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	02/20/2025

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #MI00150187. Based on interview and record review the facility failed to ensure a consent for psychotropic medications were obtained from a legally authorized resident representative for one resident (R303) of three residents reviewed for rights of legally authorized representatives. Findings include: On [DATE], a concern submitted to the State Agency was reviewed with alleged R303 was provided psychotropic medications without the consent of their legally authorized representative (Durable Power of Attorney for healthcare-DPOA-H). On [DATE] the medical record for R303 was reviewed and revealed the following: R303 was initially admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, Fall from bed and Cerebral Infarction and had expired on [DATE]. A review of R303's MDS (minimum data set) with an ARD (assessment reference date) of [DATE] revealed R303 needed assistance from facility staff with their activities of daily living. R303's BIMS score (brief interview of mental status) was 12 indicating moderately impaired cognition. A Physician Certification of Capacity dated [DATE] that was signed by two Physicians revealed R303 was deemed Incompetent to participate in medical treatment, care and custody decision-making. The reason that the resident is unable to participate is Dementia and Visual Hallucinations . A Durable Power of Attorney for Healthcare (DPOA-H) form signed by R303 on [DATE] was reviewed and revealed that R303's wife was their appointed DPOA-H. A review of R303's Medication Orders revealed R303 was ordered Sertraline on multiple dates including the following: (Anti-depressant) Zoloft Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth in the morning for depression-Start date: [DATE] . Sertraline HCl Tablet 50 MG Give 1 tablet by mouth one time a day for Depression-Start date [DATE] . Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression-Start date [DATE] . (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sertraline HCl Tablet 50 MG Give 1 tablet by mouth one time a day for Depression-Start date [DATE] . Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Depression Give in addition to 50mg to equal 75mg Daily-Start date [DATE] . Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for Depression-Start date [DATE] . Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for ANTIDEPRESSANTS, CHEMICALS-Start date [DATE] . (Anti-Anxiety)LORazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet sublingually every 6 hours for anxiety crush tablet-Start date [DATE] . A review of R303's UDA (User defined assessment) psychotropic consent and education forms was conducted and revealed the following: [DATE] was struck out XXX[DATE]-Consent and education provided to R303 [Note-deemed incapacitated on [DATE]] without the DPOA-H. [DATE]-Education/Consent field was blank. [DATE]-DPOA-H [declined consent for Sertraline.] Further review of R303's psychotropic medication consent forms did not reveal R303's legally authorized representative- DPOA-H had provided consent for either the Sertraline or the Lorazepam. On [DATE] at approximately 1:04 p.m., Social Worker C (SW C) was queried regarding the psychotropic medication consent forms for R303. SW C indicated that residents have to consent for their psychotropic medications. SW C was queried regarding R303's DPOA-H of not consenting for R303 to be provided Zoloft/Sertraline and they indicated that they were aware of R303's DOPA-H not consenting to the medication. At that time, a request for the psychotropic consent forms that R303's DPOA-H had provided consent for their psychotropic medications was requested. On [DATE] at approximately 9:42 a.m., during a follow-up conversation with SW C, SW C indicated they did not have any documentation that R303's DPOA-H had provided consent for their psychotropic medications. SW C was queried as to why and they indicated nobody had brought it to their attention that it needed to be done. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] a facility document titled Policy and Procedures-Psychotropic Medication Use was reviewed and revealed the following: It is the policy of the facility to only prescribe psychotropic medications when it is necessary to treat a specific diagnosed condition and the medication is deemed as beneficial to the resident. The facility will identify when a resident is prescribed a psychotropic medication and will obtain informed consent from the resident or authorized representative for each psychotropic medication ordered Informed Consent-For any resident taking a psychotropic medication, the Social Service employee or designee will obtain informed consent from the resident and/or authorized representative using the Psychotropic Medication Consent UDA in [electronic medical record] The Social Service employee, or designee, will review the medication prescribed, dosage, side effects, and risks versus benefits of the medication, which are outlined on the psychotropic informed consent evaluation. The Social Service employee, or designee, will discuss any Black Box Warnings associated with the psychotropic prescribed to the resident or authorized presentative <sic>so that they are aware of the potential risks. After review, the resident and/or authorized representative will either consent or refuse the psychotropic medication. The consent or refusal of the psychotropic medication may be obtained in person or verbally via a telephone conversation. If the resident and/or authorized representative refuses to consent to the psychotropic medication, the physician/medical practitioner will be notified so that the medication can be discontinued On [DATE] the facility Administrator provided a copy of R303's UDA form dated [DATE] that indicated R303's DPOA-H had declined consent for sertraline. No other documentation was provided by the end of the survey that indicated R303's DPOA-H had provided consent for R303's psychotropic medications including the multiple dose increases of sertraline or the lorazepam.