STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235518	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Woods Manor	13137 North Clio Road Clio, MI 48420

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review, the facility failed to include and document residents and resident representatives in care conferences for one resident (Resident #158) of one resident reviewed for Care planning participation Findings Include: Resident #158: Care Planning On 4/08/2025 at 11:32 AM, during an interview of the Representative/wife for Resident #158, she said the resident had been at the facility for almost 3 weeks and she had not been asked to participate in a Care conference or Care planning meeting with the resident and facility. She said she was not sure how he was doing or what the plans were for him. Resident #158 confirmed he had not been included in a Care planning meeting. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #158 was admitted to the facility on [DATE] with diagnoses: Dementia, heart failure, kidney failure, an intestinal disorder, sepsis, history of falls, rib fractures and gait and mobility abnormalities. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with Brief Interview for Mental Status/BIMS score of 13/15 and needed some assistance with all care. On 4/10/2025 at 3:10 PM, Clinical Care Coordinator/CCC F was interviewed about the Care conference meetings. She said she was responsible to conduct the meetings. She was asked if a meeting was held for Resident #158, and she said a Care conference was completed on 3/24/2025 with the resident's wife on the phone. She was asked if any other staff from the interdisciplinary team was present, and she said they were not. The CCC F was asked if Resident #158 and his wife were together in the meeting and she said they were not. The resident was not included in a meeting. The CCC F said she met with the wife again on 4/9/2025. When asked if there was documentation for the meetings. The CCC F said there was no documentation for either one. A review of the resident's medical record revealed there was no mention of an interdisciplinary care conference with Resident #158 or his wife. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Care Planning Process: Admission, Comprehensive & Short Term, dated revised 11/2017 provided, . Care plans are initiated to address interventions for prevention of functional decline, rehabilitative and restorative care, health maintenance issues, skin care, discharge potential, safety and wandering/exit seeking behavior, nutritional, psychosocial, and comfort. The care planning process is a collaborative partnership with the interdisciplinary team, resident, and or resident representative . The interdisciplinary team will provide an opportunity for the resident-who has not been judged incompetent or otherwise incapacitated- to participate in planning care and treatment changes .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37666 Based on interview and record review, the facility failed to ensure Code Status was documented and accessible in the medical record for 6 residents (#12, #21, #53, #79, #92 and #158) of 11 residents reviewed for Advance Directives, resulting in the potential for miscommunication of code status. Findings Include: Resident #12 Advance Directives A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated Resident #12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Parkinson's disease, COPD, diabetes, kidney disease, heart failure and depression. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 14/15 and needed some assistance with care. A review of the advance directives and code status for Resident #12 in the electronic medical record/EMR, revealed the chart was not marked for the resident's specific code status. The Face Sheet had a heading for Code Status and next to it Advance Directives) in a blue link. When the link was clicked on there was no information about code status. A review of the Documents tab of the EMR that contained scanned in documents, identified an assessment for Resident #12 titled, Resident Preferred Treatment Option, dated 4/16/24. The document provided, This resident/DPOA/Guardian has chosen the option of Status 1. Farther down in the document it had categories 0, 1, 2, 3, 4, with clarifying information for each. The option for Status 1 revealed the following: The resident is to be treated only in the nursing home and is to receive interventions to promote comfort and treatments for presumed infection are limited to medications. Therapeutic testing may be performed, no diagnostic testing is to be performed, nor tube feedings. Such treatments are not to include resuscitation. A review of the physician orders for Resident #12 did not identify an order for code status. There was an order that said, Refer to Preferred Treatment Option for Advanced Directives, dated 4/16/2024. It did not say what the preferred treatment was. A review of the Care Plans for Resident #12 revealed there was no mention of the resident's Code Status. A review of the Preferred Treatment Option forms in the EMR Documents tab for Residents (# 21, 53, 79, and 158) indicated they each had a form completed with an option chosen of either 0, 1, 2, 3, or 4 with verbiage explaining each. Each resident had a physician's order that said, Refer to Preferred Treatment Option for Advanced Directives, but did not specify the advance directive/code status. The resident did not have a Care Plan for their specific code status wishes. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #92 Advance Directives A record review of the Face Sheet and Minimum Data Set/MDS assessment indicated Resident #92 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, COPD, Heart failure, and depression. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss with a BIMS score of 7/15 and needed assistance with all care. He was receiving Hospice services. On 4/09/2025 at 1:44 PM, Clinical Care Coordinator/CCC E was interviewed, about the code status for the residents'. Reviewed there was no orders specifying what code status the resident preferred or care plans identifying their wishes for code status. Reviewed the charts were not flagged with code status preference. The CCC E was asked how staff would know what the resident's code status was in an emergent situation and she said there was a form in the documents section of the EMR (the Resident Preferred Treatment Option) that specified what the resident's code status was. The CCC was asked if staff would need to search through the documents section of the EMR to find the residents code status, and she said there was also a book at the nurse's desk with code status for each resident; it was not a part of the resident's medical record. On 4/10/2025 at 8:50 AM, Nurse K was interviewed at the East hall nurse's desk and was asked about the residents' code status. She said there was a binder at the nurse's desk with resident code status forms inside. A review of the binder revealed there were sections tabbed alphabetically, for example A, B etc. but within each section were all of the residents' forms for code status. The binder's pages didn't flip to the resident you needed because there were so many pages in front