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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235433	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenfield Rehab and Nursing Center	3030 Greenfield Ave Royal Oak, MI 48073

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake # MI00146550. Based on observation, interview and record review, the facility failed to maintain a safe, clean, comfortable and homelike environment, affecting multiple residents throughout the facility. Findings include: Review of complaints reported to the State Agency (some as recent as 9/10/24) included allegations that the facility was not clean, had mold, bugs/ants getting in, and had electrical issues with cords. On 9/18/24 at 8:30 AM, the outside of the facility's north parking lot was observed to have several loose wires hanging down from the building and were connected to a large rectangular box that had more loose wires that hung down. The bottom of these wires were observed hanging just next to an external water spout that had visible water drainage coming from the spout. Another area outside the facility, near the emergency exit/delivery area was observed to have long, black, loose cords that hung down from the side of the building. At 9:10 AM, the lower wall heater register along the hallway across from room [ROOM NUMBER] was observed pulled away and hanging down on one side and resting on the floor. At 9:18 AM, room [ROOM NUMBER] was observed to have various trash and debris underneath their bed. Their privacy curtain was not completely secured and had several clips removed and was hanging down. The resident reported that had been like that for a few days and someone was supposed to come around and fix it, but they had not yet. At 9:23 AM, the bottom door seal to the emergency exit/delivery door on the first floor north hallway was observed to be missing. Outside light was visible along the entire bottom of the door. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:26 AM, the bathroom shared by room [ROOM NUMBER] and 109 was observed to have bunched up toilet paper with a brown substance and a trail of similar brown splatters about two feet in length extending from the toilet towards the door that connected to room [ROOM NUMBER]. The bathroom ceiling was observed to have large water damage which was stained light to dark brownish colored stains and mold-like substance. The water damage continued to be visible down the entire upper half of the wall between the toilet and hand sink in which the paint was peeled away and hanging down from the wall in several large ripples. The privacy curtains in room [ROOM NUMBER] were observed to be soiled with several areas that had dark colored stains. The ceiling tiles just above the privacy curtains in room [ROOM NUMBER] were observed to have several areas of water damage and were stained brown in color. At 9:30 AM, Floor Care (Staff 'B') was asked about the bathroom shared with 108 and 109 and they reported they didn't go into the resident rooms, they just focused on hallway flooring. They further reported the resident bathrooms were done by the housekeepers who they thought were upstairs working currently. At 9:33 AM, Nurse 'C' was asked to observe the bathroom shared by room [ROOM NUMBER] and 109. Upon observation, Nurse 'C' confirmed the condition of the ceiling and wall sand reported they were not aware of that. They further confirmed the brown substance on the flooring and reported they were unsure what the substance was. Additional observation of the privacy curtains revealed multiple dark stains throughout the curtains in room [ROOM NUMBER]. At 9:40 AM, the first-floor north shower room was observed to have a shower chair that had a seatbelt that hung down and the fabric was soiled and various colors (brown/gray/pink). The shower tiles and corner grout appeared to be stained with pink and black colored mold-like debris. The shower curtains were also observed to have dark stains throughout. At 9:45 AM, the basement level was observed to have an egress door that led to a stairwell up to the north side parking lot. The entire portion of the interior wall just inside the door revealed painted cinder blocks with a large area of water damage, so much so that the paint was bubbled-up into a blistery, cauliflower type substance with what appeared to be dark, black mold-like substance throughout the wall surface. At 10:00 AM, an interview and observation of the facility was conducted with the Maintenance Director (Staff 'E') who reported they had been in their role since 2022. They reported they had one full-time assistant. When asked about the facility's renovations, Staff 'E' reported they were some drywall and painting on the second floor, but everything else had been completed. They were asked to observe the facility's environment. At 10:03 AM, Staff 'E' confirmed the lack of the bottom door rubber seal and reported they were not aware of that. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:05 AM, Staff 'E' confirmed the hanging wires outside the facility and reported they weren't sure what those wires went to, but thought they were the old telephone connections. Staff 'E' was asked if they were live or not and they reported they didn't think so, but they weren't actually sure. When asked why they were left like that if they were aware that was there, they were not able to offer any explanation. They confirmed the leaking water spout and close proximity to the wires and reported they felt confident they were no longer live phone lines. In regard to the black wires near the emergency exit/delivery door, they reported those were old cable lines and were not live. When asked why they were left like that, Staff 'E' reported they had thought about taking them down a few days ago, but didn't get to it. At 10:08 AM, observation of the room [ROOM NUMBER] confirmed the same concerns with the water damage to the ceiling above bed 1 and 2 and Staff 'E' reported they usually just painted over those, but don't want the paint fumes around the residents and would usually wait until the resident discharges. When asked what happens since they were staying long term, did they ever consider a temporary room change and they reported the first floor was full, nowhere to go. Staff 'E' then confirmed the extensive bathroom concerns and reported they were not aware of that before today. When asked about the water damage to the ceiling and whether that was mold, Staff 'E' reported that could've been from a leaking toilet above but should've been notified and wasn't sure about if it was mold. At 10:15 AM, Staff 'E' confirmed observation of the wall near the basement egress door and when asked about the heavy water damage and appearance of black mold-like substance, Staff 'E' That sure looks like it (black mold). They reported they were not aware of that before now. Staff 'E' was asked if they had any audits they did to monitor or identify similar concerns to maintain compliance with safe environments, and they reported they didn't keep actual audit forms. They did report they did monitor for room and water temperatures. When asked if that was done, how did they not see the bathroom shared by 108 and 109 and they offered no further response. Throughout these observations, several flying insects including house flies, sewer flies, and gnats were observed throughout each floor of the building, including the basement. On 9/18/24 at 11:45 AM, an interview was conducted with the Director of Nursing (DON) as the Administrator was unavailable due to being at an offsite conference. When asked how staff should be reporting concerns with the resident rooms, equipment, etc, the DON reported they should be logging those into books at the nursing stations. The DON was then asked to observe the environment and confirmed same concerns as seen earlier. They further reported they were not aware of those concerns but any staff that saw that should've reported that to maintenance or housekeeping. On 9/18/24 at 12:20 PM, the DON reported they wanted to clarify that staff should be logging any concerns into the facility's electronic work orders and provided a copy of those records since 7/1/24. Review of this documentation revealed there was no mention of the concerns identified above. The DON further reported there needed to be additional education regarding communication of concerns such as pests and environmental issues and reported anyone who saw that, Nurses, CNAs (Certified Nursing Assistants), Housekeepers, anyone should've reported those concerns but did not. According to the facility's policy titled, Homelike Environment dated 9/21/2023: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean, sanitary, and orderly environment .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment. Staff may assist in providing a safe and homelike environment by . reporting .bathrooms needing cleaning to the housekeeping department. Reporting any furniture in disrepair to the maintenance department .Reporting any unresolved environmental concerns to the administrator .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review, the facility failed to ensure that a portable oxygen tank was properly secured while left unattended for one (R405) of one resident reviewed for oxygen use, resulting in the potential for the tank to be knocked over, causing a potential rocketing of the cylinder and injury to residents in the immediate area. Findings include: On 9/18/24 at 9:10 AM, R405 was observed laying in bed, naked from the waist up. The roommate's privacy curtain was drawn so the resident was not visible from the hallway. There was an oxygen concentrator in use with a nasal cannula and was set to three liters. There were two portable oxygen tanks stored next to the resident's bed. One oxygen tank was secured in a metal holder/stand with two wheels, and the other oxygen tank was free-standing right next to the resident's head of bed. The resident reported that tank was empty and unsure of how long it had been like that. On 9/18/24 at 9:14 AM, Nurse 'D' was at their med cart a few doors away and was asked to observe R405's room. Nurse 'D' confirmed the unsecured oxygen tank and proceeded to leave the room to obtain a storage cart to remove the empty cylinder. The Nurse 'D' reported that should not have been left like that and was unsure of how long it had been like that. Review of the clinical record revealed R405 was admitted into the facility on [DATE] with diagnoses that included: non-st elevation myocardial infarction (NSTEMI - a type of heart attack), chronic obstructive pulmonary disease, and emphysema. Physician orders included: Oxygen Delivery via NC (Nasal Cannula) Liter flow: 3 L (liters) Duration: PRN (as needed) for SOB (Shortness of Breath). On 9/18/24 at 11:45 AM, an interview was conducted with the Director of Nursing (DON). When informed of the observation and interview regarding the unsecured portable oxygen tank, the DON reported those should never be left free-standing and would follow-up with nursing staff immediately. According to the facility's policy titled, Oxygen/Medical Gas Storage & Training Policy dated 1/23/2019: .Ensure cylinders are secured by chains, racks or in stands and valve protection caps are secured (if provided) .When in use E Cylinders are to be secured properly and monitored per physician's orders .