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	03/19/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Number MI00150954. Based on interview and record review the facility failed to timely obtain new prescription to reorder pain medication for one resident (#801) of two residents reviewed for pain management and pharmacy procedures, resulting in, Resident #801 going without her patch for three days and increased pain. Findings include: Resident #801: On 3/18/2025 at approximately 11:15 AM, a review was conducted of Resident #801's clinical record and it indicated she admitted to the facility on [DATE] with diagnoses that included, Acute Respiratory Failure, Depression, Hypertension and Amyloidosis. Resident #801 is cognitively intact and able to make her needs known to staff. On 3/18/2025 at 12:50 PM, Resident #801 reported her Fentanyl patch is supposed to be changed every three days but at the beginning of March she went without it for a few days, and no one could explain to her why. The resident shared the patch had fallen off and typically they would apply a new patch and change the application/removal schedule. During this time period her pain was increased as she did not have the patch, and she expressed frustration with the facility given the lack of communication regarding this matter. On 3/18/2025 at 4:05 PM, the DON (Director of Nursing) reported Resident #801's pain patch was applied on 3/2/2025 and was due to be replaced on 3/5/2025. On 3/4/2025 the patch had fallen off and there was not another patch to put on her as it was on order. On 3/7/25 it was found there were no more refills on Resident #801's patches and a new prescription was needed. The nurse reached out to on call who completed a onetime order, and the patch was pulled from back up and applied on 3/7/2025. The DON was unable to ascertain why a new script was not requested and refilled prior to 3/7/2025. Review was conducted of the Controlled Substance Proof of Use Log for Resident #801. It indicated on 2/10/2025 the facility received five Fentanyl 12 MCG (microgram)/HR (hour) patches for the resident. The first patch was applied on 2/18/2025 and the last patch (from the batch) applied on 3/2/2025. After application of the patch on 3/2/2025, Resident #801 would have been due for a new one on 3/5/2025. (continued on next page)

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Orders: Fentanyl Transdermal Patch 72 hours 12 MCG/HR - apply 1 patch every 3 days for pain and remove per schedule. March 2025 MAR (Medication Administration Record) -Patch applied on 3/2/2025 at 9:00 AM and 3/7/2025 at 7:00 PM. Resident #801's Fentanyl patch fell off on 3/4/2025 and was not reapplied for three days. Progress Notes: 3/4/2025 at 00:00: nurse reports residents Fentanyl patch came off and patient requested could tomorrows' dose be applied tonight. Nurse reports patient has PRN (as needed) pain medication to get through the night and new Fentanyl patch can be applied at 9 AM . 3/4/2025 at 23:02: Resident reported Fentanyl patch came off and was not able to locate it and resident requested a new one. Notified on call .who advised waiting until next dose in the morning. Resident informed no acute distress noted . 3/5/2025 at 09:49: unable to remove, patch fell off on 3/4/2025, noted by prior nurse. 3/7/2025 at 18:55: Resident daughter spoke with ADON regarding Fentanyl patch. Stating mother needs this and is concerned that she might go into withdraw. ADON spoke with writer via telephone asking for writer to contact on call for a new RX so resident will have patch over the weekend. Writer contacted oncall .who agreed to send RX over. Writer received auth to pull for patch and administered. 3/8/2025 at 18:55: Patch reapplied 3/7/25 at 1900. New order from NP. There was no other documentation located regarding contact with the pharmacy or provider regarding Resident #801's Fentanyl and the inherent delay. On 3/7/2025 at 6:35 PM, Nurse A was provided authorization from the pharmacy to pull the Fentanyl patch out of backup for Resident #801. The patch was pulled at 6:47 PM. Review was completed of the facility medications that are accessible in the back up box. The list had the following available: -Fentanyl 12 MCG/HR PAT (patch)-1 in back up. On 3/19/2025 at the DON explained, the pharmacy process is for them to either send a re-order form to the facility or contact the physician directly for a new script. The nurse re-ordered the Fentanyl patches on 3/5/25 through pharmacy, but there was not a valid script to process the refill. The pharmacy attempted to contact the provider directly multiple times for the script and was unsuccessful and a from was not sent to the facility.