

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Seacrest Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1215 N Telegraph Rd 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.			
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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: 1. Ensure proper cooling of cooked, potentially hazardous (time-temperature for safety) food, taco meat and beef tips; 2. Consistently test the dish machine to ensure proper sanitization; 3. Ensure pans were properly cleaned and allowed to air dry before stacking; 4. Effectively clean a mounted fan; and 5. Properly maintain resident refrigerator. These deficient practices had the potential to affect all residents who consumed food from the kitchen, resulting in the increased potential for food borne illness. Findings include: On 2/10/26 at 9:17 AM, a tour of the kitchen was conducted with Dietary Manager (DM) F. The following items were noted: A full-size pan containing taco meat, as identified by DM F, was cooked last night. DM F indicated that a cooling log was not available for the pan of taco meat. A full-size pan of beef tips, as identified by DM F, was cooked this morning. The internal temperature of the beef tips was obtained and determined to be 43.7 F (Fahrenheit). AM [NAME] H indicated the beef tips finished cooking at 7 AM this morning. AM [NAME] H stated, We don't document cooling temps and added the meat was not divided into smaller portions to facilitate proper cooling. Dietary Aide (DA) G was observed operating the dish machine. DA G said they visually observe the flow of sanitizing solution into the dish machine to determine that dishware was properly sanitized. DA G indicated that test strips were not used to determine if dishware was properly sanitized. DM F said we do not always test the sanitizing solution of the dish machine. Two wet and soiled full-size pans were stored in the clean pot/pan area. A round fan, mounted on a wall facing the clean side dish machine drain board, was turned on and blowing air. The fan cover, fan blades, and mounting bracket were covered with dust and dirt. DM F said the fan was blowing towards the cleaned dishware. DM F unplugged the fan and stated, I will have to call maintenance. On 2/10/26 at approximately 10:15 AM, the contents of the Unit D resident refrigerator freezer were observed with DM F and revealed the following: - an opened 1.5 quart container of strawberry ice cream was not labeled with a resident's name.- a 14 oz. boxed frozen entree of Buffalo style chicken macaroni and cheese was not labeled with a resident's name. On 2/11/26 at 1:51 PM during an interview, DM F said cooling food properly prevents undesirable bacterial growth. DM F stated, We want to make sure our residents don't get sick. DM F stated they have not been keeping a sanitizing log for the dish machine. DM F acknowledged the importance of testing the dish machine sanitizing solution in order to determine if the dish machine was properly sanitizing the dishes. On 2/11/26 at 2:22 PM, the Nursing Home Administrator (NHA) identified the following expectations: that cooling logs are kept, that kitchen policies and procedures are followed, and the kitchen should be maintained in a clean manner. A review of a facility policy titled, Food Brought by Family/Visitors, dated 7/11/18, documented the following: Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the 'use by' date. 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 to 70 F; and (2) Within a total of 6 hours from 135 F to 41 F or less. - Section 4-204.117 Warewashing Machines, Automatic Dispensing of Detergents and Sanitizers. (B) Incorporate a visual means to verify that detergents and sanitizers (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are delivered - Section 4-602.13, Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. - Section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and sanitizing, equipment and utensils shall be air-dried.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the drain lines from the dish machine were maintained in a safe and sanitary operating condition, resulting in the dish machine not being protected against contamination from sewage or other sources of contamination Findings include: During the initial tour of the kitchen on 2/10/26 at 9:17 AM with Dietary Manager (DM) F, the end of the drain lines from the dish machine were observed below the flood rim of the floor drain. DM F indicated maintenance will be contacted. On 2/11/26 at 2:22 PM, the Nursing Home Administrator indicated the position of the drain line from the dish machine will be addressed and properly air gapped. The 2013 FDA Food Code was reviewed and revealed the following in 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 equipment in which food, portable equipment, or utensils are placed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to effectively clean and maintain the physical plant effecting four resident rooms out of 21 resident rooms sampled for a clean environment. Findings include:On 2/11/2026 at 11:16 AM, an environmental tour was conducted with Environmental Services Manager (ESM) B. The following items were noted:-room [ROOM NUMBER], the flooring was soiled and appeared yellow in color with wheelchair tire marks and dark stains.