CNA U was the assigned CNA (was working an additional four hours) for residents R156, and R94. CNA U was asked was water passed for the shift. CNA U stated, I was really busy, but I am passing the resident's water now. The residents should have received fresh water before now. On 1/29/2026 at 2:23 p.m. the Director of Nursing (DON) was interviewed regarding the appropriate time staff should pass water to residents. The DON was asked should the staff pass water before 3:00 p.m. and 4:00 p.m. for the shift. The DON stated, Absolutely. The twelve-hours shift CNAs should pass water multiple times and the eight hours shift should pass fresh water before 3:00 p.m. and 5:00 p.m. usually by 10:00 a.m. fresh water should be pass because midnight usually pass the resident fresh water before leaving their shift, but regardless fresh water should be pass before 3:00 p.m. According to the facility's 1/29/2026 Oral Hydration policy: It is the policy of this facility to assist residents to maintain adequate hydration whenever possible. Procedure: 5. Each resident will be provided bedside water. |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
| F 0804<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>This citation pertains to intakes 2656662 and 2661216Based on observation, interview, and record review, the facility failed to ensure meals were served at palatable temperatures in two of two records reviewed, resulting in decreased food consumption and potential nutritional decline.Findings Include:It was reported to the State Agency that food served to the residents was not at palatable temperatures.On 1/27/2025 at 11:57 AM, an interview with Dietary Manager F found that the facility has heated bases, but they are not in use for today's meal. Further observation found plates between 75F-85F with no visible plate warmer being utilized. When asked what she expects for hot food on the steam table, DM F stated that it should be at least 150F so that residents can get their food at 135F or higher.On 1/27/2025 at 12:09 PM, a regular test tray was plated and placed as one of the first meals on the C unit cart. On 1/27/2025 at 12:20 PM, the meal cart arrived on C unit with roughly 25 meal trays present. On 1/27/2025 at 12:37 PM, all trays were delivered, and the test tray was back in the conference room. The following temperatures were found using a rapid read thermometer: Pot pie 127.6F and mixed vegetables 104F. |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                 |
| <p>F 0578</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to give information for Advance Medical Directives (AMD, the written instruction relating to the provision of health care) to one (R2) of two residents or their representatives reviewed for code status, resulting in R2's code status being changed to a full code (all possible life saving measures will be provided if the person's heart stops or they stop breathing). Findings include: On [DATE] at 2:30 PM, R2 was observed up in recliner chair watching TV. R2 was unable to be interviewed due to cognition status. On [DATE] at 2:50 PM, during interview with R2's Representative (RR1) they said they were not being included in decision making for R2. RR1 said they were not R2's Legal Guardian (LG) at this time and was currently trying to obtain it through the court system. RR1 said they did not know R2's code status had been changed to a 'full code' by the facility. According to R2's Electronic Health Record (EHR) RR1 was identified as R2's emergency contact and representative. R2 had resided in the facility since [DATE] with multiple diagnoses that included vascular dementia. The Annual Report of Guardian on condition of Legally Incapacitated Individual indicated that R2 had a LG company assigned as their LG, and a Do-Not-Resuscitate Order had been executed. The Report indicated that Guardianship was in effect from [DATE] through [DATE]. R2's AMD form dated [DATE] indicated that R2 was a DNR Do-Not-Resuscitate - No Cardiopulmonary Resuscitation. The form was signed by the LG Company representative. A second AMD form dated [DATE] identified R2 as a full code and was not signed by a LG or resident representative. The form was signed by Social Worker (SWQ) and noted that R2 was unable to sign and had a diagnosis of dementia with confusion. A review of R2's progress notes and social service notes did not reveal any documentation to support R2's representative was provided information regarding formulating an AMD. On [DATE] at 11:24 AM, during an interview with SW Q they said that R2's LG paperwork had expired on [DATE] and there had been no information to determine who was R2's LG. There was no documentation to support that R2's representative was provided information on how to formulate advanced directives or that R2's