STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Nursing and Rehabilitation	3011 North Center Road Flint, MI 48506

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that safe cleaning practices, humidification, dispensation of oxygen and storage of respiratory equipment was maintained. This deficiency affected four residents (R77, R82, R84 and R89) of four residents reviewed for respiratory standards of care. Findings include: Resident 82 (R82): On 6/1/26 at approximately 9:30 AM, an interview was conducted with R82 who answered questions and engaged in conversation. An observation was made of a water bottle for humidification positioned on the concentrator but not connected to the concentrator or tubing that was on the Resident. The bottle was empty and there was not a date on the humidification container. The Resident reported that the oxygen was drying to her nose. A review of R82's medical record revealed an admission into the facility on 4/9/25 with diagnoses that included chronic obstructive pulmonary disease and asthma. A review of the Resident's Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) revealed a score of 15/15 that indicated intact cognition. On 6/3/26 at 11:27 AM, an observation was made with Unit Manager, Nurse C of Resident 82 lying in bed with her oxygen on that was connected to the concentrator. The humidification was not attached to the tubing or concentrator. The UM asked the Resident about the oxygen and the Resident reported that it dries out her nose and throat and will make her cough. The Resident reported that bottle had been on the concentrator for a couple months. There was not a date on the container. The UM indicated the container should be dated when applied. The UM told the resident that he was unsure if humidification was ordered but it sounds like you need it so I will make sure that it gets on there. Resident 84 (R84): On 6/1/26 at approximately 9:15 AM, an observation was made of Resident #84 eating breakfast sitting up on the side of the bed. The Resident was interviewed, answered questions and engaged in conversation. The Resident had Oxygen (O2) tubing in her nose (nasal cannula) that was attached to a concentrator at 4 L (liters)/(per) minute. The Resident reported she was not supposed to change the concentration of the oxygen. The concentrator was positioned not within reach of the Resident while in bed. An observation was made of humidification bottle with a short tubing that was positioned on the concentrator but was empty and not connected to the tubing to the Resident. The Resident was asked if the oxygen at 4 Liters/minute was comfortable for the Resident. The Resident reported that sometimes she gets bloody noses and the oxygen dries out her nose. The Resident was not aware the humidification was not attached. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 84's medical record revealed an admission into the facility on 9/11/19 and readmission on [DATE] with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, depression, anxiety disorder, dependence on supplemental oxygen and adult failure to thrive. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 12/15 that indicated moderate cognitive impairment. A review of R84's medical record revealed orders for oxygen at 3 Liters/min and an order for Nasal Four Nasal solution 1%, 1 spray in both nostrils every 1 hours as needed for irritation, may have at bedside. On 6/2/26 at 4:09 PM, an interview was conducted with Unit Manager (UM), Nurse C regarding Resident #84's oxygen and the lack of humidification. The UM indicated there did not need to have an order for the humidification and it would be if the Resident needed it. An observation was made of Resident #84's oxygen. The Resident was in the room and had the oxygen nasal cannula in her nose with the tubing connected to the concentrator and set at 4 L/min. The humidification was on the top of the concentrator, empty and not connected to the concentrator and resident. The Resident was asked if the oxygen caused issues in her nasal passages and the Resident reported it made her nose dry, caused it to bleed and she would put a Q-tip in there to get the hardened crusty blood out. The UN educated the Resident about placing items in her nose and reported they would get humidification connected to the oxygen. A review of facility policy titled, Oxygen Administration, revealed, .Assessment: .3. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered per physician order. 5. O serve the resident upon setup and periodically thereafter to be sure oxygen is being tolerated and continues at the prescribed liter flow. 6. Periodically re-check water level in humidifying container and change as needed. R77: A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R77 was admitted to the facility on [DATE] with diagnoses that included: congestive heart failure (CHF/ decreased ability of heart to pump blood), respiratory failure, chronic obstructive pulmonary disease (COPD/ progressive lung disease), morbid obesity with obstructive sleep apnea (OSA), diabetes mellitus (DM), hypertension (high blood pressure) and atrial fibrillation (AFIB/ irregular rapid heart rate). The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15. On 06/01/2026 at 1:23 PM, observed R77's oxygen tubing was dated 5/18 set at 3L and Continuous Positive Airway Pressure (Cpap) mask was sitting on top of the nightstand not in use and uncovered. On 06/02/2026 at 9:33 AM, during an interview with R77 he said they do not clean his Cpap mask, and it was never stored in plastic and was always on his nightstand. Observed R77's oxygen tubing was dated 5/18 set at 3L and Cpap mask was sitting on top of the nightstand not in use and uncovered. According to a record review of R77 orders: Dated 05/05/2026: Oxygen at 2 lpm via nasal cannula, notify MD if SpO2 is less than 90%.Dated 05/07/2026: Home Auto CPAP 8-20cmH2O with home settings and o2 bled in at 2 liters to be worn at NOC (night) and as needed for naps. According to a record review of R77's care plan: Focus: Has/At risk for respiratory impairment related (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to CHF, COPD, sleep apnea, chronic resp fx (failure) O2 use. With interventions: CPAP (8-20) use per physician orders; Administer oxygen as per physician order: 2 liters via nasal cannula. There were no orders or care plans placed for oxygen or CPAP equipment cleaning care and maintenance. R89:A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R89 was admitted to the facility on [DATE] with diagnoses that included: history of repeated falls, obstructive sleep apnea (OSA), atherosclerotic heart disease (ASHD), congestive heart failure (CHF / decreased ability of heart to pump blood) and depression. The MDS assessment dated [DATE] indicated the resident had moderate impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 10/15. On 06/01/2026 1:13 PM, R89 was not present in room to interview, an observation of R89's Cpap mask hanging high on wall not in use and not covered. On 06/02/2026 at 9:27 AM, observed R89's cpap in the same position hanging high on the wall not in use and uncovered. When asked R89 said that is where they keep it, the hook was here before she moved in. On 06/02/2026 at 3:51 PM, R89 was again asked about her Cpap that was observed in the same position uncovered and high up on the wall on a hook, R89 said she was unable to reach the hook and that one of the CNAs assisted her at night to put it on/off and they put it back on the hook, she said however that she did not wear it last night. When asked she said that she had never seen anyone clean it. According to a record review of R89's care plan:Focus: I have altered respiratory status r/t OSA. With interventions: Home cpap to be worn at HS (bedtime) and NOC (night). According to a record review of R89's orders:Dated 05/11/2026: Home cpap to be worn at HS and NOC.There were no orders or care plans placed for the CPAP equipment cleaning, care and maintenance. On 06/02/2026 at 3:53 PM, during an interview with CNA J she was asked if she cleaned the residents Cpap masks and she said yes. CNA J was asked what she cleaned the mask with and she said wipes, asked what kind of wipe and she said bleach wipes and showed SA a canister of wipes with a purple top and said it was like those but that the canister with the bleach wipes had a white top, she but that couldn't find one at the time. CNA J was asked how the Cpap mask was stored when not in use and she said most residents keep then in their closet or nightstand and in a plastic bag to cover them. CNA J was asked who was responsible for the storage of the masks and she said the Nurses were. On 06/02/2026 at 3:56 PM, during an interview with Nurse K was asked who was responsible for cleaning the Cpap masks she said the respiratory therapy staff, she was asked how often they are clean she said she did not know. Nurse K was asked how the masks are stored when not in use and she said in the nightstand in a plastic bag. Nurse K was asked who was responsible for ensuring storage of the mask she said any staff that was working with the resident. Nurse K was asked how often oxygen tubing was replaced and she said every Sunday by the night shift nurse. On 06/02/2026 at 4:17 PM, during an interview with the ICP B he was asked who was responsible for cleaning of residents Cpap masks and he said it was respiratory therapy. When asked how often cleaning of Cpap masks were done he said it used to be daily, but he is not sure. ICP B was advised his staff said the masks were cleaned with bleach wipes and he was asked to confirm, he said 'I am (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not sure what is used but I know it is not bleach wipes on respiratory equipment.' ICP B was asked how often oxygen tubing was replaced, he said every Sunday on night shift by the nurse on duty. The infection control preventionist (ICP) B was asked to go on a walkthrough of both R77 and R89's rooms for observation. ICP verbally acknowledged that R77's oxygen tubing was dated 5/18 and the Cpap mask was uncovered and not in use on the nightstand. ICP verbally acknowledged that R89's Cpap mask was hanging high out of reach of resident and was uncovered and not in use.According to a record review of the facilities policy labelled Cleaning and disinfection or resident-care items and equipment: Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. With policy implementations: 1.The . Classification System is used to distinguish the levels of sterilization/disinfection necessary for items used in resident care; 1.b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (e.g., respiratory therapy equipment).; 5.a. Single resident-use items are cleaned/disinfected between uses by a single resident. According to a record review of the facilities infection prevention rounds tool – nursing department: Focus area: Unused oxygen tubing, nebulizers stored in lactic bags; tubing dated and changed per guidelines. According to a record review of the facilities Policy labelled Oxygen administration: Assessment: 4.date the oxygen tubing per the policy there was no guidelines written for timeframe of tubing placements. According to a review of the facilities ResMed CPAP preventative maintenance guidelines: 1. Daily Maintenance: Mask cushion/pillows: Wash daily with warm drinking quality water (~30ˆ degrees C / 86ˆ degrees F) and mild, non-scented detergent to remove facial oils and maintain seal integrity. Rinse thoroughly and air dry away from sunlight; Humidifier water tub (routine care): Empty remaining water each morning, rinse, and allow to air dry out of direct sunlight. Use distilled water only for therapy. And 6. Important safety notes: Avoid harsh chemicals, bleach, alcohol, scented soaps, antibacterial detergents or UV/ozone cleaners, as these may damage components.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) Ensure proper storage of medications for Resident #23 and Resident #112; 2) Ensure that medication carts and treatment carts were secured; 3) Ensure that expired medications were disposed of; 4) Ensure that a medication cart was in sanitary condition; and 5) Ensure that medication cart keys, which included narcotic keys, were not shared between nurses, for three of six medication carts, one of three medication storage areas, one treatment cart and one wound care cart reviewed for storage of medications, supplies and narcotics. Findings include: On 6/1/26 at 8:25 AM, an observation was made in the 100-Hall area of a treatment cart positioned in the hallway against the wall. The Treatment Cart was left unlocked and not secured. Staff were going up and down the hall, and there was not any Resident's in the area at this time. The Nurse had been at a medication cart at the end of the hall. The Medication cart was up against the wall with the drawers facing the hallway. The Nurse was observed assembling medication and went into the room and was not within vision of the medication cart that was left unlocked and positioned in the hallway. On 6/1/26 at 8:38 AM, an interview was conducted with Nurse V who came back out of the Resident's room and returned to the unsecured medication cart. The Nurse was asked if the medication cart should be locked when not in direct vision of the nurse and the Nurse reported that Yes, it should be locked. When asked if they had been