-room [ROOM NUMBER], the flooring was soiled with wheelchair tire marks and dark stains.-room [ROOM NUMBER], the flooring was soiled, yellow in color with wheelchair tire marks and dark stains.-room [ROOM NUMBER], the flooring was soiled, appeared yellow in color with wheelchair tire marks and dark stains.When ESM B was asked about the resident room flooring ESM B said the flooring should be white in color, the above-mentioned floors needed to be stripped and waxed. ESM B said the resident rooms had heavy markings from the wheelchairs that did not get cleaned with the regular housekeeping. ESM B stated, We haven't been able to strip and wax the floors since 2024 due to lack of proper equipment and lack of enough staff. ESM B further said the resident room floors should be stripped and waxed at least once a month.On 2/12/2026 at 9:55 AM, the Nursing Home Administrator (NHA) was interviewed and said the resident room floors needed to be deep cleaned, stripped and waxed or replaced entirely.Review of the facility policy titled, Physical Environment-Floors dated 7/11/2018 revealed in part.Floors shall be maintained in a clean, safe and sanitary manner. Floor cleaning procedures are maintained by the Environmental Services Director.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow standards of practice for medication administration for one resident (R24) of two residents reviewed for medication administration. Findings include: On 2/10/2026 at approximately 9:45 AM, R24 was observed in their room. Observed on the bedside table were prescribed eye drop medication Vysulta Ophthalmic Solution, Combigan Ophthalmic Solution, and a nasal spray. R24 said they self-administer eye drops and nasal spray, but the nurse administers their other medications. On 2/10/2026 at approximately 11:38 AM, a second observation revealed the same medications at the resident's bedside. On 02/11/2026 at approximately 9:39 AM, a third observation revealed the same medications at the resident's bedside. A record review was completed on 2/11/2026 which revealed R24 admitted to the facility on [DATE] with diagnoses that included: atrial fibrillation, hypertension, chronic obstructive pulmonary disease, anemia, cognitive communication deficit, and peripheral vascular disease. Section C of the Minimum Data Set with an Assessment Reference Date of 11/20/2025 revealed R24 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 R24 was to receive Vysulta Ophthalmic Solution 0.024% (Latanoprostene Bunod): Instill 1 drop in left eye at bedtime for cataracts, and Combigan Ophthalmic Solution 0.2-0.5% (Brimonidine Tartrate-Timolol Maleate): Instill 1 drop in both eyes every 12 hours for glaucoma, and Saline Spray Nasal Solution (Saline): 1 spray in each nostril as needed for nasal congestion. There were no orders allowing for self-administration of medications. There was no evidence in the electronic medical record of an interdisciplinary team assessment for self-administration of medications. Review of the care plan did not reveal any interventions for self-administration of medications. On 2/11/2026 at approximately 11:20 AM, LPN A was interviewed regarding medications at the bedside. LPN A stated, (R24) is alert and oriented and administers their inhalers and eye drops. LPN A confirmed that R24 did not have an order to self-administer medications. LPN A then stated, I dropped the medications off at the bedside. He does not have an order to self-administer medications and I've removed the medications. When asked what the potential risk was associated with leaving medications at the bedside, LPN A stated, R24 could overdose or double dose on their medications. On 2/12/2026 at approximately 3:12 PM, the Director of Nursing (DON) was interviewed regarding medication administration. The DON said they follow resident rights for administering medications. The DON further explained that residents would be assessed for their cognitive ability and return demonstrations prior to allowing self-administration of medications. In addition, a physician order would be obtained, and the care plan updated. When asked if R24 had an assessment or physician order to self-administer medications, the DON said no, and that R24 would be at risk for possible adverse medication effects without an assessment and physician order. A policy titled, Self-Administration of Medications dated 7/11/2018 revealed in part: 2: If a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. In addition, 4: If the resident is a candidate for self-administration of medications, this will be indicated in the chart.		