code status was changed. SW Q stated, That Guardian company went out of business in 2024, and we haven't found another one to replace it. The family has not provided us with any LG paperwork, so the resident doesn't have a legal guardian now. By default, the resident goes back to a full code. SW Q could not explain why R2's representative was not provided information on R2's AMD. On [DATE] at 11:39 AM, the Nursing Home Administrator (NHA) said R2 hasn't had a LG since [DATE] and by default had to go back to a full code. The NHA could not provide any documentation to support that R2's representative had been given any information of the AMD. There was no documentation to support that the facility had petitioned for another LG for R2. According to the facility's Advance Directive-Michigan last revised on [DATE] in part read: A. Identify. On admission, the Facility will determine whether the Resident has executed advance directives (e.g., a DPOA-HC, or Living Will), and if not, whether the Resident would like to execute advance directives-The Facility will also determine whether there was a DNR Order signed in another setting (e.g., hospital, home) and whether the Resident would like a DNR Order issued while in the facility. A Code Status Form will be signed to reflect the decision regarding CPR/DNR under the guidance provided below. B. Obtain Documents. Copies of all advance directives will be obtained from the Resident and/or family and placed in the medical record. If applicable, a DNR Order will be signed and placed in the medical record. G. Advise on Right to Establish Advance Directives. If the Resident has not executed an advance directive (i.e., a Living Will or DPOA-HC), the Resident and the Resident's family will be advised of the right to establish an advance directive and assistance will be offered regarding the same. If the initial facility cognitive evaluation (Nursing Comprehensive Evaluation and/or BIMS) indicates a level of cognition that questions the Resident's ability to participate in medical treatment decisions, the facility will initiate a capacity evaluation form as also stated above.</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                 |
| F 0640<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>Based on interview and record review, the facility failed to transmit a Minimum Data Set (MDS) assessment for one (R173) of three residents reviewed for MDS assessment transmittal requirements. Findings include: During the MDS Assessment task R173 was identified to have a MDS assessment that was due over 120 days. On 1/28/26 a review of R173's Electronic Health Record (EHR) revealed R173 discharged from the facility on 8/27/25. The MDS assessment for discharge status had not been transmitted to the CMS system at this time. On 1/28/2026 at 11:06 AM, during an interview with MDS coordinator (staff Q) R173's EHR was reviewed. Staff Q stated, We did not transmit the MDS yet. It's late. I will send it today. Staff Q said that the facility had undergone staff changes and some transmittals had been missed. On 1/29/26 at 2:10 PM the Nursing Home Administrator said the expectation is that MDS assessments will be sent timely in accordance with the federal regulations.</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                 |
| <p>F 0641</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to accurately complete Minimum Data Set (MDS) assessments for two (R2 and R4) of three residents reviewed for MDS assessments. Findings include: R2 According to R2's MDS assessment dated [DATE] section P, R2 used a limb restraint less than daily. Review of R2's Electronic Health Record (EHR) did not reveal any orders, care plans, or documentation to support R2 used a limb restraint. 01/27/2026 11:06 AM R2 was observed lying in bed on left side using wedge bolster. There were no visible restraints on R2. There were no restraint devices in R2's room. At 2:30 PM R2 was observed up in recliner chair. There were no visible restraints on R2 or in the room. R2 was unable to be interviewed due to cognition status. At approximately 2:35 PM unit manager Licensed Practical Nurse (LPN) R was asked if there were any restraints in the facility. LPN R stated, There are no restraints in the facility. We do not use them. LPN R confirmed that R2 had never had restraints. LPN R reviewed R2's MDS dated [DATE] and stated, This is wrong. The resident doesn't have restraints. There are no restraints in this building. On 1/28/2026 at 11:06 AM, during an interview with the MDS Director (staff Q) R2's MDS dated [DATE] section P was reviewed. Staff Q stated, This is an obvious mistake. The resident has been here for 10 years and has never had a restraint. I'll correct it and re-send. Staff Q said that the facility had undergone staff changes. R4 According to R4's MDS assessment dated [DATE] section O. R4 receives Hemodialysis (HD). Review of R4's EHR did not reveal any orders or documentation to support R4 was receiving HD. On 1/27/2026 at 11:33 AM, R4 was observed seated up in bed watching TV. R4 was interviewed and reported they do not get dialysis. R4 confirmed they never had dialysis. On 1/28/2026 at 11:13 AM Staff Q reviewed R4's MDS assessment dated [DATE] section O. Staff Q confirmed the MDS was inaccurate and stated, The resident did not receive dialysis. I'll correct it today.</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
