STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00145236 Based on observation, interview, and record review, the facility failed to ensure freedom from physical restraints for one resident (R503), of one resident reviewed for restraints, resulting in staff reported observations of the resident's feet and legs tied in a knot with blankets and multiple staff reports of having received an in-service education on restraints. Findings include: A complaint was received by the State Agency that alleged a resident had been physically restrained on the afternoon shift of 6/17/24. On 6/27/24 at 9:45 AM, R503 was observed in the dining area between the 500 and 600 unit seated in their wheelchair. An interview was attempted, however; R503 did not respond appropriately. A review of R503's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses that included: moderate protein calorie malnutrition, heart disease, adjustment disorder with anxiety, falls, and dementia. Further review of the record revealed R503 received Hospice services. On 6/27/24 at 10:45 AM, an interview was conducted with Certified Nurse Aide (CNA) 'G', a staff member assigned to R503 on the date of the alleged restraint incident. CNA 'G' was asked what they recalled about the incident and said they were assigned to R503 from 6AM to 2 PM and their assignment changed at 2PM. They said they were not aware it changed and thought they were still assigned to R503. They said they were going to check on R503 when they overheard Nurse 'H' say something about R503 being restrained. CNA 'G' said they immediately went to check on R503 at approximately 3 PM and found them in their bed with their feet, bound. They said they first thought the resident became tangled in their blanket, but upon further inspection, CNA 'G' said R503 presented with one of their blankets wrapped around their feet, ankles, and knees, and the blanket had been tied in a knot. CNA 'G' said R503 was agitated trying to free their feet/legs from the knotted blanket. They were asked if they believed R503 could have knotted their own blanket around their legs and said they did not believe so. CNA 'G' was asked what happened after they removed the knotted blanket from R503's legs, and they said Nurse 'H' informed Unit Manager (UM) 'I' and UM 'I' reported to the unit and told the staff residents could not be restrained. CNA 'G' was asked if the facility interviewed them after the incident and said they did an over the phone statement to the Administrator the day after the incident. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 11:09 AM, an interview was conducted with Nurse 'H', R503's assigned nurse on the day of the alleged incident. Nurse 'H' said the incident happened on their shift. They walked past R503's room and saw R503 had, two blankets tied in a knot around their legs. They said CNA 'G' untied the blankets while they (Nurse 'H') went to each of the other CNA's assigned to that unit in an attempt to find out who did it. Nurse 'H' said all the CNA's assigned to that unit denied performing the act and they then told Unit Manager (UM) 'I' R503 had been tied up in their blankets. They were then asked what UM 'I' did when they found out the information and said UM 'I' came to the unit and educated all staff that residents could not be restrained. On 6/27/24 at 11:24 AM, an interview was conducted with UM 'I'. UM 'I' said Nurse 'H' came to them and said R503 was tangled in their blankets. They were asked if they were made aware R503's blankets were, tied in a knot, witnessed by both CNA 'G', and Nurse 'H'. They said, No. They further said they went to R503's room, assessed them and observed R503 covered with multiple blankets. They then said they called the unit staff to the desk and educated them about not piling multiple blankets on top of the resident. They were asked if they educated any of the staff about restraints at that time, and said they did not, despite both CNA 'G' and Nurse 'H' reporting an in-service about restraints being held at the desk. On 6/27/24 at 11:50 AM, an interview was conducted with CNA 'J', a CNA assigned to work on the unit the day of the alleged incident. When queried, CNA 'J' exasperatedly stated, Oh no, not this again. They were asked of their knowledge of the incident and said Nurse 'H' asked them about R503, being in a restraint. They further indicated both UM 'I' and the Administrator also asked them about R503 observed in a restraint. CNA 'J' said they were not R503's assigned aide and had not observed anything. On 6/27/24 at 12:22 PM, an interview with the facility's Director of Nursing (DON) was conducted. They said they did not know a whole lot about the incident and UM 'I' reported to them R503 was tangled in their blankets. They said UM 'I' told them they gave staff an in-service about not using multiple blankets. They further said the next day, the Administrator received an allegation from a CNA about R503 having been restrained. They said the Administrator looked into the incident. At that time, they were requested to provide any investigation material regarding the incident. On 6/27/24 at 12:45 PM, a review of an investigation file was completed. A typed summary read, 1:50pm nurse placed resident in bed. 2;30 <sic> aide see's <sic> resident resting comfortably in bed. 2:40 the nurse goes in room and observed blankets tangled. These were the two main caregivers for the resident at this time that observed the resident with the blankets