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No. 0938-0391

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	04/03/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to Intake MI00149648. Based on observation, interview and record review, the facility failed to obtain consent to search personal belongings from one resident (R801) of one resident reviewed for Rights to Privacy and Confidentiality. Findings include: A complaint was filed with the State Agency that alleged the facility was going through residents personal possessions without permission. Clinical record review revealed R801 was admitted to the facility on [DATE] and resided as a long-term resident related to chronic pain to the right hip joint as a result from a complicated history involving multiple surgeries. R801's Brief Interview for Mental Status (BIMS) assessed on 3/24/25 scored 15/15 which indicated no cognitive impairment. On 4/3/25 at 11:00 AM, an interview was conducted in R801's room and inquired why they alleged the facility was going through their personal belongings. R801 said just before Christmas 2024, a friend of theirs was observed by staff talking to them through the window in their room. R801 said the staff notified the Nursing Home Administrator (NHA) and suspected they were hoarding their Oxycodone (narcotic, opioid, used to treat pain) and selling it out their window. R801 said a few days after the situation, they returned from Bingo and another resident of the facility (requested to remain anonymous) said they witnessed the NHA going through R801's belongings and told R801, the NHA tore your stuff up! R801 remarked they knew their belongings were tampered with because the bottom third drawer of their nightstand stored their mail, paperwork, and personal letters. R801 had them in a specific order, and when they went into that drawer, all the paperwork was messed up. R801 then pointed to a free standing safe located against the wall under the window, and said once that incident occurred, they had to purchase a safe and they cannot trust the facility. R801 confirmed they were never approached by the NHA to search their room and were not provided consent to do so. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 3:32 PM, an interview with the NHA and the Director of Nursing (DON) acknowledged residents' rooms can be searched when there is suspicion of illegal activity or display of suspicious behaviors. When asked if the facility obtains consent, they confirmed they obtain verbal consent only. When inquired if R801's room was searched, the NHA confirmed they searched their room without consent. When asked why they searched their room, the NHA replied they heard a rumor and would not further comment what the rumor was, but they did in fact go through their belongings. The NHA was also asked if there was suspicion of illegal activity, why were the local authorities not contacted. The NHA had no further comments. Review of the facility policy titled; Residents Rights dated 11/24 documented: .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: privacy and confidentiality .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00150488. Based on observation, interview, and record review, the facility failed to provide assistance with dressing and getting out of bed in a timely manner to one (R806) of three residents reviewed for activities of daily living. Findings include: On 4/3/25 at approximately 9:20 AM, R806 was observed lying in bed wearing a hospital gown. R806 reported she wanted to get dressed and get out of bed. R806 reported she liked to pick out her own outfit from the closet and match her shoes to it. R806 explained she notified the Certified Nursing Assistant (CNA) approximately five minutes prior that she would like to get dressed and get out of bed. On 4/3/25 at 9:55 AM, CNA 'D' was observed exiting R806's room. R806 remained in bed wearing a hospital gown. CNA 'D' reported he changed R806's brief and put pants on her. On 4/3/25 at 10:15 AM, R806 remained in bed wearing a hospital gown. CNA 'D' brought a mechanical lift into R806's room at that time. On 4/3/25 at approximately 10:20 AM, R806 remained in bed wearing a hospital gown. R806 seemed slightly confused and reported she was waiting for staff to clean her wheelchair and then they would assist her out of bed. A wheelchair was observed in R806's room at that time. At 10:25 AM, an interview was conducted with CNA 'F' who reported he planned to get R806 dressed and out of bed, but needed help from another CNA and the one assigned to that unit was busy with another resident. On 4/3/25, at 11:00 AM, approximately one hour and 45 minutes after R806 initially asked to get out of bed, R806 was observed up in her wheelchair, dressed, and in the activity room. A review of R806's clinical record revealed R806 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: vascular dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE], R806 had moderately impaired cognition, no behaviors, and was dependent on staff for upper body dressing and transfers. A review of R806's active care plans revealed R806 required assistance with dressing and required a mechanical lift with assistance of two people for transfers. On 4/3/25 at 2:30 PM, an interview was conducted with the Director of Nursing (DON). When queried about staffing on R806's unit, the DON reported there were typically two CNAs assigned to that unit giving each CNA approximately 10 residents to care for. When queried about who was permitted to assist with resident care, including mechanical lift transfers, the DON reported the CNAs and nurses, including any nurse managers, could assist. The above observations of R806 waiting approximately one hour and 45 minutes to be dressed and transferred to the wheelchair was discussed with the DON. The DON reported that was a long time to wait if the resident requested to get up and the CNA could have requested assistance from the nurse, unit manager, or DON.