| <p>F 0645</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to refer one (R158) of two residents reviewed, with a serious mental disorder, to the state designated authority for review of the pre-admission screening and resident review (PASARR) program. This resulted in the likelihood of decline related to unidentified needs. Findings include: Record Review of the Electronic Health Record (EHR) revealed no Level II PASARR completed by the facility since R158's admittance date on 8/1/25. On 01/27/2026 at 11:39 A.M., R158 was interviewed and reported that he does not receive behavior or psychiatric supports at this facility. On 01/27/2026 at 2:20 P.M., R158's record review revealed a diagnosis of PARANOID SCHIZOPHRENIA with no evidence of a Level II PASARR. Review of a Level I PASARR dated 8/1/25 which was completed by the referring hospital which denoted the following: a diagnosis of Schizophrenia, a history of previous mental health treatment and the routine prescription of the antipsychotic medication Invega (antipsychotic, a long-lasting injection used to treat schizophrenia). Record review also revealed R158 was admitted on [DATE] with the following diagnosis: Paranoid Schizophrenia, Alcohol Abuse, Hypothyroidism, Type 2 Diabetes, Hypertension, Hyperlipidemia, Rhabdomyolysis, Prostatic Hyperplasia, Ischemic Attack. The Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 -indicating R158 as cognitively intact. On 01/28/2026 at 3:36 P.M., Social Worker (SW) S was interviewed regarding PASARR screenings. SW S said that staffing changes over the summer caused the Social Work Department to fall behind on their PASARR processes and stated, To be completely transparent, it (R158's Level II PASARR) wasn't done! On 01/29/2026 at 1:17 P.M., Record Review revealed an order dated 8/1/25- Psych services to eval and treat as indicated. On 01/29/2026 at 2:05 P.M., the Nursing Home Administrator (NHA) was queried as to who is responsible for ensuring PASARR screenings are completed. NHA stated, It's the job of our Social Services Department and we are reviewing records with our social services team to catch up on these things. NHA also confirmed that R158 has not received psychiatric services or medication for Schizophrenia since admission on [DATE]. Record review of Care Plan dated 11/08/2025 revealed: Focus-(R158) is at risk for pain Rhabdomyolysis, BPH, schizophrenia, decubitus ulcer, and AKI . and Intervention-Observe for side effects of pain medication. Observe for constipation; new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria; nausea; vomiting; dizziness and falls.Review of the facility's policy titled Pre-admission Screening and Guest/Resident Review-PASRR Michigan dated for last revision on 11/21/2021, documented in part: . the PASRR process is to screen all individuals admitted for nursing care to ensure that needs are met to assist the individual in reaching their highest potential . If the responses to the Level I/3877 screening indicate the presence of a mental illness and/or intellectual/developmental disability, or related condition, the person is referred to the local community mental health program for a comprehensive screening, Level II. Review of the Level I screening criteria- Section II dated 8/1/25 identified 3 of 6 areas that meet the requirement for mental illness with instruction to contact the local community mental health services program (CMHSP) for Level II screening.1.The person has a current diagnosis of mental illness- yes2. The person has received treatment for mental illness- yes3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications with the last 14 days- Yes</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                   |                                                 |
