STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235622	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Qualicare Nursing Home	695 E Grand Blvd Detroit, MI 48207

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 - Few	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** 38230 Based on observation, interview, and record review, the facility failed to ensure one resident (R12) of two residents reviewed for dignity were aided with eating in a dignified manner, resulting in the potential for feelings of discomfort while eating. Findings include: On 2/10/25 at 1:28 p.m., during a meal observation (lunch), R12 was observed sitting up in bed, being assisted with eating by CENA D. CENA D was observed standing over R12 while putting food in the resident's mouth. While the resident was chewing the food, CENA D had the fork close to the resident's face, before allowing time for the resident to chew the food that was already in the mouth before giving more. CENA D was queried about standing while assisting the resident while eating. CENA D stated, I didn't bring one (a chair). There wasn't enough chairs in the dining room to grab one. CENA D continued to provide eating assistance while standing over the resident. On 2/12/25 at 12:51 p.m. while walking pass R12's room, the resident was sitting up in bed with CENA C standing at the bedside with a forkful of food. CENA C was then observed assisting with eating while standing over the resident. CENA C was queried about standing while assisting the resident with eating. CENA C said there was no chair in the room to sit in. CENA C was asked would they be comfortable being stood over while eating. CENA C stated, No. I wouldn't want anyone to stand over me while I'm eating. CENA C continued to provide eating assistance while standing over the resident. Review of the clinical record revealed R12 was initially admitted into the facility on [DATE] with diagnoses that included Parkinson's Disease, bipolar disorder, anxiety, and dementia. According to the quarterly Minimum Data Set assessment dated [DATE], R12 had severe cognitive impairment (BIMs=3) and dependent for all activities of daily living. Review of the Nutrition care plan dated 2/1/25 documented: Alteration in nutritional and/or hydration status r/t risk for changes in intake and self-feeding due to schizophrenia and behaviors. Risk for weight changes regarding to hypothyroidism, schizophrenia and bipolar disorder. Intervention: Assist resident with meals, including 1:1 feeding as needed and tray set-up. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Resident Dignity & Personal Privacy, revision date 3/28/24, documented in part the following: The facility provides care for residents in a manner that respects and enhances each resident's dignity and individuality . Dignity means that when interacting with residents, staff carries out activities that assist with resident in maintaining and enhancing his or her self-esteem and self-worth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER: Qualicare Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 695 E Grand Blvd Detroit, MI 48207	

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38230 Based on observation, interview, and record review, the facility failed to ensure the resident and/or legal representative formulated an Advance Directive to grant and/or withhold life sustaining treatment (Cardiopulmonary Resuscitation/CPR, Artificial Nutrition/Peg Tube, Artificial Hydration/ IV, and Diagnostic Testing) according to their wishes upon admission for two residents (R45 and R55) of four residents reviewed for advance directives, potentially resulting in inaccurate life sustaining or life withholding medical treatment. Findings include: R55 On [DATE] at 1:39 p.m. R55 was observed in the room resting in bed. R55 presented as alert, oriented to person, place, and situation. R55 was queried about the facility initiating an advance directive. R55 said the social worker came to the room and discussed it with the resident yesterday ([DATE]). R55 was asked about having any advance directive discussions with anyone from the facility prior to [DATE]. R55 could not confirm prior discussions. R55 verified the code status (Full Code) established with the advance directive by stating, I want everything done to save me. Review of the clinical record documented R55 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia, diabetes mellitus, type 2, and alcohol dependence. According to the admission Minimum Data Set assessment dated [DATE], R55 had mild cognitive impairment (BIMs=11) and was independent with all activities of daily living. Review of the face sheet documented R55 did not have a legal representative and was responsible for self. The face sheet had a section titled, Advance Directive that was incomplete (blank). Review of the Resident Profile page in the electronic medical record, did not document a Code Status that would have been established with completing an Advance Directive: Code Status (Advance Directives). Review of the Physician's orders revealed there were no orders indicating the code status. On [DATE] at 11:05 a.m. Social Service Director (SSD) A was queried about the R55 not having an advance directive upon admission. SSD A said R55 was discharged and readmitted into the facility several times however the advance directive should have been completed once admitted into the facility. If the resident was unable to complete the advance directive at the time of admission, then the resident would have been a Full Code by default (per facility policy). On [DATE] at 1:27 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) was interviewed. The DON said advance directives are supposed to be completed on the day of admission. If the resident is unable to complete the advance directive, they are Full Code by default. The nurse is to put in a physician's order with the code status and the SSD is to investigate afterwards. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Qualicare Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 695 E Grand Blvd Detroit, MI 48207	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Advance Directives- Michigan, revision date [DATE], documented in part the following: The Facility is committed to the promotion of the well-being of all our Residents. We recognize each Resident's right to refuse treatment, to live a dignified life, and to self-determination, which includes the right to refuse care and to formulate advance directives regarding future care . On admission, the Facility will determine whether the Resident has executed advance directives and if not, whether the Resident would like to execute advance directives . A Code Status Form will be signed to reflect the decision regarding CPR/DNR . Copies of all advance directives will be obtained from the Resident and/or family and placed in the medical record . All individuals are presumed to have the level of cognition to make informed health care decisions unless the Resident has been adjudicated as incompetent . If the initial facility cognitive evaluation (Nursing Comprehensive Evaluation and/or BIMS) indicates cognition to be intact, a Code Status Form will be completed by the resident .If it is determined that the resident is cognitively impaired, the code status form is completed as a full code until capacity is assessed and it is determined who should sign . 50634 R45 R45 was admitted on [DATE] with a pertinent diagnosis of Pulmonary Embolism, Lower back pain, Muscle Weakness, Sciatica, and Depression. R45 Minimum Data Set, (MDS) Quarterly Assessment from [DATE] for Brief Interview for Mental Status, (BIMS) was cognitively intact at ,d+[DATE] for cognition. Review of R45's Electronic Medical Record (EMR) revealed no signed Advanced Directive located in R45 clinical record. On [DATE] at 1:15 PM, the Social Worker, (SW) A was queried and confirmed there was no Advance Directive in R45 EMR. SW A said that the Advance Directive should been reviewed quarterly at resident's care conference. On [DATE] at 1:25 PM, The Nursing Home Administrator, (NHA) was interviewed and confirmed there was no signed Advance Directive in R45 EMR. The NHA said it appears there were two care conferences but there was still no signed Advance Directive in R45 EMR. The NHA said without having an Advance Directive R45 could receive unwanted treatment.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235622	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER: Qualicare Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 695 E Grand Blvd Detroit, MI 48207	

