STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235700	A. Building B. Wing	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at East Lansing	3500 Coolidge Road East Lansing, MI 48823

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to MI 00145328 Based on observation, interview, and record review the facility failed to thoroughly assess or provide treatment for a hot liquid burn for one Resident (#1) out of one reviewed resulting in the potential of medical complications from a hot liquid burn. Findings Included: Resident #1 (R1) Review of the medical record revealed R1 was admitted [DATE] with diagnoses that included cerebral infarction (stroke), fracture of nasal bones, history of falls, urinary tract infection, acute respiratory failure, heart failure, hypertensive heart disease, hypothyroidism (low thyroid hormone), hyperlipidemia (high fat content in blood), diplopia (double vision), dysarthria (slurred speech), anarthria (inability to articulate speech), dysphagia (difficulty swallowing), osteoarthritis, gastro-esophageal reflux, and chronic pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/17/2024, revealed a Brief Interview for Mental Status (BIMS) of 11 (moderated cognitive impairment) out of 15. During observation and interview on 07/05/2024 at 10:04 a.m. R1 was observed lying down in bed. Bed was observed to be in the lowest position. R1 explained that she had been at the facility since June of 2024. R1 was asked if she had ever spilled hot liquids on herself while at the facility. She had explained that she had but could not recount the date of the incident. Review of R1 medical record revealed a progress note dated 06/18/2024, at 06:30 p.m., which revealed, During dinner, res (Resident) was mixing 2 mild temperature beverages together and spilled them in her lap. She immediately removed her pants and cool compresses were applied. No blistering noted and redness is improving. Res (Resident) requested Tylenol for mild discomfort. Will continue to monitor. spoke with . PA (Physician Assistant). He recommended monitoring are until resolved. R1's medical record also revealed progress note dated 06/19/2024 at 04:40 a.m. Denies any discomfort to the mild redness on anterior thighs area from spilling warm beverage on lap. R1's medical record also revealed progress note dated 06/19/2024 at 02:50 a.m.no blistering noted and redness improving. (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: 235700	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/05/2024
NAME OF PROVIDER OR SUPPLIER The Willows at East Lansing		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 Coolidge Road East Lansing, MI 48823	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1 medical record revealed a progress note dated 06/27/2024 at 02:32 p.m. revealed, Wound note: bilateral thighs, resident has open area on R thigh measuring approximately 0.5cm (centimeters) x (by) 7.5cm. area is read, no drainage, or odor present. States it does not hurt or itch. L thigh open area measuring approximately 0.5cm x 0.5cm area is red, no drainage, or odor present, states area does not hurt or itch. Will continue to monitor. In an interview on 07/05/2024 at 10:30 a.m. Director of Nursing (DON) B explained that R1 had spilled mild liquids on herself that had been provided on her meal tray. She further explained that mild liquids would have been coffee. When asked if R1 had developed blisters after the spill, DON B explained that she was not aware of any blisters. DON B was asked to review progress note dated 06/27/24 at 02:32 p.m. and explain what the open areas on R1's thighs were attributed to. DON B explained that those open areas were related to R1 scratching herself. DON B could not provide an incident report for the open areas. DON B explained that a skin assessment was to be completed every shift for at least 72 hours after the coffee was spilled on R1. DON B could not provide or demonstrate that skin assessments were completed as required. DON B' also explained that an order should have been put into place to monitor the burned area and a treatment should have been provided to the open areas. DON B could not provide documentation of an order for monitoring or documentation of any treatment that had been provided following the burn or for R1's open areas. In an interview on 07/05/24 at 12:46 p.m. Certified Nursing Aide (CNA) E explained that she provides care to R1 on a regular basis. She explained that she had been told that R1 had spilled coffee on herself during a meal. CNA E explained that she had provided care the day after the 'burn. On that day CNA E explained that she had observed blisters and redness on R1's right thigh and had reported her observation to the one of the nursing managers and had also report her observation to the Nursing Home Administrator. During observation and interview on 07/05/2024 at 01:15 p.m. R1 was observed sitting up in chair. R1 was asked if she had developed any blisters after spilling coffee on herself. She stated, yes I did, and a man even took pictures of it. She was asked if any treatments had been applied to the blisters and she explained that no treatments were done on that area. R1 then proceed to get into bed and remove her pants. A red area with approximately 12 cm (centimeters) in length and 1cm in width was observed. Several scabbed areas were observed along the area. Review of R1's June physician orders, medication record, and treatment record did not demonstrate that any treatment or medication had been ordered or applied to the area of R1's burns. R1's medical record did not demonstrate any pictures of the R1's burned areas.