

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2025
NAME OF PROVIDER OR SUPPLIER  Northville Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  520 W Main St Northville, MI 48167	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>15194</p> <p>Based on observation, interview, and record review the facility failed to (1.) provide a dignified dining experience for three residents (R2, R3, and R7) of 25 residents observed during dining, resulting in staff standing over residents while assisting with feeding and (2.) meals served with an assortment of dinnerware, compromising the residents' rights to a respectful and individualized dining experience.</p> <p>Findings include:</p> <p>On 4/14/25 at approximately 10:20 A.M., R3 who was alert and oriented stated, They serve my food on plastic plates. I would like real silverware not paper and plastic. Observations at that time showed a stack of plastic ware on the resident's bedside table.</p> <p>On 4/15/25 at 12:30 p.m. during a lunch observation, Nurse J was observed standing over R7 while assisting with the resident's meal. Initially Nurse J positioned himself in front of R7 in a squatting position before standing to R7's right side, cueing and prompting the resident while intermittently checking the medication cart returning to R7's side placing spoon or pieces of food in the resident's mouth and hands without consistent engagement. While Nurse J was obtaining a napkin for R7, R2 seated at another table, self-propelled herself out of the dining room to the front lobby area wearing a soiled clothing protector. R2 was later returned to the dining room where her hands and face were cleansed and the soiled protector removed. Additionally, during this lunch observation, some residents were observed without napkins or plastic ware causing residents to delay starting their meal requesting staff to assist with cutting their hamburgers.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/25 at 12:00 P.M. at lunch approximately 15 residents in the dining room were served their meal with an assortment of dinnerware including Styrofoam cups and dessert plates, plastic utensils, and 6--inch melamine plates which were insufficient in size to accommodate both the entree and salad served. At 12:23 P.M., Dietary Manager (DM) A was asked to observe the meal service. When questioned regarding the use of assorted and inadequate tableware, DM A explained the facility had a full set of dishes available, there were no call-ins that day, and the dish machine was operational. I am not sure why cook (K) is not using those dishes. In a follow up interview at 3:45 P.M., [NAME] K was unable to provide a reason why assorted dinnerware was used during the meal service. During this same observation, Nurse L was observed standing while feeding R2. When asked, whether staff should stand when assisting residents with meals, Nurse L stated, We try to cue residents who cannot feed themselves, but sometimes the dining room get crowded and there is not sufficient room to provide one-on one feeding.</p> <p>On 4/17/25 at 11:00 A.M., a review of the facility policy titled, Promoting/Maintaining Resident Dignity, dated 11/1/2022, revealed that while the policy emphasized promoting respect and dignity and enhancing resident's quality of life by recognizing each resident's individuality, it did not specifically address dignity practices during dining.</p> <p>Upon exiting the facility on 4/17/25 at 3:00 P.M., no additional information regarding these concerns was provided.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50634</p> <p>Based on observation, interview and record review, the facility failed to follow professional standards of practice by ensuring medications were administered according to physicians' orders for three residents (R28, R2, and R21) of seven residents reviewed for medication administration, resulting in the potential for less than the therapeutic effect of the prescribed medication when medications were not taken as ordered.</p> <p>Findings include:</p> <p>On 4/15/2025 at 1:57 PM, observed Registered Nurse (RN) J administer 9 AM medications to R8. The following medications were administered: Keppra 600 mg, Metoprolol 75 mg, Vitamin D3, and Ramipril 5 mg. Vital signs were blood pressure 132/85 and heart rate of 86. Keppra 600 mg, and Metoprolol were medications that were ordered twice a day at 9 AM and 9 PM. Keppra is a medication used to treat seizures. Metoprolol is used to treat heart disease and blood pressure.</p> <p>R8 was admitted on [DATE] with a pertinent diagnosis of Major depressive disorder, vascular dementia with behavior disturbances, hypertension, and seizures.</p> <p>Review of R8 Quarterly Minimum Data Set (MDS) dated [DATE] for Brief Interview for Mental Status (BIMS), revealed R8 was severely cognitively impaired with a score of 7 out of 15.</p> <p>On 4/15/25 at 2:49 PM, RN J was observed to administer 9 AM medications to R28. The following medications were administered Keppra 500 mg, Vitamin D3, Sertraline 50 mg, Remeron 15 mg, The Keppra was a medication that was ordered to be given twice a day at 9 AM and 9 PM. Keppra is a medication to treat seizures.</p> <p>R28 was admitted on [DATE] with a pertinent diagnosis of Epilepsy, adjustment disorder with disturbances of conduct, major depressive disorder, dementia, and atherosclerotic heart disease (buildup of plaques in the arteries.)</p> <p>Review of R28 Annual MDS dated [DATE] for BIMS R28 was moderately cognitively impaired with a score of 12 out of 15.</p> <p>On 4/15/25 at 2:54 PM, RN J was observed to administer 9 AM medications to R2. The following medications were administered Duloxetine, Vitamin C, Vitamin B12, Vitamin D3 and Probiotic. The Duloxetine was a medication that was ordered to be given twice a day at 9 AM and 9 PM. Duloxetine is a medication used to treat depression.</p> <p>R21 was admitted on [DATE] with a pertinent diagnosis of Alzheimer's disease, adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, and atherosclerosis of the aorta (buildup of fat on the artery walls.)</p> <p>Review of R21, Quarterly MDS dated [DATE] for BIMS, revealed R21 was severely cognitively impaired with a score of 00.