STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation pertains to Intake Numbers MI00144106 and MI00143864. Based on observation, interview, and record review, the facility failed to ensure an environment free of abuse by a staff member for three residents (Resident #702, Resident #709, and Resident #711) of three residents reviewed, resulting in a lack of administrative oversight to identify and monitor for increased risk of abuse by staff, and prevent abuse. As a result of this deficient practice, Resident #709 experienced verbal abuse and neglect, and Resident #702 and Resident #711 experienced physical abuse, including intimidation, and the likelihood for feelings of fear and emotional distress utilizing the reasonable person concept. Findings include: Resident #709: Review of intake documentation dated received 4/10/24 revealed Resident #709 told Hospice Registered Nurse (RN) F that Certified Nursing Assistant (CNA) G had tried to touch them sexually on 4/9/24 and they did not want CNA G to take care of them. Hospice RN F notified their supervisor and the facility Director of Nursing (DON) of the abuse allegation. On 5/21/24 at 10:15 AM, an interview was completed with Hospice Registered Nurse (RN) F. RN F was asked about Resident #709 and verbalized they were Resident #709's assigned RN case manager for Hospice services while Resident #709 was at the facility. When queried if Resident #709 had verbalized concerns regarding facility staff to them, RN F revealed the Resident had verbalized multiple concerns and Hospice was in the process of coordinating transfer of the Resident to a different facility when the sexual abuse allegation occurred. RN F was asked what happened and stated, The male aide walked in while I was there and (Resident #709) said, 'I don't want you touching me today'. RN F revealed the male CNA said okay and left the room. RN F was asked if the CNA did anything else when they were in the room and replied, No, I thought it was weird. When asked what happened after that, RN F replied, (Resident #709) asked me if I wanted to know why she didn't want him to touch her. RN F revealed they said they did, and Resident #709 said because he touched me sexually yesterday. When queried if Resident #709 said anything else and/or if they asked any questions, RN F revealed that was all the Resident said and they did not ask any questions. RN F specified they have not encountered a situation like that before and they needed to report it to their supervisor. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When queried regarding Resident #709's cognitive status, RN F revealed the Resident was occasionally confused but able to verbalize their needs and responded appropriately when asked questions. When queried if Resident #709 had said anything similar in the past, RN F stated they had not. When queried what other concerns Resident #709 had verbalized and why Hospice was coordinating a transfer to a different facility, RN F stated, That same week (Resident #709) kept calling me one night when I was on call and said they were covered in poop and there was poop all over the floor. When asked why they called them rather than ask the facility staff for assistance, RN F responded by saying that Resident #709 told them they had asked facility staff for help, but the staff ignored them and told them to quit crying. RN F continued, I (called the facility and) talked to the nurse and she told me that (Resident #709) just cries all the time and said Resident #709 was fine. RN F disclosed they called the Resident back and Resident #709 said they were still covered in stool. RN F verbalized they decided to go to the facility to check on the Resident and found them covered in stool with stool all over the floor. RN F stated, (Resident #709) almost slipped in it when they tried to get up. RN F stated, That night that I went up, they (facility staff) were telling (Resident #709) to quit crying. They were talking to (Resident #709) and treating her like trash. RN F stated, (Resident #709) said they didn't want to live there anymore because of the way people treated her. When asked the date and/or the name of the nurse they spoke to on the phone and who were working, RN F revealed they did not know the staff's names at the facility. When asked how they were talking to and treated the Resident like trash, RN F stated, It was like they had no compassion, the way they spoke and acted towards (Resident #709). RN F verbalized facility staff were not attentive or sensitive to the Resident's needs and condition and Resident #709 had not been happy at the facility. When asked if there were specific concerns related to Resident #709's care, RN F revealed Resident #709 had a lot of pain and the facility ran out of their pain medications for two days. RN F revealed the staff told them they ordered the medication when they did not. With further inquiry, RN F stated Resident #709 had a difficult time with their colostomy due to its location and revealed the colostomy wafer (adhesive component of the ostomy the pouch which attaches to the skin) did not adhere well to the skin, would frequently leak, and caused the surrounding skin to become excoriated and painful. RN F indicated a cream was ordered for the area and stated, They didn't keep a layer of cream on her, and it was right on her bedside table. When asked about the Resident's current condition, RN F revealed Resident #709 is doing great at the other facility, is up and out of their room, and has no concerns or complaints. Record review revealed Resident #709 was admitted to the facility on [DATE] with diagnoses which included depression, diabetes mellitus, colostomy (surgically created opening through the abdomen to the colon to allow for the passage of stool), and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required partial to total assistance from staff to complete all Activities of Daily Living (ADL) with the exception of set up assistance for eating and oral hygiene. The MDS further revealed the Resident did not have any hallucinations and/or delusions but did display physical behaviors directed at others and other behavioral symptoms not directed at others. Review revealed Resident #709 was