of it and it had to be turned section by section to arrive at the resident's name. She said normally you would send someone to get the book at the desk to find the code status. On 4/10/2025 at 2:45 PM, Nurse E was interviewed about the Residents' code status forms in the binders on the [NAME] hall. Upon review of the binder, it was noted to be set up like the binder on the East hall. Nurse E said each hall had a binder with the residents' code status preferences and each book had all of the facilities residents in it. While reviewing the binder/book, Nurse E was observed turning sections of the binder until she reached Resident #92's form Resident Preferred Treatment Option. The form was a copy of the original and was so dark it was not readable. At the top the resident's name was barely legible and the option 0 could be seen, but not the clarifying information. The rest of the document was blacked out, due to the poor quality of the document. Nurse E said the form should not have been placed in the binder like that. A review of the document in the EMR indicated it was very dark, but the 0 could be seen and the signatures read. The remaining words were blurry. A review of the facility policy titled, Advanced Directives, dated revised November 2016 provided, It is the policy of this facility to honor the health care decisions made by residents . The document did not detail the process for ensure the residents' code status was easily accessible in the medical record for all residents and staff access in an emergent situation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to timely revise/update care plans for two residents (R33, R63) of five residents reviewed for care plan revision, resulting in care plans not being revised as the status and needs of the residents changed related to weight loss and pressure ulcers. Findings include: Resident #33: Pressure Ulcers R33 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dementia, major depressive disorder, chronic systolic heart failure, anxiety and hypertension. On 04/09/25 at 10:27AM, record review revealed that R33 has a suspected deep tissue injury (SDTI) on her right heel and ankle. On 04/10/25 at 09:56AM, record review of the admission minimum data set (MDS) does not reference R33 having a SDTI on the right heel and ankle. Record review of a skin assessment dated [DATE] revealed no skin conditions. Record review of a skin assessment dated [DATE] revealed R33 has multiple skin concerns, including an open area on the coccyx and an unstageable wound on the right heel. Record review revealed that a skin assessment was not completed on or around the week of 03/16/25-03/22/25. On 04/10/25 at 09:58AM, record review of the care plan for skin impairment revealed that it did not mention the area of skin impairment and was last revised on 02/27/25. On 04/10/25 an interview was conducted with Unit Manager (UM) F'. UM F was asked who is responsible for revising care plans related to changes in skin impairments, UM F stated the nurse that observed the wound would update the care plan. UM F was asked why the care plan had not been revised to reflect the residents current skin conditions. UM F stated, there should be a short-term care plan for the SDTI and for the actual skin issue and it they should also be on the activities of daily living (ADL) care plan. UM F reviewed the ADL care plan and noted that the Skin Impairment Location had not been revised since 02/27/25 and there wasn't a short-term care plan in place for the actual skin issue. UM F revised the care plan on 04/10/25 after being notified that it wasn't revised. Review of the policy titled, Skin at Risk Assessment, Documentation, Staging & Treatment, revealed: Procedure: 8. Individualize the residents goals and interventions as documented on the plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Reassess the resident, the pressure ulcer and the plan of care if the ulcer does not show signs of healing as expected despite appropriate local wound care, pressure redistribution, and nutrition. a. Expect some signs of pressure ulcer healing with two weeks. b. Adjust expectations for healing in the presence of multiple factors that impair wound healing. Resident #63: R63 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dementia, major depressive disorder, encephalopathy and hypertension. Nutrition On 04/09/25 at 10:33AM, record review revealed that R63 has experienced a 17% weight loss in the last six months. On 10/08/24 R63 was 227.6lbs and on 04/03/25 weighed 194.2lbs Record review of the care plans for R63 revealed there was no care plan for weight loss and the care plan for nutrition has interventions that have not been updated since 2021. R63 was started on supplement shakes to aide in weight gain on 3/7/25, the care plan was not updated to reflect that. On 04/10/25 at 12:10PM, an interview was conducted with certified dietary manager (CDM) D. CDM D was asked if they update the care plans or develop a specific care plan when weight loss is identified. CDM D stated, I have not done a specific care plan for weight loss, sometimes I put it in the care plan for nutrition. For the most part it is just in the notes, nutritional assessments and quarterly assessments. CDM D was asked if they think there should be a specific care plan for weight loss with the interventions that are put in place. CDM D stated they were unsure and have just always put weight loss in the nutritional care plan. Review of the policy titled, Weight Management, revealed: Policy: It is the policy of this facility that resident's weight will be monitored by the interdisciplinary team (IDT) in coordination with the nutritional plan of care. Procedure: 8. The nutritional plan of care is evaluated a minimum of quarterly and as indicated to determine if current interventions are being followed and if they are effective in attaining nutritional and weight goals.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure documentation, assessment and monitoring of a hand brace/splint for one resident (Resident #53) of one resident reviewed for rehab and restorative services. Findings Include: Resident #53: Rehab and Restorative On 4/09/25 at 9:05 AM, Resident #53 was observed lying in bed in her room; she was awake and talkative. She was observed to have a splint/brace on her right hand. She said her daughter had brought it in for her and the staff assisted her in putting it on and off. The resident was asked if she performed any exercises for her right hand or arm and she said she did not. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #53 was admitted to the facility on [DATE] and readmitted on [DATE] ith diagnoses: paraplegia, heart failure, COPD, diabetes, history of seizures, kidney disease, anxiety and depression. The MDS assessment dated [DATE] revealed the resident had mild cognitive loss and needed assist with care. A record review of the physician orders identified the following: Okay to wear soft brace to right wrist, provided by daughter, dated 3/19/2025. A review of the electronic medical record/EMR Tasks documentation for Resident #53 identified a heading titled, Restorative-Splint/Brace Assistance, a review of 30 days identified that no one had documented they completed this task. Further review of the Tasks documentation indicated there was no documentation for Restorative services for Resident #53. A review of the EMR for Resident #53 indicated there was no documentation of restorative services or assistance with the right-hand brace for Resident #53. A review of the Medication Administration Record/MAR and Treatment Administration Record/TAR for Resident #53 indicated there was no documentation of assistance with or monitoring of the right-hand splint. A review of the assessments and progress notes for Resident #53 revealed there was no documentation of assistance or monitoring of the right-hand brace. A review of the Care Plans for Resident #53 indicated there was no mention of a right-hand brace/splint. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/20 25 at 11:30 AM, Therapy Director L was interviewed and said the facility did not have a restorative nursing department, but the nurse aides were all trained to perform restorative nursing functions. On 4/10/2025 at 1:30 PM, during an interview with Clinical Care Coordinator E she was asked about Resident #53's right hand brace, she said there was an order for it. A review of the medical record revealed there was no further documentation of the brace or monitoring of the brace or a Care Plan. A review of the facility policy titled, Restorative Nursing Program, dated revised November 2021 provided, It is the policy of this facility to evaluate residents on an individual basis for inclusion in a restorative program to assist the resident to attain or maintain their highest possible functional level. Purpose: To support enhanced self-esteem, deter loss of avoidable function, and improve a resident's Quality of Life . The program will be documented as needed electronically under the headings as outlined in the MDS 3.0 for Range of Motion, Splint or brace assistance .

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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** 38471 Based on interview and record review the facility failed to act timely on a change in mental status for one resident (Resident #11) of one resident reviewed for a change in condition. Findings Include: Resident #11: On 4/9/2025 at approximately 11:40 AM, Resident #11 was observed resting in bed, she appeared to be in good spirits. When asked how her stay has been at the facility, she stated the, staff thinks I'm nuts, the resident was asked to expound upon this, and she explained she sees cats atop her tall dresser, wrapped in her peace sign blanket. The staff tell her that she is nuts due to her observation of cats. She continued the cats resemble wolves and the staff won't grab them down for her. Resident #11 continued she does not see them on a daily basis nor do they cause her any distress. On 4/9/2025 at 1:00 PM, Social Worker B was informed of the discussion with Resident #11 who stated other than depression she does not have a mental health history. Typically, nursing staff will alert her to things of this nature but stated she would follow up with the resident. Resident #11 is not open to their outside psychiatric group for services. On 4/9/2025 at 1:15 PM, a review was conducted of Resident #11's medical record and it indicated she was admitted to the facility on [DATE] with diagnoses that include, Spinal Stenosis, Dysphagia, Major Depressive Disorder, Heart Failure, Hypertension, Anemia and Diabetes. Resident #11 is able to make her needs know to staff. On 4/9/2025 at 4:30 PM, Social Worker B followed up stating she spoke to the resident who initially denied seeing cats but as the conversation continued, she did share she was observing cats or rats and they may have come with her from her mother's home. But the sight of them was not distressing to her. This is a new onset for the resident as she has never experienced delusions or visual hallucinations. Social Worker B enacted a shift-to-shift log to monitor her delusions and hallucinations and is going to speak to nursing staff about a medical work up to rule out any metabolic changes. This is a change in condition for the resident as she does not have a mental health history and if the medical workout is negative they will refer out for mental health. Review was completed of Nurse Practitioner I documentation from 4/1/2025 which stated, .(Resident #11) was seen today for routine follow-up visit. Staff also report confusion continues. She states she is seeing rats in her room. She pointed them out to me, which actually were her Christmas tree, sitting in the corner . We discussed that the change in condition was noted over a week ago but was dismissed by the practitioner and no further assessment or monitoring was conducted regarding the mental status change. Further review was completed of Resident #11's progress notes: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/31/2025 at 22:50: CNA reported that pt was talking about seeing live rats in the window. No rats observed. Pt is A&O x 4 Later CNA also reported that pt told her that this used to be her grandma's house. Pt was serious, she not joking. Noted in dr book . 4/1/2025 at 00:00: . (Resident #11) was seen today for routine follow-up visit. Staff also report confusion continues. She states she is seeing rats in her room. She pointed them out to me, which actually were her Christmas tree, sitting in the corner. No other complaints reported . 4/9/2025 at 14:03: Visited with resident in room, resident in bed awake. Resident able to recall the year and month, knew this writer, knew where she was at. No change in cognition except resident is verbalizing seeing either rats or cats in the room. Resident stated seen them for a couple of days but not anymore. Stated I think they came back with me from the other facility I went to. Resident having delusions, has not left this facility. Resident verbalize feels like vision is doing ok and verbalized that seeing the rats or cats was not upsetting. Denies any comments from staff, denies concerns with staff, states they are good to me. Resident stated (Nurse Practitioner I) came and seen me and said everything is ok. Behavior log initiated, Physician or NP notified to rule out medical, physician to review cognition and decision making, if medical is ruled out then will refer to BCS for services . On 4/10/2025 at 10:45 AM, an interview was conducted with Nurse Practitoner I regarding Resident #11's change in condition. He stated given her longevity at the facility it may be underlined Parkinson's that is undiagnosed . About ten or so days ago she mentioned she saw rats and pointed to an area by her Christmas tree. There was some confusion but she agreed that it was her Christmas tree and not rats that she was visualizing. He stated there were no other signs/symptoms or complaints from the resident. 4/10/2025 at 13:33: Writer obtained UA via straight cath using sterile technique. Chem 10 dip completed and positive for leukocytes and nitrites. Per order, specimen in tubes and in fridge awaiting pick up to lab. Resident #11's new onset of visual hallucinations and delusions were a change from her baseline mental status. That while noted on 3/31/2025, was not addressed by the facility until nine days later, when alerted during the survey process.

