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Form Approved OMB
No. 0938-0391

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	02/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intakes 2713005 and 2717874.Based on observation, interview and record review, the facility failed to fulfill residents' rights with timely responses to call lights for five Residents (#1, #3, #4, #5, and #6) of six residents reviewed for residents' rights and call light response times. Findings include:Resident 1 (R1):A review of Resident 1's (R1) medical record revealed an admission into the facility on [DATE] with diagnosis that included heart failure, atrial fibrillation, chronic obstructive pulmonary disease and dependence on supplemental oxygen. Review of intake documentation revealed the Resident had been put on an oxygen tank when the concentrator malfunctioned. The oxygen tank had run out of oxygen, the Resident experienced a developing headache, dizziness, and lightheadedness. The Resident activated his call light and waited approximately 25 minutes before staff responded and then left the room to locate a full tank of oxygen. The incident placed (R1) at serious risk of harm and represents a failure to ensure basic medical safety and timely response. Resident 3 (R3):A review of Resident 3's (R3) medical record revealed an admission into the facility on [DATE] and discharged home on [DATE], with diagnoses that included femur fracture, disorders of muscle and history of falling. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status (BIMS) score of 9/15 that indicated moderately impaired cognition, and the Resident was dependent on helper for toileting hygiene and lower body dressing and needed partial/moderate assistance with toilet transfers. On 2/4/26 at 2:07 PM, an interview was conducted with Confidential Person (CP) L and Confidential Person (CP) M regarding concerns of the care Resident 3 received when at the facility. CP M reported that R3 had had falls and had a fracture in her hip. The CP reported that R1 would need to use the bathroom and she had fallen, they said she walked out of the room to another resident's room and was found in middle of the floor with her pants down below her knees. The CP reported that they did not attend to her as they should and didn't help her to the bathroom. CP L reported being at the facility to visit, putting the call light on so R3 could get to the bathroom, waited more than 30 minutes with no staff response and had taken her to the bathroom by themselves. The CP reported that staff got mad and said we could not do that, we had to wait for them to get her to the bathroom, but she could not hold it that long and would try to get up on her own, she could not wait that long for them to come. The CP reported R3 would be incontinent waiting for staff to come and stated, response times are terrible for call lights! The CP stated, (R1) would be sitting in the wheelchair, we pulled that button (call light), no one came, I would take her. She had accidents multiple times. The CP reported that when I came in, she had (incontinence of bowel movement), and I had changed her myself. It took too long for someone to come. Resident 4 (R4):A review of Resident 4's (R4) medical record revealed an admission into the facility on 4/24/19 and readmission on [DATE] with diagnoses that included cerebral infarction (stroke), diabetes, adjustment disorder with mixed anxiety and depressed mood, hemiplegia and hemiparesis. A review of the R4's MDS (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed a BIMS score of 14/15 that indicated intact cognition and the Resident was dependent on a helper for oral hygiene, toileting hygiene, bathing, dressing and personal hygiene, mobility and transfers. On 2/3/26 at 2:45 PM, an observation was made of the light on above the door in room [ROOM NUMBER]. When questioned, R4 reported she had the call light on for about a half an hour now and reported no one had come in to check on the Resident. An observation of the wall where the call lights were plugged in revealed the call light was on for R4's roommate who indicated she had not put the call light on. R4 pressed her call light again and the call light did not go on. The Resident pushed the call light multiple times in a row and the call light on the wall did not activate. R4's roommate was unsure why their call light was on and did not know that it had been activated. R4 reported no staff have been into the room.The Maintenance S came into check the call light after being requested to R4's room. Maintenance S had the resident push the call light and it did not work until after adjustment to where the call light plugged into the wall. On 2/4/26 at 12:40 PM, R4 was observed lying in bed, was interviewed, answered questions and engaged in conversation. The Resident reported long call light wait times of more than 30 minutes sometimes and at different times during the day. The Resident stated, Can take an hour, for the call light to be