| <p>F 0658</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow standards of practice for medication administration for one resident (R183) of four residents reviewed for medication administration. Findings include: On 01/27/2026, at approximately 10:05 AM, R183 was observed in their room. Three pills in a medication cup were observed on R183's bedside table. Upon inquiry, R183 said the nurse leaves them since they cannot swallow the pills all at once. R183 further said they are not sure what the pills are taken for, or what they are. A record review was completed on 1/28/2026 which revealed R183 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right side, muscle wasting and atrophy, hyperlipidemia, hypertension, gastro-esophageal reflux disease, depression, and insomnia. Section C of the Minimum Data Set with an Assessment Reference Date of 1/6/2026, revealed R183 scored a 15/15 on the Brief Interview for Mental Status assessment - indicative of no cognitive impairment. A review of physician orders in the electronic medical record revealed no orders allowing for self-administration of medications. On 1/28/2026 at approximately 11:09 AM, Licensed Practical Nurse (LPN) D was interviewed regarding the process of medication administration. LPN D confirmed that R183 did not have an order to self-administer medications. LPN D further said that professional standards include observing the resident take the medication and that it is not safe or appropriate to leave medications at the bedside. On 1/28/2026 at approximately 1:40 PM, the Director of Nursing (DON) was interviewed regarding medication administration standards. When asked if it was appropriate to leave medications at the bedside, the DON stated, We do not leave pills at the bedside - that is not our process. A policy titled, Medication Administration last revised on 10/17/2023 documented, Resident medications are administered in an accurate, safe, timely, and sanitary manner . #7. Observe that the resident swallows the oral medications. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of the medication.</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure two residents (R118 and R33) out of four residents reviewed for accidents had wheelchair footrests in place during wheelchair mobility. Findings include: R33</p> <p>On 1/27/2026 at 10:25 a.m. R33 was observed sitting in a wheelchair and unable to answer questions about care. Observed both of R33's leg lifted off the floor with intervals of the left leg dropping to the floor while Licensed Practical Nurse (LPN) V propelled R33 without any footrest into the hallway. There was no footrest in the room or the closet.</p> <p>On 1/27/2026 at approximately 10:35: a.m. LPN V was interviewed regarding R33's footrest. LPN V was asked did the resident have footrests for the wheelchair for safety? LPN V stated, the resident do not have leg rests but I will call therapy to get some for her. The resident should have them for safety reasons.</p> <p>According to the electronic medical record (EMR), R33 was admitted into the facility on 2/10/2017 and readmitted on [DATE] with diagnosis that included sequelae of cerebral infarction, sensorineural hearing loss bilateral, dementia, hypertension, osteoarthritis of left and right shoulder, R33's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R33 was moderately cognitively impaired with a BIMS (brief interview for mental status) score of 09/15.</p> <p>Review of the 11/6/2025 Activity Daily Living (ADL) care plan revealed, R33 had a functional ability deficit and requires assistance with self-care/mobility related to fatigue/weakness, impaired balance, impaired cognition, and impaired mobility.</p> <p>R118</p> <p>On 1/28/2026 at 8:25 AM, R118 was observed sitting in the rehab wing day room in a wheelchair without footrests feet resting directly on the floor. R118 was unable to answer questions about care. Licensed Practical Nurse (LPN) I was asked how R118 was transported to the day room. LPN I said Certified Nursing Assistant (CNA) J pushed R118 in a wheelchair.</p> <p>On 1/28/2026 at 9:25 AM, R118 was observed sitting outside of the rehab wing nurses' station in a wheelchair without footrests, feet resting directly on the floor.</p> <p>On 1/28/2026 at 12:52 PM, R118 was observed pushed by CNA K from R118's room to the rehab wing day room approximately 250 feet in a wheelchair without footrests with R118's feet sliding directly on the floor. When CNA K was asked about R118's wheelchair CNA K said R118's wheelchair should have footrests.</p> <p>On 1/29/2026 at 9:39 AM, LPN L was interviewed and said R118 should have leg/footrests and that R118 was dependent for wheelchair mobility. LPN L further said all residents that are dependent should have footrests for wheelchair mobility, it was a potential accident.</p> <p>On 1/29/2026 at 11:54 AM, the Director of Nursing (DON) was interviewed and said the expectation for staff is to make sure dependent residents have footrests/leg rests on the wheelchair prior to (continued on next page)</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                   |                                                 |