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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 upon interview and record review, the facility failed to notify the physician regarding elevated blood sugars for one resident (R54) of one resident reviewed for diabetes management. Findings include: A review of the clinical record for R56 documented an original admission date of 8/21/23 and readmission date of 10/25/25. R56's diagnoses included diabetes mellitus-type 2 (DMII), congestive heart disease and chronic obstructive pulmonary disease. A Minimum Data Set assessment dated [DATE] documented intact cognition. Physician ordered blood sugar sliding scale for R56 documented the following: Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro) Inject as per sliding scale: if 0 - 150 = 0 units; 151 - 200 = 0 units; 201 - 250 = 4 units; 251 - 300 = 8 units; 301 - 350 = 14 units; 351 - 400 = 20 units. Administer subcutaneously before meals and at bedtime for DMII. A review of recorded blood sugars for R56 revealed the following: 12/1/25 at 6:00 AM: 484 mg/dl. No corresponding nursing or medical provider (MP) note available. 12/3/25 at 5:00 PM: 482 mg/dl. Corresponding nursing note documented: subcutaneously before meals and at bedtime for DMII (diabetes mellitus-type 2) - 26 units administered-MD (medical doctor) aware. 12/20/25: at 9:00 PM: 404 mg/dl. No corresponding nursing or MP note available. 12/26/25 at 9:00 PM: 480 mg/dl. No corresponding nursing or MP note available. 1/11/26 at 6:00 AM: 532mg/dl. No corresponding nursing or MP note available. 1/22/26 at 9:00 PM: 430 mg/dl. No corresponding nursing or MP note available. 2/1/26 at 9:00 PM: 500 mg/dl. No corresponding nursing or MP note available. Review of R56's care plan documented in part the following: (R56) has risk for fluctuations in blood sugar and complications related to diabetes. Revised on 10/20/25. Interventions included: Obtain fingerstick glucose as ordered and as needed. Report abnormal (blood sugar level) or changes in pattern to physician for review and adjustment of plan of care as directed. Revised on 10/20/25. Review of referral to the endocrinologist dated 12/4/25 documented that R56 had uncontrolled diabetes mellitus-type 2 and blood sugars were fluctuating high. Endocrinology consult dated 1/29/26 documented in part the following: Progress note: A1c high at 10.4% - per patient, (R56) eats snacks all the time. Blood sugars are elevated, will increase insulin and follow up in six weeks. Updated Diagnosis: uncontrolled diabetes mellitus-type II Orders: increase Lantus to 40 units in AM and 35 units at bedtime. Increase Lispro to 8 units three times a day with meals plus sliding scale. During an interview on 2/11/26 at 12:11 PM, Licensed Practical Nurse (LPN) D said the parameters for contacting the medical provider for a resident's elevated blood sugar were in the orders. LPN D said not all residents are managed the same, but generally if a resident has a blood sugar over 400, the MP was called to see if additional units of insulin were to be administered. During an interview on 2/11/26 at 12:14 PM, LPN A said, in the absence of an order, they would contact the MP if a resident's blood sugar was over 400 to find out the proper dose of insulin to give. During an interview on 2/11/26 at 1:42 PM, the Director of Nursing (DON) said that typically the physician will set parameters for when to call regarding an elevated blood sugar level. The DON added that if there were no parameters set, the physician should be contacted when a blood sugar value was higher than the sliding scale to obtain an order for additional insulin if needed. During an interview and review of R56's clinical record on 2/11/26 at 2:39 PM with the DON and Regional Nurse Consultant (RNC) J, it was determined that there were no current written instructions or orders for nurses to follow when R56's blood sugar exceeded the prescribed sliding scale. During an interview on 2/11/26 at 3:17 PM, Physician K indicated that hypoglycemia was more of an issue because R56 received a hefty dose of insulin. Physician K said he could not recall if R56's blood sugars had ever been over 450. Physician K stated the facility nurses were aware of R56's dietary noncompliance and consumption of junk food galore, potato chips, and pop. When queried about what nurses should do when R56's blood sugars were over 400, Physician K reiterated if R56 was given additional insulin, it may result in a hypoglycemic reaction. According to Physician K, it was unclear if written guidelines existed that directed the nurses on when to report R56's elevated blood sugars. Physician K (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged the medical provider directs medical care and it was the nurse's duty and responsibility to follow their orders. Physician K agreed that it should be communicated to nursing on when to contact the medical provider regarding R56's blood sugar levels.