in the treatment cart that was positioned partially down the hallway, the Nurse reported she had been in there earlier. When asked if the treatment cart should be locked when in not direct vision of the nurse, the Nurse indicated it should be locked as well. A review of the treatment cart with Nurse V revealed treatment/dressing supplies, and prescription ointments, powders and treatments. On 6/1/26 at 1:10 PM, an observation was made in the 100-Hall area of the medication cart stored at the end of the hallway up against the wall with the drawers facing the hallway. There was a resident in the hallway. The medication cart was unlocked. Nurse T was observed earlier at the cart and had gone up the hall and off the unit. The Medication cart was not directly supervised by the nurse. A couple minutes later Nurse T came back and when asked about the security of the medication cart, the Nurse locked the cart. On 6/2/26 at 4:15 PM, an observation was made in the 200-Hall of a treatment cart unlocked and positioned near a resident's door with the drawers facing up the hallway and would be in reach for Residents. There were three Residents propelling themselves in the hallway. At 4:17 PM, the treatment cart remains unsecured. An observation was made of a Nurse walking by the treatment cart, passed the cart without securing the cart, the nurse goes into the med room, comes back by the treatment cart and down the hall where they go into a Resident's room and not in direct vision of the treatment cart. An observation was made of three other residents propelling themselves past the treatment cart. At 4:20 PM, an interview was conducted with Nurse T who comes out of the Resident's room where the treatment cart was positioned near. When asked the Nurse reports the treatment cart should be locked when they are not there. The Nurse reported the treatment cart was the wound cart and contained dressing and treatment supplies. On 6/3/26 at 9:28 AM, an observation was made on the 600 Hall during medication storage review (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Nurse H who was also observed passing medication to Residents. The Nurse was getting a narcotic medication out for a Resident and had asked the other for the keys to the middle cart. The Nurse had passed the keys to the other Nurse, and a narcotic count had not been completed. When asked about why the other Nurse had the keys, Nurse H reported that they had two med carts in use, but she had some residents' medications in the middle cart. The Nurse explained that they sometimes have three nurses but due to census, they only had the two nurses working and the other Nurse had taken the medications out of the cart at the beginning of the shift, but she still had the keys even though she had some of her residents' medication in that cart. When asked who had counted the narcotics on the middle cart, the Nurse reported she had. An observation was made of the narcotic count sheet that the nurses were to sign upon counting the narcotic medication and it was blank where she should have signed after narcotic count. The Nurse reported she had forgot to sign after counting with the nightshift nurse and signed the sheet at this time. The 600-Hall medication cart was reviewed with Nurse H and the following items were identified: -The medication discard bottle to waste medication was in a bag with brown liquid leaking out of the bottle, down the sides and there was brown liquid on the bottom of the drawer where the liquid was kept with bottles of medication. -Container of Acetaminophen 325mg (milligrams) expired 4/2026. -Container of Famotidine 10 mg, expired 1/2026. -Container of Melatonin 3 mg, expired 1/2026. -Container of Aspirin 325mg, expired 1/2026 that had a date of opening on 5/18/26. -Container of Vitamin B1, expired 3/2026. -The glucose monitor control solutions were opened with the date opened on 12/20 (2025). When queried regarding how long the control solution was good for, the Nurse was unsure and indicated the nightshift nurses perform the glucose controls on the monitors. Reviewing the box of control solutions, the box had underneath the manufacturer's expiration date instructions that revealed, good for 45 days after opening. On 6/3/26 at 10:19 AM, an observation was made with Nurse U, of the Central Supply medication storage area where over-the-counter medications and medical supplies were stored, with the following items identified: -Hydrophilic coated Cure Catheter x (times) 6 catheters, expired 2/8/2026. -14 French catheter expired 7/13/2025. -Self Catheters x 13, expired. -Vitamin B6 x 2 bottles, expired 3/2026. -Vitamin B6 bottle, expired 1/2026. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Melatonin 3 mg expired 1/2026. -Melatonin 3 mg expired 2/2026. -Acetaminophen 325 mg, expired 4/2026. -Vitamin B12 expired 5/2026. -Geri Kot, x 2 containers, expired 1/2026. On 6/3/26 at 10:58 AM, a review of the medication cart in the 400-Hall area was reviewed with Nurse C. An observation was made of Sevelamer Carbonate tablets for a Resident that were in a bottle that had an expiration date of June 2025. The Nurse explained that they had gotten the bottle from the Resident's family and will check to see if they had some that were not expired. A review of the treatment cart in the 400 hall with Nurse C was reviewed. There were open bottles of iodoform dressing for packing that were not dated with an open date. When asked if the items were to be dated, the Nurse stated, I can't tell how long it's been open, I don't know how long it is good for, when there was not an expiration date, just a lot number. On 6/3/26 at 1:16 PM, an interview was conducted with Unit Manager, Nurse T regarding facility policy on ensuring secure medication carts and treatment carts. The Unit Manager indicated that the med carts should be locked when the nurse was not within reach or vision of the med cart of treatment cart. Regarding expired medications in the medication carts, the Unit Manager reported that the Nurses should be checking for expired meds on a monthly basis and stated, We need to establish a schedule. On 6/3/26 at 1:28 PM, an interview was conducted with the Director of Nursing regarding the medication cart observations not secure. The DON reported they should be locking the carts when the carts were not in sight of the nurse. Regarding the expired medications, the DON reported she will make sure they were disposed of and that the night nurses should be looking at it and indicated they had a weekly schedule. Regarding the glucose monitoring solutions opened for extended period of time, the DON stated, They should be getting rid of it after the 45 days. It was reviewed with the DON that the two Nurses both had access to the med cart keys that included the narcotic keys but had not ensured an accurate account of the narcotic medications. A review of facility policy titled, Storage of Medications, revealed, .3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 8. Compartments.containing drugs and biologicals are locked when not in use. 9. Unlocked medication carts are not left unattended. 