STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235234	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Nursing and Rehabilitation Center	9500 Grand River Ave Detroit, MI 48204

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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 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: 1. Ensure the use of hair restraints of staff working in the kitchen; 2. Effectively clean multiple surfaces in the kitchen (walls, ice machine, ice scoop holder, reach-in cooler floor, reach-in cooler storage racks); 3. Ensure cleaned pans and dishes were allowed to air dry before stacking; 4. Ensure surfaces inside the kitchen were smooth and easily cleanable (insulated foam board); and 5. Ensure cleaned ladles were properly stored. Findings include: On 3/3/26 at 8:40 AM during a tour of the kitchen with Dietary Manager (DM) Q, the following items were noted: Dietary Aid (DA) U was observed operating the dish machine. DA U's facial hair was not covered with a beard guard. DM Q indicated DA U should have had on a beard guard that properly covered their facial hair. A ball of dust, approximately the size of a large marble, was protruding from a ceiling tile located above the prep handwashing sink. A panel inside of the ice machine was stained with a brown colored substance. When the panel was wiped with a clean paper towel, brown smears were observed on the paper towel. DM Q agreed that the panel was not properly cleaned. The ice scoop holder on the side of the ice machine was observed with standing, discolored water that contained loose brown sediment. A metal threshold strip was not securely fixed to the floor inside of the walk-in cooler. Part of the metal strip was missing. A predominately brown colored substance was observed around the missing and displaced metal strip. The residue on the floor smeared a clean paper towel when wiped. DM Q was unable to explain or describe the brown-colored substance on the floor of the walk-in cooler. Wire racks inside of the walk-in cooler were discolored. When one of the racks was wiped with a clean paper towel, brown-colored smears were observed on the paper towel. DM Q acknowledged that the racks did not pass the wipe test. Three ladles of varying sizes were hanging from a rack, bowl side up. Four 1/2-size pans, two full-size pans, and three 1/2-size sheet pans were stacked in the clean pot/pan storage and observed to have droplets of water. The top plate, stored in the plate dispenser, was observed to have droplets of water. A green colored insulation foam board, applied to the outside of the walk-in freezer, was chipped and crumbling. Broken pieces of the underlying white foam were observed on the floor. On 3/4/25 at 12:49 PM per DM Q, surfaces within the kitchen should be smooth and cleanable. DM Q indicated that maintenance was responsible for cleaning the inside of the ice machine and food service was responsible for cleaning the outside of the ice machine including the ice scoop bin. On 3/4/26 at 1:25 PM Corporate Maintenance Director, R said the insulation foam board was installed about four years ago because the freezer wall did not have enough insulation to maintain the proper temperature. The freezer condenser pump was replaced, the freezer is operating okay, and the foam insulation is no longer necessary. I never removed the foam. I guess it can come off today. On 3/5/26 at 3:14 PM, the Nursing Home Administrator (NHA) indicated the kitchen was to be up to par. The NHA added they were actively correcting the concerns. According to the 2013 FDA Food Code: Section 2-402, Hair Restraints. Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Section 4-601.11 Equipment, (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 - Many	Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Section 4-602.11. Equipment Food-Contact Surfaces and Utensils. Equipment food-contact surfaces and utensils shall be cleaned (5) at any time during the operation when contamination may have occurred. 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. Section 6-201.11 Floors, Walls, and Ceilings. Except as specified under 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper handling of clean linen resulting in the potential for infection among all residents in the facility.Findings include:On 3/5/2026 at approximately 8:20 AM, an observation and tour of the laundry room was conducted with the Housekeeping Manager (HM C). Two blue laundry barrels were observed near the washing and dryer machines. HM C said the barrels were used to transport washed linen to the dryer, and from the dryer to the clean linen area. Both barrels were observed to have paper tissue debris, dried corn kernels, and other unidentifiable debris. HM C confirmed these findings and stated, these barrels need to be kept clean. An undated policy titled, Laundry was provided and revealed the following: Linen can become contaminated with pathogens from contact with intact skin or body substances, or from environmental contaminants or contaminated hands.Separate carts will be used for transporting clean and contaminated linen. Carts will be cleaned when visibly soiled, and routinely according to facility schedule.