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review the facility failed to maintain accurate reconciliation records for controlled medications (narcotics) in two of three medications carts resulting in the potential for drug diversion to go undetected. Findings include: On 2/11/2026 at approximately 9:20 AM the 500 hall E-South cart was inspected with Licensed Practical Nurse (LPN) D. The 2/11/26 narcotic reconciliation log was not signed by the on-coming nurse, LPN D. LPN D stated, I forgot to sign. I did count with the night shift nurse. I know I should have signed it at the time of the count. A continued inspection of the cart revealed a discrepancy for R37's Morphine Sulfate Contin 30 milligram (MS Contin 30 mg) pills. There were 12 pills observed in the blister pack for R37's MS Contin 30 mg. The controlled substance reconciliation sheet documented 13 pills. LPN D stated, Oh, I gave that to the resident this morning. I just forgot to sign it out. LPN D confirmed that standard of practice is to sign out the medications when they are administered. Review of R37's Medication Administration Record (MAR) revealed that R37 was prescribed and administered the MS Contin 30 mg on 2/11/26 at 9:00 AM dose. On 2/11/2026 at approximately 9:40 AM the 200 hall B-North cart was inspected with Licensed Practical Nurse (LPN) E. The 2/11/26 narcotic reconciliation log was not signed by the on-coming nurse, LPN E. LPN E stated, I just forgot to sign that. I did it (the count). A continued inspection of the cart revealed a discrepancy for R47's Oxycodone 10 mg pills. There were 5 pills observed in the blister pack for R47's Oxycodone 10 mg. The controlled substance reconciliation sheet documented 6 pills. LPN E stated, I gave it. I forgot to sign it out. LPN E confirmed that standard of practice is to sign out the medications when they are administered. Review of R47's Medication Administration Record (MAR) revealed that R47 was prescribed and administered the Oxycodone 10 mg at the 9:00 AM dose. reviewed narc sheets. On 2/12/26 at 1:00 PM during an interview, the Director of Nursing (DON) confirmed the facility's policy was to count the narcotic reconciliation sheet and sign at the time of shift change. The DON stated, The nurse should sign out any narcotic at the time they take it out of the med cart. The policy for Medication Administration was requested for review. According to the facility's policy for Medication Administration for Controlled Drugs updated on 5/14/2020 read in part: Narcotic Count and Inventory: 1. Controlled drugs are counted every shift by the nurse reporting on duty WITH the nurse reporting off duty. 2. The inventory of the controlled drugs must be recorded on the narcotic records and signed for correctness of count. 3. The controlled drug checklist must be signed by the nurse coming on duty and the nurse going off duty to verify that the count of all controlled drugs is correct.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to store unopened insulins at the proper temperature in two of three medication carts reviewed for safe storage of medications and biologicals resulting in the potential for decreased efficacy of the insulin. Findings include: On 2/11/2026 at 8:51 AM during inspection of medication cart #1 on C-South Hall with Licensed Practical Nurse (LPN) C, an unopened bottle of Humalog insulin was observed in the medication cart at room temperature. The bottle was inside an unopened box that was inside a plastic bag. Both the box and plastic bag were labeled with instructions to Keep refrigerated. Neither the box nor plastic bag had a delivery or received on date. Upon interview LPN C said, That insulin should be refrigerated. There is no way to tell how long it has been at room temperature. We'll have to waste this bottle. On 2/11/2026 at 9:54 AM during inspection of medication cart #2 on E-South Hall with LPN D, an unopened bottle of Novolog insulin was observed in the medication cart at room temperature. The bottle was inside an unopened box that was inside a plastic bag. Both the box and plastic bag were labeled with instructions to