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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** 38471 Based on interview and record review the facility failed to implement meaningful interventions to prevent the development of a pressure ulcer for one resident (Resident #83) and ensure that skin assessments were completed timely for one resident (Resident #33) of two residents reviewed for wounds. Findings Include: Resident #83: On 4/8/20205, during initial tour Resident #83 was observed sitting in her wheelchair enjoying her lunch. On 4/5/2025 at approximately 3:00 PM, a review was conducted of Resident #88's medical records and it indicated she admitted to the facility 4/19/2024 with diagnoses that included, Heart Disease, Pressure Ulcer of Left Buttock Stage 3, Alzheimer's Disease, Dementia, Anxiety and Chronic Obstructive Pulmonary Disease. Further review revealed the following: Progress Notes: 2/21/2025 23:35: Pt (patient) has open area on LT (left) buttock measuring 0.5 x 0.4 x 0.1 cm with red and yellow wound bed. Border foam dressing ordered and applied. 3/09/2025 at 23:00: Pressure ulcer of left buttock, stage 3: wound note reviewed, cont (continue) with wound care . 3/11/2025: (Resident #83) was noted to have impaired skin impairment to her left buttock. Per wound tracing is healing slowly . Further review was conducted of Resident #83's medical record as it related to her facility acquired pressure ulcer. Weekly Skin Assessments: 2/7/25: Residents skin remains clean dry and intact. Mucous membranes pink and moist. No new skin issues are noted at this time. 2/27/2025: Residents skin remains clean dry. Resident is noted to have small open area on sacrum 1 cm X 1/2 cm. Treatment in place. Mucous membranes pink and moist. Wound Assessments: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/27/2025: (Resident #83) has a wound on her left buttock. She has recently signed off of hospice as she is no longer declining enough to recertify for hospice care .She is now on an air mattress with alternating pressure to help decrease skin breakdown and prevent future breakdown . (Resident #83) enjoys sitting up in her wheelchair for the majority of the day doing crossword puzzles and does not like her feet elevated . Measurements: 0.5 cm (centimeter) x 0.4 cm x 0.1 cm ; stage II. 3/5/2025: . (Resident #83) is sitting up in her wheelchair completing cross word puzzles while using the bedside table. She consents to assessment and uses the restroom grab bars to stand with two persons assist. The old dressing was removed to reveal a small amount of serosanguinous drainage on the removed dressing. The wound presents with 25% coverage of loosely adherent slough. The wound edges are well approximated without evidence of tracking, tunneling or rolling. There is no evidence of maceration .The peri-wound is intact. After cleansing, the wound was covered with the foam border dressing. (Resident #83) is reliant upon staff for assistance with turning and re-positioning but is able to make small positional changes in the chair and bed independently. She prefers to be up in the chair for several hours throughout the day and rarely lays down in bed until later in the evening . Measurements: 1.7 cm x 0.6 cm x 0.1 cm: Stage III. 3/10/2025: The peri-wound is intact. After cleansing, the wound was covered with the foam border dressing. (Resident #83) is reliant upon staff for assistance with turning and re-positioning but is able to make small positional changes in the chair and bed independently . Measurements: 1.0 cm x 1.0 cm x 0.1 cm; Stage III. 3-17-2025: (Resident #83) continues to have a stage 3 pressure wound on her right buttock . 3-24-205: .Standing balance with 1 PA (person assist) maintained while wound was assessed, cleansed and treatment applied. Tx order remains: WOUND CARE: Left buttock: Remove old dressing, cleanse with cleansing spray, pat dry with gauze. Apply TheraHoney Gel to wound bed and apply Equos dressing. Change Q3 days and PRN when soiled. Wound measurements remain the same. Wound bed is pink with signs of epithelialization . Measurements: 1.0 cm x 1.0 cm x 0.1 cm; Stage III. 3-31-2025: (Resident #83) accepted assistance into the restroom with the C.N.A. 2PA transfer completed and [NAME] stood well for wound care assessment. Wound was cleansed with wound cleanser, patted dry and assessed. Wound measures slightly larger this week from last week. 1 x 1 x 1 cm stage 3 Left Buttock last week, 1.3 cm x 1.5 cm by 0.5 cm depth this week. Wound bed has pebbled appearance of granulation tissue and is filling in for wound depth. Wound has scant amount of serosanguinous drainage, non odorous, and peri wound is without signs of infection, not red, not warm, no discomfort . 4/5/2025: Area remains unchanged. Granulation tissue to the center of the wound is firm. There is no drainage . Measurements: 1.5 cm x 1.7 cm x 0.5 cm; Stage III. Care Plan: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Bed Mobility: assist of one .ADL (Activities of Daily Living)'s: Staff to anticipate needs and give physical and verbal cueing for tasks .Assistive Devices: Wheelchair with padded cushion .New wheelchair cushion to promote pressure reduction .Previous gel cushion from home worn . revised 3/31/2025. The facility was aware prior to Resident #73's wound development her resolve to remain out of bed and yet it took over one month to replace the worn cushion on her wheelchair. On 4/10/2025 at 4:00 PM, an interview was conducted with Clinical Care Coordinator E regarding Resident #83's facility acquired pressure ulcer. She stated after development of the wound they added a protein supplement and changed her wheelchair cushion as the one she had on the chair was worn. Resident #83 likes to stay in her chair most of the day and will not agree to a lay down schedule for the facility. Coordinator E was asked what interventions were in place prior to development of her wound. After review of the chart, it was found there were no meaningful interventions in place prior to the development of Resident #83's wound. Review was completed of the facility policy entitled, Documentation, Staging & Treatment, revised 1/2020. The policy stated, It is the policy of the facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated .Stage II: Partial- thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or op open/ruptured blister. Including incontinence, associated dermatitis . 