receiving Hospice services and was transferred to a different facility on 4/12/24. Review of facility-provided investigation documentation did not reflect CNA G's suspension following the allegation, interviews with other facility residents, the staff schedule/assignments and/or any interviews with other facility staff who worked on the day of and/or proceeding the allegation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA G's Human Resource (HR) file was completed with HR Director L on 5/21/24 at 3:00 PM. Review revealed CNA G began employment at the facility as a CNA on 2/22/23. A Disciplinary Action Record dated 6/29/23 was present in CNA G's employee file. The Disciplinary Action Record was a Final Warning and detailed, Describe the reason (s) for disciplinary action, including date, time and supporting documentation: - Employee may not engage in careless behavior involving a resident's safety, health and/or physical comfort. - Residents state that CNA's bedside manner and approach made them uncomfortable during care and was unprofessional. The Disciplinary Record further revealed, Specific Plan for Improvement, including timeline (to be completed by supervisor): Education on approach, bedside manner, and resources for resident with behaviors if needed. CNA G did not write any comments in the Employee Comments section of the form. The form had four signatures including CNA G, Unit Manager Licensed Practical Nurse (LPN) K, the facility Administrator, and a Union Representative. The disciplinary action did not include what specifically transpired and resident(s) involved which resulted in CNA G receiving the final warning Disciplinary Action. When queried regarding the events precipitating the Disciplinary Action, HR Director L replied they did not know. An interview was completed with Unit Manager LPN K on 5/21/24 at 3:39 PM. When shown CNA G's Disciplinary Action Record dated 6/29/23, LPN K confirmed they had signed the form. When asked what the concerns were which resulted in a Final Warning Disciplinary Action being given to CNA G, LPN K stated, We take the concerns very seriously but did not state what had occurred. LPN K then revealed the facility Administrator was involved and that any investigation would have been completed by them. LPN K was then asked to review the reasons for disciplinary action listed on the Disciplinary Action Record. After review, LPN K was asked what careless behavior as well as bedside manner and approach making residents feel uncomfortable meant. LPN K did not provide a specific response but stated, I think it may have been his size and tone. When asked what they meant when they said tone, LPN K stated, I don't know I wasn't in there. I don't know why I said that. LPN was asked what they meant when they said size and replied, Because (CNA G) is a guy. When asked if CNA G was large in stature or had a booming, deep voice, LPN K replied, No. No further explanation was provided. When queried if they recalled the Resident or residents who had complained about CNA G which resulted in the Disciplinary Action, LPN K replied, (Resident #702). When asked what happened following the Disciplinary Action, LPN K stated, (CNA G) got moved to the 400 hall. When queried if they were familiar with Resident #709, LPN K stated, I know what you're talking about, and I don't know. LPN K explained they are the Unit Manager for 200 and 500 halls of the facility. Review of Resident #709's Documentation Survey Report for April 2024 revealed CNA G documented Shower/Bathing on 4/9/24 at 11:38 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 9:15 AM, an interview was conducted with CNA G. When queried if they recalled Resident #709, CNA G confirmed they did. When asked about the Resident, CNA G stated, (Resident #709) could be difficult but I never had a problem with her. CNA G was asked what they meant by difficult and replied, She would cry all the time for no reason. Just difficult. Had to calm her down. When queried how they would calm Resident #709, CNA G replied, I tried to calm her down by bringing her out in the hallway. CNA G then stated, The day before the incident she had a fall. When asked what incident they were referring to, CNA G replied that the Resident had made accusations about them. When queried how Resident #709 transferred and how much assistance they required from staff, CNA G replied, Depend on the day. One person. Sometimes she was dead weight, sometimes she could pivot (transfer). CNA G then stated, She went to the hospital because of that fall. CNA G continued, The next day, it was right after she got back from the hospital, I had made sure I got her comfortable in the bed and she was sleeping. I think she was getting ready to have another facility come for a visual check. I left the room, and the hospice nurse came out in the hall and let me know she was getting restless and may need to be changed. When asked if they went back into the Resident's room, CNA G stated, I went back in and she said, don't touch me, don't touch me. I left it at that and walked out. When queried if Resident #709 had ever said anything like that to them before, CNA G revealed they had not. When asked if they told the Resident's nurse or a nurse manager, CNA G verbalized they had not. When asked why they did not report the unusual behavior, an explanation was not provided. When asked if they got a different staff member to assist the Resident and provide incontinence care, CNA G indicated they did not and stated, About that time was when second shift was coming on. It was really close to time for me to leave. When asked if they left work, CNA G replied, Yes. When queried what happened then, CNA G stated, I got a call from the DON, probably around 4:00 PM. (The DON) said (Resident #709) made a complaint that I sexually assaulted her. CNA G stated, (The DON) asked me if I took care of (Resident #709) that day and I told (the DON) that I had and what was said. When asked if anything else was said, CNA G revealed the DON told them they would be completing an investigation and they would contact them. CNA G then stated, I got a call back probably around 6:00 PM and (the DON) said that I would be working on 600 (hall) and not to walk