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	01/15/2025

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 - Few	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** 32568 This citation pertains to Intake Number: MI00149259. Based on observation, interview, and record review, the facility failed to ensure a resident bathroom was maintained in a clean, comfortable, and safe manner for one (R803) of three residents reviewed for the environment, resulting in the resident having to change their clothing often due to leaking water, having to wait for a community bathroom, and feeling frustrated. Findings include: On 1/15/25 at approximately 8:55 AM, R803 was observed walking in the hallway of the 1 South Unit. R803 asked, When will my toilet be fixed? It has been seven days like this and now we don't have a toilet to use. At that time, R803 was interviewed regarding their concerns about the toilet. R803 reported seven days ago, the ceiling over the toilet began leaking onto the resident and their roommate when they were seated on the toilet. R803 said every time they used the toilet they had to change their clothing because it would get wet from whatever was leaking from above. R803 stated, The toilet drains on you. R803 reported as of the previous day, they were not allowed to use the toilet in their room and had to use the toilet in the shower room, which was often occupied. At that time, an observation was made of R803's bathroom. The toilet was covered with sheets and a plastic bin was on top of the toilet collecting liquid that was leaking from the ceiling. A strong, foul odor was observed in the bathroom and multiple flying insects were observed near the toilet. The concrete ceiling above the toilet was observed to have what appeared to be water damage (discolored area where the liquid was leaking and the ceiling was cracked). On the surface of the concrete with the water damage, multiple dark brown, raised, circular, textured areas were observed. R803 expressed feeling nervous that they would get in trouble for talking about the condition of the bathroom. (continued on next page)

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 - Few	On 1/15/25 at 10:17 AM, an interview was conducted with Maintenance Director 'A'. When queried about what was going on in R803's bathroom, Maintenance Director 'A' reported he found out about the issue on 1/14/25 and the leaking was coming from the toilet in the bathroom on the second floor above R803's bathroom and that he was in the process of fixing it. At that time, an observation of R803's bathroom was conducted. Maintenance Director 'A' confirmed that the crack and discoloration on the ceiling was due to water damage but said It's dry already. When queried about the circular, raised, textured, dark brown areas that had since been cleaned off the concrete, Maintenance Director 'A' stated, It's probably paint. When queried about whether mold could form due to the leaking of water into the floor/ceiling, Maintenance Director 'A' stated, I'm not sure if it can. Maintenance Director 'A' reported that the water damage present likely occurred for a longer period than one day, but that nobody notified him and they should have. On 1/15/24 at approximately 10:40 AM, an interview was conducted with the Director of Nursing (DON). The DON reported he became aware of the issue with R803's toilet on 1/14/25 and that Maintenance Director 'A' was in the process of fixing it. The above observations were shared and an observation of the bathroom was made with the DON. The DON reported all staff were required to report any maintenance issues and the residents who used that bathroom should have been moved out of that room. R803 was tearful when the DON asked them about the toilet. R803 said again that it had been seven days since it started. On 1/15/25 at 12:50 PM, an interview was conducted with the Administrator. The Administrator reported he became aware of the issue with R803's toilet on 1/15/24 and if there were maintenance issues, they should be reported to himself, Maintenance Director 'A', and/or the DON. A review of R803's clinical record revealed R803 was admitted into the facility on [DATE] with diagnoses that included: cancer, type 2 diabetes, and chronic kidney disease. A review of R803's Minimum Data Set (MDS) assessment revealed R803 had intact cognition.