Keep refrigerated. Neither the box nor plastic bag had a delivery or received on date. A two-pack of insulin Kwik-pens (disposable, prefilled, multi dose injection device to deliver insulin) were observed unopened and undated inside a plastic bag. Both the Kwik-Pens and the bag they were stored in were labeled with instructions to Keep refrigerated. Neither the Kwik-pens nor the plastic bag had delivery or received on date. Upon interview LPN D said, Those are supposed to be in the refrigerator. I'm not sure why they aren't. There is no way to tell how long they have been at room temperature. LPN D removed both the bottle of insulin and set of Kwik-pens from the medication cart. On 2/12/26 at 1:00 PM during an interview with the Director of Nursing (DON) they confirmed the facility's policy was to store all medications according to the manufacturer's recommendations. This included storing unopened insulin at the proper temperature controls to maintain the potency and effectiveness of the medication. The DON was asked to provide the facility's policy for medication storage. According to the facility's policy for Medication Access and Storage adopted on 7/11/2018 read in part; It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. 11. Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label.		

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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 ensure staff completed appropriate hand hygiene during resident care for one resident (R60) of five residents reviewed for infection control, resulting in the potential for an increased risk of infection among residents. Findings include: On 2/10/2026 at approximately 11:20 AM, LPN A was observed conducting blood glucose tests on the 500-unit hallway. LPN A sneezed while in the hallway, did not perform hand hygiene, and continued down the hallway with a medication cart in front of them. On top of the medication cart were gloves, lancets, and a glucometer. Upon arriving at R60s room, LPN A donned gloves without performing hand hygiene. LPN A entered the room and performed a blood glucose test on R60. Upon exiting the room, LPN A removed the gloves but did not perform hand hygiene. LPN A then went to room [ROOM NUMBER]. LPN A did not perform hand hygiene, donned gloves, and proceeded into the room to conduct a blood glucose test. Upon exiting room [ROOM NUMBER], LPN A removed their gloves and did not perform hand hygiene. LPN A then went to room [ROOM NUMBER], did not perform hand hygiene, donned gloves, and proceeded into the room to conduct a blood glucose test. Upon exiting the room, LPN A removed their gloves and did not perform hand hygiene. A record review was conducted on 2/11/2026 which revealed R60 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, bipolar disorder, osteoarthritis, dementia, generalized anxiety disorder, and metabolic encephalopathy. Section C of the Minimum Data Set with an Assessment Reference Date of 1/18/2026 revealed R60 scored a 9/15 on the Brief Interview for Mental Status assessment - indicative of a moderate cognitive impairment. R60 had a physician order to check blood glucose levels daily before meals and at bedtime. On 2/11/2026 at approximately 9:05 AM, LPN A was interviewed regarding the process of performing hand hygiene when completing blood glucose tests. LPN A stated, I should have performed hand hygiene before putting gloves on, after removing my gloves, and in between residents. When asked why hand hygiene should be performed at these times, LPN A stated, To decrease risk of infection between residents. On 2/12/2026 at approximately 9:00 AM, an interview was conducted with the Infection Preventionist/Director of Nursing (DON) regarding hand hygiene. When asked what their expectation was for performing hand hygiene during blood glucose checks, the DON stated, Hand hygiene should be completed before putting on gloves and entering a resident room to perform patient care and when they come out of the room to remove their gloves and perform hand hygiene. The DON further said there are potential infection control concerns for cross contamination when hand hygiene is not performed. A policy titled, Hand Hygiene, last updated 3/24/2022 revealed: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a resident; proper hand hygiene should be performed between all services to residents; after touching a resident or the resident's immediate environment; after contact with blood, body fluids, or contaminated surfaces; immediately after glove removal.		