STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235482	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fenton Healthcare	512 Beach Street Fenton, MI 48430

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing, resulting in the potential for increased risk of respiratory infection among all residents in the facility.Findings include: On 12/02/2025 at 1:15pm during the environmental tour with the Environmental Services Director I, the Environmental Services Director I tested the chlorine residual at the staff bathroom sink on the first floor and the result was undetectable on the [NAME] K-2005 chlorine test kit. The testing kit measures chlorine residual from 1 to 10 parts per million (ppm). The test kit is primarily designed to test for chlorine in swimming pools, not drinking water. When interviewed on whether there's another test kit they've been using to measure the chlorine residual since the chlorine logs have results below 1 ppm and the Environmental Services Director I answered no. On 12/02/2025 at 2:17pm during record review of the Water Management Plan, on the Legionella Environmental Assessment Form the free chlorine residual results were recorded as .1 ppm. On the Water Management Team Meeting Minutes dated 3/3/25-6/16/25, it states under chlorine residual range Were control limits acceptable? Chlorine 0.2-4.0 ppm and it was marked Yes. On 12/02/2025 at approximately 2:30pm, interviewed the Administrator on how the chlorine residual results are recorded at below 1 ppm when the chlorine test kit is not sensitive enough to measure below 1 ppm, and she answered that the Environmental Services Director I, made a mistake. According to the State Operations Manual for Water Management, Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems . In addition, it states the water management plan must include, Measures to prevent the growth of opportunistic waterborne pathogens (also known as control measures), and how to monitor them.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the advance directive status was ordered, signed by the physician, and posted in the resident's clinical record per facility policy for one resident [Resident #80 (R80)] of 5 residents reviewed for advance directives.Findings include:Resident #80 (R80)R80 was observed in her room' lying in bed on [DATE] at 11:5 am. When R80 was asked about the life vest she was wearing, R80 explained it was to monitor her heart. A review of the Electronic Medical Record revealed that R80 was [AGE] years old, admitted at the facility on [DATE], with a diagnosis of Non-ST Elevation (NSTEMI) Myocardial Infarction, Ischemic Cardiomyopathy, Right Bundle Branch Block, Paroxysmal Atrial Fibrillation, Chronic Obstructive Pulmonary Disease (COPD), Pleural Effusion, and Heart Failure in addition to other diagnoses. A review of R80's clinical record revealed that there was no Code Status specified in the Advance Directive section in the chart. Although a Code Status Form was signed by R80 on [DATE], the facility did not indicate the code status in the Code Status/Advance Directive section of the resident's chart for the staff to know her wishes. According to the Preadmission Screening (PAS Annual Resident Review (ARR) dated [DATE], R80 has a current diagnosis and is receiving treatment for Dementia. She was receiving Remeron for dementia. The physician's orders was reviewed, however, did not include Remeron in the list of current medications.A care plan for R80 included a Functional ability deficit requiring assistance with self-care and mobility, at risk for cardiac complications related to multiple cardiovascular diseases: NSTEMI, CHF, AFib, CAD, Hyperlipidemia, HTN. Right Bundle Branch Block and Ischemic Cardiomyopathy. A care plan for a full code was entered on [DATE] but did not have a physician order obtained and a Full Code was not indicated in the Advance Directive section of the resident's data.On [DATE] at 11:30 AM, the Social Worker (SW A) reviewed R80's Electronic Medical Record (EMR) and confirmed that R80 was cognitively intact and signed a full code. However, The Advanced Directive status (referring to the full code) was not written in R80's clinical record. Upon admission, on [DATE], R80 signed as full code on [DATE]. SW B revealed that she could not find the physician's order. There was no indication of a full code posted on her face sheet, in the physician's orders, nor in the resident's profile. The SW B further explained the process where the nursing staff determines the code status from the resident day one of admission. R80 was her own responsible party and was competent when she signed up for her advanced directive in [DATE], but it was not ordered. SW 'B was wondering why the resident's Advance Directive section of the resident's medical record did not reflect a full code. The resident's choice as a Full code should be followed and staff must be informed of the updated Advance Directive, so the immediate and correct action is provided without further delay.According to the Director of Nursing (DON), during an interview on [DATE] at 11:40 AM, R80's Advanced Directive full code status signed on [DATE], should have been entered in her chart. The DON admitted he order for Full code was not put in her record. I just put a doctor's order in her record as we speak. Furthermore she admitted that the Full code was not found in the resident's clinical file. However, the DON confirmed that she only entered the Full Code status order while she was talking with the surveyor during the query on [DATE] 11:45 AM. Furthermore, the DON stated that R80's Full Code status should be reflected in the electronic chart of each of the residents. There is also a Code Book in each unit. The book contains the current residents Advance Directive signed form, along with the resident's face sheet.The facility policy for Advanced Directives was reviewed on [DATE] at 3:00 PM, noted the definition of an Advance Directive is a written document that is prepared when the Resident retains capacity and in which the Resident specifies what type of medical care that the Resident wants in the future and/or whom the Resident wants to make decisions for them in the event the resident loses the ability to make decisions for him/ herself.F. Full Code. In the event of respiratory and/or cardiac (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arrest, 911 will be called, and the resident will receive all resuscitative measures, including but not limited to CPR, until EMS arrives. ^^