14. Access to controlled medications is limited to authorized personnel. Personnel access to controlled medications is recorded. A review of the facility policy titled, Storage of Controlled Substances, revealed, .Procedures: .2. Schedule II through V medications and other medications subject to abuse or diversion are stored in either a permanently affixed, double locked compartment separate from all other medications or in accordance with state regulations. The access system to controlled medications is not the same as the access system for other medications (e.g., the key that opens the compartment is different from the key that opens the medication cart). If a key system is used, the medication nurse on duty maintains possession of the key to controlled substance storage areas. a. At each shift change, or (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and is documented. Resident #23: On 6/1/2026 at approximately 8:30 AM, Resident #23 was observed lying in bed after finishing breakfast. At the bottom of her bed were two bottles of OTC (over the counter) [NAME] and an unlabeled Albuterol inhaler with 46 administrations remaining. The resident was asked about the medications and stated she takes [NAME] as needed when she is stuffed up. She added she has COPD and uses an inhaler daily- she stated they (the nursing staff) don' t know that she has the inhaler in her room. Resident #23 then asked for medications to be covered prior to leaving the room. Nurse N entered the room to complete vitals on Resident #23 and observed the medications at the end of her bed. She picked up the medications and walked to her cart and reported the resident and her significant other have been educated multiple times on bringing in OTC and home medications. Nurse N checked the cart and saw Resident #23's Albuterol box was empty and determined the inhaler in her room was the one from the medication cart. Nurse N reported she did not administer an inhaler to her, so it was a different shift that provided her with the inhaler. On 6/2/2026 at approximately 10:00 AM, a review was conducted of Resident #23's records and it revealed the resident admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, Diabetes, Major Depression, Mood Disorder, and Atrial Fibrillation. Further review yielded the following: June 2026 MAR (Medication Administration Record): Albuterol Sulfate HFA Inhalation Aerosol Solution- 2 puff inhale orally every 4 hours as needed for SOB (shortness of breath). It was last administered on 6/1/2026 at 11:12 PM. Progress Notes: 6/1/2026 at 10:20 AM: Pt (patient) educated on not having family bring in medications from home, pt has been educated before and educated again we have a routine med pass time and medication administration of meds, pt stated she understood this. On 6/3/2026 at 2:00 PM, the DON stated they have educated Resident #23 and her significant other on bringing in home medications. She stated they should not have been at bedside with her. Resident #112: On 6/1/2026 at approximately 8:00 AM, Resident #112 was greeted in her room. She recently admitted to the facility after fracturing her leg from a fall at home. Sitting on Resident #112's bedside dresser was a bottle of Omeprazole 40 mg (milligrams) with approximately 40 capsules in the bottle. The resident shared she had her family bring in her medication this weekend to show the nurse what she takes. The nurse from the weekend knew the omeprazole was in her room but not her current nurse. Resident #112 reported she was unaware of the facility rules regarding unsecured medications. Nurse M was outside of the resident room and was asked if she observed the bottle of omeprazole on the bedside dresser. Nurse M stated while she had been in the residents' rooms this morning, she did not see the medication bottle on the dresser now did the resident alert her to the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/1/2026 at approximately 8:10 AM, the DON (Director of Nursing) was informed of the medications found at Resident #112's bedside. The DON reviewed her chart and shared on day of admission Omeprazole was ordered so she was uncertain why she would bring them in. On 6/2/2026 at approximately 10:30 AM, a review was conducted of Resident #112's record and it revealed she was admitted to the facility on [DATE] with diagnoses that included, Hypotension, left fibula fracture, Diabetes, Atrial Fibrillation, GERD (Gastro-Esophageal Reflux Disease), COPD and Heart Disease. Further review of the record yielded the following: May 2026 MAR: Omeprazole Oral Capsule Delayed Release 40 MG- Give 1 cap by mouth two times day. Medication was first administered on 5/25/2026 at 5:00 AM.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that menus and/or food preferences were followed for three residents (#12, #13, #84) of three residents reviewed for preferences and nine residents observed during the dining task.Findings include:Resident 84 (R84): A review of Resident 84's medical record revealed an admission into the facility on 9/11/19 and readmission on [DATE] with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, depression, anxiety disorder, dependence on supplemental oxygen and adult failure to thrive. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 12/15 that indicated moderate cognitive impairment. On 6/1/26 at approximately 9:00 AM, an interview was conducted with R84 who answered questions and engaged in conversation. The Resident was observed with her breakfast tray at her bedside, and the Resident was putting jelly into her oatmeal. The Resident was asked about food and the Resident reported that she uses brown sugar and jelly in her oatmeal for breakfast. The Resident reported that they never bring her brown sugar. The Resident had a single packet of white sugar and said, Who puts white sugar in their oatmeal! The Resident reported she only got one jelly today and she uses more than one. The Resident reported going down to the kitchen yesterday to complain and they still have it wrong. The meal tag was on the Resident's tray, and it indicated the Resident was to get oatmeal and also indicated jelly and sugar. When asked if she usually used the white sugar or brown sugar on her oatmeal, the Resident reinstated who puts white