past (Resident #709's) room. When asked if they missed any work, CNA G stated, No. When asked if they provided ADL/Peri care to Resident #709 on 4/9/24, CNA G stated, I made sure her brief was clean. When asked what bathing activity they provided the Resident on 4/9/24 as the documentation did not specify, CNA G reviewed the EMR report and stated, Gave a shower on 4/9 (2024). When asked if they were alone in the room when giving Resident #709 a shower, CNA G confirmed they were. When asked if they touched Resident #709 inappropriately, CNA G replied, No. When asked Resident #709 said anything to them during the shower about being uncomfortable, CNA F stated, No. CNA G was asked if anything was different in the way the shower was provided and replied that they did not recall anything different. Resident #702: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When queried regarding receiving a final warning disciplinary action in June 2023, CNA G confirmed they had and revealed it was related to Resident #702. When asked what happened, CNA G stated, I got called into the office. (Resident #702) said I put my hands around her throat. When asked occurred, CNA G stated, They had me sign the disciplinary thing because it was an abuse allegation. When asked if they were suspended when Resident #702 made that abuse allegation, CNA G replied they were not but were moved off that room assignment and had to sign the disciplinary action form. CNA G then stated, I have taken care of (Resident #702) since then and have had no concerns. CNA G did not provide a direct response when queried if they are supposed to take care of Resident #702. CNA G was then queried if they worked seven days straight prior to the sexual assault allegation, as specified in the facility provided 5-day investigation summary report, and revealed they did not know. When queried how much overtime time they worked, CNA G stated, Eight to 16 hours a pay. With further inquiry, CNA G stated, We were working a lot of doubles for a while. When queried when that was, CNA G replied, Around tax time, the beginning of April. We were mandated twice of week. CNA G was asked how long that lasted, CNA G replied, From March to April. When queried if management assisted and filled in shifts, CNA G replied, Not for us. When queried if staff got burned out and short-tempered working that many hours, CNA G stated, Yes. No further explanation was provided Documentation of CNA G's suspension as well as their clock in/out timesheet for 4/10/24 and assignment sheets for 4/1/24 to 4/12/24 were requested from the Administrator on 5/22/24 at 1:50 PM. On 5/22/24 at 10:35 AM, Resident #702 was observed sitting in a wheelchair in their room. An interview was completed at this time. When queried if they had any concerns with staff and how they were treated, Resident #702 replied, Not now. Resident #702 was asked if they had concerns in the past and stated, Yes. Resident #702 was asked what their concerns were and revealed they had told their sibling and they had both complained about it. When asked what happened, Resident #702 stated a male CNA pushed me down on my bed and grabbed the front of my shirt. Resident #702 was asked how they pushed them down on their bed and indicated they were standing beside the bed and the CNA pushed them down. When asked where they were standing, Resident #711 pointed towards the area right next to their bed. This Surveyor proceeded to stand in the spot they pointed towards and asked the how the staff member pushed them. Resident #702 indicated the staff member pushed them down on the bed by the front of the shoulders causing them to fall back onto the bed. When asked if they were hurt, Resident #702 indicated they were not physically hurt but that it took them off guard. When queried how the staff member grabbed the front of their shirt, Resident #702 demonstrated on themselves. The Resident was observed grabbing the front of their shift, between their breasts, with a fist and pulling upwards aggressively. When asked who they had complained to about it, Resident #702 replied, To one of the big wigs. When asked what happened after they reported the incident, Resident #702 revealed the staff member got in trouble and wasn't supposed to work down here (hallway/unit) anymore but he does sometimes. Resident #702 was asked what the staff members name was and replied, (CNA G). When asked to describe what the staff member looked like, CNA G's description matched CNA G's physical characteristics. When asked how the incident made them feel, Resident #702 revealed it was upsetting and brought a lot of bad memories back. Resident #702 revealed they were in an abusive marriage in the past and were never going to be treated like that again. Resident #702 then stated, I wasn't the only one. When asked what they meant, Resident #702 revealed CNA G had been physically aggressive with another Resident who resided on the same hallway. When asked who the Resident was, Resident #702 stated, (Resident #711). \ Resident #711: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was competed with Resident #711 on 5/22/24 at 10:55 AM. When queried if they had any concerns with facility staff, Resident #711 stated, A fell ow here (employee) grabbed me by the back of my neck. I ignored it the first time and the second time I turned him in. When asked what they meant, Resident #711 demonstrated placing their hand around the back of their neck forcefully. Resident #711 revealed the staff member grabbed them by the back of the neck and pulled them. Resident #711 stated, He was facing me. When asked how that made them feel, Resident #711 revealed it was as if the staff member was trying to intimidate them. Resident #711 stated, The second time (it happened), I was mad. The second time was the one that settled it. Resident #711 was asked what the staff members name was and replied (CNA G's name). When queried if they said anything to the staff member, Resident #711 replied, No. Resident #711 was then asked who they reported the incidents to and replied, One of the head people here. When asked what they told the head person and who the head person was, Resident #711 was unable to provide their name and stated, They got the same information. My family knew about it too. When asked what happened after they reported the incidents, Resident #711 stated, He got transferred off the floor. When queried if they still saw the staff member in the facility, Resident #711 replied, Yeah. When queried how that made them feel, Resident #711 stated, What bothered me is trying to intimidate me. Record review revealed Resident #702 was most recently admitted to the facility on [DATE] with diagnoses which included gait abnormalities, difficulty walking, depression, and dementia. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and displayed no behaviors, hallucinations and/or delusions. Record review revealed Resident #711 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included heart disease, dementia, and bipolar disorder. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and displayed no behaviors, hallucinations and/or delusions. An interview was conducted with the DON and ADON on 5/22/24 at 2:00 PM. The DON was queried if they had completed interviews for the sexual abuse allegation involving Resident #709 and CNA G and confirmed they had. When asked if they interviewed other staff who had worked prior to and the day of the allegation, the DON revealed they interviewed CNA G, RN I, the Hospice Director and Nurse, and the Resident's family member. When asked if they interviewed any other residents, the DON replied they did not. When queried why they did not interview any other staff or residents, the DON indicated they did not feel it was necessary after speaking to the Resident's family member and learning about the Resident's history. The DON further explained the Resident's story of what had occurred was inconsistent, they did not know the staff member's name, and were diagnosed with a Urinary Tract Infection (UTI). The DON was asked how they would know if other residents had concerns if they did not speak to them and/or if other staff working may have observed something pertinent if they did not speak to them, the DON verbalized understanding. The DON was then queried regarding the lack of times documented on the investigation and revealed everything had transpired quickly after they received the phone call from Hospice, and they did not know the specific times. The DON was asked about the reason Resident #709 was transferred to a different facility and when queried regarding the Hospice provider reporting the incident, the DON indicated they spoke to the Hospice Director regarding reporting the facility immediately and what to report. When queried if they were aware CNA G's having a complaint and receiving a final working disciplinary action in June 2023, the DON revealed they were on vacation when it had occurred and did not know any specific information related to what had happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the facility Administrator on 5/22/24. The Administrator was asked if they recalled the reason CNA G received a final warning Disciplinary Action in June 2023 and indicated it was related to a customer service issue. When asked who the resident and/or residents involved in the customer service issue were, the Administrator responded they did not. When asked if they had any additional documentation related to the reason the CNA G received the Disciplinary Action, the Administrator verbalized they do not maintain documentation of for customer service concerns. The Administrator was then informed that Resident #702 was the Resident involved per LPN K and CNA G. The Administrator was then informed of Resident #702, Resident #711, and CNA G's statements during interviews. When asked why an investigation had not been completed and abuse not reported. The Administrator stated they were unaware of the allegations. When queried who the abuse was reported to, the Administrator did not provide a response. When asked, the Administrator indicated the allegations should have been reported to the State Agency and an investigation completed. When asked what allegations they were aware of which resulted in the Disciplinary Action, the Administrator reiterated hey were only aware of customer service issues and had no documentation of the concerns and would not have any grievance/concern forms and/or Incident Reports. Review of CNA G's time sheet with clock in and out times revealed they worked on 4/9/24 and 4/10/24 day shift (6:00 AM to 2:30 PM) and on 4/11/24 from 5:57 AM to 10:30 PM. Review of provided assignment sheets from 4/1/24 to 4/10/24 revealed CNA G was assigned to provide care to Resident #709 eight out of 10 days and every shift they worked. Review of Hospice documentation for Resident #709 revealed the following: - 4/9/24: Visit Note Report . Issues Identified . out of oxycodone (narcotic pain medication for severe pain) which is scheduled q (every) 6 hours . Pain . Yes . Crying . Frightened . Emotional/Behavioral Findings . Depressed, Anxiety, Tearful, Emotional Distress - 4/10/24: Client Coordination Note Report . As I was leaving a face-to-face visit today, a male aide (CNA) walked into the room near the patient and the patient look at the aide and stated, 'I don't want you touching me today.' The aide said, 'Ok' and walked out of the room. After the aid left, the patient said, 'He touched me sexually yesterday.' I told her I would report it. I called my supervisor from the facility parking lot. I was instructed to notify our (Hospice) Social Worker. I called Hospice Social Worker and reported it to them . Follow up comment . (Director H) noted by (RN F) and Social Worker . Called facility DON to notify . Narrative: PRN (As Needed) RN visit for fall. Patient was in geri chair in room alone and fell face forward out of chair . Patient was crying and upset when I arrive . able to . calm down by taking deep breaths. Currently has a sitter . During my visit in count narcotics, it was found that patient ran out of oxycodone yesterday . missed at least 2 doses. I asked the facility nurse to give the patient's PRN Tylenol#3 (with codeine) for pain . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility-provided policy/procedure entitled, Abuse Prohibition Policy (Reviewed 9/9/22) revealed, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse . To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents . Allegations of guest/resident abuse, exploitation, neglect, misappropriation of property, adverse event, or mistreatment shall be thoroughly investigated and documented by the Administrator . E. Investigation 1. Allegations by anyone who becomes aware of verbal, physical, mental, sexual or emotional abuse and mistreatment, neglect, exploitation, involuntary seclusion or misappropriation of property must immediately report it to his/her Administrator. 2. The Director of Nursing or designee will complete an assessment . 7. The investigation may consist of .c. Interviews with any witnesses to the incident . f. An interview with staff members having contact with the guest/resident during the period/shift of the alleged incident. G. Interviews with the guest's/resident's roommate . visitors . h. A review of circumstances surrounding the incident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - 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** 37668 This Citation pertains to intake MI00138800. Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for pressure ulcer (wounds caused by pressure) prevention and management for two residents (Resident #704 and Resident #710) of two residents reviewed, resulting in a lack of implementation and documentation of meaningful, resident-centered interventions for pressure ulcer prevention, the development and worsening of facility-acquired pressure ulcers, unnecessary pain, and the likelihood for a decline in overall heath status. Findings include: Resident #704: Review of intake documentation dated as received on 8/3/23 revealed concerns related to Resident #704 developing pressure ulcers while at the facility and staff failing to appropriately treat the Resident. Record Review revealed Resident #704 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes mellitus, heart disease, weakness and cerebral infarction (stroke) with resulting left sided hemiplegia and hemiparesis (one sided paralysis), left shoulder and lower leg contractures (tightening of the muscle, tendons, ligaments, and/or skin that prevents normal movement) and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to complete all Activities of Daily Living (ADL) with the exception of eating. The MDS further detailed the Resident was at risk for pressure ulcer development and had one Stage III (full thickness tissue loss) facility-acquired pressure ulcer. Resident #704 was discharged to the hospital on 6/29/24 and did not return to the facility. On 5/21/24 at 12:23 PM, an interview was completed with Confidential Witness A. When queried regarding Resident #704's care at the facility, Witness A verbalized concerns related to staff not being attentive to the Resident and not responding to their needs while they were in the facility. Review of Resident #704's Electronic Medical Record (EMR) revealed documentation indicating the Resident developed a facility-acquired Stage II (partial thickness tissue loss presenting as an open ulcer) pressure ulcer on their left buttocks/gluteus on 1/14/23. The pressure ulcer worsened from a stage two to a stage three pressure ulcer. Additional review of the Resident's EMR revealed they had a history of pressure ulcers including a prior stage two pressure ulcer on their left buttocks which had healed. Documentation in Resident #704's EMR detailed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - Actual harm Residents Affected - Few	- 1/16/23 at 9:39 AM: Skin & Wound Evaluation . Pressure . Stage 2 . Left Buttocks . In-House Acquired . How long has the wound been present? Exact Date: 1/14/23 . Measurements . Length: 1.4 cm (centimeters) . Width: 1.4 cm . Depth: 0.2 cm . Exudate . Light . Serosanguineous . Pain . Controlled . Healable . Treatment . 1. Dressing appearance . None . Notes: Notified about open area to Left Buttock. Cleansed with wound cleanser & assessed. Treatment completed: Swabbed peri-wound with skin protectant. Applied Collagen Particles to wound bed & covered with a bordered gauze. Daily & PRN (as needed). Hall Nurse to continue treatment as ordered . - 6/14/23 at 4:06 PM: Skin & Wound Evaluation . Pressure . Stage 3 . Left Gluteus . In-House Acquired . How long has the wound been present? Exact Date: 1/14/23 . Length: 3.8 cm . Width: 2.4 cm . Depth: 0.1 cm . Wound Bed . Slough . 50% . Exudate . Light . Serosanguineous . Healable . Deteriorating . Notes: Evaluated during weekly wound care rounds. This wound is to be cleansed with wound cleanser and Medihoney applied to the wound bed. Dress with border gauze. Education: Educated staff and resident on new treatment orders, and the importance of turning and repositioning resident to aid in wound healing . Resident #704 was in the hospital from 6/21/23 to 6/26/23. - 6/28/23 at 10:37 AM: Skin & Wound Evaluation . Pressure . Stage 3 . Left Gluteus . In-House Acquired . How long has the wound been present? Exact Date: 1/14/23 . Length: 1.3 cm (centimeters) . Width: 2.4 cm . Depth: 0.1 cm . Wound Bed . Slough . 20% . Exudate . Light . Serosanguineous . Healable . Notes: Evaluated during weekly wound care rounds. This wound is to be cleansed with wound cleanser, Apply Medihoney to the wound bed, and cover with Bordered Gauze . Education: Educated staff and resident on new treatment orders, and the importance of turning and repositioning resident to aid in wound healing . Review of progress note documentation in Resident #704's EMR revealed no documentation of refusal to turn and reposition. Review of Resident #704's EMR revealed a care plan entitled, (Resident #704) has Actual impairment to skin integrity AEB (As Evidenced By) pressure ulcer to left gluteus (Initiated: 11/8/22; Revised: 6/5/23). The care plan included the interventions: - Encourage frequent repositioning as tolerated (Initiated and Revised: 6/28/23) - Encourage good nutrition and hydration in order to promote healthier skin. Provide dietary supplements as ordered (Initiated: 2/16/19; Revised: 7/22/22) - Apply pressure relieving/reducing mattress to protect the skin while in bed (Initiated: 9/1/21; Revised: 7/22/22) - Refer to at risk for skin break down for further interventions (Created and Initiated: 6/5/23) Another