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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** 32568 This citation pertains to Intake Number(s): MI00149894. Based on observation, interview, and record review, the facility failed to promptly identify a new skin impairment and implement interventions to prevent reoccurrence for one (R806) of two residents reviewed for pressure ulcers. Findings include: On 4/3/25 at approximately 9:20 AM, R806 was observed lying in bed. An indwelling urinary catheter drainage bag was observed attached to the side of the bed. R806 reported she was waiting to get assistance with getting dressed and getting out of bed. A review of R806's clinical record revealed R806 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: vascular dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R806 had moderately impaired cognition, no behaviors, required substantial/maximal assistance for rolling left and right, had an indwelling catheter, was at risk of developing pressure ulcers, and did not have any pressure ulcers or other skin impairments. A review of R806's Physician's Orders revealed an order dated 3/27/25 for Wound care right lateral thigh . apply betadine, leave open to air q (every) shift . On 4/3/25 at 9:55 AM, CNA 'D' pulled down R806's right pant leg to expose the right lateral (outside) thigh. A flat black area that appeared to be approximately the size of a dime was observed. On the top of R806's thigh an adhesive dressing was observed anchoring the urinary catheter tubing to her leg. When queried about how she got the wound on the outside of her thigh, R806 said, I have a catheter and they stuck that on there with glue. A review of R806's progress notes revealed the a Nursing/Clinical note dated 3/20/25 that read, The afternoon aide informed writer that there was a change in skin on resident. Assessed resident and came across a skin tear on the side of the right thigh . On 4/3/25 at 1:30 PM, all incident reports with associated investigations for R806 since March 2025 were requested from the Administrator and Director of Nursing (DON). A review of an incident report for R806 dated 3/20/25 revealed, While resident was being changed, daughter and aide observed a skin tear on the side of the right thigh .Resident unable to give description . In addition, the facility provided a pain assessment dated [DATE] and a copy of the progress note mentioned above. A review of R806's Treatment Administration Record (TAR) for March 2025 revealed an order for Body audit - daily every day shift for skin observation 0-no skin breakdown, 1-Previously identified wound/breakdown, 2-Newly identified wound/breakdown - describe in progress note. On 3/19/25, 1 was documented which indicated R806 had a previously identified skin impairment. On 3/20/25, 2 was documented which indicated R806 had a newly identified skin impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Wound Evaluation dated 3/21/25 revealed R806 had an in-house acquired blister (a small pocket of body fluid within the upper layers of the skin) to the right lateral thigh that measured 1.16 centimeters (cm) in length and 0.78 cm in width. No further description of the wound was documented. The photo taken at the time of the evaluation showed a irregular shaped small black area. It was not documented that a medical provider was notified. It should be noted that the wound in the photo appeared flat and did not appear raised and fluid filled). A review of a Wound Evaluation dated 3/27/25 revealed R806 had an in-house acquired blister to the right lateral thigh that measured 1.86 cm in length and 1.31 cm in width. The photo taken at the time of the evaluation showed a flat black area that did not resemble a fluid filled pocket (blister). On 4/3/25 at 1:54 PM, an interview was conducted with the wound nurse, Registered Nurse (RN) 'A'. When queried about the facility's process when a new skin impairment was identified, RN 'A' reported he was notified by the nurse. RN 'A' assessed all wounds and the Nurse Practitioner (NP) (either the facility's NP or the wound clinic's NP) would diagnose the wound and ensure the correct treatment was in place. When queried about R806's skin impairment to the lateral right thigh, RN 'A' reported he first assessed the wound on 3/21/25 and at that time it was scabbed over. When queried about whether a scab meant it was in a stage of healing, RN 'A' reported it did. When queried about how R806 obtained the wound on the thigh, RN 'A' reported he did not know and stated, Maybe the wheelchair rubbed on it but said he only assessed the wounds and did not determine the cause. On 4/3/25 at 2:30 PM, an interview was conducted with the DON. When queried about what was done to determine the cause of the skin impairment to R806's right lateral thigh, the DON reported she did not know, but that it was possibly caused from friction and rubbing or maybe the wheelchair or the (mechanical lift). When queried about what was implemented to prevent further occurrences of the same kind, the DON stated, You can't prevent friction from happening. When queried about whether the wound was identified timely when it was first identified as a black scabbed area, the DON reported she felt it was identified timely because she was notified on 3/20/25 and it was assessed on 3/21/25 and it likely scabbed in that time frame. A review of a facility policy titled, Skin Management Guidelines . dated 11/2024, revealed, in part, the following: .Inspect the skin on a daily basis when performing or assisting with personal care or ADLs .Review the interventions and strategies for effectiveness on an ongoing basis .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake MI00149894 Based on observation, interview and record review, the facility failed to prevent pressure ulcer formation and ensure accurate skin assessments for one (R807) of two residents reviewed for pressure ulcers resulting in R807 developing a Deep Tissue Injury (DTI - persistent non-blanchable deep red, maroon or purple discoloration) to the left medial (inside) heel . Findings include: On 4/3/25 at 11:23 AM, R807 was observed sitting in a wheelchair in the therapy room. At that time, R807 walked with a four-wheeled-walker from the therapy room to their room with a Physical Therapist walking behind with their wheelchair. R807 was observed walking at a brisk pace. R807 explained their heel felt better since they had put a dressing on it. R807 was observed wearing gripper socks and their left heel had a dressing under the sock. After sitting in a recliner in their room, R807 was asked about the wound on their heel. R807 explained the facility told them they developed their wound because they were rubbing their heel on the bed, but they did not remember doing that. A pair of foam boots were observed laying in another chair in the room, R807 was asked if the staff put the foam boots on them when they were in bed. R807 explained they did now. When asked if they put them on before there was a wound, R807 said no. R807 was asked if they could turn (or reposition) themselves. R807 explained it was very difficult. R807 was asked if staff came in and turned them routinely when they were in bed. R807 explained only if they asked to be turned would the staff turn them, but at night they could not get anyone to come into their room when they put the light on. Review of the clinical record revealed R807 was admitted into the facility on [DATE] with diagnoses that included: aftercare following joint replacement surgery, macular degeneration and rotator cuff tear or rupture of right shoulder. According to the Minimum Data Set (MDS) assessment dated [DATE], R807 was cognitively intact and was dependent on staff for activities of daily living (ADL's). Review of R807's ADL care plan revealed interventions revised 3/5/25 that read, BED MOBILITY: I require assistance by (ext {extensive} x 1) staff to turn and reposition in bed. Review of R807's skin integrity care plan revealed an intervention initiated 3/4/25 that read, . Prqafo [sic] (Pressure Relief Ankle Foot Orthosis) boots WIB (while in bed) as tolerated . Turn and reposition q2h (every two hours). Review of a Nursing Assessment Admission/Readmission for R807 dated 3/4/25 revealed no documentation of any issue with R807's left heel in Section K. Skin. Review of R807's progress notes revealed a nursing note dated 3/4/25 at 2:54 PM read in part, 2nd skin assessment completed . Heels intact . Review of Braden Scale for Predicting Pressure Sore Risk assessments for R807 revealed: 3/4/25 scored 15, indicating AT RISK 15-18 3/12/25 scored 17 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/25 scored 20, indicating above the risk scale 3/26/25 scored 19 Review of R807's 30 day Look Back for Reposition every 2 hours when in bed/chair revealed no documentation on the midnight shift on: 3/5/25, 3/8/25, 3/9/25, 3/12/25, 3/20/25, 3/25/25, 3/26/25, 3/28/25, and 3/31/25. On 3/19/25 the documentation was marked No at 12:14 AM. Review of a late entry Wound Practitioner Progress note for R807 dated 3/20/25 at 1:48 PM read in part, . was found today to have a deep tissue injury to the left heel with reports of heel pain. Staff report that (they) often refuses to wear (their) heel boots . 