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the reach-in juice cooler, the inside of the walk-in cooler and the walk-in freezer were properly maintained and in good working order. Findings include: On 3/3/26 at 8:40 AM during a tour of the kitchen with Dietary Manager (DM) Q, the following items were noted: The door gaskets of the reach-in juice cooler were damaged and loose in several places. A metal threshold strip was not securely fixed to the floor inside of the walk-in cooler. A significant build-up of ice and condensation was visible on the outside of the walk-in freezer door. DM Q said the freezer door does not fully close. On 3/4/26 at 12:50 PM, DM Q said the maintenance supervisor was supposed to check the dietary maintenance log at least once a week. The Maintenance/Dietary Service Log was reviewed with DM Q and revealed the following: 10/30/25 Problem: Freezer door cracked. Solution: Working on it 11/14/25.2/1/26 Problem: Freezer built up on door. Solution: (Area blank.) During an interview on 3/5/26 at 3:14 PM, the Nursing Home Administrator said they were actively correcting the kitchen related concerns presented. A review of the 2013 FDA Food Code documented the following:Section 4-501.11. Good repair and proper adjustment. (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. Section 6-201.11 Floors, Walls, and Ceilings. Except as specified under S 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. Section 6-501.11 Repairing. Physical facilities shall be maintained.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the walls and cove base outside of the walk-in cooler were in good condition and cleanable and the leak in the janitor's closet was repaired correctly and timely. Findings include: On 3/3/26 at 8:40 AM during a tour of the kitchen with Dietary Manager (DM) Q, the following items were noted: A metal baseboard, approximately eight by four inches, was missing on the outside of the walk-in cooler. The concrete floor in the janitor's closet (chemical closet) was observed to be damp and with standing water. Portions of the cinder block walls in the janitor's closet showed signs of peeling paint and moisture exposure. On 3/4/26 at 12:50 PM, DM Q said the maintenance supervisor was supposed to check the dietary maintenance log at least once a week. The Maintenance/Dietary Service Log was reviewed with DM Q and revealed the following: 12/1/25 Problem: Chemical closet still has leaks from 2nd floor. Solution: (Area blank.) 1/7/26 Problem: Chemical closet still leaking. Solution: (Area blank.) On 3/4/26 at 1:22 PM the Nursing Home Administrator (NHA) said that maintenance had fixed the ceiling leak more than once, but they were probably not fixing it right. On 3/4/26 at 1:25 PM Corporate Maintenance Director (CMD), R said the leak in the janitor's closet was coming from a supply line located inside the concrete. CMD R added they are getting quotes to replace the supply line in the closet. CMD R agreed it should not take months to get a quote. During an interview on 3/5/26 at 3:14 PM, the Nursing Home Administrator said they were actively correcting the kitchen related concerns presented. A review of the 2013 FDA Food Code documented the following:Section 4-501.11. Good repair and proper adjustment. (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. Section 6-201.11 Floors, Walls, and Ceilings. Except as specified under S 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable. Section 6-501.11 Repairing. Physical facilities shall be maintained.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to deposit the resident personal funds (resident trust fund) in an interest-bearing account that is separate from the facility's operating account and credit all interest earned on the resident funds to that account. This deficient practice has the potential to affect R90 and 27 of 36 residents that had over $100.00 in the facility's resident trust fund account in the month of January 2026.On 3/4/26 at 1:44 PM, R90 reported that they received their $60.00 a month but it is always late. According to R90's Electronic Health Record (EHR), R90 admitted on [DATE] with multiple diagnoses that included congestive heart failure. R90 had a court appointed Legal Guardian. R90's annual Minimum Data Set (MDS) dated [DATE] identified R90 to be cognitively intact and totally dependent on staff for all activities of daily living.On 3/5/26 at 10:09 AM during the facility task for resident's Personal Fund with the facility's Business Office Manager (BOM) G, the resident's trust fund account was reviewed for the months of 12/ 2025, 1/ 2026, and 2/2026. BOM G produced facility created excel spread sheets that detailed each resident's activity within their account. There was no credit or documentation to indicate there had been any interest accrued to the resident's trust fund. At this time 35 residents were consistently using the trust fund. BOM G could not produce actual banking statements and stated, The corporate accountant manages the resident's trust funds. I have the quarterly statements and resident's monthly deposits and withdrawals on an accounting sheet, but I don't know if the resident's trust fund is in an interest-bearing account. I'll have to call the accountant. On 3/5/26 at approximately 10:20 AM Corporate Accountant (CA) H was interviewed by phone and asked if the resident's trust fund was in an interest-bearing account. CA H said, Yes, it's in an interest-bearing account but it's in with the facility's account so we just deposit $1.00 per month into each resident's account. CA H was asked why there were no monthly $1.00 credits into the resident's trust fund account for the months of 12/2025, 1/2026, and 2/2026. CA H said, I will provide the updated spreadsheet.On 3/5/26 at 11:46 AM CA H sent over an updated spread sheet that indicated every resident had $1.00 deposited in their account for the months off 12/2025, 1/2026, and 2/2026. CA H could not explain how the previous reviewed spread sheets did not include any deposit for $1.00 to each resident. CA H said, It accumulates very little interest and it's difficult to determine how much each resident should be accruing. On 3/5/26 at 12:31 PM the Nursing Home Administrator (NHA) was asked about the resident's trust fund account and said, I don't have anything to do with it. The corporate accountant handles that. The NHA confirmed the corporate accountant is CA H.On 3/5/26 at 12:34 PM the Legal Guardian (LG) J for R90 was interviewed over the phone. LG J reported that they had received quarterly statements for R90's account from the facility but had not seen any interest accrued or deposited into that account. LG J confirmed that R90 does receive $60.00 per month on the 5th of every month, not the 1st of every month.On 3/5/26 at 2:35 PM, BOM G provided a third set of resident trust fund excel spreads sheet for 12/2025, 1/2026, and 2/2026. This set of spread sheets indicated that each of the 35 residents received a pro-rated amount of interest each month. The BOM did not produce any actual banking statements to indicate the resident's trust fund was in an interest-bearing account. When asked how each resident's interest was determined, BOM G replied, I received these from the corporate accountant.On 3/6/2026 at 10:06 AM during an interview with the NHA and BOM G they confirmed that the excel spread sheets do not match the trust fund account. A review of the actual bank statement for the resident's trust fund did not reveal how interest was determined and had significant amounts of money deposited and withdrawn weekly that did not match with the resident's activity on their personal facility statements. On 3/06/2026 at approximately 11:30 AM the facility's business owner (FBO) I was interviewed and said, The resident's trust fund was co-mingled with the facility's general bank account and interest had not been pro-rated accordingly. We will correct this going forward.According to the facility's Resident Personal Funds policy implemented 10/27/22 in part reads:Deposit of FundsThe facility will deposit (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any resident's personal funds in excess of S100 in an interest-bearing account (or accounts) separate from any of the facility's operating accounts and will credit all interest earned on resident funds to that account. (In pooled accounts, there must be separate accounting for each resident's share.)The facility will maintain a resident's personal funds that do not exceed $100 in a non-interest-bearing account, interest bearing account, or petty cash fund.Residents whose care is funded by Medicaid: the facility will deposit the resident's personal funds in excess of $50 in an interest-bearing account (or accounts) separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account, (In pooled accounts, there must be separate accounting for each resident's share.)