and did not note any other staff going into room. It was noted that resident has a history of tying items around her feet per roommate and becomes restless and fidgets with articles A review of R503's care plans and progress notes was conducted for a 12 month look-back period and did not indicate R503 demonstrated any of the roommate's reported behavior. It was further noted R503's most recent Minimum Data Set Assessment indicated R503 required maximal assistance for bed mobility, transferring, and ambulation. Continued review of the investigation file revealed the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A signed statement dated 6/18/24 from Nurse 'H' that read, I put (R503) to bed around 150p (1:50 PM). When I got back around 240p (2:40 PM) I walked in her room and her legs were tied together with 2 thin throw blankets. I walked out of the room to find the aide. I came across (CNA 'G') first and asked her if she had (R503) for the 2nd shift, she said no. (CNA 'G') walked into the room untied the sheets .I asked all the other aides and they said they did not take care of (R503) . An unsigned, undated statement from CNA 'G' that read, I saw (R503) around 230p (2:30 PM) resting comfortably in bed. (Nurse 'H) came and got me about 10 minutes later and asked me to come with her to the room. It looked initially looked <sic> they were tangled up but the blankets were wrapped all along her legs in a knot. I have never seen anything like this in [AGE] years as an aide . An unsigned , undated statement from CNA 'J' that read, (UM 'I') called us for a meeting saying that (R503) got tied up . An unsigned statement dated 6/18/24 from CNA 'K' that read, .We had a meeting with (UM 'I') that it had come to her attention that the resident <sic> feet were tied with blankets . An unsigned, undated statement from UM 'I' that read, It was sometime in the afternoon, the nurse came to my office and stated she was upset and frustrated. She explained (R503) was in her bed with blankets wrapped around her legs tight. I did not hear the words tied .I immediately walked to the room .As I walked into the room, I observed the patient sitting on the edge of the bed .I observed medium thick blankets on the side of the bed. My immediate concern was of the patient possibly being overheated. As I had seen no evidence of binding . On 6/27/24 at 1:54 PM, an interview via telephone was conducted with the facility's Administrator/Abuse Coordinator regarding the allegation R503 had been restrained. They said they looked into the incident but believed R503 bound their own feet/legs in a knot with their blankets and they had not been restrained. A request for a restraint policy was made on 6/27/24 at 1:15 PM, however; a policy was not provided by the end of the survey.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 This citation pertains to intake #MI00145236 Based on observation, interview, and record review, the facility failed to ensure abuse was immediately reported to the abuse coordinator and reported to the State Agency for one resident, (R503) of two residents reviewed for abuse. Findings include: A complaint was received by the State Agency that alleged a resident had been physically restrained on the afternoon shift of 6/17/24. On 6/27/24 at 9:45 AM, R503 was observed in the dining area between the 500 and 600 unit seated in their wheelchair. An interview was attempted, however; R503 did not respond appropriately. A review of R503's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted [DATE] with diagnoses that included: moderate protein calorie malnutrition, heart disease, adjustment disorder with anxiety, falls, and dementia. Further review of the record revealed R503 received Hospice services. On 6/27/24 at 10:45 AM, an interview was conducted with Certified Nurse Aide (CNA) 'G', a staff member assigned to R503 on the date of the alleged restraint incident. CNA 'G' was asked what they recalled about the incident and said they were assigned to R503 from 6AM to 2 PM and their assignment changed at 2PM. They said they were not aware it changed and thought they were still assigned to R503. They said they were going to check on R503 when they overheard Nurse 'H' say something about R503 being restrained. CNA 'G' said they immediately went to check on R503 at approximately 3 PM and found them in their bed with their feet, bound. They said they first thought the resident became tangled in their blanket, but upon further inspection, CNA 'G' said R503 presented with one of their blankets wrapped around their feet, ankles, and knees, and the blanket had been tied in a knot. CNA 'G' said R503 was agitated trying to free their feet/legs from the knotted blanket. They were asked if they believed R503 could have knotted their own blanket around their legs and said they did not believe so. CNA 'G' was asked what happened after they removed the knotted blanket from R503's legs and said Nurse 'H' informed Unit Manager 'I' and Unit Manager 'I' reported to the unit and told staff that residents could not be restrained. CNA 'G' was asked if the facility interviewed them about the incident and said they did an over the phone statement to the Administrator the day after the incident. On 6/27/24 at 11:09 AM, an interview was conducted with Nurse 'H', R503's assigned nurse on the day of the alleged incident. Nurse 'H' said the incident happened on their shift. They walked past R503's room and saw R503 had, two blankets tied in a knot around their legs. They said CNA 'G' untied the blankets while they (Nurse 'H') went to each of the other CNA's assigned to that unit in an attempt to find out who did it. Nurse 'H' said all the CNA's assigned to that unit denied performing the act and they then told Unit Manager (UM) 'I' R503 had been tied up in their blankets. They were then asked what UM 'I' did when they found out the information and they said UM 'I' came to the unit and educated all staff that residents could not be restrained. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 11:24 AM, an interview was conducted with UM 'I'. UM 'I' said Nurse 'H' came to them and said R503 was tangled in their blankets. They were asked if they were made aware R503's blankets were, tied in a knot, witnessed by both CNA 'G', and Nurse 'H'. They said, No. They further said they went to R503's room, assessed them and observed R503 covered with multiple blankets. They then said they called the unit staff to the desk and educated them about not piling multiple blankets on top of the resident. They were asked if they educated any of the staff about restraints at that time and said they did not, despite both CNA 'G' and Nurse 'H' reporting an in-service about restraints being held at the desk. On 6/27/24 at 11:50 AM, an interview was conducted with CNA 'J', a CNA assigned to work on the unit the day of the alleged incident. When queried, CNA 'J' exasperatedly stated, Oh no, not this again. They were asked of their knowledge of the incident and said Nurse 'H' asked them about R503, being in a restraint. They further indicated both UM 'I' and the Administrator also asked them about R503 observed in a restraint. CNA 'J' said they were not R503's assigned aide and had not observed anything. On 6/27/24 at 12:22 PM, an interview with the facility's Director of Nursing (DON) was conducted. They said they did not know a whole lot about the incident and UM 'I' reported to them R503 was tangled in their blankets. They said UM 'I' told them they gave staff an in-service about not using multiple blankets. They further said the next day, the Administrator received an allegation from an aide about R503 having been restrained. They said the Administrator looked into the incident. At that time, they were requested to provide any investigation material regarding the incident. On 6/27/24 at 12:45 PM, a review of an investigation file was completed. A typed summary read, 1:50pm nurse placed resident in bed. 2;30 <sic> aide see's <sic> resident resting comfortably in bed. 2:40 the nurse goes in room and observed blankets tangled. These were the two main caregivers for the resident at this time that observed the resident with the blankets and did not note any other staff going into room. It was noted that resident has a history of tying items around her feet per roommate and becomes restless and fidgets with articles A review of R503's care plans and progress notes was conducted for a 12 month look-back period and did not indicate R503 demonstrated any of the roommate's reported behavior. It was further noted R503's most recent Minimum Data Set Assessment indicated R503 required maximal assistance for bed mobility, transferring, and ambulation. Continued review of the investigation file revealed the following: A signed statement dated 6/18/24 from Nurse 'H' that read, I put (R503) to bed around 150p (1:50 PM). When I got back around 240p (2:40 PM) I walked in her room and her legs were tied together with 2 thin throw blankets. I walked out of the room to find the aide. I came across (CNA 'G') first and asked her if she had (R503) for the 2nd shift, she said no. (CNA 'G') walked into the room untied the sheets .I asked all the other aides and they said they did not take care of (R503) . An unsigned, undated statement from CNA 'G' that read, I saw (R503) around 230p (2:30 PM) resting comfortably in bed. (Nurse 'H) came and got me about 10 minutes later and asked me to come with her to the room. It looked initially looked <sic> they were tangled up but the blankets were wrapped all along her legs in a knot. I have never seen anything like this in [AGE] years as an aide . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An unsigned , undated statement from CNA 'J' that read, (UM 'I') called us for a meeting saying that (R503) got tied up . An unsigned statement dated 6/18/24 from CNA 'K' that read, .We had a meeting with (UM 'I') that it had come to her attention that the resident <sic> feet were tied with blankets . An unsigned, undated statement from UM 'I' that read, It was sometime in the afternoon, the nurse came to my office and stated she was upset and frustrated. She explained (R503) was in her bed with blankets wrapped around her legs tight. I did not hear the words tied .I immediately waked to the room .As I walked into the room, I observed the patient sitting on the edge of the bed .I observed medium thick blankets on the side of the bed. My immediate concern was of the patient possibly being overheated. As I had seen no evidence of binding . On 6/27/24 at 1:54 PM, an interview via telephone was conducted with the facility's Administrator/Abuse Coordinator. They were asked about the incident. They said a staff member reported to them on 6/18/24, rumors going around about a patient being tied up the previous day. They said they immediately started their investigation and at 2:40 PM (on 6/17/24) a nurse saw R503's sheets were tied. The Administrator was