49944 Resident #33 (R33): R33 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dementia, major depressive disorder, chronic systolic heart failure, anxiety and hypertension. Pressure Ulcer/Injury On 04/09/25 at 10:27 AM, record review revealed that R33 has a suspected deep tissue injury (SDTI) on her right heel and ankle. On 04/10/25 at 09:56 AM, record review of the admission minimum data set (MDS) does not reference R33 having a SDTI on the right heel and ankle. Record review of a skin assessment, dated 03/14/25, revealed no skin conditions. Record review of a skin assessment dated [DATE] revealed R33 has multiple skin concerns, including an open area on the coccyx and an unstageable wound on the right heel. Record review revealed that a skin assessment was not completed on or around the week of 03/16/25-03/22/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 an interview was conducted with unit manager (UM) F. UM F was asked how often skin assessments are completed for the residents. UM F stated that skin assessments are completed by the nurses, usually with shower days. UM F stated that skin assessments are scheduled twice weekly and the nurse on shift at the time of the shower completes the assessment. UM F was asked why there wasn't a skin assessment completed between the assessment on 03/14/25 and the assessment on 03/28/25. UM F stated, I am not sure, they should have been completed. UM F stated they assessed the skin of R33 on 03/31/25. Review of the policy titled, Skin at Risk Assessment, Documentation, Staging & Treatment, revealed: Procedure: 6. The following guidelines are reviewed and implemented as indicated for each individual risk factor: a. Daily skin inspections with am and pm care. b. C.N.A reporting of abnormal skin inspections to the charge nurse. g. Shower twice weekly as accepted and desired and prn including skin inspections.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to 1. Follow a physician's order for enteral nutrition, 2. Notify a responsible party of changes to enteral nutrition, and 3. Complete routine cleansing and assessment/monitoring of a PEG (Percutaneous Endoscopic Gastronomy) tube for one resident (Resident #95) of two residents reviewed for tube feeding. Findings Include: Resident #95: On 4/8/2025 at 1:15 PM, Resident #95 was observed asleep in bed as her enteral feed was infusing. Observation of the pump rate showed it was infusing at 50 mL (milliliters)/hour with 150 mL flush every four hours. Review was completed of Resident #95's physician orders which indicated the following, Glucerna 1.5 at 60 ml per hour for 20 hours via pump. The Glucerna 1.5 was hung at 9:30 AM with the incorrect infusing rate. Resident #95's Nurse (O) was queried what the residents enteral feed rate was, which she replied 50 ml. The rate infusing on the resident's pump was visualized with Nurse O as currently infusing at the rate of 50ml/hour. Review was then completed of the physician's order which stated the rate at 60 ml/hour. After further review it was found the rate was increased from 50 ml to 60 ml on 4/1/2025. Nurse O did not have an answer as to why the incorrect rate was infusing. On 4/8/2025 at approximately 3:30 PM, a review was conducted of Resident #95's medical records and it indicated she admitted to the facility on [DATE] with diagnoses that included, Dementia, Major Depressive Disorder, Diabetes, Atrial Fibrillation, Hemiplegia and Chronic Obstructive Pulmonary Disease. Resident #95 is not cognitively intact and her daughter DPOA (Durable Power of Attorney). Further review was conducted of Resident #95's medical record and it yielded the following: Progress Notes: 3/28/2025 at 16:30: (Resident #95) readmitted on the 21st after a hospitalization at [NAME]. She was transferred back to facility with orders for Daptomycin 400mg x 10 days and Augmentin 875mg q12 hours x 10 days. Review of hospital records reveal that CT of abdomen was done and showed mispositioned PEG tube placement with balloon within anterior abdominal wall and a area of fluid was located within anterior abdominal wall, unknown if fluid was a seroma, hematoma or abscess . 4/1/2025 at 09:36: Recommend changing TF of Glucerna 1.5 to 60 ml/hr x 20 hours or until 1200 ml infused via PEG. This will allow time off of pump. Continue free water flush as ordered . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/8/2025 at 13:57: Writer aware that residents tube feed setting was set at 50cc/hr when tube feed was turned on this morning at 1000. Residents TF (tube feed) settings increased to 60cc/hr as of 04/01/2025. Writer spoke with . dietician . verbalized to writer an order to run residents TF at 70cc/hr from 1400-1800 to make up the 40cc that resident had previously missed this shift. Writer started order and increased rate. On coming nurse notified and aware to change the rate to 60cc/hr at 1800. NP aware of changes and verbalized agreeance to the adjustment . MAR (Medication Administration Record): March 2025: .Enteral feed via Pump Glucerna 1.5 at 50 ml per hour for 24 hours via pump per G-tube. Order was discontinued on 4/1/2025 . April 2025: .Enteral feed via Pump Glucerna 1.5 at 60 ml per hour for 20 hours via pump per g-tube . Order initiated on 4/1/2025 and was being marked off as completed by facility staff. There was no documentation located regarding notification to Resident #95's DPOA with the change in her tube feed rate on 4/1/2025 and the incorrect rate being infused on 4/8/2025. Furthermore, after Resident #95's readmission on 3/21/2025 there were no orders for assessment, monitoring nor cleansing of the PEG tube insertion site per nursing standard of care. On 4/9/2025 at 9:40 AM, Resident #95's daughters shared they were not informed her tube feed rate was increased from 50 ml to 60 