answered. The Resident reported calling for assistance to get changed after incontinence and to get ice water. Resident 5 (R5):A review of R5's medical record revealed an admission into the facility on 5/10/23 and readmission on [DATE] with diagnoses that included peripheral vascular diseases, depression, diabetes, and left above the knee amputation. A review of R5's MDS assessment revealed a BIMS score of 15/15 that indicated intact cognition and the Resident was dependent on helper for toileting hygiene, bathing, lower body dressing and transfers. On 2/4/26 at 12:50 PM, an observation was made of the call light above R5's door. An interview was conducted with R5 who answered questions and engaged in conversation. The Resident reported she had put the call light on. When asked how long she had been waiting, the Resident stated, It's been on for a little while, and indicated she needed to be changed and wanted a drink. The Resident was asked if she had any issues with her call light response by staff. The Resident reported that sometimes it works and sometimes it doesn't, and stated, They will shut it off and say they will be back, and they don't come back. When asked if they waited more than 30 minutes, the Resident stated, sometimes when they don't come back. At 1:02 PM, an observation was made at the nurse's station that was positioned in the middle with the halls extending out. There were staff at the nurses' station behind the desks, staff in and around the area. The call light above R5's door can be seen from the nurse's station, and another call light was on a couple of doors down from R5's room.At 1:04 PM, an observation was made of no staff at the nurses' station, but staff remain in and around the area. A staff breakroom was in the same hall as R5. An observation was made by staff going into the breakroom. R5's light remains activated above the door and no staff were observed entering the room.At 1:08 PM, an observation was made of Housekeeping staff entering the room with the activated call light down from R5's room.At 1:11 PM, an observation was made of Staff going into R5's room, the light was turned off, and the Staff goes into the breakroom.At 1:16 PM, an observation was made of R5 with a diet coke. The Resident reported she had gotten her drink. The Resident had not been changed. Resident 6 (R6):A review of R6's medical record revealed an admission into the facility on 4/7/21 and readmission on [DATE] with diagnoses that included anxiety disorder, heart failure, need for assistance with personal care, respiratory failure, and dependence on supplemental oxygen. A review of R6's MDS revealed a BIMS score of 15/15 that indicated intact cognition and the Resident was dependent on a helper for toileting hygiene, lower body dressing, mobility and transfers. On 2/3/26 at 3:38 PM, an observation was made of Resident 6 lying in bed. The Resident was interviewed, answered (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	questions and engaged in conversation. An observation was made of R6's call light on. When queried about when she had activated the call light, the Resident stated, It hasn't been too long. The Resident was asked if she had any concerns with call light response times and the Resident stated, It can be an hour, but they do a good job when they get here, and they are too thin on staff. Resident Council Concern/Recommendations notes taken during Resident Council Meetings for October, November, December, and January were reviewed. -Dated 11/24/25 revealed, .Nursing Call light response times are longer than normal. Resident Council Follow Up: . Nursing: Remind all staff about answering call lights (with Department Manager Signature and Date 11/24/25) .-Dated 1/2/26 revealed, .Nursing Call light response times are taking longer. Resident Council Follow Up: . Nursing: Remind all staff during monthly educations to answer call lights timely, (with Department Manager Signature and Date 1/8/26) .-Dated 1/30/26 revealed, .Old Business. 2. Concern: Call light response times are taking longer (not indicated as resolved or unresolved) Actions Taken: Remind all staff to answer call lights timely. New Business: .Nursing: Call lights not being answered timely. On 2/4/26 at 3:10 PM, an interview was conducted with Assistant Director of Nursing (ADON) N. When asked about call light response times, the ADON indicated that the call light should be answered as soon as possible, about 5 minutes, 10 minutes max. The ADON reported that if the need was not met when staff answer the call light, the call light needs to stay on. On 2/5/26 at 9:45 AM, an interview was conducted with the Director of Nursing and the Administrator (NHA) of concern from residents and intake complaints regarding long call light response times, observations during survey and concerns from residents of the call light being turned off, their needs not met and staff not returning timely. The NHA reported they have been working on the concern, but when staff ask about call light concerns when asked daily, the Residents were not giving the concern to the staff member. The concern of the call lights functioning properly was reviewed with the DON and NHA. A review of facility policy titled, Call Lights, with a effective date of 3/12/25, revealed, Policy: Call lights will be placed within the resident's reach and answered in a timely manner. Responding to a Call light: 1. Identify the location and answer the resident promptly. 