| <p>F 0689</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>transport to reduce the risk for accidents.</p> <p>On 1/29/2026 at 2:16 PM, Rehab Manager M was interviewed and said dependent residents should not be pushed in a wheelchair without footrests. They would be at risk of an injury or fall.</p> <p>Record review of R118's Electronic Health Record (EHR) revealed R118 admitted to the facility on [DATE] with diagnoses that included pneumonia, and adult failure to thrive.</p> <p>Review of R118's Brief interview for Mental Status assessment performed on 1/15/2026 revealed a BIMS of 6/15 severe cognitive impairment. Review of R118's mobility rating dated 1/21/2026 revealed dependent for wheelchair transfers and mobility.</p> <p>Review of the facility policy titled Wheelchairs undated revealed in part. Assisting a patient to safely achieve mobility is a goal of all the members of the interdisciplinary rehabilitation team. The patient's cognition, vestibular function, judgment, physical endurance and strength play a part in selecting the appropriate equipment. After selection of an appropriate wheelchair and accessories, nurses play an important role in assisting the patient to use the equipment safely.</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
| <p>F 0695</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow physician's orders to apply oxygen for one resident (R118) out of four residents reviewed for oxygen use. Findings include: On 1/28/2026 at 8:25 AM, R118 was observed sitting in the rehab wing day room in a wheelchair with a portable oxygen tank with Certified Nursing Assistant (CNA) actively assisting R118 with breakfast. R118 was observed not wearing the oxygen canula. R118 was observed coughing. R118 was unable to answer questions regarding care. Licensed Practical Nurse (LPN) I was asked how R118 was transported to the day room. LPN I said Certified Nursing Assistant (CNA) J pushed R118 in a wheelchair. When LPN I was asked if R118 should be on oxygen LPN I stated, Yes she just got out of isolation for Covid-19 and acknowledged R118 was not wearing the oxygen canula. LPN I checked R118's portable oxygen tank and said R118's tank was empty and proceeded to get R118 a new portable oxygen tank and applied R118's oxygen canula. On 1/28/2026 at 8:57 AM, CNA J was interviewed and stated, I brought R118 to the day room this morning. The portable oxygen was out, I should have told the nurse, but I got distracted. On 1/29/2026 at 9:39 AM, LPN L was interviewed and said R118 should have been wearing the portable oxygen, staff should know because it should be care planned and resident care is discussed in morning meetings. LPN L said R118 could become short of breath without the oxygen. Record review of R118's Electronic Health Record (EHR) revealed admitted to the facility on [DATE] with diagnoses that included pneumonia, and adult failure to thrive. Review of R291's Brief interview for Mental Status assessment performed on 1/15/2026 revealed a BIMS of 6/15 severe cognitive impairment. Review of R118's physician orders revealed O2 (oxygen) per nasal cannula @ 2L/min (at two liters per minute) continuously dx: SOB start date 1/8/2026. Review of R118's care plan did not reveal oxygen use. Review of R118's Kardex did not reveal oxygen use. On 1/29/2026 at 11:56 AM, the Director of Nursing (DON) was interviewed and said the expectation for staff is to follow physician orders and check the portable oxygen tanks prior to transporting residents. The DON further said oxygen use should be on the care plan and Kardex and agreed oxygen use was not care planned for R118. Review of the facility policy titled Oxygen Administration undated, revealed in part. Inspect all equipment and supplies. Implementation verify the practitioner's order for oxygen administration via humidified high-flow nasal cannula. Make sure the order contains the prescribed flow rate and oxygen level.</p> |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                   |                                                 |
| F 0745<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to obtain a Legal Guardian (LG) for one (R2) of one legally incapacitated resident resulting in R2 not having a court appointed legal guardian since 2024. Findings include: On [DATE] at 2:30 PM, R2 was observed up in recliner chair watching TV. R2 was unable to be interviewed due to cognition status. On [DATE] at 2:50 PM during interview with R2's Representative (RR1) they said they were not being included in decision making for R2. RR1 said they were not R2's Legal Guardian (LG) at this time and was currently trying to obtain it through the court system. RR1 said they had not been assisted by the facility to assist with Legal Guardianship paperwork. RR1 stated, I was told because I did not live in the same county as the facility, they had