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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** 38271 This citation pertains to intake #MI00149259 Based on observation interview and record review, the facility failed to ensure medications were administered per the Physician's orders for one resident (R801) of two residents reviewed for medication administration. Findings include: On 1/15/25 a concern submitted to the State Agency was reviewed and alleged R801 was not receiving their medications as ordered. On 1/15/25 at approximately 8:23 a.m., R801 was observed in the hallway, up in their wheelchair. R801 was asked if they had any concerns regarding receiving their medications and they reported they did and that the facility keeps missing their medications because another Nurse on the other side has to give them. R801 reported they were not given their Synthroid or their regular Tylenol that morning and that the issue happens frequently. On 1/15/25 the medical record for R801 was reviewed and revealed the following: R801 was initially admitted to the facility on [DATE] and had diagnoses including Hypothyroidism and Osteoarthritis. A review of R801's MDS (minimum data set) with an ARD (assessment reference date) of 10/25/24 revealed R801 needed assistance from staff with most of their activities of daily living. R801's BIMS score (brief interview of mental status) was 15 indicating intact cognition. A Physicians order with a start date of 11/17/24 revealed the following: Synthroid Oral Tablet 137 MCG (Levothyroxine Sodium) Give 1 tablet by mouth one time a day for hypothyroidism **GIVE ON EMPTY STOMACH ** A second Physician's order with a start date of 11/22/24 revealed the following: Acetaminophen Extra Strength Tablet 500 MG (milligrams) Give 2 tablet by mouth every 8 hours for Pain Do Not Exceed 4 Gms (grams) of Acetaminophen daily . A review of R801's January 2025 MAR (medication administration record) revealed R801 was not administered either of their 6:00 a.m. doses of Extra strength Tylenol and Synthoid. On 1/15/25 at approximately 10:51 a.m., Nurse D was queried regarding the Synthroid and Tylenol not being administered. Nurse D indicated that both of the medications were not administered and that they had planned to administer them that shift after calling the Physician for one-time orders for both medications. At that time, the DON was also queried regarding the issue and reported that R801 does not like the midnight Nurse to give them their medications and so the process for R801 is for the Nurse on the other side on the floor to come over and give them. The DON reported that was no excuse for R801 not to be given their medications. On 1/15/25 a facility document titled Medication Administration was reviewed and revealed the following: POLICY OVERVIEW: To safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs .General Instructions- .Administer medication in accordance with frequency prescribed by physician and standards of practice .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number: MI00148850. Based on observation, interview, and record review, the facility failed to ensure recommendations from the orthopedic specialist were implemented for one (R802) of one resident reviewed for coordination of care to outside appointments. Findings include: A review of a complaint submitted to the State Agency revealed an allegation that the facility was not properly coordinating and assisting R802 with appointments with outside providers. On 1/15/25 at 8:30 AM, R802 was observed lying on their bed. When R802 attempted to reach for the remote control for the television, they appeared to have difficulty moving their arm. When queried about any concerns they had with their care in the facility, R802 reported their main issue was with the facility not following through with recommendations and orders from medical specialists. R802 reported that she went to an outside provider who recommended a brace for their foot. R802 explained that the braces were never implemented at the facility and when they asked staff, they were told It won't help you and they do not apply the devices. R802 was unsure if the device were available for use. R802 questioned why it was beneficial to go to a specialist if recommendations were not going to implemented by the facility. A review of R802's clinical record revealed R802 was admitted into the facility on [DATE] with diagnoses that included: rheumatoid arthritis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had intact cognition and was dependent on staff for transfers and required substantial/maximum assistance for bed mobility. It was documented R802 had foot drop of the left foot. A review of R802's progress notes revealed the following: On 11/12/24, it was documented in a Physician Team - Progress Note that R802 had L/R (left/right) foot drop. It was documented R802 was to be referred to podiatry to evaluate the need for special DME (durable medical equipment) boot vs (versus) brace vs other . A review of a consultation completed by R802's orthopedic doctor on 12/19/24 revealed the orthopedic doctor's recommendations/instructions were as follows, Compression socks 20 mmHg (millimeters of mercury) for left leg .AFO (ankle foot orthosis - brace) ordered. Remove at night and for skin checks . A review of R802's Physician's orders revealed no order for a AFO or compression socks as of 1/15/25, approximately one month after R802 had the orthopedic consultation. Further review of R802's clinical record revealed no documented by a medical provider to justify not following the specialist's recommendations. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 12:52 PM, an interview was conducted with the Director of Nursing (DON). When queried about how care was coordinated to ensure recommendations from outside specialists were reviewed and implemented in the facility, the DON reported the consultation report was reviewed and if the physician was in agreement, the orders would be put into the electronic medical record. If the physician did not agree with the recommendations, it was expected that a conversation was had with the specialist and justification was documented by the physician.