sugar on oatmeal, I want the brown sugar, and reported she should not have to go down there to complain and then they still don't get it right. Resident #13: On 6/1/2026 at approximately 7:10 AM, Resident #13 was observed resting in bed and shared he had a fall at home and was admitted to the facility for strengthening and to get back to his prior level of functioning. He added he routinely is not provided with the menu items that are listed on the meal ticket and that can become frustrating. On 6/1/2026 at 8:05 AM, Resident #13 breakfast tray had been delivered, and we reviewed the meal ticket to his tray provided for completeness. The ticket stated, scrambled eggs with ham, on his plate it only appeared to be eggs without ham. The resident reported they typically dice the ham and cook it with the eggs but there was no ham cooked into his eggs this morning. Resident #13's roommate was still enjoying breakfast and asked about his scrambled eggs with ham-. He reported there was no ham in his eggs and moved around the eggs on his plate to ensure the ham was not missed. Observation was made of multiple resident's breakfast trays on 300 Unit and the following was observed: 303-1- Sitting up in bed with breakfast tray in front of her. The meal ticket read scrambled eggs with ham, there was no ham observed on her plate or cooked in with the eggs. 303-2- The resident reported there was no ham on her plate although that was listed on the meal ticket. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	06/03/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	304-1- Observation of meal tray and ticket and there was no ham on her plate or cooked within her eggs. 305-1 – CNA (Certified Nursing Assistant) P was observed assisting the resident with her breakfast and was asked if there was ham cooked with the eggs or anywhere on the plate when received. CNA P reported there was no ham provided. 305-2 Observation of meal tray and ticket and there was no ham on her plate or cooked within her eggs. 308-1- Observation of meal tray and ticket and there was no ham on her plate or cooked within her eggs. 309-1- Observation of meal tray and ticket and there was no ham on her plate or cooked within her eggs. 309-2- Observation of meal tray and ticket and there was no ham on her plate or cooked within her eggs. 311-1- Observation of meal tray and ticket and there was no ham on her plate or cooked within her eggs. On 6/1/2026 at approximately 1:50 PM, a review was conducted of Resident #13 medical record and it revealed he admitted to the facility on [DATE] with diagnoses that included Hypertensive Heart Disease, Heart Failure, Diabetes, Generalized Anxiety Disorder and Spinal Stenosis. His diet is listed at general diet, regular texture, think consistency. On 6/2/2026 at 3:24 PM, an interview was conducted with Dietary Manager Q regarding breakfast provided to the residents on 6/1/2026. Manager Q was asked if they currently have ham and she stated yes as they received a shipment today and last week. She was asked why ham was not provided to facility residents during breakfast yesterday morning. She reported she did not receive any complaints yesterday regarding breakfast and was unaware of this. If if there was no diced ham, they could have used the sliced ham and diced it to their needs. Observation was made of the following in the kitchen freezer: 1- unopened box of diced ham delivered on 6/2026. 1- unopened box of diced ham delivered on 5/28/2026 On 6/2/2026 at 3:50 PM, Dietary [NAME] R stated he was the cook for breakfast yesterday (6/1/26).He explained the menu called for scrambled eggs with ham and they typically have pre-diced ham that they cook into the eggs but they did not have any ham yesterday – so he only made the scrambled eggs. Shortly after the phone call ended [NAME] R called back and stated that there indeed was ham in the freezer but he did not realize that and took full accountability. On 6/3/2026 at 9:15 AM, review was completed of the menu for 6/1/26 it showed the following: Choice of juice (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Choice of hot or cold cereal Scrambled Egg with cheese English Muffin Jelly Margarine 2% milk Coffee/Hot Tea Condiments There were 70 residents that were supposed to be served scrambled eggs with ham on 6/1/2026.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 who consume food from the kitchen. Findings include: On 06/01/2026 at 6:16AM whole milk with a best buy date of 5/28/26 was observed in the walk-in cooler. On 06/01/2026 at 6:17AM lemon flavor thickener with a best buy date of 4/24/26 was observed in the walk-in cooler. According to the 2022 Food Code, 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date.On 06/01/2026 at 6:18AM large chunk of built-up ice accumulation on food storage shelf, was observed in the walk-in freezer.According to the FDA 2022 Food Code, 6-501.12 Cleaning, Frequency and Restrictions, Physical facilities shall be cleaned as often as necessary to keep them clean. Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of food is exposed such as after closing.On 06/01/2026 at 6:20AM a knife was observed visibly soiled, stored in the knife rack. According to the facility's policy on Sanitation, All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.According to the FDA 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.On 06/01/2026 at 6:23AM the ice machine drain was observed sitting inside the drain, located in the dining room adjacent to the kitchen. According to the 2022 FDA Food Code, 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 equipment in which food, portable equipment, or utensils are placed. On 06/01/2026 at 7:04AM interviewed Dietary Manager A on how long milk is kept for, and she stated the facility doesn't keep it past the expiration date. On 06/01/2026 at 7:09AM two gnats were observed on the floor in the dishwashing area. On 06/01/2026 at 7:10AM several gnats were observed flying around the drain to the dishwasher. On 06/01/2026 at 7:20AM interviewed Dietary Manager A on how often pest control comes out to the facility, she stated they will come once a month.According to the FDA 2022 Food Code, 6-501.111 Controlling Pests, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by .Routinely inspecting incoming shipments of food and supplies .Routinely inspecting the premises for evidence of pests .Using methods, if pests are found, such as trapping devices or other means of pest control . Eliminating harborage conditions.Record review of the facility's pest control logs under service comments found that .3 drain flies were found in the kitchen. Changed glue boards, replaced bait, and cleaned equipment as necessary.

