STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235530	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marywood Nursing Care Center	36975 W. Five Mile Road Livonia, MI 48154

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident requests were honored timely or in a dignified manner for one resident (R135) of two residents reviewed for resident rights. Findings include:On 09/09/2025 at 12:35 PM, R135 was observed to be dressed and seated in their wheelchair in the hallway outside their room. R135 self-propelled their wheelchair with their arms and feet into the common area between the nurse station and the doorway to the cafe. R135 asked how to get up to the front door of the building as they wanted to go outside. R135 then reported to an unidentified female staff wearing blue scrubs that they would like to go outside. The staff member promptly said the resident could not go outside and indicated the nurses needed to know where R135 was and R135 would have to notify the nurse or get activities to help them. R135 continued up the hallway toward the doorway. Staff E then walked toward R135 from the main hall and R135 asked them about going outside. Staff E told R135 they could not go outside and offered to take them back to their room. R135 was quiet, shook their head slightly and turned around and headed back toward their room. R135 appeared frustrated by the replies of the staff members. At 12:37 PM, R135 was through the doorway when the nurse for R135, Licensed Practical Nurse (LPN) D walked by R135 and R135 asked the nurse to go outside and the nurse replied to R135 that they could not go outside and R135 asked, What is this a prison and the nurse who kept walking, turned slightly and said almost. None of the staff members offered to take R135 outside. R135 had been observed on 09/08/25 to wheel themselves around the facility onto different units. On 09/09/2025 at 12:55 PM, R135 was observed to be seated in a wheelchair in their room with they're TV on. R135 had a window to an interior courtyard, and it was a sunny day. At 1:12 PM, R135 was observed in the hallway outside the therapy entrance and was asked about going outside and reported some frustration and reported staff must think they were going to go five miles away or something. At 2:08 R135 was in bed resting. At 2:47 PM, R135 was observed to be in the therapy room seated in their wheelchair for a physical therapy session. On 09/10/2025 at 8:04 AM, R135 was out of bed seated in wheelchair watching tv back to door, R135 was asked again about the observation and with a smile reported they had been taken outside by a staff member later in the afternoon. On 09/10/2025 at 10:02 AM, Staff E reported residents were not allowed to go out front alone but could go into the courtyard in the summer months. Staff E further noted it was usually activities that took the residents out but was later able to sit with R135 during their lunch. On 09/10/2025 at 10:10 AM and 11:26 AM, concerns were reviewed with the Director of Nursing (DON). The DON reported the expectation was that staff would assist the resident with their request or arrange a time to go outside. A review of the record for R135 revealed R135 was admitted into the facility on [DATE]. Diagnoses included heart disease and Traumatic Brain Injury. The active care plan initiated 09/04/25 documented moderate cognitive impairment with a Brief Interview for Mental Status score of 11/15 and a self-care performance deficit for which R59 required limited assistance with toileting, transfer and bathing. Mobility was documented as wheelchair. A review of the facility policy titled, Resident Rights updated 06/2021, documented, Employees will treat all residents with kindness, respect and dignity .These rights include the resident's right to .self-determination .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to secure confidential medical records for one resident (R139) out of one reviewed for confidential information. Findings include: On 9/8/2025 at 8:30 AM, the laptop located on the B300 hallway cart was observed to be open and visible with patient Medication Administration Record (MAR) displayed. The nurse was not observed to be in the hallway or near the cart. On 9/9/2025 at 8:58 AM, the laptop located on the B300 hallway portable cart was observed to be open with patient Medication Administration Record (MAR) information visible. Registered Nurse (RN) A was not observed to be in the hallway or near the cart. On 9/9/2025 at 11:15 AM, the laptop located on the B300 hallway portable cart was observed to be open with patient MAR information visible. RN A was noted to be in a patient's room. RN A acknowledged the screen was unlocked and stated they would close it when they walked away. On 9/9/2025 at 1:27 PM, the laptop located on the B300 hallway cart was observed to be open with R139's MAR information visible. RN A was noted to be in a patient's room. On 9/10/2025 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they recognized the problem with screens being open and implemented the screen protectors and medical record timing out quicker (Medical record will go in sleep mode after a few minutes with inactivity). The DON reported their expectation is for screens to be closed and secured when the nurse walks away from them. On 09/10/2025 at 7:50 AM, the P wing resident report sheet (a sheet in which resident confidential information is recorded) was observed to be left face up, exposing confidential resident information to visitors, staff, and passersby on the portable computer station outside room P213. Licensed Practical Nurse (LPN) H was observed at the opposite end of the hall exiting a resident room. On 09/10/25 at 11:40 AM, LPN H noted it had been a busy morning and confirmed the report sheet should not have been left face up. A review of a facility policy titled, Confidentiality of Information and Personal Privacy noted the following, .1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure hand hygiene was completed during medication administration for three residents (R134, R84 and R30) of five residents observed during the medication pass. Findings include: On 09/09/2025 at 9:20 AM, Licensed Practical Nurse (LPN) J was observed to check the vital signs of R134 and then return to the medication cart and prepare medications for the resident. LPN J then placed on gloves and brought the medications into the room and started to administer them to R134. R134 needed additional water to take their milk of magnesia and LPNJ went to the medication cart, doffed their gloves, poured water from a pitcher into a cup, donned a pair of gloves and re-entered the room and administered the medication. No hand hygiene was completed. R134 required additional water so LPN J returned to the medication cart, removed their gloves, poured a cup of water from the pitcher and donned a pair of gloves and re-entered the room of R134. No hand hygiene was completed. LPN J completed the medication pass and upon exit dispensed some hand sanitizer but did not rub it on all surfaces of the hands. LPN J acknowledged the need for sanitizer between glove changes. On 09/10/2025 at 8:54 AM, LPN I was observed to prepare medications for R84. The medications included pills and an inhaler. The pills were administered to R84 with a spoon. R84 began to cough after administration of the pills and LPN I exited the room and retrieved the pulse oximeter to check the oxygen of R84 and returned to the room. Hand hygiene was not observed upon exit nor re-entry. R84 was then administered the inhaler and was provided a cup of water to rinse their mouth. LPN I then exited the room. No hand hygiene was observed to be performed on exit. LPN I confirmed the need for hand hygiene after patient care. On 09/10/2025 at 9:30 AM, Registered Nurse (RN) A was observed to prepare medications for R30. Medications included pills and an inhaler. RN A entered the room and provided the pills and inhaler for R30. R30 self-administered the inhaler and RN A provided a cup of water to R30 to rinse their mouth. R30 swished and set the empty cup on the sink. RN A picked it up to throw it away and R30 asked to keep it, so the cup was returned to R30. RN A took the inhaler back to the cart. Hand hygiene was not completed on the way out of the room. RN A set the inhaler on top of the cart and signed off the medications on the computer.On 09/10/2025 at 10:00 AM, Infection Control Preventionist (ICP) B was informed that hand hygiene with residents during med pass was not being completed. ICP B stated Hand hygiene should be completed when entering the patient's room, leaving the patients room and before moving on to another patient.On 09/10/2025 at 10:10 AM, the Director of Nursing (DON) indicated the expectation was that hand hygiene be completed.A review of a facility policy titled, Hand Washing/Hand Hygiene noted the following.1.All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.