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review the facility failed to maintain a separate accounting system for the resident trust fund account and use generally accepted accounting principles for 35 residents utilizing the facility's resident trust fund account. This deficient practice has the potential for the misappropriation of resident's funds.Findings include:On 3/5/26 at 10:09 AM during the Personal Fund task with the facility's Business Office Manager (BOM) G, the resident's trust fund account was reviewed for the months of 12/2025, 1/2026, and 2/2026. BOM G produced facility created excel spread sheets that detailed each resident's activity within their account. At this time 35 residents were consistently using the trust fund. BOM G could not produce actual banking statements and stated, The corporate accountant manages the resident's trust funds. I have the quarterly statements and resident's monthly deposits and withdrawals on an accounting sheet, but I don't know if the resident's trust fund is in an interest-bearing account. I'll have to call the accountant. On 3/5/26 at approximately 10:20 AM Corporate Accountant (CA) H was interviewed by phone and asked to provide the actual banking statement for the resident's trust fund. CA H reported that the resident's trust fund account was in an interest-bearing account and bank statements would be provided. Upon further inquiry CA H said, We just deposit $1.00 per month into each resident's account. CA H was unable to provide any consistent banking statements to confirm there was interest deposited into the resident's trust fund account for 12/2025, 1/2026, and 2/2026. CA H said, I will provide the updated spreadsheet.On 3/05/26 at 11:46 AM CA H sent over an updated spread sheet that indicated every resident had $1.00 deposited in their account for the months of 12/2025, 1/2026, and 2/2026. CA H did not provide actual banking statements of the account at this time. On 3/5/26 at 12:31 PM the Nursing Home Administrator (NHA) was asked about the resident's trust fund account and said, I don't have anything to do with it. The corporate accountant handles that. The NHA confirmed the corporate accountant is CA H.On 3/5/26 at 2:35 PM, BOM G provided a third set of resident trust fund excel spreads sheet for 12/2025, 1/2026, and 2/2026. This set of spread sheets indicated that each of the 35 residents received a pro-rated amount of interest each month. The BOM did not produce any actual banking statements to indicate the resident's trust fund was in a separate interest-bearing account from the facility. On 3/6/26 at 10:06 AM during an interview with the NHA and BOM G the actual bank statements for the resident's trust fund was provided. BOM G confirmed that the amount in the excel spread sheets did not match the trust fund's amount. A review of the actual bank statement for the resident's trust fund did not reveal how interest was determined and had significant amount of money deposited and withdrawn weekly that did not match with the resident's activity on their personal facility statements. On 3/6/26 at approximately 11:30 AM the facility's business owner (FBO) I was interviewed and said, The resident's trust fund was co-mingled with the facility's bank account. We were withdrawing money out of the resident's trust fund account at the end of every month so it would not get levied (legal seizure of property of assets, such as bank accounts) by an outside entity. FBO I went on to say that the resident's trust fund would now be separated out from the corporation to prevent possible loss of resident's monies. According to the facility's policy for Resident Personal Funds implements on 10/27/2022 in part reads:Accounting and Records1. The facility will establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's person funds entrusted to the facility on the resident's behalf.2. The system will preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide periodic reviews and to adequately update information on Advance Medical Directives (AMD- the written instruction relating to the provision of health care) for five (R5, R6, R55, R45, and R25) of thirteen residents reviewed for advanced directives. Findings include: On 3/3/25 at 1:27 PM, R25's face sheet indicated R25 was a full code (in the event the resident stops breathing, and/or heart stops beating, healthcare providers will use all available aggressive life-saving measures). A Resident Code Status form dated 11/18/24 indicated R25 was a 'full code'. This form had the resident's initials next to it, a physician signature, and undeterminable facility staff signature. However, a Code status/Do Not Resuscitate (DNR) Directive form with an earlier date of 5/16/23 indicated R25 was a 'Do Not Resuscitate (in the event the resident stops breathing, and/or heart stops beating, healthcare providers will not use any medical interventions). This form was signed by R25's Legal Guardian (LG), the physician, and two witnesses. Valid LG paperwork was verified in R25's EHR. At this time R25 was observed seated in his bed drinking coffee and was unwilling to be interviewed regarding this subject matter. On 3/4/26 at 2:20 PM during an interview with Social Worker (SW) K the two different code status forms were reviewed. SW K could not explain why there was a change in code status and said, That is not my signature on either form. I don't know who signed those code status forms. I will have to review it with resident's Legal Guardian. Further review of R25's EHR did not reveal any documentation to support the LG had been consulted regarding code status. On 3/4/26 at 2:45 PM R25's court appointed LG L for R25 was interviewed over the phone regarding code status and said that R25 was a DNR. LG L stated, I will email the Social Worker to clarify this. We email monthly and no one has asked me about this. I don't know why it would be changed. On 03/03/2026 at 3:03 PM, record review revealed R5 has a code status of Full Code with no documentation of information offered regarding the option of formulating an advanced directive. Further record review revealed no documentation to support a periodic review of an advanced directive. There was also no evidence of a periodic review of advance medical directives as part of the comprehensive care planning process. Record review of the admission record revealed R5 was admitted to the facility on [DATE] with a diagnosis of Anemia, Hypertension, Peripheral Vascular Disease, Renal Failure, Diabetes and Hyperlipidemia. The Minimum Data Set, dated [DATE] revealed R5 has a Brief Interview for Mental Status (BIMS) of 14 out of 15 which indicates cognitively intact. On 03/03/2026 at 2:35 PM, record review revealed R6 has a code status of Full Code with an Advance Directive signed by R6 on 03/08/24. Record review also revealed R6 has a legal guardian. Further record review revealed no documentation to support a periodic review of an advanced directive since 03/08/2024. Record review did not reveal documentation of a discussion with the legal representative regarding formulating an advanced directive or the provision of updating the current advanced directive. There was also no evidence of a periodic review of advance medical directives as part of the comprehensive care planning process. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the admission record revealed R6 was admitted to the facility on [DATE] with a diagnosis of Hypertension, Reflux, Diabetes, Hyperlipidemia and Huntington's Disease. The Minimum Data Set, dated [DATE] revealed R6 has a Brief Interview for Mental Status of 7 out of 15 which indicates severe impairment. On 03/03/2026 at 2:00 PM, record review revealed R45 has a code status of Full Code. An advanced directive form, located in the electronic health record (EHR) was signed by R45 on 11/18/2024.Record review also revealed R45 has a legal guardian. Further record review revealed a lack of documentation supporting a discussion with the legal representative regarding formulating an advanced directive or the provision for periodically reviewing and/or updating an advanced directive. A record review revealed there was also no evidence of a periodic review of advance medical directives as part of the comprehensive care planning process. Record review of the admission record revealed R45 was admitted on [DATE] with a diagnosis of Schizoaffective Disorder, Bipolar Type, Major Depression, Generalized Anxiety Disorder. The Minimum Data Set, dated [DATE] revealed R45 has a Brief Interview for Mental Status of 12 out of 15 which indicates a moderate impairment. On 03/03/2026 at 2:10 PM, record review revealed R55 has a code status of Full Code with an advanced directive signed by R55 on 02/13/2023. Record review also revealed R55 has a legal guardian. Further record review revealed no documentation to support a periodic review of an advanced directive since 02/13/2023. Record review also did not reveal documentation of a discussion with the legal representative regarding formulating an advanced directive or the provision of updating the current advanced directive. There was also no evidence of a periodic review of advance medical directives as part of the comprehensive care planning process. Record review of the admission record revealed R55 was admitted on [DATE]. The Minimum Data Set, dated [DATE] revealed R55 has a Brief Interview for Mental Status of 15 out of 15 which indicates cognitively intact. On 03/04/2026 at 2PM, Social Worker (SW) K was interviewed and stated, Advanced Directives are reviewed at the time of admission and should be reviewed at least quarterly. On 03/05/2026 at 9AM, the Nursing Home Administrator (NHA) was queried on expectations of advance directives. The NHA said, Advance Directives should be reviewed quarterly and updated yearly. The resident and their guardian should sign, and the discussion should be documented. Reviewed policy on Advanced Directives entitled, Residents' Rights Regarding Treatment and Advance Directives date revised- 01/07/2026, which reads in part: . During the care planning process, the facility will identify, clarify and review with the resident or legal representative whether they desire to make any changes related to any advance directives.Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehension care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. Any decision making regarding the resident's choices will be documented in the medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. No further information provided for advanced directives.

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	235234	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Manor Nursing and Rehabilitation Center	9500 Grand River Ave Detroit, MI 48204

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a supra-pubic (s/p, a tube inserted through the abdomen directly into the bladder to drain urine) indwelling urinary catheter care plan for one (R9) of two residents reviewed for urinary catheter.Findings include:On 3/4/26 at 9:35 AM R9 was observed seated on their bed in t-shirt and sweatpants. A urinary catheter tubing was observed pulling tightly downward from under R9's T-shirt. The catheter was attached to a collection bag resting on the floor. There was approximately 1 liter of urine in the collection bag. R9 was asked about the catheter and said, It's bothering me. R9 lifted up their T-shirt and lowered the waistband of their sweatpants to show the s/p catheter's insertion site. There was an anchoring device on the catheter, but it was not adhered to R9's body. The insertion site had no dressing over it and was open to air. A small shallow ulcer was observed around the stoma (surgically created hole the tubing goes through). The ulcer was pink, moist, and without visible drainage. There was some redness to the surrounding area. It appeared that the waistband of R9's sweatpants was directly resting over the s/p catheter's insertion site. Licensed Practical Nurse (LPN) A was present and stated, I'm going to call the doctor about the redness at the site, it (the catheter insertion site) should be covered. This (the collection bag) should be emptied out and picked up off the floor. LPN A confirmed that the anchoring device was not attached correctly. LPN A stated, It's not sticking to anything. It needs a new one. According to R9's Electronic Health Record (EHR) they admitted on [DATE] with multiple diagnoses that included neuromuscular dysfunction of the bladder and required a s/p catheter to drain urine. On 2/2/26 a Physician's order for urinary catheter care included: ensure the anchor is in place. The last annual Minimum Data Set (MDS) dated [DATE] indicated R9 had a supra-pubic catheter. Section 'V triggered urinary incontinence/indwelling catheter as a care area assessment, but there is no urinary or catheter care plan. R9 had a care plan for urinary tract infection initiated on 2/16/26, but there are no interventions for catheter care. On 3/6/26 at 10:40 AM the Director of Nursing (DON) was asked about R9's s/p catheter and lack of care plan and said, There are orders to cleanse and dress the site every day and as needed. A care plan has been started. I don't know why it wasn't done before. The DON was asked to provide a policy for resident care planning and stated, We don't have one. It's part of the MDS assessment that a care plan would be started.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist a wheelchair dependent resident (R35), reliant on the use of the elevator to smoke, of one resident reviewed for smoking resulting in missed opportunities for smoking.Findings include: On 3/3/2026 at approximately 1:00 PM, R35 was observed in their wheelchair at the 2nd floor elevator. R35 said they were waiting to go outside and smoke. On 3/3/2026 at approximately 1:20 PM, R35 was observed at the 1st floor elevator. When asked if they went outside to smoke, R35 stated, no, I missed it. On 3/3/2026 at approximately 1:45 PM, R35 said that they miss their smoke breaks often because there is only one elevator out of two elevators in the building that work. R35 further said that it can take up to 30 minutes to get on the elevator because so many residents and staff are waiting to use it. In addition, R35 stated, It is very upsetting to miss my smoke breaks. If you miss it, it's a non-negotiable - they close the door and won't let you smoke. It happens a lot. A record review was completed on 3/4/2026 and revealed that R35 was admitted to the facility on [DATE] with diagnoses that included seizures, hemiplegia and hemiparesis, heart disease, cerebral infarction, anxiety, and depression. Section C of the Minimum Data Set with an Assessment Reference Date of 12/4/2025 revealed R35 scored a 15/15 on the Brief Interview for Mental Status assessment - indicative of no cognitive impairment. Section GG of the Minimum Data Set with an Assessment Reference Date of 12/4/2025 revealed R35 needed partial moderate assistance from staff to transfer from their bed to wheelchair. A Smoking Risk Assessment was last completed on 3/4/2025 and revealed that R35 was safe to smoke. R35's care plan indicated they had the ability to smoke. On 3/4/2026 at approximately 3:00 PM, a sign posted on a bulletin board near the activity director office listed facility designated smoking times as 9:15 AM, 1:00 PM, and 5:15 PM. On 3/4/2026 at approximately 3:30 PM, Activity Director (AD B) was interviewed regarding the facility smoking procedures. AD B stated, once the smoke break is over, the activity staff go to other responsibilities, so the smoke break ends. On 3/5/2026 