STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235582	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health and Rehabilitation Center	19933 West Thirteen Mile Road Southfield, MI 48076

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 This citation pertains to intake #s MI00143487 and MI00143823. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, safe, and homelike environment, as evidenced by soiled floors, walls, trash/debris throughout the facility, broken chair and tile, unsecured sharps and chemicals, and visible harborage of pests. This deficient practice has the potential to affect multiple residents throughout the facility. Findings include: Review of multiple complaints reported to the State Agency included allegations that the facility was not clean. During the abbreviated survey conducted on 5/28/24, the following concerns with the facility's environment were identified: At 9:50 AM, the hallway outside room [ROOM NUMBER] and 114 was littered with debris. The chair outside room [ROOM NUMBER] had linens and used gloves stored directly on the floor behind the chair. The flooring throughout hallway near room [ROOM NUMBER]/202 observed with scattered debris. At 9:57 AM, the Anna's House unit was observed to have a linen cart with dried dark brownish/black splatters on bottom shelf inside cart right next to the linens. At 10:05 AM, the hallway wall outside room [ROOM NUMBER] was observed soiled with brown debris. At 10:08 AM, the shower room on the Oakridge unit had the door open and there was a wall cabinet that had a sticker which read, KEEP LOCKED AFTER USE. The wall cabinet was not locked and upon opening the small door, there were loose gloves (unknown if used) and a large bottle of BNC-15 (a disinfectant cleaner) that was labeled in red marker OAK SPA B and 1 bottle of skin/hair cleanser with no resident name. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:16 AM, the shower room on the Oakridge unit (SPA A) was observed to have a shower bench that was leaning slightly down towards the left, with a used brief in an open bag underneath the shower chair, a gerichair recliner had used gloves stored on the seat (turned inside out), there were several towels on the floor and washcloths bunched into the handrails of the shower area. There were no staff present. At 11:57 AM, the shower room on the Oakridge unit (SPA A) contained the same wet washcloths that hung from the assist handrails and shower floor, there were two unlabelled bottles of bodywash/shampoo, soiled washcloth, roll of trash bags, a hair brush with visible hair strands which were not labeled. Additionally, the grout appeared to have areas of a dark mold-like substance and there were several dead bugs observed behind the doors, and in the corners of the shower room. The wall cabinet had a bottle of disinfectant cleaner labeled BNC-15 stored on top of the cabinet, unsecured. The floor tile at the threshold area of the shower room was observed to have chipped tiles. At 12:03 PM, the shower room on the Hickory unit (SPA A) was observed to have used gloves (turned inside out) on the floor, there were seven bottles of bodywash/shampoo, roll-on deodorant, three disposable razors stored on the half wall near the shower, there was a trash bag on floor, an opened brief stored on top of wall cabinet, a roll of medical tape was taped and hung down from the shelf of the wall cabinet, and multiple garbage/debris scattered throughout the flooring of the shower room. Additionally, the grout appeared to have areas of a dark mold-like substance and there were several dead bugs observed behind the doors, and in the corners of the shower room. At 12:20 PM, the Redwood unit was observed to continue to have garbage/debris scattered throughout the flooring of the unit, and the soiled linens and gloves remained behind the chair outside room [ROOM NUMBER]. At 12:41 PM, Nurse Manager 'B' was asked to observe the Oakridge and Hickory unit and confirmed the above observations. Nurse Manager 'B' reported the personal care items should not have been left like that and were unable to identify who they were used for and would need to be discarded. When asked about the storage of the chemicals and razors, Nurse Manager 'B' reported those should've been secured. At 2:04 PM, there was a disposable mask and used gloves (turned inside out) observed on the floor in the common area outside room [ROOM NUMBER]. At 2:09 PM, Anna's House unit was observed to have food debris in both of the lounge/dining/activity areas under the tables and throughout the floors. Additionally, there were spider webs and multiple pests on the wall by the water fountain and scattered debris throughout the flooring of the unit and resident rooms. At 2:11 PM, there was a used glove (turned inside out) and a small white cup on the floor near the med cart. There were multiple paper wrappers and debris throughout the flooring near rooms [ROOM NUMBER]. At 2:15 PM, the Hickory unit was observed to have a blood lancet (sharps) observed on the floor by the three drawer dresser outside room [ROOM NUMBER]. The wall and baseboard behind the med cart outside room [ROOM NUMBER] was observed heavily soiled with a brown substance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:18 PM, the treatment cart next to the soiled utility room and nursing desk on the Hickory unit was observed to have trash overflowing from the receptacle secured to the cart, which forced the lid to remain open and expose the contents. At 2:30 PM, the front conference room was observed to have a large black ant crawling on the wall and ceiling. On 5/28/24 at 2:53 PM, an interview was conducted with the Director of Housekeeping and Laundry (Staff 'C') who reported they had been in their role since July 2023. When asked about the facility's housekeeping assignments and staffing, Staff 'C' reported each wing had one housekeeper and they tried to keep the same staff to each wing for consistency. When asked about their work schedule, Staff 'C' reported they worked usually 7:00 AM to 3:30 PM, but some worked 8:00 AM to 4:00 PM if they had children. When asked about weekend coverage, Staff 'C' reported that was the same. When asked if any staff had called-in today, Staff 'C' reported No, not today. When asked if there was a list of what should be cleaned and when, Staff 'C' reported they have