3. Go to the location of the call light, and turn off the light if you are able to meet the resident request.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2717874.Based on observation, interview and record review, the facility failed to ensure that physicians' orders for oxygen use were followed for 1 resident (Resident #6),; oxygen was provided to 1 resident (Resident #5); and nebulizer equipment was stored properly for 1supplemental (Resident #7), of three residents reviewed for oxygen administration and one supplemental resident.Findings include:Resident #7:On 2/3/25 at 2:44 PM, an observation was made during the initial tour of the facility of Supplemental Resident #7's room. The Resident was not in the room at the time. The Resident had oxygen equipment set up in the room that included a nebulizer machine. The nebulizer mask and tubing were stored inside a clear bag. The nebulizer medicine chamber was observed to be stored inside the bag wet with drops of liquid inside the chamber.A review of Supplemental Resident #7's Medication Administration Record revealed the Resident had Ipratropium-Albuterol Inhalation solution, four times a day for COPD (chronic obstructive pulmonary disease), scheduled at 0900 (9:00 AM) and documented as last as administered and the 1300 dose (1:00 PM) was documented as not given. Resident #5:On 2/3/25 at 3:30 PM, an observation was made with Resident #5 (R5) lying in bed, awake with head of bed elevated. An observation was made of the Residents oxygen tubing and nasal cannula positioned by the wall and not within reach of the Resident. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about her oxygen. The Resident reported that she was to use it all the time and stated, The aide forgot to give me my oxygen back. The Resident reported she had the CNA (certified nursing assistant) help in getting her shirt off and new one put on and had taken the oxygen off. When asked how long it had been since she was left without her oxygen in place, the Resident stated, It's been about an hour. Staff were alerted to the Resident needing her oxygen and a CNA came in with the vital sign machine, obtained an oxygen saturation of 87% to 88% and a Nurse came in and put the oxygen onto the Resident.A review of R5's medical record revealed admission into the facility on 5/10/23 and readmission on [DATE] with diagnoses that included peripheral vascular diseases, depression, diabetes, and left above the knee amputation. A review of R5's MDS assessment revealed a BIMS score of 15/15 that indicated intact cognition and the Resident was dependent on helper for toileting hygiene, bathing, lower body dressing and transfers.A review of R5's orders for oxygen dated 8/22/25, revealed and order 0.5-5L of supplementary oxygen to maintain SpO2>90% . Resident #6:On 2/3/25 at 3:38 PM, an observation was made of Resident #6 (R6) lying in bed, awake with head of bed elevated. The Resident was interviewed, answered questions and engaged in conversation. An observation was made of R6 with oxygen on, supplied by a nasal cannula on the nose and connected to an oxygen concentrator. The Oxygen (O2) was set at 4 L (liters of oxygen per minute). When asked if the Resident knew what her O2 was to be set at the Resident reported it should be at 4.A review of R6's medical record revealed an admission into the facility on 4/7/21 and readmission on [DATE] with diagnoses that included anxiety disorder, heart failure, need for assistance with personal care, respiratory failure, and dependence on supplemental oxygen. A review of R6's MDS revealed a BIMS score of 15/15 that indicated intact cognition and the Resident was dependent on a helper for toileting hygiene, lower body dressing, mobility and transfers. On 2/4/25 at 3:10 PM, an interview was conducted with Assistant Director of Nursing (ADON) N. A review of R6's medical record with the ADON revealed an order for Oxygen for 2 L/min (liters per minute). An observation was made of R6's oxygen concentrator set at 4L/min. The oxygen the resident was receiving did not match the physician order for oxygen. The ADON reported she would look into it and find out how many liters of oxygen the Resident should be on. A review of the facility policy titled, Use of Oxygen, did not give directive of following (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider orders for oxygen use or monitoring liters of oxygen to be used. A review of the facility policy titled, Nebulizer therapy, small volume, revealed, Implementation. Rinse the nebulizer with water and allow it to air-dry.