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #MI00150047 Based on interview, and record review, the facility failed to follow pest control procedures for one resident (R305) of three residents reviewed for pest control. Findings include: On 2/19/25 a concern submitted to the State Agency was reviewed which alleged staff were not utilizing effective procedures to maintain pest control resulting in an infection of bed bugs. On 2/19/25 at 10:03 a.m., during a conservation with Maintenance Director A (MD A), MD A was queried regarding allegation of a bed bug infestation in the facility. MD A reported they did have multiple rooms in where bugs were found and that the facility pest control provider had been out multiple times to inspect and treat the rooms. MD A indicated that the rooms with alleged infestation were 414 and 409. A request for documentation of the bed bug procedures and treatments were requested. On 2/19/25 a review of the facility's investigation into the bed bug infestation revealed the following: Bed Bug Investigation 2/6/2025 . On 2/5/25 sister of resident, [Name of resident] in (room) 414L visited resident. At that time, she brought in resident's clothing and belongings that were from her old apartment before admission to Evergreen. Bed bugs were noted on resident [Name of resident] in 414L after her sister [name of sister] had visited her. Before sister left, she hugged resident's roommate [R305]. Bed bug policy and procedures initiated. Both residents were showered. Resident's rooms were moved and orientated to their new bedrooms. Families notified. [Name of roommate] moved to 416 and [R305] moved to 409. All linen and clothing from bedroom [ROOM NUMBER] bagged and sent to laundry. Room cleaned, UV'd (ultra violet light) and exterminator contacted. Items that were unable to be thoroughly cleaned or washed were inspected by the exterminator and UV'd. Both resident's wheelchairs were also inspected and UV'd. On 2/6/25, bed bugs were noted in [R305's] hair. Resident voiced that CENA (Certified Nursing Assistant) showered her yesterday and put her old clothes back on her. Facial edema and lip swelling noted. Per UM (Unit Manager) EpiPen was administered. Facial edema occurred by an unknown reason. Provider notified. No new orders at this time. Bed bug policy and procedure started over. Resident showered and provided a gown. All clothing and linens were sent to laundry. Resident's room was cleaned and UV'd. CNA B was educated and disciplined regarding bed bug policies and procedures. On 2/19/25 at approximately 12:48 p.m., CNA B was queried regarding being disciplined as result of R305 having bed bugs in their hair on 2/6/25 after being showered on 2/5/25. CNA B reported that they were unaware that putting on the same clothes that R305 was in previous to the shower was wrong and that they thought they were fresh clothes. CNA B reported they were disciplined and educated on the bed bug procedures after the incident. On 2/19/25 at approximately 1:50 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the bed bug investigation and CNA B placing the potentially infested clothing back on R305 after being showered. The DON indicated that they re-educated CNA B on the correct procedures when bed bugs are found on a resident and that all the education was completed as of 2/6/25 and they have not had any more bed bug occurrences. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of CNA B's re-education on the facility bed bug procedures was reviewed and revealed the following: Employee Counseling and Corrective Action Record Date: 2/6/25 .CENA assist resident with shower secondary to suspected bed bugs. After completing shower, CENA assisted patient with same clothes patient was wearing before shower An education in-service attendance record for CNA B dated 2/6/25 revealed the following: Topic-Bed Bug Policy and Procedures .Objective/Outline-Resident to be fully showered with hair washed and new/clean outfit to be put on resident after shower . On 2/19/25 the medical record for R305 was reviewed and revealed the following: R305 was initially admitted to the facility on [DATE] and had diagnoses including Bipolar disorder and Post traumatic stress disorder. A review of R305's MDS (minimum data set) with an ARD (assessment reference date) of 2/9/25 revealed R305 needed assistance from facility staff with their activities of daily living. R305's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A Physician progress note dated 2/6/25 revealed the following: .Pt (patient) alert and conversive upset as had to evacuate room d/t (due to) bedbugs. Reports bed bugs found in hair and few small bites observed on inner thighs. Pt was thoroughly showered. All belongings cleaned, clothes washed . On 2/20/25 A review of the facility policy pertaining to bed bugs was reviewed and revealed the following: Policy-Bed Bug .Policy Overview: The purpose of this policy is to provide guidelines for the identification and treatment of bed bugs .The resident(s) should be thoroughly bathed and changed into a fresh gown. The resident(s) should be moved to a different room using a new wheelchair, walker, cane, etc. per their plan of care and given fresh clean linens and personal care products During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included staff specific education, implementation of the current policy and follow through after interventions (showers, linen change, room treatments). The facility was able to demonstrate monitoring of the corrective action and maintained compliance.