asked if they considered the allegation of R503 being tied up as an allegation of abuse and they said it was a, rumor, not an allegation. They further reported through their own investigation they determined R503 did it on, their own volition, and staff had not restrained the resident. They were asked if a rumor could be considered an allegation of abuse reportable to the State Agency, but declined to answer the question. Lastly, the Administrator was asked if the incident should have been reported to them as the Abuse Coordinator at the time of the incident and agreed it should have. A review of a facility provided policy titled, ABUSE AND NEGLECT PROCEDURAL GUIDELINES was conducted and read, .Investigation: Resident abuse must be immediately reported to the Administrator and/or Director of Nursing. The Administrator and/or Director of Nursing will ensure a thorough investigation of alleged violations and document findings and appropriate action .Reporting: Facility employees who become aware of abuse or neglect, shall ensure safety of the resident and IMMEDIATELY report the matter to the facility Administrator and/or Director of Nursing. Facility must report alleged violations- If the event results in the allegation of abuse or serious bodily injury, the event will be reported immediately but not more than two hours after the individual first suspects that a crime has occurred .If the event does not result in serious bodily injury or allegation of abuse, the suspicion will be reported immediately but not more than twenty-four hours after the individual first suspects that a crime has occurred .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00145092. Based on observation, interview, and record review the facility failed to timely implement effective wound interventions/treatments and ensure physician follow-up, assessment, and monitoring of a worsening wound for one (R502) of two residents reviewed for skin concerns. Findings include: Review of a complaint submitted to the State Agency documented concerns of the facility's failure to prevent worsening of R502's pressure ulcers. On 6/26/24, R502 was observed in their room sitting in their wheelchair. Blue inflated boots were observed on the resident's bed. R502 requested to be assisted to the community room to conduct the interview. R502 was assisted by staff to the community room and an interview was conducted with R502. R502 was asked if they had any wounds on their body and R502 said they had one on their buttocks and one on each heel. When asked if they ever refused to be turned and repositioned in bed or to wear the inflated blue boots observed on their bed, R502 said they never refused. R502 said staff put their inflated blue boots on them at night time and removed them in the morning. R502 did admit to refusing therapy and their tube feeding at times, and said they were having a hard time adjusting to the decline of their health. Review of the medical record revealed R502 was admitted to the facility on [DATE], with diagnoses that included: cerebral infarction, hemiplegia and hemiparesis affecting dominant right side. The record further reviewed R502 required staff assistance for all Activities of Daily Living and had a Brief Interview for Mental Status score of 15/15 calculated on 5/14/24 that indicated intact cognition. Review of a, Nursing Assessment Admission . dated 5/7/24 at 1:56 PM, documented in part . Is there a skin issue present . Yes . Sacrum - open wound . Right lower leg (front) - redness . Left lower leg (front) - redness . Right heel- open blister . The Braden score was documented as a, 15 . At Risk. Review of the May 2024 Medication/Treatment Administration Record (MAR/TAR) documented the following treatment orders: An order dated 5/8/24- wound care coccyx/sacrum; cleanse with wound cleanser and gauze, apply zinc-based barrier cream to wound. One time a day for wound care (9AM). This order was discontinued on 5/17/24. An order dated 5/9/24- Sacro-coccyx/bilateral buttock: Cleanse with normal saline, apply moisture barrier to wound base, cover with comfort foam dressing. Every day shift for wound care Also PRN. This order was discontinued on 5/13/24. Both orders were applied on the dayshift to the same area from 5/9/24 to 5/13/24. Review of the medical record documented no clarification of either order, or explanation of the two treatments for the same area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An order on 5/13/24- cleanse right heel with wound cleanser, apply skin prep, leave open to air. This order was discontinued on 5/16/24. This order was implemented six days after admission to the facility, although the opened blister to the right heel was identified on admission on 5/7/24. A review of the admission note dated 5/7/24 at 11:35 AM, revealed no documentation the physician was informed of the, open blister to the right heel. A review of a, Skin & Wound Evaluation dated 5/8/24, documented . Moisture Associated Skin Damage . to the sacrococcygeal area and a, . Blister . to the right heel. A review of a Skin & Wound Evaluation dated 5/16/24, documented the identification of a, Blister on R502's, Left Heel . In-House Acquired . A review of the right heel, Skin & Wound Evaluation dated 5/16/24, documented the right heel as a, . Unstageable: Obscured full-thickness skin and tissue loss . Slough and/or eschar . A review of the May 2024 MAR/TAR documented the following treatment for the left heel: 5/17/24- Cleanse