no way to help me. According to R2's Electronic Health Record (EHR) RR1 was identified as R2's emergency contact and representative. R2 had resided in the facility since [DATE] with multiple diagnoses that included vascular dementia. The Annual Report of Guardian on condition of a Legally Incapacitated Individual indicated that R2 had a LG company as their LG until [DATE]. There was no further information to determine if R2 had a current LG. R2's Advance Medical Directive (AMD) form dated [DATE] identified R2 as a full code and was not signed by a LG or resident representative. The form was signed by Social Worker (SWQ) and noted that R2 was unable to sign and had a diagnosis of dementia with confusion. R2's progress notes and social service notes did not reveal any documentation to support R2 had a LG. There was no documentation to indicate the facility had made attempts to acquire a LG for R2. On [DATE] at 11:24 AM, during an interview with SW Q they said that R2's LG paperwork had expired on [DATE] and there had been no information to determine who was R2's LG. SW Q stated, That Guardian company went out of business in 2024, and we haven't found another one to replace it. The family has not provided us with any LG paperwork, so the resident doesn't have a legal guardian now. SW Q could not provide any documentation to support the facility had attempted to obtain a LG for R2. SW Q stated, The family was supposed to apply for guardianship, but we haven't heard back from them. On [DATE] at 11:39 AM the Nursing Home Administrator (NHA) said R2 hasn't had a LG since [DATE]. The NHA could not provide any documentation to support the facility had attempted to acquire a LG for R2. The NHA stated, We do not have a specific policy for social services to obtain legal guardianship for legally incapacitated residents, but it is the expectation that they do. |                                                                                   |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                   |                                                 |
| <p>F 0805</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the physician ordered diet was provided to one resident (R203) of two residents reviewed for diet and nutrition, resulting in the potential for the resident to aspirate or choke. Findings include:</p> <p>On 1/27/2026 at approximately 1:40 PM, R203 was observed in their room with their lunch meal tray. The meal ticket on the tray listed the diet order as a regular diet with a pureed texture. The following food was observed on the tray: chicken pot pie, bread roll, peas and carrots, and applesauce. The food was not in a pureed form. R203 began to remove the plastic wrap from the bread roll to consume it.</p> <p>At approximately 1:45 PM, the surveyor notified LPN A of the concern. Upon entering the resident's room, the nurse was asked to verify the diet order on the meal ticket and stated, it's pureed, but that's not pureed food. I'll remove it and get (R203) the correct food. A record review revealed that the resident was admitted to the facility on [DATE] with a diagnosis of dysphagia. A Brief Interview for Mental Status assessment was completed on 1/24/2026. The resident scored a 7, indicative of severe cognitive impairment. A physician order dated 1/24/2026 in the electronic medical record identified the diet as a regular diet with pureed texture and thin liquids. Section GG of the Minimum Data Set with an Assessment Reference Date of 1/26/2025 revealed the resident needed supervision or touching assistance with eating. A care plan focus dated 1/26/2026 revealed: Ord'd Reg diet, Puree texture, thin consistency. 1/26 Tray set up for meals.</p> <p>An interview with Speech Language Pathologist (SLP B) was conducted on 1/28/2026 at 11:35 AM via phone with the facility Rehabilitation Director present. During this interview, SLP B said that R203 admitted to the facility from the hospital with a diet order of mechanical soft. Nursing then downgraded the diet to pureed after observing R203 with chewing and swallowing difficulties. The resident was provided with speech language therapy services with the goal of returning R203's diet to mechanical soft. SLP B confirmed that during current treatments, R203 has been observed with continual difficulty chewing and swallowing and stated, it would be concerning if the resident received a regular textured diet.</p> <p>An interview with Registered Dietitian (RD C) was conducted on 1/28/2026 at approximately 1:45 PM. RD C said they work with the kitchen staff to ensure each resident receives the correct diet as ordered. RD C said it would be concerning if R203 received the incorrect diet because it would put them at-risk for aspiration. An interview with the Nursing Home Administrator (NHA) conducted on 1/28/2026 at approximately 2:25 PM. The NHA said it was their expectation that each resident receives the correct diet and meal, and that multiple things could happen to the resident should the wrong diet and meal be provided to a resident, including adverse health effects.