care plan entitled, (Resident #704) is at risk for impaired skin integrity/pressure injury R/T (related to) Decreased mobility . hemiplegia/paresis after CI (Cerebral Infarct- stroke) affecting L (left) side . prefers to lie on back while in bed. Hx (history): fungal infection. History of reopening wounds over scar tissue (Initiated: 4/13/20; Revised: 6/28/23). Care plan interventions included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - Actual harm Residents Affected - Few	- Encourage frequent repositioning as tolerated (Initiated: 6/28/23) - Pressure reduction cushion to w/c (wheelchair) or chair (Created and Initiated: 6/5/23) - Dietary consult and/or physician review as needed to make recommendations, for supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing (Created and Initiated: 6/28/23) - Follow facility policies/protocols for the prevention/treatment of impaired skin integrity (Created and Initiated: 6/28/23) A care plan entitled, (Resident #704) has an ADL Self Care Performance Deficit and requires assistance with ADL's and mobility r/t: skin impairment . contractures of left leg and left shoulder, hemiplegia/hemiparesis left side . decreased mobility (Initiated: 4/13/20; Revised: 6/28/23) was present in the EMR. This care plan included the interventions: - Bed Mobility . requires extensive assistance with 2-person assist to reposition and turn in bed (Created: 2/18/19; Initiated and Revised: 6/28/23) - Transfer . requires total two-person assistance with Hoyer (mechanical lift for dependent individuals using a sling) lift for transfers (Initiated: 4/13/20; Revised: 4/27/20) Review of Resident #704's Treatment Administration Record (TAR) for June 2023 revealed there was no treatment in place on the TAR for the Resident's left buttocks/gluteal. The treatments in place on the TAR, which matched the Skin and Wound Evaluation documentation specified the wound location as being the Coccyx. The ordered treatment for the coccyx was blank, indicating the treatment was not completed, on 6/10/24. Further review of documentation in Resident #704's EMR revealed the Resident did not have a specialty mattress implemented beyond the pressure reduction mattress utilized for all facility residents, did not have a pressure reduction cushion implemented on their wheelchair until 6/5/23 and there was not documentation of turning and repositioning every two hours at a minimum. Resident #710: Review of facility-provided CMS-802 form revealed Resident #710 had a Stage Three facility-acquired pressure ulcer. Review of Resident #710's EMR revealed the Resident was admitted to the facility on [DATE] with diagnoses which included heart failure, weakness, and falls. Review of the MDS assessment dated [DATE] revealed the Resident was cognitively intact and required partial to moderate assistance from staff to complete ADL's including rolling, repositioning, and transferring. The MDS further detailed the Resident was at risk for pressure ulcer development but did not have any pressure ulcers. Review of Resident #710's EMR revealed a care plan entitled, (Resident #710) is at risk for impaired skin integrity/pressure injury R/T (related to): decreased mobility (Initiated: 4/30/24; Revised: 5/1/24). The care plan included the interventions: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - Actual harm Residents Affected - Few	- Cue to reposition self as needed (Initiated: 4/30/24) - Follow facility policies/protocols for the prevention/treatment of impaired skin integrity (Initiated: 4/30/24) Another care plan entitled, (Resident #710) has Actual impairment to skin integrity r/t left jaw, left elbow, left shin (Initiated: 4/30/24; Revised: 5/13/24). The care plan included the interventions: - Encourage frequent repositioning as tolerated (Initiated: 4/30/24; Revised: 5/1/24) - Encourage good nutrition and hydration in order to promote healthier skin. Provide dietary supplements as ordered (Initiated: 4/30/24) - Apply pressure relieving/reducing mattress, pillows to protect the skin while in bed (Initiated: 4/30/24; Revised: 5/1/24) Review of Resident #710's EMR revealed the following documentation: - 5/17/24 at 2:13 PM: Skin & Wound Evaluation . Pressure . Stage 3 . Left Heel . In-House Acquired . How long has the wound been present? . Exact Date: 5/17/24 . Length: 1.0 cm . Width: 1.5 cm . Depth: < (less than) 0.1 cm . Wound Bed . Slough . Exudate . Light . Serosanguineous . Healable . Progress . New . Notes: Cleanse the area with wound cleanser and allow to dry. Apply honey to the wound bed and cover with a border gauze. Daily and PRN . Education: Continue with supportive care. Elevate the extremities and float the heels. Reposition frequently . On 5/23/24 at 9:27 AM, an interview was completed with Certified Nursing Assistant (CNA) B. When queried if Resident #710 had a pressure ulcer, CNA B stated, No. With further inquiry, CNA B revealed the Resident had areas on the front of their legs that were weeping from fluid and edema but did not have a pressure ulcer. When queried what interventions the Resident had in place for pressure prevention, CNA B revealed the Resident did not have any specific interventions in place. CNA B was then asked how the Resident transferred and replied, With assist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - Actual harm Residents Affected - Few	At 9:30 AM on 5/23/24, Resident #710 was observed in their room. The Resident was sitting in a wheelchair with bilateral footrests in place. The Resident was wearing non-slip socks, and their feet/heels were directly against the footrest rests. Both of the Resident's legs were visibly edematous. An interview was completed at this time. When queried if they had any wounds, Resident #710 stated, I wasn't getting my water pill. The skin busted open, and the water was leaking all over my left front leg. When asked, Resident #710 revealed a lady from (insurance company) came. They called my heart doctor and indicated they were now receiving their diuretic (water pill) medications. Resident #710 was asked if they had any other wounds since coming to the facility and stated, One on my heel, I'm not sure what it's from. When queried regarding treatment for their heel, Resident #710 stated, They (facility staff) put a dressing on it this morning. When queried if their heel hurt where the wound was, Resident #710 replied, Sometimes. I can tell it is there when I put pressure on it. When queried if they had heel boots to reduce the pressure on their heels, Resident #710 stated, Not here (at facility). Resident #710 revealed they knew what heel boots were because they had them when they were in the hospital. When asked if facility staff floated their heels when they were in bed by putting a pillow or wedge under their legs with nothing under their heels, Resident #710 replied, No. The Resident revealed staff will sometimes put a pillow under their legs to elevate them but indicated their heels press into the pillow. An interview was conducted with Wound Care Registered Nurse (RN) E on 5/23/24 at 11:00 AM. When queried regarding Resident #710's left heel pressure ulcer, RN E confirmed it was facility-acquired. RN E was asked how they were notified of the pressure ulcer and stated, I was informed by one of the nurses that when they took (Resident #710's) sock off that there was something. When queried if Resident #710 was at risk for pressure ulcer development prior to developing the facility acquired pressure ulcer, RN E reviewed the EMR and verified they were. When asked what interventions were in place to prevent pressure ulcer development, RN E replied, We started treating it right away and indicated the pressure ulcer was improving but did not provide a response to the question asked. RN E was then asked what the facility did to prevent the pressure ulcer from developing, with the Resident's known risk, RN E reviewed the Resident's care plan and indicated the Resident was encouraged to reposition. When asked if Resident #710 was able to reposition independently or if they required staff assistance, RN E revealed they were unsure and indicated the Resident is working with therapy and improving. A review of Resident #710's Visual/Bedside Kardex (CNA tasks) was completed with RN E at this time. The Visual/Bedside Kardex revealed Resident #710 was only able to ambulate with therapy and required substantial/maximum assistance of one staff member for dressing, bathing, transferring, and bed mobility. The Skin section on the Visual/Bedside Kardex included the task, Cue to reposition self as needed. When asked how Resident #710 was able to reposition themselves when they required one assist from staff, RN E was unable to provide an explanation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - Actual harm Residents Affected - Few	Another section entitled, Resident Care on the Visual/Bedside Kardex specified, Apply pressure relieving/reducing mattress, pillows to protect the skin while in bed. Encourage frequent repositioning as tolerated. When queried what the pressure relieving/reducing mattress was, as a specialty mattress was not observed on Resident #710's bed, RN E revealed the standard mattress for all resident beds is pressure relieving/reducing. When asked what pillows to protect the skin in bed meant, RN E revealed that mean pillows for positioning as needed. Resident #710's care plan was then reviewed with RN E. When queried why the Resident's actual skin impairment care plan had not been updated to include the pressure ulcer on their left heel, RN E indicated care plans are updated weekly. When asked about the lack of specific interventions related to the Resident's heel such as floating heels and/or heel boots, RN E confirmed there were no specific intervention in place but reiterated the Kardex included pillows to protect the skin when in bed. When asked if CNA staff were the primary staff who assisted and positioned residents, RN E agreed they were. When queried how CNA staff assigned to Resident #710 knew to float the Resident's heels and/or specific positioning recommendations when they are not aware of positioning needs and/or current pressure ulcers, RN E did not provide an explanation. When informed that CNA B was unaware Resident #710 had a pressure ulcer on the left heel, RN E indicated direct care staff should be aware, but no further explanation was provided. When queried regarding Resident #704's pressure ulcer, RN E revealed they were not working at the facility during Resident #704's admission. RN E was queried regarding Resident #704 having pressure ulcers prior to the one identified as developing on 1/14/23 and interventions in place to prevent development and reviewed the Resident's EMR. RN E verbalized Resident #704 had the standard facility pressure reduction mattress in place. When asked why a specialty mattress was not implemented, due to the Resident's risk and history, RN E was unable to provide an explanation. When queried if Resident #704's pressure ulcer documented as both left buttock and left gluteus with the identification date of 1/14/23 was the same pressure ulcer, RN E reviewed the Resident's EMR and confirmed it was. When asked if the pressure ulcer was facility acquired, RN E indicated that was what was documented. When queried if the pressure ulcer worsened from a Stage Two to a Stage Three, RN E confirmed it had. RN E was then asked what frequent meant when included in the care plan care intervention, encourage frequent turning and repositioning RN E did not provide a response. RN E was then asked where documentation of turning and/or repositioning was completed in Residents EMR's and revealed staff do not document how often and/or when residents are turned and/or repositioned. No further explanation was provided. Review of facility policy/procedure entitled, Skin Management (Revised: 5/14/24) revealed, It is the policy that the facility should identify and implement interventions to prevent development of clinically unavoidable pressure injuries . Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes . Practice Guidelines . 3. Appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan. 4. Residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37668 This Citation pertains to Intake MI00141928. Based on observation, interview and record review, the facility failed to ensure monitoring and accessibility of non-expired and necessary emergency medical equipment and supplies in two of two emergency medical response carts resulting in expired and unsanitary emergency medications and medical supplies, lack of easily accessible, critical, and consistent equipment and supplies during an emergency situation and the likelihood for delay of care and deterioration of all resident(s) experiencing an emergency medical situation. Findings include: Review of intake documentation, received 1/5/24, revealed the facility crash cart was not fully stocked and the supplies on cart were outdated resulting in a delay in care. On 5/22/24 at 11:30 AM, an observation of the emergency medical cart (Crash Cart) in the central (long term) area of the facility, directly across from the nurses' station revealed the number on the plastic lock did not match the number documented on the Crash Cart May 2024 log. The Crash Cart log included the sections, AED (Automated External Defibrillator), AED pads, Back Board, Ambu Bag, Suction Machine, Full Tank O2 (oxygen), Drawer Stock, Re-lock Number if opened, Lock Number, Signature. The form was signed as completed from 5/1/24 to 5/21/24. An interview and tour of the Crash Cart was conducted with the Director of Nursing (DON) on 5/22/24 at 11:31 AM. The DON was shown the lock number on the cart and the log. When asked if the numbers should match, the DON indicated the cart had been opened and used that morning and staff had not completed the log for today yet. Upon opening the cart, the following expired medications and medical supplies were noted: - Epinephrine Auto Injector (used to treat life threatening allergic emergencies), 0.3 milligram (mg); Expired: 12/2023 - Intravenous (IV) start Kit; Expired: 8/10/22 - Biohazard Spill Kit; Expired: 9/30/23 - Two 20-gauge (g) X 1 inch (in) IV catheter; Expired 11/1/23 - 20-gauge X 1 inch (in) IV catheter; Expired 8/1/23 - Two 22g X 1.5 in Safety needle; Expired: 4/3/24 - Three Maxpro needless IV connector; Expired: 12/2021 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When queried regarding the expired medication and medical supplies, the DON verbalized expired supplies should not be in the cart. The DON was asked what supplies are supposed to be in the cart and indicated they would need to review the policy/procedure. Upon opening the Automated External Defibrillator (AED), the AED was observed to be visibly soiled with an unknown orangish colored substance. When queried what the substance was, the DON confirmed the color but was unable to state what it was. When asked, the DON confirmed the AED needed to be cleaned. When asked if the facility had any other emergency medical equipment carts, the DON stated there was another cart on the 600-hall of the facility. A tour of the 600-hall emergency medical equipment cart was completed with the DON on 5/22/24 at 11:42 AM. Suction tubing was connected to the suction machine on the top of the cart. The tubing and suction machine were uncovered. When asked if the tubing was supposed to be connected and uncovered, the DON stated, Not supposed to be connected. The following expired items were present in the cart: - 15 grams True Plus oral glucose gel, 1 fluid ounce (oz); Expired: 8/2020 - Two 250 milliliter (mL) Sterile Water containers; Expired: 6/1/23 - Three 10 mL prefilled Normal Saline (NS) IV flushes; Expired: 3/31/24 - Three 10 mL prefilled Normal Saline (NS) IV flushes; Expired: 4/21/22 - Two Yankauer suction (hard plastic suction tip commonly used for oral suctioning); Expired: 2/28/24 - Thirteen 22g X 1.5 in Safety needle; Expired: 4/3/24 - Six 1 mL insulin safety syringe; Expired: 2/29/24 - 20g X 1 in IV catheter; Expired 6/1/23 - Eight 25g X 5/8 in needles - Open and undated Evencare blood glucose testing strips The AED was noted to only have one set of pads. When asked, the DON indicated the facility was having a difficult time ordering the pads. There were no IV start kits, no Epinephrine pen, and no glucometer control/testing solution in the 600- hall emergency medical equipment cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235550	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Rd Flint, MI 48532

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When queried how often staff check and run controls on the glucometer in the crash cart, the DON replied, When open cart. When asked where the glucometer control/testing solution was, the DON stated, In the med carts. When asked it staff are supposed to run the glucometer controls after using the glucometer during an emergency situation/code, the DON replied, I see what you are saying. When queried how staff can start an IV with IV catheters but no start kits, a response was not provided, The main cart and the 600-hall cart contained different items including but not limited to the main cart not containing a glucometer and glucose gel and the 600-hall cart not having an Epinephrine pen. When queried why the crash carts did not contain the same supplies and medications, the DON stated, I don't know. The DON was then asked how staff are supposed to quickly locate necessary items when the carts in the facility contain different items, an explanation was not provided. When queried how staff knew what to stock in the cart when checking and signing the form as completed which included Drawer Stock, the DON indicated they believed the unit managers had a list. A copy of the list was requested at this time but not received by the conclusion of the survey. Review of facility provided policy/procedure entitled, Medical Emergency Management (Revised: 8/15/23) revealed, The facility ensures residents receive timely and appropriate interventions in the event of a medical emergency . Guidelines 1. The facility should maintain emergency supplies on a rolling cart . 2. Supplies should not be removed from their storage location unless used in an emergency situation. The facility staff should check on a regular basis to ensure supplies are available for use . Upon request for a policy/procedure related to testing/running controls for glucometers from the facility Administrator on 5/22/24 at 1:35 PM, a policy/procedure entitled, Glucometer . Decontamination (Revised: 9/1/19) was received. Review of the policy revealed no information related to controls/testing.