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	235184	A. Building B. Wing	06/03/2026

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure appropriate backflow prevention was installed at plumbing fixtures, resulting in the potential for contamination to the water supply, affecting all residents. Findings include: On 06/03/2026 at 9:10AM the cap to an atmospheric vacuum breaker to the utility sink was observed missing in the supply closet in Station C Hall. On 06/03/2026 at 10:26AM an attached hose with a spray nozzle downstream of a hose bib vacuum breaker on an outside spigot was observed around the corner from the front entrance. During this observation, Maintenance Director S stated there's another hose at the front entrance that is probably set up the same way. On 06/03/2026 at 10:27AM an attached hose with a spray nozzle downstream of a vacuum breaker on outside spigot was observed at the front entrance.According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess and monitor for potential changes in condition of a hydrocele (fluid-filled sac in the scrotum that causes swelling) for one resident (Resident #97) of one resident reviewed for assessment and monitoring. Findings Include:Resident #97:On 6/1/2026 at 10:30 AM, as Nurse N entered the room to complete vitals and assess Resident #97's roommate, prior to her assessment she observed Resident #97 sitting up on the side of the bed and it appeared he was attempting to get up unassisted. Resident #97 only had on white shirt sleeve T-shirt and a large hydrocele about the size of a melon was observed.On 6/1/2026 at approximately 11:30 AM, a review was conducted of Resident #97's record and it revealed he admitted to the facility on [DATE] with diagnoses the included Dementia, Anxiety, Overactive Bladder, Spinal Stenosis, and Hydrocele. Review was conducted of his care plan and Kardex and there was nothing noted regarding monitoring of Resident #97's hydrocele. Further review yielded the following:Progress Notes:8/13/2025 at 8:41 AM: 78yo male admitted from (hospital) on 8/12/25 . Imaging showed a small left hydrocele and a massive complex right hydrocele measuring 10.7 X 13.7 X 10.3 cm. Hydrocele was noted to be a chronic problem. The patient was evaluated by Urology in the ER (Emergency Room) they recommended outpatient workup with his primary urologist. Skin Assessment: Scrotal swelling noted, Treatment Plan; Monitor scrotum for increased swelling or s/s of infection Q shift.The measurements listed in the chart were completed at the hospital on 8/5/2025 and there were no other measurements, assessment or monitoring found regarding Resident 97's hydrocele.On 6/3/2026 at 10:20 AM, Nurse N stated Resident #97 admitted with the hydrocele and she typically observed the area while completing care or in moments such as Monday. Nurse N reviewed the chart and stated she was unable to locate measurements or monitoring of the hydrocele- she continued since there is no open area it would not be under the wound tab. On 6/3/2026 at 10:30 AM, CNA (Certified Nurse Assistant) O reported Resident #97 admitted to the facility with the hydrocele and it appears it has enlarged since his admission. She explained when she assists him to the bathroom he has to maneuver around to fit the hydrocele within the toilet bowl and this has not always been the case.On 6/3/2026 at 10:55 AM, an interview was conducted with Wound Nurse C regarding Resident #97's hydrocele. He reported they are not following Resident #97 for wounds as he does not have any current open areas. He was asked if there was any ongoing monitoring, assessment or measurements of the hydrocele and he stated there would not be. Nurse C was asked how the facility would recognize if the hydrocele had increased in size since and nurse stated they would not be able to.

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	235184	A. Building B. Wing	06/03/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the prescribed nutritional formula was consistently available and that the quality was maintained. This failure affected one resident (Resident #106) of one resident reviewed for enteral nutrition standards of care. Findings include: Resident #106 (R106): A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R106 was admitted to the facility on [DATE] with diagnoses: hemiplegia (mild to moderate weakness on one side) and hemiparesis (severe to complete paralysis on one side) following cerebral infarction (interrupted blood flow to brain) affecting right dominant side, aphasia (cognitive communication deficient with speech and understanding), dysarthria (motor speech disorder), percutaneous endoscopic gastrostomy tubes (PEG / delivers nutrition and medications directly into the stomach) placed 05/22/2026, adult failure to thrive, neuromuscular dysfunction of bladder. The MDS assessment dated [DATE] indicated the resident had moderate impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 10/15 and was bed bound (confined to bed) and dependent on assistance for care. 06/01/2026 6:02 AM, observed R106 resting in bed with eyes closed. Tube feeding Jevity 1.5 calorie label had a black handwritten date of 05/30/2026 at 0200 (2AM) on label side, the back side of same tube feeding formula bottle had a black handwritten date of 05/31/2026 at 2000 (8PM), the rate was running at 45 ml (milliliter)/ hour.According to record review of R106: R106 had a PEG tube placed at (hospital name) on 05/22/2026 related to decreased oral intake.According to a record review of R106's Nutritional evaluation dated 05/26/2026 revealed: 3. 05/26/2026 most recent body weight 103.6#'s; 4. UBW (usual body weight) 150#'s and 6d. Jevity 1.5 at 30 ml/hr. Discrepancy noted in goal rate noted. Current TF order is at 30 ml/ hr. and MD note reference's goal of 45 ml/ hr. TF currently observed to be infusing at 45 ml/hr.06/01/2026 08:15 AM, CNA D was asked to observe to two dates on the tube feeding bottle and then was asked what the two dates were about, she said she was unsure and that was a question for the nurse.06/01/2026 8:20 AM, the Unit Manager (UM) C was asked what the date on the tube feeding was and he said it was the date it was opened and hung. UM C was asked how long a tube feeding was appropriate for use after opening, and he replied, for 24 hours. UM C was asked to observe R106's tube feeding formula bottle and verified the two different dates, after it was observed he was asked which date the Tube feeding was opened and hung and he said he was unsure. UM C proceeded to unhook the tube feeding formula and said he would take of it and get a new one hung and dated.06/01/2026 8:40 AM, Nurse E was observed at the medication cart and was requested for SA to observe when the new tube feeding replaced. Nurse E said she would do it after she passed pain medications to her other residents and that