ml at the beginning of April. They continued they are typically at the facility daily, and their mothers tube feed has been infusing at 50 ml for the month of April. When asked if they were notified yesterday regarding the short-term tube feed increase, they stated they were not. On 4/9/2025 at 2:20 PM, Clinical Care Coordinator G stated the Administrator provides them with a list of residents receiving tube feed but staff can access the MAR for accuracy. She stated she was not sure if Resident #95's tube feed was being ran at the appropriate rate as she was not aware it had been changed. Coordinator G was asked if Resident #95 has orders for daily cleansing, assessment and monitoring of the PEG tube site. She stated she completed wound care on the resident today and cleansed the site and changed the split gauze. After review of the resident's chart there were no orders found for PEG site care or dressing change. Coordinator G was asked if there are no orders how are they certain the site is being appropriately maintained. Coordinator G did not have an answer but expressed understanding of the concern. On 4/10/2025 at 9:50 AM, an interview was held with Registered Dietitian S regarding the infusion rate for Resident #95. She stated it was increased on 4/1/2025 and they would notify the nurse of the change. Dietitian S was asked if Resident#95's responsible party was notified of the change (review was completed of the progress note from 4/1/2025) which did not indicate the DPOA was alerted to the change. A discussion ensued regarding Resident #95's infusion rate change and the lack of communication with her DPOA. Dietitian S expressed understanding of the concern. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/2025 at 12:50 PM, Corporate Nurse A was asked if there were orders located the cleaning, assessment and monitoring of Resident #95's PEG tube site. She explained their medical record system has standing orders for feeding tubes to streamline it for facility staff. They would mark the appropriate entry and the order set would prorogate in the MAR/TAR. But if it is a specialty order it would have to be manually inputted. Nurse A stated upon review of Resident #95's chart she did not locate an order (since readmission on 3/21/25) for daily cleansing or assessment of her PEG tube site. The resident also had an order for split gauze upon readmission that was not ordered until today. Review was completed of the facility policy entitled, Medication Administration by Various Route, revised 12/2024. The policy stated, .Review the physician order. Resolve any discrepancy before proceeding with the administration of the medications .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to complete quarterly assessments to determine the continued need for enabler bars, along with initial and monthly maintenance inspections of enabler bars, for four residents (#2, #71, #75, #76) of four residents reviewed for assist bars. Findings Include: Resident #2: On 4/9/2025 at 11:20 AM, Resident #2 was observed visiting with her son while enjoying lunch. Observed affixed to her bed were bilateral enabler bars. On 4/10/2025 at approximately 9:00 AM, a review was conducted of Resident #2's medical records and it indicated she was admitted to the facility on [DATE] with diagnoses that included, Atrial Fibrillation, Hypothyroidism, Dysphagia, Hypertension and psychotic disorder. Resident #2 required the assistance of one staff for daily cares. Further review was completed and it yielded the following results: Care Plan: Resident #2 does not have a care plan related to their enabler bars. Assist Bar Maintenance Log: Enabler bars installed on 3/20/25 but unknown if initial four-day monitoring was completed as all the spaces are blank. On 4/10/2025 at 9:45 AM, Maintenance Director C was asked the process for installing enabler bars on resident beds. The Director explained the Unit Manager would verbally communicate that to her or place a request in their electronic maintenance system. The maintenance staff completes so many days of safety inspections upon install and then monthly. Director C was asked to verify Resident #2 needed the enabler bars. Upon the director returning she stated the Clinical Care Coordinator informed her the resident did need the enabler bars and was careplanned to have them. Director C was asked to provide their logs of initial inspections and monthly checks. Resident #71: On 4/10/2025 at approximately 1:00 PM, a review was conducted of Resident #71's medical records and it indicated he admitted to the facility on [DATE] with diagnoses that included, Heart Disease, Atrial Fibrillation, Kidney Disease, Pulmonary Hypertension and Depression. Further review yielded the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan: . ASSIST RAILS: To enhance independent mobility and transfer . initiated 6/29/2022. Restraint/Enabler Bar Assessment: 3/12/2024 11/12/2024 2/4/2025 It can be noted the assessments for the continued usage of the enabler bars are completed quarterly (every three months) or with significant change. Resident #71 assessment was due June 2024 and was completed five months late. Assist Bar Maintenance Log: The log indicated the resident's enabler bars were installed on 9/1/2023. The monthly logs are logged by room number and not resident name. There is an X next to room [ROOM NUMBER]-2 and its unclear if the x indicates the resident had an enabler bar or that they were inspected for safety/functionality and there were no issues. Resident #76: On 4/10/2025 at approximately 1:15 PM, a review was conducted of Resident #76's medical records and it indicated she admitted to the facility on [DATE] with diagnoses that included, Diabetes, Atrial Fibrillation, Hypertension, Depression and Anemia. Further reviewed yielded the following: Care Plan: .ASSIST RAILS: To enhance independent mobility and transfers . Initiated on 3/14/2024. Restraint/Enabler Bar Assessment: 5/09/2024 10/26/2024 1/08/2025 Resident #76's continued assessment for usage were not completed at the appropriate intervals. Assist Bar Maintenance