left heel with wound cleanser, swab with skin prep q (every) shift, leave open to air, every shift for wound care. This order was discontinued on 5/24/24. A review of a, Skin & Wound Evaluation dated 6/6/24, documented the following, . Pressure . Unstageable . Slough and/or eschar . to the sacrococcygeal area. Continued review of R502's May 2024 MAR/TAR revealed the following: An entry on the MAR/TAR dated 5/17/24- PRAFO (Pressure Relief Ankle Foot Orthosis) boots on bilateral heels at all times as tolerated every shift for Wound care. This order was implemented 10 days after admission to the facility. An order dated 5/17/24- Cleanse right heel with wound cleanser, apply calcium alginate, cover with abd (abdominal) and kerlix, Q (every) daily and PRN (as needed) every shift. This order was applied twice a day, with no clarification of the, Q daily and PRN, every shift noted in the medical record. An order dated 5/17/24- wound care coccyx/sacrum; cleanse with wound cleanser and gauze, apply zinc based barrier cream to wound, every shift for wound care. Review of the medical record revealed R502 was seen by multiple Medical Doctors and Nurse Practitioners who prescribed multiple treatments to the coccyx/sacrum, right and left heels, however; there was no evidence The Medical Doctors and Nurse Practitioners assessed/examined or documented on any of R502's skin impairment/wounds until 5/29/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a, Physician Services note dated 5/29/24 at 7:00 AM, documented in part, . Bilateral DTI (deep tissue injury- intact skin with non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) . Patient seen today for DTI management to bilateral heels. Patient heels assessed, noted boggyness <sic>, intact skin dark area to heels. Patient arterial doppler results shows mild peripheral vascular disease without occlusion, right lower extremity, mild to moderate peripheral vascular disease without occlusion . Surrounding skin to DTI blanchable . Diagnosis/Status/Plan . Deep tissue pressure injury of left heel . Pressure induced deep tissue damage of left heel (chronic) - cleanse right and left heels, cover with betadine Q (every) daily and PRN, elevate BLE (bilateral lower extremities) daily, bilateral heel protector in place, wound nurse monitoring . It was noted this was the first documentation of the Physician team to have assessed R502's heels since the resident admitted more than three weeks prior. It was also noted the Physician team had no documented evidence the sacrococcygeal (sacrum/sacral/coccyx) was assessed. A review of a, Physician Services note dated 6/2/24 at 12:22 PM, documented in part, . CHIEF COMPLAINT: Bilateral heel wounds, sacral wound, and right-sided hemiparesis . He developed bilateral deep tissue injury in both heels as well as sacral and buttocks area . ASSESSMENT AND PLAN . Bilateral heel wounds . Sacral and buttocks wound condition is also most likely related to shearing forces as well as noncompliance with turning position, but the patient does have some disruption of the skin level wound care . Multiple wounds sacral, buttock, bilateral heels. Wound care team is on the case. We will follow up. The patient to be turned every two hours while protective heel wear at all the time . This was the first documentation of the Physician team to document or acknowledge the sacral wound. There was no documented assessment or examination of the sacral wound for this consultation. Review of the medical record revealed no documentation of R502's noncompliance with turning and positioning. Review of a (veteran hospital name) consultation dated 6/13/24, documented in part . B/L (bilateral) heel pressure wounds - unstageable . Wound clinic in the interim he is high-risk for bad outcome . Sacral wound - draining, probes to bone - sending to Wound clinic . Review of a (veteran hospital name) wound care orders dated 6/21/24, documented in part . Rt (right) heel MRI (magnetic resonance imaging) showing osteomyelitis. Sacral ulcers have not yet spread to bone . On 6/26/24 at 3:07 PM, the Director of Nursing (DON) was interviewed and asked about the concerns of the sacral and right heel skin impairment identified on admission for R502. The DON was asked about the duplicate treatment started for the sacral area and delayed implementation of the right heel treatment. The DON was also asked about the many treatments implemented by the physicians/nurse practitioner for R502's wounds, without physician/nurse practitioner monitoring and assessing the effectiveness of the treatment prescribed. The DON said they (nursing staff and interdisciplinary team) were following R502's wounds but would look into the medical record for the physician/nurse practitioner assessment of R502's wounds. Review of a follow up email that contained documents provided by the Administrator and DON, revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235288	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marvin & Betty Danto Health Care Center	6800 West Maple West Bloomfield, MI 48322

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing note dated 5/17/24 at 12:37 PM, documented in part . Doctor aware of wound status and new blister and agrees with treatment plan. Care plans reviewed and revised as needed . This sentence was underlined by the DON. Copies of the resident wound orders were included in the email. The DON provided the date of 6/11/24 as R502's first wound care appointment.