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that oxygen humidification was provided, physician's orders for oxygen were followed and nebulizer equipment was stored according to facility policy for two residents (#51 and #69) of three residents reviewed for respiratory care. Findings include: Resident #51A review of Resident #51's medical record revealed an admission into the facility on 7/20/22 and readmission on [DATE] with diagnoses that included chronic obstructive pulmonary disease and pneumonia. On 12/2/25 at 2:05 PM, an observation was made of Resident #51 lying in bed. The Resident was interviewed, was able to answer some questions but did not engage in conversation. An observation was made of a nebulizer and mask on top of the bedside table. The nebulizer was stored in a see-through bag, and the medication chamber was observed to have liquid inside the chamber. The nebulizer was not dried prior to being stored in the bag. The Resident indicated use of the nebulizer treatment when he was sick.A review of Resident #51's orders revealed an order with a start date 11/28/25 for Ipratropium-Albuterol solution 0.5-2.5 (3) MG/3ML (milligrams per 3 milliliters), 3ml inhale orally every 4 hours as needed for SOB (shortness of breath) or Wheezing via nebulizer. Resident #69A review of Resident #69's medical record revealed an admission into the facility on 9/16/25 with diagnoses that included heart failure, and pneumonia. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 10/15 that indicated moderately impaired cognition and was dependent on a helper for toileting hygiene, bathing, dressing and transfers to chair/bed. On 12/2/25 at 10:48 AM, an observation was made of Resident #69 lying in bed. The Resident was interviewed, answered questions and engaged in conversation. An observation was made of the Resident's oxygen tubing positioned over her ears with the nasal cannula on her chin. The oxygen was on a concentrator and was set at 3 liters per minute. The concentrator was positioned between the wall and bedside table in front of the concentrator near the head of the bed. An observation was made of the humidification dry with no water or condensation in the container. The humidification container was dated 11/15/25. The date on the O2 tubing was 12/1/25. The humidification container had not been changed with tubing change. The Resident was asked about her oxygen and the Resident reported taking it off and on and that it was on most of the time. The Resident reported having nose bleeds that she attributed to the oxygen and that it would dry out her nose too much. On 12/2/25 at 3:15 PM, an interview was conducted with Unit Manager (UM), Nurse A regarding Resident #69's humidification for the oxygen. The UM reported that the nurses were responsible for changing the humidification when it was emptied on an as needed basis and that the tubing would be changed weekly. An observation was made with the UM of Resident #69 lying in bed with the nasal cannula positioned on her nose. The humidification had not been changed out and was dated 11/15/25. The UM indicated a new container should be changed when needed, took off the old one and replaced it with a new container. On 12/4/25 at 3:54 PM, an interview was conducted with Nurse D and UM A regarding Resident #69's oxygen order. An observation was made with the UM of Resident #69's oxygen concentrator set at 3 L/min as verified by the UM. A review of the physician orders indicated the oxygen was ordered for 2 L/min. Nurse D explained that the oxygen had been increased recently due to the resident being sick. A review of the orders revealed no orders to increase oxygen administration. The Nurse reported the resident should be at 2 L/min and will change the O2 while monitoring the oxygen saturation for the Resident. When asked about humidification, the Nurse reported that she thought it was changed with the tubing change. After the date on the humidification container was identified as 11/15/25, the Nurse reported that the humidification container does not last that long and should be changed out and stated, that's too long, they don't last that long I don't think. The Nurse reported the Resident also got nasal spray to help with the dryness in her nose. A review of Resident #69's Medication Administration Record revealed O2 via nasal cannula at 2L every shift with a start date 9/16/2025, documented as checked on 12-hour shift with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the O2 sats (oxygen saturation). On 12/4/25 an interview was conducted with the Administrator (NHA) regarding the concern of Resident #69 lack of humidification and oxygen administration orders not followed. The NHA was informed of the concern of storage of the nebulizer treatment supplies for Resident #51. A review of the facility policy titled, Nebulizer therapy, small volume, revealed, .Rinse the nebulizer with water and allow it to air-dry. Alternatively, discard it after the treatment. Complications. Complications associated with small-volume nebulizer therapy may include: .infection from contaminated equipment. A review of the facility policy titled, Use of Oxygen, dated 2/28/25, revealed, .V. If a disposable humidifier is used, it may be used until empty.