a list, but their staff know what to do and they have been at the facility a long time and Know the routine. When asked about the cleaning of the shower rooms, Staff 'C' reported those were cleaned before they left, around 2:00 PM/2:30 PM and they use sanitizer spray and mop the floors, clean the walls and everything what is in there. When asked about the tile areas like the grout, Staff 'C' reported they power washed two times a month but their staff that did that had been on vacation. When asked about the cleaning of the dining rooms, Staff 'C' reported housekeeping comes in to clean after every meal but that sometimes after eating, there is an activity so they might not be able to clean it. When asked who cleans after dinner, Staff 'C' reported there was no one after dinner, but should be cleaned up when they come in first thing the next morning. On 5/28/24 at 3:00 PM, Staff 'C' was asked to observe the facility and confirmed the same observations as identified earlier. When asked about who the housekeeper was on the Redwood unit, Staff 'C' reported there wasn't anyone today and they had assisted with cleaning the resident rooms. When asked about the soiled linens behind the chair, Staff 'C' proceeded to pick them up and offered no further response. At 3:06 PM, observations on Anna's House unit revealed the same concerns. When asked about the spider webs and pests, Staff 'C' proceeded to wipe them away with their hands and reported they were not aware of that. At that time, Staff 'C' approached a housekeeper on the hallway and asked them about the cleaning of the dining room floors and the housekeeper reported they had cleaned that earlier and was not able to since there were residents in there. When asked why at least the one side was not cleaned since there were no residents, Staff 'C' directed them to clean the flooring now. At 3:11 PM, Staff 'C' was asked about the items observed on the Hickory unit and they reported the housekeeper that was assigned to this area was new. When asked about the overflowing trash receptacle on the treatment cart and who was responsible for that, Staff 'C' reported that was the CNA (Certified Nursing Assistant) and Nurse's responsibility to empty the trash on the medication and treatment carts. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:14 PM, continued observations of the Hickory unit shower room (SPA B) revealed there was a bowl of food on the floor that had moldy contents and was covered with several small black bugs. Staff 'C' confirmed the multiple bugs and dark grout tile and reported they had someone dedicated to power-washing the shower rooms, but they had been on vacation for the past two weeks. At 3:20 PM, continued observations of the Oakridge unit shower room (SPA B) revealed the toilet contained a dark ring of build-up on the inside of the toilet bowl. Staff 'C' reported the toilet was cleaned everyday. When asked if it was cleaned everyday, how was there a build-up of debris around the water line in the toilet bowl, Staff 'C' offered no further response. The bathtub was observed to have a stack of towels, a wheelchair cushion and there were several dead winged bugs scattered on the bottom of the tub. When asked who was responsible for maintaining the bathtub, Staff 'C' reported housekeeping didn't do that, the CNAs did. When asked to clarify earlier they mentioned that housekeeping cleaned the main flooring and areas of the shower rooms, but the CNAs had to clean the bathtub, Staff 'C' confirmed and then reported maybe they needed to change that since it was not done. When asked if the housekeeping staff cleaned the shower rooms daily, how was there molding food, build-up of webs, and bugs, Staff 'C' reported they weren't sure. At 3:25 PM, observation of the dining room on the Oakridge unit revealed there was a chair in front of the door wall that had a broken armrest, and there were many webs and live spiders and bugs throughout the dining room (in which residents were observed eating lunch in earlier) and behind the doors. When asked to observe the area behind the plant next to the door wall, Staff 'C' stated Oh god, nobody reported that. When asked if insects/pests were observed, what was the process to notify staff, Staff 'C' reported the staff should report to the Maintenance staff. At 3:30 PM, the shower room on the Oakridge unit (SPA A) revealed concerns with dark grout, webs and insects in corners of the room, and chipped tile at the threshold. Review of the documentation provided by Staff 'C' of the areas of concern identified by staff included some spider and ant concerns, but did not identify concerns with bath/shower rooms or dining rooms. According to the Safety data Sheet for product BNC-15, .Hazard Statements .Harmful if swallowed. Causes severe skin burns and serious eye damage .Store locked up . Review of the documentation provided by the facility regarding a policy for maintaining clean, comfortable, safe, homelike environment revealed an undated, unapproved policy with no specific facility name that addressed only process for cleaning resident rooms upon discharge.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation and interview, the facility failed to ensure a medication cart was locked and secured, resulting in the potential for unauthorized access and diversion of narcotic medications. Findings include: On 5/28/24 at 3:23 PM, a medication cart located on the Oakridge Unit, in front of room [ROOM NUMBER], was observed unlocked and unattended by authorized staff. The medications were accessible in all drawers, including the narcotic storage drawer. Registered Nurse (RN) A returned to the cart on the Oakridge Unit indicating a medication count was being performed with another nurse, away from the assigned medication cart. RN A confirmed the cart was left unlocked, unattended, and medications, including scheduled narcotics were accessible to unauthorized personnel. On 5/28/24 at 3:38 PM, the Director of Nursing (DON) was interviewed and acknowledged medication carts are to be locked and secured by authorized personnel. Review of the facilities policy title; Medication and Treatment Cart Storage dated 5/4/22 documented: .All drugs and biologicals will be stored in locked compartments (i.e., medication carts) .Narcotics and Controlled Substances: medications are stored under double-lock and key .