STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235225	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fountain View of Monroe	1971 N Monroe Street Monroe, MI 48162

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure proper cooling of cooked, potentially hazardous (time-temperature for safety) food, pulled pork. This deficient practice had the potential to affect all the residents who consumed food from the kitchen, resulting in the potential for food borne illness. Findings include.On 12/3/25 at 10:45 AM, during observations of the kitchen with Certified Dietary Manager (CDM) A, a container with approximately one pound of previously cooked pulled pork cooked on 12/1/25 was stored with the active food stock in the walk-in cooler. CDM A said cooling logs were used to ensure cooked food was cooled properly and safely. CDM A was unable to produce the cooling log for the pulled pork. On 12/3/25 at 10:50 AM, Relief [NAME] (RC) B stated the pulled pork was cooked for dinner on 12/1/25. RC B said that following dinner service, the steam table was turned off. The pork was then transferred to another container after ten minutes and subsequently covered, dated, and placed in the walk-in cooler after another 45 minutes. RC B said that a cooling log was not used for the cooked pork and temperatures were not obtained during the cooling process. On 12/3/25 at 11:35 AM, CDM A noted that RC B failed to follow proper procedures for cooling the cooked pork. CDM A said it was important to properly cool previously cooked food to minimize the growth of harmful bacteria, thereby ensuring the food remained safe to eat when reheated. On 12/3/25 at 1:40 PM, the Nursing Home Administrator (NHA) said kitchen staff should follow the policy for cooling cooked food. On 12/3/25 at 3:45 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked. According to the 2013 FDA Food code:- Section 3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F (Fahrenheit) to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less. A review of the facility policy titled, Food Safety, dated 1/9/25, documented in part the following regarding cooling cooked foods:- Staff will use an ice bath to rapidly cool food items removed from the oven or steam table prior to refrigerating. - Larger food quantities, such as soups, should be placed in smaller pans (e.g. 2 inches deep) to allow cooling to occur more quickly.- Bulk items, such as roasts, will be cut in half or quarters to allow heat to escape- Items in ice bath will not be covered to prevent heat from becoming trapped.- Food will be placed in an ice bath until 41 F is reached then placed in refrigeration.- Foods will be rapidly cooled from 135 F to 70 F in two hours, then 70 F to 41 F in four hours.- Food items that have been out of safe temperatures for more than four hours will be discarded.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235225	A. Building B. Wing	12/03/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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 identify, assess, and implement potential issues related to skin care for one resident (R104). Findings include:On 12/1/25 at 3:19 PM, R104 was observed alert and sitting up in his room. R104's scalp was observed to what appeared to be raised, crusted scabs. R104 said he keeps his hands off his scalp and denied getting cream or treatment for his scalp. On 12/3/25 at 9:10 AM, R104's scalp was observed with Registered Nurse/Unit Manager (RN/UM) C. R104 said the areas on his scalp do not bother him. RN/UM C stated even though the areas on his scalp do not bother him, It definitely looks like (R104) needs to see a dermatologist. R104's admission assessment was reviewed with RN/UM C and the area on his scalp was not noted on this document. RN/UM C added, We have no diagnoses or information on his scalp. If it was there upon admission, it should have been identified. On 12/3/25 at 2:01 PM, RN D was interviewed and said he has a clear memory of the yellow skin tag on top of R104's scalp. RN D feels like the yellow skin tag was on R104's scalp upon admission. On 12/3/25 at 2:18 PM, Licensed Practical Nurse (LPN) E identified the area on top of R104's head as a cuticle corn. LPN E said that the areas on his scalp have not changed since admission to the facility. On 12/3/25 beginning at 1:44 PM, the Director of Nursing (DON) was interviewed regarding the areas of concern on R104's scalp. The DON said she spoke with RN/UM C regarding the areas on top of R104's scalp. The DON said she was unaware of seeing it before today. The DON reported that R104's son was contacted regarding areas of concern on R104's scalp. R104's son said that R104 had not previously seen a dermatologist for the scalp issues and granted approval for the facility to schedule an appointment. The DON referred to a nursing note written on 12/3/25, in which the areas on R104's scalp were identified as seborrheic keratosis. A review of R104's physician documentation, conducted by the DON, revealed no record that the area on the resident's scalp had been observed or addressed. The DON said she participated in R104's admission assessment but did not document the area on his scalp. The DON said when the area on R104's scalp was first observed, it should have been documented on the skin assessment. The DON said the area on R104's scalp was not brought up as a potential concern before today and acknowledged the clinical importance of addressing concerns and potential concerns of the facility residents. A review of the clinical record for R104 documented an admission date of 8/22/23 with diagnoses that included transient cerebral ischemic attack (TIA), anxiety disorder, and atherosclerotic heart disease of native coronary artery (CAD). A Minimum Data Set assessment dated [DATE] documented moderate cognitive impairment. Review of R104's care plans documented in part the following:- (R104) is at risk for impaired skin integrity/pressure injury related to: resident with past medical history of: TIA, hypertension, CAD, hyperlipidemia, dementia, and diabetes mellitus. As evidenced by decrease mobility, continence of bowel and bladder, receive anti-hypertensive as ordered. Nursing note dated 12/3/25 documented: Resident observed to have thick, dry white raised areas on scalp. Upon assessment resident denies any pain or discomfort, denies itching. Contacted resident's son to discuss, resident's son requesting dermatology consult, stating that he has not been to dermatology for this issue before. Spoke to PCP (primary care physician), PCP states that resident has been without any complaint of pain, itching or discomfort and felt that areas are consistent with seborrheic keratosis and is fine with resident being seen by dermatology. At this time no treatment initiated due to areas being stable and nonbothersome for the resident. Scheduler to arrange derm appointment as soon as available. On 12/3/25 at 3:45 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked. A facility policy titled, Skin Management, dated 9/14/24 was reviewed and documented in part the following:- Upon admission/re-admission all residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record.- Residents admitted with any skin impairment will have:-- Appropriate interventions implemented to promote healing,-- A physician's order for treatment, and-- Skin impairment location, measurements and characteristics documented