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review, the facility failed to ensure resident medications were not left at the bedside for one (R406) of one resident reviewed for medication storage. Findings include: On 9/18/24 at 9:30 AM, R406's bedside table was observed to have a single white circular pill stored on top. The resident was not in the room. On 9/18/24 at 9:33 AM, Nurse 'C' was observed at the medication cart a few rooms down. When asked to observe R406's room, upon entry to the room, Nurse 'C' confirmed the pill on the bedside table and proceeded to don a glove and remove it. They reported they weren't sure who put that there, and it could've been from midnights since they had given the resident their medication earlier in the hallway, and that resident was now in the therapy room upstairs. Nurse 'C' was asked to verify what the medication was and upon reviewing R406's blister packs in the medication cart, it was confirmed the pill was carvedilol (a pill for high blood pressure) which was to be given at 6:00 AM. Nurse 'C'' reported that medication had actually been held earlier due to a low blood pressure reading of 106/72. Review of the clinical record revealed R406 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: cerebral infarction, acute metabolic acidosis, encephalopathy, mild cognitive impairment of uncertain or unknown etiology, essential hypertension, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic systolic heart failure, paroxysmal atrial fibrillation, and hyperlipidemia. According to the facility's documentation of Physician Statement of Competency dated 2/15/24 and 2/19/24, . Incompetent to make his medical decisions, provide informed consent or participate in decisions regarding their financial affairs. The specific cause and/or contributing diagnosis to support this decision: Moderately impaired reasoning and executive decision making. Review of the Physician orders and Medication Administration Records (MARs) included: Coreg Oral Tablet 6.25 MG (Milligrams) (Carvedilol) Give 1 tablet by mouth two times a day for Afib/HTN (Atrial Fibrillation/Hypertension) Hold for SBP (Systolic Blood Pressure) <110 or HR (Heart Rate) <60. This medication was due to be given at 9:00 AM and 9:00 PM, not 6:00 AM as indicated by Nurse 'C'. Review of the MARs indicated over the past few days, this medication was last documented as given on 9/17/24 at 9:00 PM. On 9/16/24 at 9:00 PM the MAR was noted as 10 (10 = Vitals outside of parameters for administration). On 9/18/24 at 9:00 AM, Nurse 'C' documented a 10 with vital signs of 106/76 and Pulse 92. Review of the progress notes included none since 9/17/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 11:45 AM, an interview was conducted with the Director of Nursing (DON). When informed of the medication left at bedside for R406, they reported no medication should be left at the bedside and would follow-up with nursing staff. According to the facility's policy titled, Medication and Treatment Storage dated 8/7/2023: .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 30675 This citation pertains to intake # MI00146550. Based on observation, interview, and record review, the facility failed to maintain an effective pest control program, resulting in the presence of gnats, house flies and sewer flies throughout the facility. This deficient practice had the potential to affect all residents in the facility. Findings include: Review of complaints reported to the State Agency included allegations that the facility had bugs/ants getting in. On 9/18/24 from 9:00 AM to 11:45 AM, multiple observations of several flying insects including house flies, sewer flies, and gnats were observed throughout each floor of the building, including the basement. At 9:23 AM, the bottom door seal to the emergency exit/delivery door on the first floor north hallway was observed to be missing. Outside light was visible along the entire bottom of the door (in which bugs/insects were able to enter). At 10:00 AM, an interview and observation of the facility was conducted with the Maintenance Director (Staff 'E') who reported they had been in their role since 2022. They were asked about the facility's pest control services and reported they had a company coming out monthly and had recently switched to a new company. Staff 'E' reported they would provide the binder of service calls for review. At 10:03 AM, Staff 'E' confirmed the lack of the bottom door rubber seal and reported they were not aware of that. On 9/18/24 at 11:45 AM, an interview was conducted with the Director of Nursing (DON) as the Administrator was unavailable due to being at an offsite conference. When asked how staff should be reporting concerns such as pests, the DON reported they should be logging that into books at the nursing station. The DON was requested to provide copies of that documentation for review. Review of the pest control documentation provided service dates for 9/12/24, 8/8/24, and 7/15/24, but did not identify the missing door seal, or identify/recognize any flying insects. On 9/18/24 at 12:20 PM, the DON provided a copy of the facility's electronic work orders since 7/1/24 which revealed there was no documentation of insect concerns. They further reported they were aware there was a concern and confirmed the flies were seen during the earlier observations with this surveyor. The DON reported there needed to be additional education regarding communication of concerns such as pests and environmental issues and reported anyone who saw those, including Nurses, CNAs (Certified Nursing Assistants), Housekeepers, anyone should've reported those concerns but did not. According to the facility's policy titled, IC (Infection Control) - Pest Control dated 12/27/2023: (continued on next page)

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