at approximately 3:30 PM, the Nursing Home Administrator (NHA) was interviewed regarding resident smoke breaks. The NHA stated, the resident should be allowed to smoke.A policy titled, Resident Smoking, Vaping, and Smokeless Tobacco, reviewed/revised 6/5/2025 revealed, Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement appropriate indwelling urinary catheter care for one (R9) of two residents reviewed for urinary catheter care resulting in discomfort and irritation at R9's supra-pubic catheter (s/p, a tube inserted through the abdomen directly into the bladder to drain urine) insertion site along with the potential for infection and catheter dislodgement.Findings include:On 3/4/26 at 9:35 AM R9 was observed seated on their bed in t-shirt and sweatpants. A urinary catheter tubing was observed pulling tightly downward from under R9's T-shirt. The catheter was attached to a collection bag resting on the floor. There was approximately 1 liter of urine in the collection bag. R9 was asked about the catheter and said, It's bothering me. R9 lifted up their T-shirt and lowered the waistband of their sweatpants to show the s/p catheter's insertion site. There was an anchoring device on the catheter, but it was not adhered to R9's body. The insertion site had no dressing over it and was open to air. A small shallow ulcer was observed around the stoma (surgically created hole the tubing goes through). The ulcer was pink, moist, and without visible drainage. There was some redness to the surrounding area. It appeared that the waistband of R9's sweatpants was directly resting over the s/p catheter's insertion site. Licensed Practical Nurse (LPN) A was present and stated, I'm going to call the doctor about the redness at the site, it (the catheter insertion site) should be covered. This (the collection bag) should be emptied out and picked up off the floor. LPN A confirmed that the anchoring device was not attached correctly. LPN A stated, It's not sticking to anything. It needs a new one. According to R9's Electronic Health Record (EHR) they admitted on [DATE] with multiple diagnoses that included neuromuscular dysfunction of the bladder and required a s/p catheter to drain urine. On 2/2/26 a Physician's order for urinary catheter care included: ensure the anchor is in place. The last annual Minimum Data Set (MDS) dated [DATE] indicated R9 had a supra-pubic catheter. Section 'V triggered urinary incontinence/indwelling catheter as a care area assessment, but there is no urinary or catheter care plan. R9 had a care plan for urinary tract infection initiated on 2/16/26, but there are no interventions for catheter care. On 3/4/26 at 11:00 AM LPN A said the physician ordered for wound care to consult and treat R9's s/p catheter site. On 3/6/26 at 10:40 AM the Director of Nursing (DON) was asked about R9's s/p catheter site and said, There are orders to cleanse and dress the site every day and as needed. It should have been done before. There are care plans in place now. According to the facility's Indwelling Catheter Use and Removal policy implemented on 11/1/2022, in part reads: It is the policy of this facility to ensure that indwelling urinary catheters that are inserted or remain in place are justified or removed according to regulations and current standards of practice.4. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to:f. Ongoing monitoring for changes in condition related to potential catheter-associated urinary tractinfections, recognizing, reporting and addressing such changes.7. Additional care practices include:a. Recognition and assessment for complications and their causes, and maintaining a record of anycatheter-related problems d. Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethraltears or dislodgement of the catheter; ande. Securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioningbelow the level of the bladder.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare vegetables to the proper food consistency for four residents receiving pureed textured meals in the facility. Findings include: On 3/3/26 at 11:04 AM, during observations of the kitchen lunch service with Head [NAME] S and Dietary Manager (DM) Q, the steam table was set with pans of food ready to be served to facility residents. Due to a lack of space on the steam table, the pan of prepared pureed green beans, also ready to be served to the residents, was sitting in a pan of water on the hot stove. While taking food temperatures, the pureed green beans appeared lumpy. DM Q and the two State Surveyors present obtained and tasted a sample of the green beans. The consensus from the tasting was that the green beans contained lumps. DM Q said the green beans needed to be smoother. Head [NAME] S informed the staff on the tray line to put the meal tickets for the residents on pureed diets aside because the pureed green beans were being smooth out in the blender. On 3/4/26 at 12:34 PM, when Registered Dietitian, T was queried about the consistency of pureed food, they said, It should be smooth like pudding.