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to MI 00145328 Based observation, interview, and record review the facility failed to prevent accidents (falls) by not following the plan of care, for one Resident (#1) out of five Residents reviewed resulting in injury related to a fall. Findings Included: Resident #1 (R1) Review of the medical record revealed R1 was admitted [DATE] with diagnoses that included cerebral infarction (stroke), fracture of nasal bones, history of falls, urinary tract infection, acute respiratory failure, heart failure, hypertensive heart disease, hypothyroidism (low thyroid hormone), hyperlipidemia (high fat content in blood), diplopia (double vision), dysarthria (slurred speech), anarthria (inability to articulate speech), dysphagia (difficulty swallowing), osteoarthritis, gastro-esophageal reflux, and chronic pain. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/17/2024, revealed a Brief Interview for Mental Status (BIMS) of 11 (moderated cognitive impairment) out of 15. During observation and interview on 07/05/2024 at 10:04 a.m. R1 was observed lying down in bed. Bed was observed to be in the lowest position. R1 explained that she had been at the facility since June of 2024. She explained that she had several falls while at the facility. She explained that her last fall had occurred while she was in the bathroom taking a shower. R1 explained that a certified nursing aide, that was helping her with her shower, had left her alone in the shower. R1 explained that she was reaching for a washcloth and fell off the shower chair. R1 explained that she was taken to the hospital after the fall, at which time she received several sutures to her forehead. R1 explained that she was not to be left alone while she was in the shower because the facility knew she had a history of falling. Review of the facility Event Report dated 07/01/2024, timed at 03:49 p.m., revealed, Resident with fall on 07/01/2024 while in the shower, the resident had requested privacy. Resident states was reaching for a wash cloth that was on the hand rail and slid of the shower chair. Resident was sent to ER (emergency room) for further evaluation and treatment. Review R1's progress notes dated 07/01/2024 at 10:10 p.m. revealed . returned from . hospital, received 6 stitches to the laceration on her forehead . (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/05/2024 at 10:30 a.m. Director of Nursing (DON) B explained that she was aware of the R1's fall that occurred on 07/01/2024. She explained that R1 had been left alone in the shower, because she had asked for privacy, and feel off the shower bench while reaching for a washcloth. DON B was asked if she had interviewed R1 and she explained that she had not, but the nurse had interviewed R1 after the fall. She explained that Certified Nursing Aide (CNA) D had been interviewed and provided a statement. DON B explained that CNA D had reported that R1 had requested privacy and CNA D was honoring her request. In a telephone interview on 07/05/2024 at 11:10 a.m. Registered Nurse (RN) I had been taking care of R1 on 07/01/2024. RN I explained that Certified Nursing Aide (CNA) D had been assisting R1 with a shower. She explained that CNA D had left her alone because R1 had requested privacy. When R1 was left unattended she fell of the shower bench. RN I was asked if she interviewed R1 and she explained that she had not. RN I explained that the events were told to her by CNA D. During observation and interview on 07/05/2024 at 01:15 p.m. R1 was observed sitting up in her wheelchair. R1 was asked additional details regarding her fall on 07/01/2024. She was asked if she had requested privacy during her shower. R1 explained that she had not asked for privacy during her shower and that the facility understood she was not to be left alone, as she has a history of falling. In a telephone interview on 07/05/2024 at 01:27 p.m. Certified Nursing Aide (CNA) D explained that she was the person taking care of R1 on 07/01/2024. CNA D explained that she was assisting R1 with a shower and R1 had fallen off the shower bench. She explained that she had left R1 alone because she had assumed that she would like some privacy. CNA D was asked if R1 had requested privacy and she responded that R1 had not asked for privacy. CNA D explained that she was aware that R1 was a fall risk and explained that if a resident is a fall risk they should not be left alone. CNA D could not explain why she had assumed that R1 wanted privacy during the shower. CNA D explained that she had received a teachable moment, from the facility after R1's fall, which she was re-educated that resident that are a fall risk are not to be left alone while providing shower care. Review of the facility Teachable Moment document dated 07/03/2024 revealed On 07/02/2024 you were providing a shower for a resident with a history falls when you left the shower room. Resident had requested privacy however due to her impulsivity and history of falls, the resident should have remained near and within vision while providing as much privacy as possible. Going forward resident with a history of falls are not be left unattended in the shower. The Teachable Movement document dated 07/03/2024 demonstrated Certified Nursing Aide's (CNA) D signature.