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	09/18/2024

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 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. 37666 This Citation pertains to Intake Numbers MI00145623 and MI00145776. Based on observation, interview and record review, the facility failed to ensure that wounds were assessed, monitored, and appropriate interventions were in place for one resident (Resident #3) of 3 residents reviewed for wounds, resulting in Resident #3 developing a wound on the left foot great toe, left foot third toe and right foot third toe. Findings Include: Resident #3: On 9/16/2024 at 4:00 PM, Resident #3 was observed lying in bed in her room. She was awake, alert and very talkative. The resident was observed to have thick socks on. A review of the Face sheet and Electronic Medical Record (EMR) indicated that Resident #3 was admitted to the facility with the following diagnoses: Chronic kidney disease Stage 4, anemia, history of falls, fracture left ankle, diabetes, depression, history of seizures, anxiety, hypothyroidism, Dementia, and hypertension. A record review of an Orthopedic consult for Resident #3, dated 8/29/2024 at 10:00 AM, identified the following: Continue wound care for pressure sore on Left 1st digit . A review of the physician orders for Resident #3 indicated there was no mention of a wound on the resident's left foot 1st digit. A review of Resident #3's Medication Administration Record/Treatment Administration Record for September 2024, revealed there was no mention of a wound on the resident's left great toe. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/2024 at 9:45 AM, during an interview with Wound Nurse B, Resident #3 was observed in her room lying in bed awake. Wound Nurse B removed the resident's socks and showed a blackened necrotic (dead tissue) wound approximately 1.5 cm x 1.5 cm underneath and beside the resident's left great toe. The Wound Nurse said the resident was diabetic and it appeared to be a diabetic ulcer. There was also a small, red, abraded area on top of the resident's left foot 3rd toe. The toe was raised at the joint directly below the wound. The Wound Nurse said it was blanchable. On the resident's right foot 3rd toe, was another small area, dark with a scab. The 3rd toe was also raised at the joint. The resident commented that everyone wanted to look at her toes today. On 6/18/2024 at 10:05 AM, after observing Resident #3's feet and toes, with Wound Nurse B, the nurse was asked why there was no assessment of the wounds or interventions for prevention of the wounds occurring or worsening, as the Ortho provider mentioned the wound on 8/29/2024 during the resident's appointment. She said the consult was missed, and an assessment was started 9/16/2024. The Wound Nurse was asked if the resident's skin was routinely assessed and she said the nurses performed a weekly skin assessment but did not identify the wounds. On 9/18/2024 at 11:00 AM, a review of a Skin & Wound Evaluation, dated In progress: 9/16/2024 at 5:14 PM, (it was incomplete), identified a Diabetic wound on Resident #3's Left Plantar- 1st Digit and was In-House Acquired. The wound was dated as occurring on 9/16/2024, but the Orthopedic provider had already identified it on 8/29/2024. The area was measured as 1.3 cm length x 1.5 cm width and depth of <0.1 cm. The rest of the Skin and Wound Evaluation, was blank. There was no description of the blackened area or surrounding area of the toe. There was no mention of the other wounds on the residents left foot 3rd toe and right foot 3rd toe. A review of the Care Plans for Resident #3 identified the following: (Resident #3) is at risk for fluctuation in blood sugar levels (related to) r/t: diabetes . date initiated and revised 10/13/2019 with Interventions: Check body for breaks in skin during care/showers and treat promptly as ordered by physician. Inspect feet during care/showers for open areas, sores, pressure areas, blister, edema, or redness; Provide proper foot care as needed. Observe for changes in circulation. Observe for changes in skin integrity to the feet. Document findings and report any abnormal findings to the physician . date initiated 8/9/2023. (Resident #3) is at risk for impaired skin integrity/pressure injury . created on 10/11/2029 and revised and initiated 2/19/2022 with Interventions: Conduct weekly head to toe skin assessments, document and report abnormal finding to the physician, date initiated 10/11/2019. On 9/18/2024 at 11:15 AM, during an interview with the Director of Nursing/DON the blackened area on Resident #3's left great toe, and the scabbed areas on the resident's left and right 3rd toes was discussed. Reviewed the Orthopedic consultant physician identified the left great toe wound, but it was not mentioned in Resident #3's medical record. The DON said the wound should have been identified and documented. She said the wounds on the left and right foot 3rd toes would be further assessed, but also had not been identified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Skin Management, origination date 5/1/2010 and revised 8/14/2014 provided, . 