</p> <p>A facility document titled, Diet Orders with a revision date of 12/10/2024 revealed: The goal for each diet order is to be the least restrictive to effectively manage the resident's medical condition and to assist the resident in reaching their highest functioning potential. Further, #6 &amp;ndash; The facility will adhere to therapeutic diet parameters during food preparation and when dispensing condiments.</p> <p>On 1/27/2025 at 3:03 PM, an interview with Dietary Manager F found that during meal service there are two dietary aides that check tickets and ensure proper diets are given. One of the aides is receiving the plates and putting together the tray, and the other dietary aid checks over the tray and meal before placing it on the cart.</p> |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                   |                                                 |
| F 0883<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (R33) out of five residents reviewed for immunizations, was provided influenza and pneumococcal vaccination and education resulting in the potential for development and spread of influenza and pneumonia among vulnerable residents in the facility. Findings include:On 1/29/2026 at 10:00 AM, the Infection Preventionist (IP) O was interviewed and reported R33 did not have documentation of a current influenza or pneumococcal immunizations or refusals signed by the guardian.Review of the Electronic Health Record (EHR) for R33 revealed R33 admitted on [DATE] with diagnosis of transient cerebral ischemic attack, dementia and Alzheimer's disease. R33 did not have documentation to indicate that the influenza or pneumococcal vaccines were declined by the guardian or were contraindicated.On 1/29/2026 at 11:59 AM the Director of Nursing (DON) was interviewed and said R33's guardian should have been contacted to obtain consent or declination.Review of the facility policy titled Immunizations: Influenza Vaccination of Residents dated 4/17/2025, revealed in part.It is the policy of this facility that, annually residents will be offered immunization against influenza. Document resident refusal and education of risk vs. benefit. Review of the facility policy titled Immunizations: Pneumococcal Vaccination of Residents dated 11/4/2024, revealed in part.Informed consent in the form of a discussion regarding risks and benefits of vaccination will occur prior to vaccination. (This may be with the resident's authorized representative when appropriate. If signed consent were required according to state law, it would occur at this procedural step.) |                                                                                   |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>235177                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>01/29/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hartford Nursing & Rehabilitation Center                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>6700 W Outer Dr<br>Detroit, MI 48235 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                   |                                                 |
| F 0887<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure one resident (R33) out of five residents reviewed for immunizations, was provided Covid-19 vaccination and education resulting in the potential for development and spread of Covid-19 among vulnerable residents in the facility. Findings include: On 1/29/2026 at 10:00 AM, the Infection Preventionist (IP) O was interviewed and reported R33 did not have documentation of a current Covid-19 immunization or refusal signed by the guardian. Review of the Electronic Health Record (EHR) for R33 admitted on [DATE] with diagnosis of transient cerebral ischemic attack, dementia and Alzheimer's disease. R33 did not have documentation to indicate that the Covid-19 vaccine was declined by the guardian or was contraindicated. On 1/29/2026 at 11:59 AM the Director of Nursing (DON) was interviewed and said R33's guardian should have been contacted to obtain consent or declination. Review of the facility policy titled Resident Covid-19 Vaccination dated 10/6/2025, revealed in part. The facility will obtain a signed consent form for the administration of the Covid-19 vaccine from the resident or the resident's designated health care representative. A declination will be signed if consent is not given.</p> |                                                                                   |                                                 |