

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/07/2025
NAME OF PROVIDER OR SUPPLIER  Greenfield Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0760  Level of Harm - Actual harm  Residents Affected - Few	Ensure that residents are free from significant medication errors.  (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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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Complaint #2633707. Based on observation, interview, and record review, the facility failed to prevent a significant medication error when they did not administer insulin according to physician's orders for one (R801) of three residents reviewed for medication administration, resulting in the resident being hospitalized in the intensive care unit (ICU) for low blood sugar after they received 100 units of short acting insulin instead of the ordered three units. Findings include: A review of a complaint submitted to the State Survey Agency (SSA) revealed an allegation that on 9/28/25, R801 was given 100 units of insulin by facility staff instead of the prescribed three units. On 10/7/25 at 8:40 AM, an interview was conducted with R801. R801 reported she was given too much insulin and was admitted to the ICU for a couple days. R801 reported she experienced dizziness and then her blood sugar went down. R801 reported she was given some sugar stuff either by EMS (emergency medical services) or the facility to make her blood sugar increase. On 10/7/25 at 8:59 AM, an observation of R801's insulin and the insulin syringes present in the medication cart was conducted with Licensed Practical Nurse (LPN) 'A'. R801's Insulin Lispro (short acting insulin) was observed in a vial that required inserting a needle attached to a syringe to draw up the prescribed dose. At that time, LPN 'A' said the insulin syringes were not present in the medication cart and obtained a box of single use syringes with an orange cap that were labeled to be used with insulin. One syringe held one ml which was equal to 100 units of insulin. A review of R801's clinical record revealed, R801 was admitted into the facility on 4/1/25 and readmitted on [DATE] with diagnoses that included: necrotizing fasciitis and type 2 diabetes mellitus upon initial admission date of 4/1/25 and a diagnosis of hypoglycemia (low blood sugar) as of 10/1/25. A review of R801's physician's orders revealed an order with a start date of 9/3/25 and a discontinued date of 10/1/25 for Insulin Lispro (short acting insulin) Injection Solution 100 unit/milliliter (ml). inject 3 units subcutaneously before meals. Notify MD (medical doctor) if BG (blood glucose) is (less than) 60 or (greater than) 400. A review of R801's Treatment Administration Record (TAR) for September 2025 revealed on 9/28/25 at 4:30 PM, Registered Nurse (RN) 'B' administered insulin to R801 as evidenced by her electronic signature on the TAR. A review of a Nursing - Progress Note dated 9/28/25 at 6:43 PM, written by RN 'C' revealed, RN thinks pt (patient) received 100ml (100 ml would be 100 syringes filled up) of insulin instead of 3ml (3 ml of insulin lispro would be 300 units per the strength noted in the physician's order and would require filling up the syringe 3 times). Resident alert and oriented, no signs or symptoms of hypoglycemia, 911 called, on call called, sugar rechecked 118 result, DON (Director of Nursing) notified, resident taken to hospital. On 10/7/25 at 10:28 AM, an interview was conducted with RN 'C' via the telephone. When queried about what happened with R801's insulin, RN 'C' reported she read the strength of the insulin (100 units/ml) instead of the prescribed dose and gave 100 units instead of three units. RN 'B' reported she discovered the error when she went to sign off that the insulin was administered. RN 'B' notified the nurse who was previously her preceptor, RN 'D', called 911, assessed R801, and rechecked the resident's blood sugar. When queried about whether she rechecked the order after she filled the whole syringe with insulin to ensure the proper dose, RN 'C' said she did but compared it with the strength again. RN 'C' reported she did not have a lot of experience administering insulin, that it was her first bedside nursing job and she never worked in a long-term care facility previously. RN 'C' reported she received three days of orientation where she shadowed another nurse and asked for a couple extra days before being assigned on her own. RN 'C' further reported when she drew up R801's insulin, she thought it was a lot, but because another resident on that same set was prescribed a very high dose of insulin she thought it was correct. RN 'C' did not seek out clarification and verified the dose, but read the incorrect part of the order. On 10/7/25 at 9:36 AM, an interview was conducted with RN 'D' via the telephone. When queried about what happened with R801's insulin on 9/28/25, RN 'D' reported RN 'C' came to her and said she thought she had a medication error. When queried about the error, RN 'D' reported RN 'C' thought she gave 100 units of insulin to R801 instead of 3 units. RN 'D' reported R801 was assessed and blood sugar was rechecked. At that time, R801's blood sugar remained at baseline. RN 'D' reported RN 'C' called the physician and sent R801 out 911. A review of an Incident Report dated 9/28/25 at 5:00 PM, completed by RN 'C', revealed a statement by RN 'C' taken on 10/1/25 that noted, . I took the pt (patient's) blood 124. I read the order thinking the medication strength was the dose to be given, drew up 100 units in the insulin syringe instead of the 3 units ordered. I administered the insulin in her left arm. I went to chart administration was complete and</p>		