4.4cm (centimeters) x 3.7cm x 0.1cm . Purple - 100% . Boggy . On 4/3/25 at 2:01 PM, Registered Nurse (RN) A, who served as the Wound Care Nurse, was interviewed and asked how R807 acquired a DTI on their left heel. RN A explained R807 might have been rubbing their foot on the bed when they were lying on it. RN A was asked how likely it would be that R807 would be raising and lowering their knee to rub that foot as it was on the same side as their hip replacement they were admitted for . RN A explained that was not likely, but as R807 was always lying on their right side, the medial aspect of the left heel would be against the mattress, and had been told R807 did not like to wear their foam boots. RN A was asked why there was no documentation of R807 refusing to wear foam boots until after the DTI was acquired. RN A had no answer. Review of R807's March 2025 Treatment Administration Record revealed an order with a start date of 3/7/25 for, Body audit - daily every day shift for Skin observation 0-No skin breakdown, 1-Previously identified wound/breakdown 2-Newly identified wound/breakdown- describe in progress note. The body audit was marked as 1 every day except on 3/19/25 when a second body audit on the same day was marked as 2. The associated progress note dated 3/19/25 at 1:49 PM documented on a sacral wound R807 was admitted with. Review of R807's assessments revealed a Skilled Daily: Medically Complex form. There was a section of the form for documentation of skin, .B. Skin . 6. Skin items noted: (Check all that apply) 1. Surgical 2. Pressure 3. Other 4. None; 6a. Describe skin conditions; 6b. Are treatments or daily monitoring needed related to wounds? 1. Yes 2. No . In the 30 days R807 had been in the facility the daily assessment form had only been completed 10 times. Of the 10 assessments completed, eight documented 4. None for skin items noted and five of the 10 assessments marked 2. No for treatments or daily monitoring needed. It should be noted R807 was admitted with a surgical wound and a pressure injury to the sacrum, both had daily wound treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 2:44 PM, the Director of Nursing (DON) was interviewed and asked how R807 acquired the DTI to their left heel. The DON explained it was possible the DTI was present on admission. The DON was asked if it had been present on admission why was there no documentation on it for over two weeks after R807's admission. The DON explained it might not have been noticed until it was a blister. When asked if the nurses should have noticed a discoloration or a boggy heel in their daily body audit, the DON had no answer. The DON was asked how often the Skilled Daily: Medically Complex assessment should be completed. The DON explained it should be done daily. When informed of 20 days with no assessment, the DON explained she was more concerned if the skin assessments were accurate. When informed of the mostly inaccurate skin assessments of the completed Skilled Daily assessments, the DON had no answer. The DON was asked why there was no documentation of R807 refusing the foam heel boots until after acquiring the left heel DTI. The DON explained she had talked to R807 who told her they did not like the boots. The DON was asked if it should be documented if a resident did not like to wear the boots, or took them off. The DON agreed it should be documented. Review of a facility policy titled, Skin Management Guidelines Prevention of Pressure Ulcers/Injuries revised 1/2023 read in part, .Skin is assessed on admission to the facility and at least weekly to identify alterations in skin, and any wound assessment should be documented in the medical record . 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., nonblanchable erythema) . b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc.) . e. Reposition resident as indicated on the care plan .

