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	03/20/2026

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** This citation pertains to Intake 2808417.Based on observation, interview, and record review, the facility failed to complete wound care as ordered for one (R201) of one reviewed.Findings include:Review of the medical record revealed R201 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis and paraplegia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/26 revealed R201 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had an indwelling urinary catheter, was frequently incontinent of bowel, and had moisture associated skin damage (MASD-inflammation and erosion of the skin caused by prolonged exposure to moisture, such as urine, stool, sweat, or wound secretions). Review of the Physician's Order dated 3/15/26 revealed an order to cleanse the right thigh wound with normal saline or wound cleanser, pat dry, apply skin prep to peri-wound, apply collagen dressing to wound bed, apply border dressing, and change daily. The wound treatment was scheduled to be completed daily between 2:00 PM and 10:00 PM. Review of the Wound Note dated 3/16/26 revealed right thigh wound is pink in color .measuring 1 centimeter (cm) by 3 cm. On 3/20/26 at 12:02 PM, R201 was observed in bed. Certified Nursing Assistant (CNA) C and CNA D were observed completing incontinence care for R201. R201 was incontinent of loose stool that had leaked out of the left side and the top of the brief onto the bedding, resulting in a complete linen change. A dressing was observed to the back of R201's thigh. The dressing was dated 3/16/26, indicating wound care had not been completed since 3/16/26. CNA D agreed the dressing was dated 3/16/26. Review of the Treatment Administration Record (TAR) revealed R201's wound care to the right thigh was documented as completed on 3/17/26 and 3/19/26 by Licensed Practical Nurse (LPN) E. The wound care was documented as refused on 3/18/26. Attempts to contact LPN E via telephone on 3/20/26 at 12:34 PM and 1:54 PM were unsuccessful. Nursing Home Administrator (NHA) A was asked to assist with contacting LPN E via telephone. On 3/20/26 at 2:28 PM, NHA A reported the facility was also unsuccessful with contacting LPN E via telephone. In an interview on 2/20/26 at 1:55 PM, Assistant Director of Nursing (ADON) F reported she was the facility's wound nurse. ADON F reported R201 had MASD to his right thigh that required daily wound care. A request was made to observe R201's wound and wound care with R201's permission. On 3/20/26 at 2:15 PM, ADON F reported R201 refused wound care upon request. In an interview on 3/20/26 at 2:36 PM, Director of Nursing (DON) B reported R201 had MASD, was being followed by the wound nurse, and had orders for daily wound care. DON B reported any wound care refusals would be documented in the Progress Notes or the TAR. DON B agreed that according to the TAR, R201's wound care was documented as completed on 3/17/26 and 3/19/26. DON B reported LPN E might have just clicked it off [as completed] or forgotten to document that R201 refused wound care on those days. DON B reported the facility was trying to contact LPN E to clarify. R201's medical record did not indicate that R201 refused wound care on 3/16/26 or 3/19/26.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2808417.Based on observation, interview, and record review, the facility failed to ensure the accuracy of medical records for one (R201) of three reviewed. Findings include: Review of the medical record revealed R201 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis and paraplegia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/26 revealed R201 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had an indwelling urinary catheter, was frequently incontinent of bowel, and had moisture associated skin damage (MASD-inflammation and erosion of the skin caused by prolonged exposure to moisture, such as urine, stool, sweat, or wound secretions). Review of the Physician's Order dated 3/15/26 revealed an order to cleanse the right thigh wound with normal saline or wound cleanser, pat dry, apply skin prep to peri-wound, apply collagen dressing to wound bed, apply border dressing, and change daily. The wound treatment was scheduled to be completed daily between 2:00 PM and 10:00 PM. Review of the Wound Note dated 3/16/26 revealed right thigh wound is pink in color .measuring 1 centimeter (cm) by 3 cm. On 3/20/26 at 12:02 PM, R201 was observed in bed. Certified Nursing Assistant (CNA) C and CNA D were observed completing incontinence care for R201. R201 was incontinent of loose stool that had leaked out of the left side and the top of the brief onto the bedding, resulting in a complete linen change. A dressing was observed to the back of R201's thigh. The dressing was dated 3/16/26, indicating wound care had not been completed since 3/16/26. CNA D agreed the dressing was dated 3/16/26. Review of the Treatment Administration Record (TAR) revealed R201's wound care to the right thigh was documented as completed on 3/17/26 and 3/19/26 by Licensed Practical Nurse (LPN) E. The wound care was documented as refused on 3/18/26. Attempts to contact LPN E via telephone on 3/20/26 at 12:34 PM and 1:54 PM were unsuccessful. Nursing Home Administrator (NHA) A was asked to assist with contacting LPN E via telephone. On 3/20/26 at 2:28 PM, NHA A reported the facility was also unsuccessful with contacting LPN E via telephone. In an interview on 2/20/26 at 1:55 PM, Assistant Director of Nursing (ADON) F reported she was the facility's wound nurse. ADON F reported R201 had MASD to his right thigh that required daily wound care. A request was made to observe R201's wound and wound care with R201's permission. On 3/20/26 at 2:15 PM, ADON F reported R201 refused wound care upon request. In an interview on 3/20/26 at 2:36 PM, Director of Nursing (DON) B reported R201 had MASD, was being followed by the wound nurse, and had orders for daily wound care. DON B reported any wound care refusals would be documented in the Progress Notes or the TAR. DON B agreed that according to the TAR, R201's wound care was documented as completed on 3/17/26 and 3/19/26. DON B reported LPN E might have just clicked it off [as completed] or forgotten to document that R201 refused wound care on those days. DON B reported the facility was trying to contact LPN E to clarify. R201's medical record did not indicate that R201 refused wound care on 3/16/26 or 3/19/26.