Log: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The log indicated the enabler bars were installed on 3/20/2024 and there is a line through the four initial days of monitoring, its unclear what that means. There is an X next to room [ROOM NUMBER]-2 and it's unclear if the x indicates the resident had enabler bar or that they were inspected for safety/functionality and there were no issues. On 4/10/2025 at 1:50 PM, Clinical Care Coordinator E explained the standard is when a resident is discharged from the facility, they completely strip the room down and would take off any assist bars. The process for assist bars is for each resident to be assessed for their need for the enabler bars and maintenance would complete measurements and safety inspections. The nursing assessment would be completed initially and then quarterly or with a significant change. We reviewed Resident #76's charting for enabler bars which showed the resident being careplanned for the assist bars on 3/14/2024 but the first nursing assessment related to usage was not completed until two months later (5/9/2024). With the next assessments were completed on 10/28/2024 and 1/8/2025. The maintenance log was reviewed as well, and Resident #76 was listed as the bars being affixed on 3/20/2024. There were lines through the four days of initial monitoring and monthly safety inspections. Review was completed of Resident #71's enabler assessments which showed the following dates of completion: 3/12/2024, 11/12/2024 and 2/4/2025. Coordinator E was asked who was responsible for ensuring the assessment were completed and she stated it would be the responsibility of each unit's manager. Coordinator E expressed understanding of the concern. On 4/11/2025 at 10:25 AM, the maintenance Bed Rail Audit book was reviewed in tandem with Maintenance Director C. The last monthly audits of the enabler bars in the facility was completed in February 2025 and November 2024. The director shared the inspections should be completed for daily for four days after initial installation and then monthly inspections thereafter. Review was completed of the facility policy entitled, Bed Rails/ Assist Bars, revised [DATE]. The policy stated, .The nurse will perform and assessment of the resident need for bed rails or assist bars including the risk and alternatives .The 4- day observation and rail mattress entrapment zones will be performed for newly installed bed rails OR assist bars .Measurements review entrapment zones will be done at least every 30 days after initial 4-day assessment. Residents' need and use of rails will be evaluated by the interdisciplinary team a minimum of quarterly . 49944 Resident #75 (R75): R75 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dementia, anxiety, history of falling and encephalopathy. On 04/08/25 at 11:02AM, R75 was observed in resting in bed. R75's bed was noted to have bilateral turn assist bars on it. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed that R75 had an initial assessment for enabler bars completed on 08/23/24, no assessments for the bars had been completed since. Review of the policy titled, Bed Rails/Assist Bars, revealed: Procedure: 8. Residents' need and use of rails will be evaluated by the interdisciplinary team a minimum of quarterly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37666 Based on observation, interview and record review, the facility failed to monitor and respond to abnormally low hot water temperatures per standards of practice for the prevention and management of Legionella for a census of 111 residents, resulting in the potential for growth of infectious organisms in the facility water supply. Findings Include: FACILITY Infection Control: On 4/09/2025 at 2:11 PM, the Infection Prevention and Control/IPC Nurses J and K were interviewed. Infection surveillance was reviewed and the IPC J said she and the Maintenance Director reviewed the facilities water management program and monitoring of water for Legionella at the monthly Infection Control Committee meeting that was a part of the Quality Assurance Process Improvement meetings. IPC J said if there was a problem with the water, the Maintenance Director would tell her about it. The IPC J was asked if there had been any mention of problems, and she said not that she knew. A review of the Water management program book identified a Legionella assessment form dated 3/17/25. It said the emergency water systems were tested annually and the last test was 4/4/2023. During an interview with the Administrator on 4/09/2025 at 3:35 PM, related to the outdated annual water system testing, She said she had another book and said the last water test was in 2024 and again that day 4/9/2025. On 4/09/2025 at 3:39 PM, the Administrator was interviewed while reviewing additional documents in the Water management book. A document titled, (The Facility) water testing results 5/6/2024, indicated the chlorine in the water in certain areas of the building including the hand sink in the main dining room tested at . 01 ppm/parts per million chlorine and the minimum parameter was .2 ppm chlorine; the .01 ppm chlorine was 20 times less than what was required. Reviewed with the Administrator the document indicated the water would be retested yearly, and asked what measures were implemented in the meantime to address the low chlorine levels in the water. She said she would have to get back to me. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Water Testing Results 5/6/2024, document stated the following, . (Facilities domestic hot water supply systems equipped with a water mixing valve its beneficial to keep the water in storage tanks at 140 degrees Fahrenheit. The facility is equipped with a mixing valve in the domestic water system. The domestic hot water that is supplied to the facility is maintained between 114 degrees to 118 degrees Fahrenheit, this will minimize the potential for biofilms (when microorganisms attach to surfaces and form a slimy surface) to grow in the water supply. The domestic hot water within the (Facility) has a (Free) chlorine level that is .01 ppm at one of the farther points of the facility. There is a little disinfectant still available in the hot water but not enough to meet the minimum perimeters of .2 ppm; therefore, the temperature that is maintained within the facility's hot water system is important. We will pull another sample within the next calendar year to see if the testing results change. The facility did not provide an updated test result. On 4/10/2025 at 9:04 AM, the Administrator and Corporate Maintenance Director M were interviewed about the low chlorine levels in the facility's water system in some areas of the building, per the May 6, 2024, water testing report. Corporate Maintenance M said the water was chlorinated by the city, so the facility did not have control over that. Reviewed with the Corporate Maintenance Director M that the Water Testing results document dated 5/6/2024 provided, The water coming into the facility did test over the minimum range of what can provide disinfection towards the growth of biofilm at the .2 ppm level . Also reviewed the Water testing results document relayed, The domestic hot water that is supplied to the facility is maintained between 114- 118 degrees Fahrenheit .The temperature that is maintained within the facilities hot water system is important. We will pull another sample within the next calendar year . The report indicated the chlorine levels in the water when entering the building were sufficient, but as water traveled throughout the building it did not meet the minimum requirements. The Corporate Maintenance M was asked about the facility's testing of hot water temperatures and said water temperatures should be tested daily but may not be tested on the weekend. A review of the water temperature tests was requested. On 4/10/2025 at 9:50 AM, the facility's daily water temperature check books were reviewed. There were many days that areas of the building that were tested had low water temperatures below 110 degrees Fahrenheit. This was well below the recommendation of 114-118 degrees Fahrenheit, due to the low chlorine levels in the building. Corporate Maintenance M was interviewed on 4/10/2025 at 10:00 AM, he said he thought a mixing valve had been replaced at the facility. Reviewed the water temperatures with him over the past year and the temperatures varied with some well below 110 degrees Fahrenheit and some below 100 degrees Fahrenheit. Corporate Maintenance M referenced the facility's Daily Temperature Checks water testing documents that provided the following, . Water temperatures at point of use must be maintained between 110 and 115 degrees at all times. Any water temperature outside of the safety zone must be reported to nursing so showers and baths can be discontinued until proper water temps can be restored. Notify your supervisor of any issues . If there are no temperature issues on weekends and holidays, hot water temperatures may be recorded from one point of use on each hallway. The hot water temperature on the mixing valves must be within normal range . Reviewed with the Corporate Maintenance M a 110-115-degree Fahrenheit range did not take into account the chlorine levels in the water were too low in some areas of the building and the water temperatures were required to be maintained at a higher level of 114-118 degrees Fahrenheit because of this. Also noted, the facility was not taking weekend water temperatures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235518	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Woods Manor	13137 North Clio Road Clio, MI 48420

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	On further review of the Daily Temperature Check, it was identified that there were no water temperatures for April 2024; many days were missing for May 2024 and then temperature checks did not begin again until May 9, 2024; July 2024 temperatures were very low: from July 24, 2024- September 6, 2024, water temperatures were below 110 Fahrenheit daily and many were in the 90's. On occasion someone had written the system was being serviced. There were no water temperatures from December 24, 2024, to January 7, 2025. In October 2024 there were several undated days of audits. A repair work order was in the book from a repair company dated 10/17/2024. It said it found neither boiler in the building was working correctly, and the temperatures were adjusted. The water temperatures were improved for a while and gradually reverted to abnormally low levels again. During the water temperature review with Corporate Maintenance M on 4/10/2025 at 10:00 AM, he pointed to a document in the Water Management book titled, Developing a Legionella Water Management Program, dated June 24, 2021. The document revealed, Water Temperature Fluctuations: Provide conditions where Legionella grows best (77` F-113`F) . The Corporate Maintenance M confirmed the water temperatures for the building had consistently been below 114 and often below 110. Maintenance M was asked what measures were put in place to protect the residents while the temperatures were below the expected levels. No additional information was received. On 4/10/2025 at 10:41 AM, Maintenance staff N was interviewed and said the facility was taking water temperatures until recently, as they had not had time to do the daily's like they used to. Maintenance N was asked about the very low water temperatures and said the facility had an issue with a mixing valve. He said they were usually obtained from Monday to Friday. He said the facility did not take the temperatures on some days because they knew they wouldn't reach the necessary temperatures. When asked what the facility did if the temperatures were low, he stated, We would report to the Maintenance director if they were below 115. A review of the Centers for Disease Control and Prevention's/CDC's June 24, 2021, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings: A Practical Guide to Implementing Industry Standards, identified the following: Legionnaires disease is a serious type of pneumonia caused by bacteria, called Legionella, that live in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained .