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	10/16/2024

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Number MI00147318. Based on observation, interview and record review the facility failed to assess and monitor intravenous medication therapy per professional healthcare standards and a provider's order for two residents (Resident #702 and Resident # 703) of two residents reviewed for intravenous antibiotic therapy, resulting in Resident #703 being administered two doses of Vancomycin after elevated levels were received and a lack of monitoring and dosing of Resident #702's Vancomycin. Findings Include: Resident #702: On 10/15/2024 at approximately 4:00 PM, a review was conducted of Resident #702's medical records and it revealed the resident admitted to the facility on [DATE] with diagnoses that included, Necrotizing Fasciitis, Hypertension, Peripheral Vascular Disease, Stage 3 Kidney Disease and Supraventricular Tachycardia. Resident #702 was alert and able to make his needs known to staff. Further review was completed and yielded the following results: Physician Orders: Vancomycin HCl Intravenous Solution 1500 MG (milligram)/15ML (milliliter)- use 1500 mg intravenously in the morning for necrotizing fasciitis & osteomyelitis BLE (bilateral lower extremities) for 32 days until finished. Initiated on 9/12/2024 and first dose administered on 9/13/2204. Pharmacy to dose Vancomycin - initiated on 9/12/2024 Practitioner Notes: 9/16/2024 at 00:00: .nursing to notify pharmacy for dosing purposes. 9/23/2024 at 00:00: .Continue with IV Ertapenem and IV Vancomycin- pharmacy to dose Vancomycin (nursing to notify pharmacy of Vancomycin level 14.7) . 9/26/2024 at 00:00: .Continue with IV Ertapenem and IV Vancomycin - pharmacy to dose Vancomycin (Nursing to notify pharmacy of Vancomycin level 14.7) . (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/9/2024 at 00:00: .He is being seen today to follow-up on recent lab results from 10/4 . Vancomycin level continues to be subtherapeutic at 13.7 (down from 15) without change in dosing. Order in PCC for pharmacy to dose. Provider called Omnicare infectious disease pharmacy and spoke with pharmacist. No order for pharmacy to dose has been received via fax; order faxed again today . Progress Notes: 9/13/2024 at 03:46: Resident was bring in by EMS (Emergency Medical Service) resident alert x 4, able to make needs known, resident has life vest .Numerous ulcer. The left heel is completely open all the way to the bone it had to be packed due to debridement after surgery to remove infection it's the entire left foot heel. The right heel is closed but also compromised, discoloration, Wound team is needed for numerous necrotizing fasciitis. Resident is on IV (intravenous) vanco, Invanz Also there is an moderate size open area left buttocks, open area. The PICC line in right arm upper . Vancomycin Laboratory Results: Normal Vancomycin levels per the facility's laboratory is 20.00-40.00. 9/13/2024: 17.1- indicated on report as low 9/20/2024: 14.7- indicated on report as low 9/27/2024: 15.5- indicated on report as low 10/4/2024: 13.7- indicated on report as low It can be noted there was no documentation located that the facility contacted the pharmacy when Resident #702's Vancomycin levels resulted, until the practitioner followed up on 10/9/2024. On 10/26/2024 at 10:10 AM, discussion was held with Pharmacist F from the IV Department at the facility's contracted pharmacy. Pharmacist F explained when facility residents are prescribed Vancomycin, they have it set up in their system to call the facility to check on laboratory results if they have not been received. Their systems for laboratory results are not interfaced with the facility and they rely on the facility to provide the results. Pharmacist F was queried regarding Resident #702 Vancomycin order and dosing. It was explained they had communication with the facility regarding it, but they did not receive the order to dose his Vancomycin until 10/9/2024. When asked what prompted the change Pharmacist F stated its possible when his laboratory values were 13.7 the facility practitioners thought it was low and wanted pharmacy to dose going forward. It was explained to Pharmacist F that in the facility documentation prior to 10/9/2024 it stated pharmacy was dosing. Pharmacist F stated they did not have the orders to dose Resident #702's Vancomycin so until their orders were received the facility practitioners were responsible dosing. On 10/16/2024 at 3:10, the DON stated they were not aware the pharmacy was not dosing Resident #703's Vancomycin as there was an order that was in his medical chart. The facility was under the impression that the pharmacy was dosing Resident #702's Vancomycin, while the pharmacy asserted, they never received an order to dose until approximately 4 weeks after initiation of the antibiotic. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #703: On 10/15/2024 at approximately 3:30 PM, a review was completed of Resident #703's medical records and it indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Acute Kidney Failure, Cerebral Infarction, Heart Failure, Diverticloisis, Vascular Dementia and Hypertension. Further review of her chart yielded the following: Physician's Orders: Vancomycin 1000 MG/10 ML- use 1 gram intravenously two times a day for osteomyelitis R (right) heel. Cefepime HCl Intravenous Solution- use 2 grams intravenously every 8 hours for Osteomyelitis. Laboratory Values: Reference range values for Vancomycin, creatinine and BUN (blood urea nitrogen) are as follows: BUN Reference: 7.00-25.00 Creatinine Reference: 0.60-1.30 Vancomycin Reference: 20.00-40.00 7/10/2024: BUN: 22 Vancomycin: 19 Creatinine: 0.78 no changes made 7/15/2024: BUN: 22 Creatinine: 0.71 Vancomycin: 30.3 7/23/2024: BUN :26- indicated at high Creatinine: 0.75 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vancomycin: 34.1 No facility documentation located that levels were communicated to the pharmacy 7/24/2024: BUN: 27- indicated at high Creatinine: 0.76 Vancomycin: 33.7 No facility documentation that levels were communicated to the pharmacy 7/29/2024: Bun: 39- indicated as high Creatinine: 1.18 Vancomycin: 44.4 -indicated as high The laboratory results were reported to the facility on [DATE] at 13:49. Facility staff contacted the pharmacy 24 hours labs related to results. 7/31/2024: BUN: 54- indicated as high Creatinine: 1.86- indicated as high Vancomycin: 64.2- indicated as high No facility documentation that levels were communicated to the pharmacy July 2024 MAR (Medication Administration Record): Review was conducted of the MAR, and it showed Resident #703 was administered Vancomycin the evening of 7/29/24 and morning of 7/30/24, without prior communication to their pharmacy regarding the elevated Vancomycin levels. Contact was made with the pharmacy on 7/30/2924 at 14:24 (24 hours after results were received) after the levels resulted. Once pharmacy was alerted to her levels, an order was received to hold further administration of the antibiotic. On 10/15/2024 at 4:40 PM, an interview was conducted with the DON (Director of Nursing) regarding Resident #703. She reported when labs result, they show on the home board and if they are critical the laboratory would call them. Pharmacy doses their resident's Vancomycin and once the results were received the staff would fax them to pharmacy. She stated for them to receive Vancomycin they have to fax the physical copy of the order to the pharmacy. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/2024 at 5:08 PM, an interview was conducted with Nurse G regarding procedures when residents are prescribed Vancomycin. Nurse G explained they do not a plethora of residents that are prescribed Vancomycin. If the lab is critical, they will receive a phone call from the laboratory, otherwise they have to check the chart for the results. Upon receiving the results, they would contact the pharmacy with the results. Nurse G reviewed Resident #703's Vancomycin laboratory results from 7/29/2024 and her documentation of administrating the Vancomycin on the morning of 7/30/2024. Nurse G was asked if she called pharmacy with the laboratory results prior to administration of the Vancomycin or if it was received in report that pharmacy had been contacted. The nurse stated she did not receive any information in report that she can recall and was not sure why she did not contact pharmacy with the results prior to administration. On 10/16/2024 at 10:50 AM, an interview was conducted with the DON, she stated the nursing staff receive education regarding Vancomycin upon hire and additional education is provided if needed. The DON was asked when their last Vancomycin training was and it was reported she did not believe their had been one. She stated they complete spot education for specialty concerns. The DON further shared their phlebotomist is responsible for multiple buildings but is there daily for lab draws. Upon completing the draws a courier will pick up the specimens and deliver them to the laboratory. The DON further expressed they do not believe the times listed on the laboratory results are accurate, and they are working to see where the problem is. A discussion was held that the facility was unaware of the timing issue prior to survey and those times are documented in his chart. On 10/16/2024 at approximately 11:20 AM, Resident #703 was observed sleeping in her room, she was well groomed and did not appear to be in any distress. On 10/16/2024 at 2:20 PM, ADON (Assistant Director of Nursing)/Infection Preventionist explained when a resident is admitted on Vancomycin the admitting nurse will input the initial orders and she will review them for accuracy and add any other additional orders required. For the facility to receive the Vancomycin they have to print the order and then fax it to the pharmacy. The pharmacy to dose order has to be faxed as well. Upon the Vancomycin labs resulting the nurse could either fax to the pharmacy or call to alert them to the values and receive dosing orders, if applicable. For Resident #702, the ADON stated she inputted the order for pharmacy to dose but could not recall if she was the one that faxed it to pharmacy or if it handed to the nurse to do so. It is not standard practice to upload fax confirmations pages or complete a progress note once these tasks are completed. The ADON stated at their facility the pharmacy always doses their Vancomycin and was uncertain how this incident occurred. On 10/16/2024 at 10:10 AM, Pharmacist F was queried regarding Resident #703 Vancomycin dosing. They reported on 7/30/24 is when the facility reported her 44.4 levels, and this was when the antibiotic was placed on hold due to her elevated levels. The Administrator and DON stated there was no facility policy for Intravenous medications or a policy/procedure when residents are prescribed Vancomycin.