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 . appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan . skin impairment location, measurements and characteristics documented . The licensed nurse will initiate documentation . document weekly until the area is resolved . A review of the facility policy/protocol titled Change in status, identifying and communicating, long-term care, revised: August 19, 2024 provided the following, . Communicate the change in the resident's status to the appropriate practitioner .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Number MI00145623. Based on observation, interview and record review, the facility failed to provide necessary management of an indwelling urinary catheter for one resident (Resident #4) of 3 residents reviewed for urinary catheters, resulting in staff being unaware if Resident #4 had a urinary catheter. Findings Include: Resident #4: A record review of the Face sheet and Minimum Data Set (MDS) assessment, indicated Resident #4 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses: Heart disease, Bipolar disorder, diabetes, left leg below the knee amputation, peripheral vascular disease, COPD, asthma, history of seizures, hypertension, neuromuscular dysfunction of the bladder, chronic pain, depression and anxiety. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities and needed some assistance with care. The MDS section H identified the resident had an indwelling urinary catheter. A review of the physician orders for Resident #4 revealed the following: Pt. (patient) has a 14 fr. Catheter and unit to be changed every 30 day or as needed, date initiated 3/20/2024. Change foley catheter as needed, date initiated 5/25/2024. D/C (discontinue) Indwelling foley, order date 8/27/2024. A review of the August 2024 Medication Administration Record and Treatment Administration Record-MAR/TAR revealed the following: Foley catheter care q (every) shift, start date 3/22/2024 and D/C date 8/29/2024. The nurses documented that Foley (urinary indwelling catheter) care was completed each shift (3 times a day) and was stopped on 8/29/2024. A review of the September 2024 MAR/TAR identified the following: Change foley catheter as needed, start date 5/25/2024. Pt. has a 14 fr. Catheter and unit to be changed every 30 days or as needed for change if patient is not voiding, start date 3/20/2024. The orders for an indwelling urinary catheter had not been discontinued after the catheter was removed on 8/27/2024. A review of the progress notes provided the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/27/2024 at 10:58 AM, a nurses note Resident indwelling foley removed per order . 8/29/2024 a provider note, . Pt had catheter discontinued a couple days ago . 9/12/2024 an encounter note, . recently was able to have indwelling catheter removed. Pt is noted with some episodes of incontinence . A review of the Tasks documentation by the nurse aides for 8/19/2024 to 9/17/2024 identified the following: Indwelling catheter: the options were Yes or No. After the indwelling catheter was removed on 8/27/2024 there were 12 entries for Yes the resident had an indwelling catheter. Was indwelling catheter care performed per the resident's plan of care? After the catheter was removed on 8/27/2024, the staff documented 34 times that they had performed catheter care. The orders for a urinary catheter were still in the resident's orders and the staff continued to document the resident had the urinary catheter after it was removed. A review of the Care Plans for Resident #4 revealed: (Resident #3) is at risk for urinary tract infection and catheter-related trauma: has Indwelling Catheter (related to) neurogenic bladder, 14 Fr., date initiated 2/20/2023 and revised 6/14/2023. There was no mention the indwelling urinary catheter had been removed on 8/27/2024. On 9/17/2024 at 1:05 PM, Infection Preventionist/IP A was interviewed about Resident #4 having a urinary catheter; she said the resident no longer had a catheter. Reviewed with the Nurse that the orders still said she did and the staff were documenting that she had a urinary catheter. Entered the resident's room with IP A and viewed Resident #4 did not have a urinary catheter. On 9/17/2024 at 4:00 PM, reviewed with the Director of Nursing/DON that Resident #4 no longer had an indwelling urinary catheter, but there were still orders for the catheter and the staff continued to document there was a urinary catheter. The DON said the resident did not have a urinary catheter and she was looking into why the staff were documenting that she did. A review of the facility policy titled, Indwelling urinary catheter (Foley) care and management, dated 12/19/2023 revealed there was no mention of discontinuation/removal of the urinary catheter.