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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** 49083 Based on observation and interview, the facility failed to maintain a sanitary healthcare environment amongst residential common areas including a shared shower room, flooring, training bathroom and rehabilitation equipment, and shared Hoyer lift (lift device used to transfer residents). This deficient practice has potential to affect all residents that utilize these areas and equipment. Findings include: On 4/3/25 at 8:46 AM, entrance into a shared shower room located on the 600 hallway revealed a four sectioned area that contained two shower rooms, one tub room, and one private toileting room. Upon entrance, an odor of sewage was identified. Observation in the tub room revealed an uncovered floor drain, and the sewage smell was greater the closer contact with inspecting the drain. Adhered to the floor were two exposed metal sharp fasteners. The corner baseboard was observed with a broken aqua green colored corner tile lying on the floor surrounded by dry wall debris. The central tub identified as a Carousel Tub was observed storing a bedside commode and a floor mat. The tub drain was dirty with a thick ring of brown colored discoloration. A black and red electric wheelchair was noted in the room with one wheelchair footrest on the chair. The shower bed was on the opposite wall and the blue colored foam padding was cracked exposing the foam interior. Black hairs were observed on the headrest of the pad. The two shower rooms were observed containing used wet towels and washcloths on the floor. The shower room on the right was observed with bulked up wet washcloths lying on a shower chair and black colored hairs were noted on the bench and floor. Puddled water and soap residue was noted in front of the shower chair. Wet towels and washcloths were on lying on the floor within the shower and flooring of the entire room. The shower room to the left was observed having used towels bagged in the corner and wet wash cloths lying on the floor in the shower, outside the shower area, and in the sink. The private toilet room door was observed locked. On 4/3/25 at 8:57 AM, a hoyer lift was observed in front of room [ROOM NUMBER] with a moderate amount of crushed food crumbs on the rolling base of the machine. On 4/3/25 at 9:05 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were brought down the 600 hallway and acknowledged the Hoyer lift was soiled with crumbled food matter and was not sanitary. The shared shower room on the 600 hallway was opened and the NHA commented that there were soiled towels on the floor and this was not acceptable. The tub room was confirmed by the DON and NHA that it was currently used as a storage room. The DON and NHA were not aware of the open floor drain and identified there was an odor. It was confirmed the shower bed was currently used for residents and noted the padding was damaged, and the black hairs were not sanitary. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When questioned why the toilet room was locked, the DON said it should not be locked and access to the key to unlock was outside of the locked shower room. Both agreed having the door locked was not safe or sanitary in case a resident needed to use the facility pre or post their shower and there was no easy way to open the door. On 4/3/25 at 9:35 AM, the Rehabilitation (Rehab) Training Bathroom was observed storing three bottles of opened, partially used peri care spray, one container of multiuse sanitation wipes, and a large spray bottle containing an unidentified blue liquid on the top of the toilet tank. The perimeter of the rehabilitation area was observed storing multi use rehab equipment and the floor was observed dusty, and dirty. The window towards the back right corner of the room stored three potted plants with dead leaves and soil on the windowsill, and on floor next to the rehab equipment. On 4/3/25 at 9:45 AM, The Director of Rehab Services (DRS) E was shown the top of the toilet tank storing bottles of opened, partially used peri care spray and agreed that was not sanitary. DRS E was informed the sanitizing wipes previously observed had since been removed, but the spray bottle containing the blue liquid had remained and DRS E remarked they had no idea what it was. DRS E acknowledged the equipment stored against the perimeter of the room on the floor was currently used by the residents and acknowledged the floors were unkempt and needed a deep clean.