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	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willowbrook Manor	G-4436 Beecher Road 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to intake Number 2659743.Based on interview and record review, the facility failed to transfer to the hospital in a timely manner one resident (Resident #1) of 1 resident reviewed for a delay in transfer to the hospital, upon an acute change of condition. Findings Include:On [DATE] at 9:15 AM, EMT (Emergency Medical Technician)/ LPN (Licensed Practical Nurse) C shared they were dispatched to the facility around 1:30 AM on [DATE] for a male resident with difficulty breathing, pulse of 150 and unresponsiveness. Upon arrival the nurse informed them she had recently arrived for her shift and per Resident #1's brother he had been in this condition prior to the beginning of her shift. The CNA (Certified Nurse Assistant) was sitting at the edge of the resident's bed and shared this was not his baseline and the night prior this was not how Resident #1 presented.EMT/LPN C stated the Resident #1 was unresponsive, diaphoretic and would awaken only to painful stimuli. He was hot to touch with a temperature of 104.1, his catheter was noted to be dark in color with sediment, and his lung sounds were wet bilaterally. Resident #1 would open his eyes for about 10-15 seconds, and he looked scared. They could hear him trying to breath and how wet it sounded. Resident #1 was intubated within 10 minutes of his arrival to the Emergency Room.On [DATE] at 10:10 AM, an interview was conducted with Resident #1's Brother/Guardian D. He reported the resident was still admitted at the hospital and was initially in the ICU (Intensive Care Unit) but stepped down. When he visited his brother on [DATE] at the nursing care facility, he raised some concerns to them regarding his brother's decrease in mobility, posture and slower than usual response times. Brother/Guardian D, stated Resident #1 was unable to raise his right arm and the facility said they would order some bloodwork. At about 1:30 AM he received a phone call that Resident #1 was unresponsive and would be transported to the Emergency Room. Upon his arrival at the hospital his brother had been placed on a ventilator. On [DATE] at approximately 10:30 AM, a review was conducted of Resident #1's medical records and it indicated he was admitted to the facility on [DATE] with diagnoses that included, Gram- Negative Sepsis, Anxiety, Myocardial Infarction, Heart Failure, Dependence on Supplemental oxygen, Bipolar and Schizoaffective Disorder. Further review yielded the following:Care Plan: .(Resident #1) has a potential for difficulty breathing and risk for respiratory complications R/T (related to): CHF.Supplemental oxygen use.observe for difficulty breathing (dyspnea) or exertion.observe for acute respiratory insufficiency .observe residents respiratory status at a minimum of daily and as needed ie. Auscultate lung sounds; observed respiratory rate; symmetry of chest expansion and any changed in color or level or consciousness.Resident is dependent on staff for toileting.There were no care-planned interventions listed for Resident #1's Foley catheter.Kardex: .Bed Mobility: Resident is dependent on staff for bed mobility. This is including rolling side to side. Lying to sitting on side of bed and sitting to lying.There was nothing mentioned in the Kardex related to Resident #1's Foley catheter. On [DATE] at 1:20 PM, Nurse E stated she did work on the night shift that Resident #1 was sent to the Emergency Room. She observed Nurse F moving back and forth quickly during medication pass and when asked if she was OK? she stated, No, and that Resident #1 needed to be sent out as he looked off.On [DATE] at 4:30 PM, CNA G stated nothing was passed on in report regarding Resident #1 that would have alerted her to check in on the resident more frequently. Upon arrival she completed her initial set of vitals and water pass around 11 PM and she recalls Resident #1 appearing that he was asleep and leaning to the side. She completed vitals and he did not stir while completing them. Sometime after midnight Resident #1's roommate needed something and she heard Resident #1 breathing loudly as if he was snoring, CNA G had never heard this from him before. CNA G called out the resident's name, and he did not respond or open his eyes. The CNA lifted his head off the bed, and his eyes were open, but he was not speaking. CNA G alerted Nurse F who asked for another set of vitals and his pulse was around 130 and steadily increasing. Resident #1's eyes were open, but he was just staring and not responding to any of their verbal commands. She reported, from what she could recall, they only completed a set of vitals when she heard him breathing oddly. Nurse G had her remain in the room with him as she went to contact the provider and prepare to send him to the emergency room for evaluation.CNA G was queried if she recalled the color of Resident #1's urine and she stated she did not but offered he did not have a lot of urine output and was unable to recall the color of his urine.It can be noted during review of the chart there was only one set of vitals entered between 10 PM -2 AM on the night shift of [DATE]/[DATE]- which were the entered by Nurse F. It is unknown what Resident #1's vitals were upon arrival of the night shift. On [DATE] at 4:40 PM, CNA H shared Resident #1 was total