she would inform SA prior.06/01/2026 at 10:21AM, Registered Dietician (RD) G approached SA and requested an interview. RD G said there is currently no tube feeding in the facility available for the R106 and that the physician put it on hold until they were able to get it. RD G said it is on its way and should be there soon. RD G said they planned to increase the rate to 68 ml/ hour to make up the nutritional loss. RD G was asked how she calculated the loss and the new rate since they did not know how long R106 would be without formula since none was available yet and she said it could be adjusted. RD G said that R106 had some oral intake and when asked she was unable to verify how much oral intake R106 had. RD G said R106 was a 1:1 assist with oral feeding and that it was not charted for the morning yet. RD G was asked how long tube feeding formula was good for and she was unable to answer. According to a review of progress notes for R106:Dated: 6/1/2026 at 09:16 Nutrition-Note Text: Tube feeding formula updated d/t (due to) product availability, Jevity 1.5 currently out of stock. Order changed to Osmolite 1.5 as substitute. Physician notified and in agreement. Will continue to monitor and make recommendations as indicated.A record review of R106's history of medical orders for tube feeding formula revealed: Dated 05/28/2026: Enteral Feed- (continued on next page)

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	235184	A. Building B. Wing	06/03/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Jevity Formula, infuse at 45mLs/hour. Infuse until 1080mls infused.Dated 06/01/2026: Enteral Feed- .Osmolite 1.5 Formula, infuse at 45mLs/hour. Infuse until 1080mls infused. 06/1/2026 at 11:29AM, observation of resident resting in bed with eyes closed there was no tube feeding hanging. CNA D assigned to R106 was asked what resident consumed at breakfast and she said, maybe one bit and that R106 does not eat much but that she will usually drink her juice.06/1/2026 at 1:19PM, additional observation of resident resting in bed eyes closed, with no tube feeding formula hanging. 06/02/2026 at 9:39 AM, observation of R106 resting in bed eyes closed. There was a tube feeding formula Jevity 1.5 running at 60 ml/hour with a black handwritten date of 06/01/2026 at 1700 on the label.According to an additional review of progress notes for R106:Dated: 6/1/2026 at15:29 Nutrition- Note Text: Notified substitute formula was not immediately available. TF was interrupted ~8 hrs. related to tube feeding shortage. According to an additional record review of R106's history of medical orders for tube feeding formula revealed: Dated 06/02/2026: Enteral Feed- .Jevity 1.5 Formula, infuse at 60 mLs/hour . Infuse until 1440 mls has infused.Dated 06/02/2026: Enteral Feed- .Jevity Formula, infuse at 45mLs/hour. Infuse until 1080mls infused.According to a review of the facilities policy titled Enteral Nutrition: Policy Statement: Adequate nutritional support through enteral nutrition is provided to residents as ordered.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on the interview and record review, the facility failed to ensure the adequate competency and verification of skills for one (1) certified nursing assistant of five (5) certified nursing assistants reviewed for completion of annual 12 contact hours, and the competency/training checklist required by the facility was completed before being taken off the training schedule for resident care.Findings include:On 6/3/26 at 9:22 AM, the employee records of Certified Nursing Assistant TB (CNA TB) were reviewed. CNA TBs employee record revealed that her original hire date was 8/25/25. Her termination date was 11/11/2025. CNA TB was rehired on 1/26/2026 and was verified as currently employed during the state recertification survey from June 1, 2026, to June 3, 2026. The Human Resources (HR) Director stated that she was new in her position as HR, and the Regional HR asked to be present during the interview with the HR staff and the review of 5 CNAs (Certified Nurse Aide) Records. The 2 HR staff agreed that CNA TB did not have a record of the facility completing 12.0 Continuing Education because she was considered a new hire and restarted in January 2026. The facility's Staffing Scheduler CB was interviewed on 6/3/26 at 12:40 PM and confirmed that CNA TB was on the facility CNA schedule and was off the training/orientation schedule assigned to patient care independently for quite some time now after she was rehired in January 2026. The Staff Scheduler indicated that she did not know when they would complete their training. And stated, They will not be on the floor if they have not signed off on their competencies. CNA TB had been released from the orientation schedule, so she assumed the competency checklist had been completed. Staffing Scheduler CB stated, Besides, she was a rehire, so she should have received all the training needed in her prior employment with us. The facility scheduler, CB, denied reviewing the completed checklist before scheduling CNA TB because it was the training/in-service nurse's and HR (Human Resources) 's job.Staff Inservice/Training Manager was interviewed on 6/3/26 at 3:50 PM. He denied knowledge of CNA TB's missing training checklist in the past hired date and the current employment date. The training/in-service nurse indicated that he will help search for it.CNA TB was not present at the facility and was unavailable for interview on June 3,2026 during survey.The Director of Nursing on June 3,2026 at 3:30 PM, was aware and revealed that they looked for CNA TB's orientation checklist in the past employment (HR) file and the current rehire HR file, and they could not find any record or proof that the orientation/competency checklist was completed by CNA TB.The Administrator confirmed on 6/3/26 at 3:45 PM that the competency checklist was not in CNA TBs HR File. The proof of the competency checklist record was not found for both 2025 and 2026 employment.The facility policy entitled New Staff Member Orientation, with a facility review date of 05/2025, indicated that the Certified Nursing Assistant (CNA) Timeline for Completion of Training is 3 to 5 Training Days.The Facility Policy Interpretation and Procedure specified the following: .2. The new staff member will complete the appropriate new-hire document during orientation.3. The orientation program is separate from the required state-approved Nurse Aide Training Program and the role-specific training and/or in-service training of new and existing staff.4. The administrators and Managers will ensure completion of the new hire general orientation as well as all new hire documents.5. A general Orientation Checklist will be completed and maintained as part of the staff members' personal files.6. In addition to our general orientation, each department orients the newly hired employee/transfer/volunteer/contractor to his or her other data that will aid and procedures, as well as the department's policies and procedures, as well as other data that will aid him/her in understanding the team concept , attitudes, and approaches to resident care7. The Department Orientation Checklist will be completed and maintained as part of the member's personnel file. This must be completed to verify the staff member's competency and understanding of the department in which they will work. Completion and verification are REQUIRED to be taken off the training schedule.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, implement and follow enhanced barrier precautions (EBP) for a resident identified with qualifying medical needs for one resident (Resident #106) (R106) of three residents reviewed for infection prevention. Findings include: Resident #106 (R106):A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R106 was admitted to the facility on [DATE] with diagnoses: hemiplegia (mild to moderate weakness on one side) and hemiparesis (severe to complete paralysis on one side) following cerebral infarction (interrupted blood flow to brain) affecting right dominant side, aphasia (cognitive communication deficient with speech and understanding), dysarthria (motor speech disorder), percutaneous endoscopic gastrostomy tubes (PEG / delivers nutrition and medications directly into the stomach), adult failure to thrive, neuromuscular dysfunction of bladder with the presence of indwelling urinary catheter. The MDS assessment dated [DATE] indicated the resident had moderate impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 10/15 and was dependent on assistance for care.On 06/01/2026 6:02 AM, observed R106 resting in bed with eyes closed. Tube feeding Jevity 1.5 calorie label had a black handwritten date of 05/30/2026 at 0200 (2AM) on label side, the back side of same tube feeding formula bottle had a black handwritten date of 05/31/2026 at 2000 (8PM), the rate was running at 45 ml (milliliter)/ hour. There was no sign posted for enhanced barrier precautions (EBP) posted for R106's room and there was no personal protective equipment (PPE) cart present at door.On 06/01/2026 08:15 AM, observed R 106's foley catheter had 600+ milliters of yellow urine in it. Observed CNA D don gloves, no gown and emptied R106's foley catheter and performed catheter care. CNA D was asked what if any precautions the resident had with care and she said standard, gloves and hand washing.On 06/01/2026 8:20 AM, Unit manager C was asked to observe R106 tube feeding and catheter. UM C was asked if a resident with catheter and PEG tube and indwelling catheter had any precautions with care and he paused then stated EBP, I believe and then He was asked to identify where the PPE cart and EBP sign was for R106. UM C looked around and walked over to the door of the room and stated, it should be right here, and it is not. Observed UM C verbally confirm with the ICP B that R106 should have EBP and advised him there was nothing posted to identify that and there was no PPE present at R106's room.A record review of R106 medical record revealed: R106 was originally admitted to the facility on [DATE] and was sent out to the hospital on [DATE] for decreased oral intake, R106 had a PEG tube placed 05/22/2026 and was readmitted to the facility on [DATE]. There was no EBP in place for resident until after observation and interview with UM C on 06/01/2026. On 06/03/2026 at 10:00 AM, Observed EBP sign on R106's door and PPE cart inside room door. Observed CNA D don gloves no gown and perform a bed bath for R106's. A record review of R106's medical orders revealed: Dated 05/29/2026: 14 fr (French) urinary catheter with 10 ml (milliliters) balloon, change PRN (as needed) for pain, occlusion, infection.Dated 06/01/2026: Enhanced Barrier Precautions - Gloves and gown prior to the high-contact care activity. Eye protection when performing activity with risk of splash or spray.Dated 06/02/2026: Enteral Feed-.Jevity Formula, infuse at 45mLs/hour. Infuse until 1080mls infused. A record review of R106's care plan revealed: Focus: I am at risk for MDRO infection r/t (related to) presence of TF (tube feeding) / Foley catheter (urinary catheter) Date Initiated: 06/01/2026. With Intervention: Enhanced Barrier Precautions: Staff will wear PPE (gown and gloves) while engaged in high contact activities Educate on Hand hygiene. On 06/03/2026 at 10:12AM, During an interview with the ICP B for infection control task he was asked about high contact activities with infection control practices, and he said that the staff have education on it, and he does weekly walk throughs and monthly rounds to observe compliance. ICP reviewed high contact activities which included bathing and catheter care. ICP B advised on observed continued noncompliance with R106 after the EBP was posted on 06/01/2026 and he said he planned to reeducate staff and increase surveillance of staff compliance with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Nursing and Rehabilitation	3011 North Center Road Flint, MI 48506

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	posted CDC signs. According to a record review of infection prevention rounds tool - nursing department performed monthly per ICP B: Focus area: Proper PPE worn based on patient precautions and tasks. Focus area: signage posted for specific precautions, if applicable. According to a record review of the facilities policy labelled Enhanced barrier precautions revealed: Policy Statement Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. With Implementations: 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities; 2. Enhanced barrier precautions apply when: b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices.; 5. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheotomies.; 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. 7a. Gloves and gown are applied prior to performing the high contact resident care activity; 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care); i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and.; 12.Enhanced barrier precautions are in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place that at higher risk; 16. Staff are trained prior to caring for residents on EBPs; 17. Signs are posted on the door or wall outside the residents' rooms which communicate the type of precautions and PPE required.According to a record review of the facilities policy labelled Infection prevention and control program (IPCP) revealed: Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. With Implementation: 4. The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers.; 2.c.(2) assessment of staff compliance with existing policies and regulations.; 7.a. (7) implementing appropriate enhanced barrier and transmission-based precautions when necessary.