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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	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50634 Based on observation, interview and record review the facility failed to ensure that one resident's (R73) medications were properly stored during medication administration of three residents reviewed for medication pass. Findings include: While observing medication pass on the second floor with Registered Nurse, (RN) E, medications were observed in a cup on the top of the medication cart. RN E walked away from the medications on top of the cart, leaving the medications unattended. RN E was observed to take vitals on another resident (R33) down the hallway. RN E returned to the cart and prepared R33's medications then left the cart again to administer R33 medications. When RN E returned to the cart, they were queried about the medications that were left in the medication cup on top of the cart. RN E explained R73 was sleeping and they were going to try later to give them the medications. RN E said they held on to them, but they should have locked them in the drawer. The unit manager, Licensed Practical Nurse, (LPN) B came to the cart where they observed the medications that were sitting in a cup on top of the cart. The unit manager advised the nurse that medications should not have been left on the top of the cart unsecured. The medications left in the cup were the following: Aspirin 81mg, Farxiga 5mg, Ferrous sulfate, Folic Acid 1mg, Sitagliptin 50mg, Multivitamin, Zoloft 50mg and Metoprolol 25mg. On 2/11/25 at 10:45 AM, the Director of Nursing, (DON) was interviewed and said the Nurse E: should have placed the medications in a locked drawer and reoffered the medications to R73 once they woke up. On 2/11/25 at 10:47 AM the Nursing Home Administrator (NHA) was interviewed and said their expectations was for RN E to follow the medication passing policy. Review of the Medication Administration Policy, dated 10/17/2023, documented medications should be prepared immediately before administration.

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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. 50634 Based on observation, interview and record review the facility failed to ensure that one resident (R73) of reviewed during medication administration medications were properly stored. Findings include: While observing medication pass on the second floor with Registered Nurse, (RN) E, medications were observed in a cup on the top of the medication cart. RN E walked away from the medications on top of the cart, leaving the medications unattended. RN E was observed to take vitals on another resident (R330 down the hallway. RN E returned to the cart and prepared R33's medications then left the cart again to administer R33 medications. When RN E returned to the cart, they were queiried about the medications that were left in the medication cup on top of the cart. RN E explained R73 was sleeping and they were going to try later to give them the medications. RN E said they held on to them, but they should have locked them in the drawer. The unit manager, Licensed Practical Nurse, (LPN) B came to the cart where they observed the medications that were sitting in a cup on top of the cart. The unit manager advised the nurse that medications should not have been left on the top of the cart unsecured. The medications left in the cup were the following: Aspirin 81mg, Farxiga 5mg, Ferrous sulfate, Folic Acid 1mg, Sitagliptin 50mg, Multivitamin, Zoloft 50mg and Metoprolol 25mg. On 2/11/25 at 10:45 AM, the Director of Nursing, (DON) was interviewed and said the Nurse E: should have placed the medications in a locked drawer and reoffered the medications to R73 once they woke up. On 2/11/25 at 10:47 AM, the Nursing Home Administrator, (NHA) was interviewed and said their expectations was for RN E to follow the medication passing policy. Review of the Medication Administration Policy, dated 10/17/2023, documented medications should be prepared immediately before administration.