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/15/25 at 3:00 PM, RN J was interviewed about they were administering 9 AM medications after scheduled time. RN J said he got behind after a medical emergency that had occurred around 10:30 AM. RN J was queried if they had advised the Director of Nursing (DON) that he was late passing medications. RN J said no.</p> <p>On 4/17/25 at 11:00 AM, the DON was interviewed about medications that were administered after the scheduled medication administration time. The DON said they would expect medications to be given within the scheduled administration time. The DON said if the nurse is unable to pass medications in the scheduled time the nurse should let her know, so she could assist them. The DON was queried about the medications administered after scheduled medication time the DON said she was aware there were late medications given. The DON was queried if the provider was contacted about medications given late to see if they should have been rescheduled. The DON said the provider was not contacted about late medications. The DON acknowledged that giving medications outside the scheduled time frame can cause adverse effects.</p> <p>On 4/17/25 at 12:30 PM, the Nursing Home Administrator (NHA), was interviewed about medications given outside of the scheduled medication administration time. The NHA said the expectation is for medications to be administered as ordered.</p> <p>Record review of the facility document titled, Medication Administration with a revision date of 6/12/24, noted medications are to be administered by licensed nurse or other staff members who are legally authorized to do so under the laws of this state. In addition, the policy noted medications should be administered within 60 minutes prior or after the scheduled administration time. The scheduled administration time can be adjusted by the physician.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964</b></p> <p>Based on observation, interview, and record review the facility failed to provide behavioral health services for five residents (R6, R7, R8, R9 and R16) out of twelve residents reviewed for behavioral health resulting in the potential for residents not to attain or maintain their highest practicable mental and psychosocial well-being.</p> <p>Findings included:</p> <p>R6</p> <p>On 4/14/25 at 10:56 AM R6 was observed sitting in a wheelchair holding a stuffed animal in her left hand, leaning to the right with a bruise on her right elbow. When R6 was asked about the bruise on her R elbow R6 could not recall how she got the bruise.</p> <p>Record review of R6's Electronic Health Record revealed R6 was admitted to the facility on [DATE] with pertinent diagnoses that included Alzheimer's Disease, adjustment disorder with anxiety, adjustment disorder with depressed mood, unspecified intellectual disabilities, and unspecified dementia. Review of the Minimum Data Set (MDS) dated [DATE] revealed that R6 had severely impaired cognition and was wheelchair bound. Review of the nurse's progress note dated 1/28/25 revealed R6 had a fall on 1/28/2025 with no injuries.</p> <p>Review of R6's physician orders revealed R6 was prescribed diazepam (antianxiety) and sertraline(antidepressant) medications.</p> <p>On 4/15/25 at 2:55 PM the Nursing Home Administrator (NHA) was interviewed and said R6 was last seen by the psychiatric practitioner on 8/12/24 to address the psychotropics and antidepressants.</p> <p>Review of the physician progress notes dated 1/21/25, 2/26/25 and 3/17/25 revealed Psych follows the patient for history of dementia. Dementia-continued input from Psych appreciated.</p> <p>Review of R6's care plan revealed Problem start date 4/5/23 I have verbal behavioral symptoms directed toward others; I have physically aggressive behavior towards others. Approach start date 4/25/23 obtain a psych consult/psychosocial therapy as needed.</p> <p>R8</p> <p>On 4/14/25 at 10:44 AM R8 was observed sitting in her wheelchair in her room yelling out. When R8 was asked about how she felt R8 yelled out, Fine and [NAME] just like candy.</p> <p>On 4/15/25 at 8:20 AM R8 was observed in her room slumped in her wheelchair yelling out.</p> <p>On 4/16/25 at 12:26 PM R8 was observed in the dining room banging the table with frequent yelling.</p> <p>(continued on next page)</p>

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/17/25 at 8:25 AM R8 was observed sitting alone in her room banging an empty glass on plate yelling out.</p> <p>On 4/15/25 1:30 PM Social Worker F was interviewed about R8's behaviors and said psychiatric services last saw R8 on 8/24 and the expectation is for the resident to receive psychiatric services at least quarterly.</p> <p>Record review of R8's Electronic Health Record revealed R8 was admitted to the facility on [DATE] with most recent readmission on 8/31/2024 with pertinent diagnoses that included reaction to severe stress, unspecified, major depressive disorder, recurrent unspecified, vascular dementia with behavioral disturbance. Review of the Minimum Data Set (MDS) dated [DATE] revealed that R6 had severely impaired cognition and was wheelchair bound.</p> <p>Record review of physician orders revealed order date 8/4/23 may have ancillary services psychiatric.</p> <p>Record review of R8's care plan revealed, Problem Start Date: 07/05/2023 Category: Behavioral Symptoms I am at risk of displaying signs and symptoms of mood distress R/T dx of major depressive disorder recurrent unspecified. Approach Start Date: 07/05/2023 Obtain a psych consult as needed. Problem Start Date: 07/05/2023 Category: Behavioral Symptoms I have behavioral symptoms not directed to others. I yell out. I remove my clothing. I pull my shirt over my head which exposes my chest/torso area. Approach Start Date: 07/05/2023 Obtain a psych consult as needed.</p> <p>Review of the physician progress notes dated 2/11/25 and 3/17/25 revealed Patient is followed by psych, with recommendations to continue current treatment regimen. Dementia: Psych is following.</p> <p>On 4/17/25 at 10:00 AM the Director of Nursing (DON) was interviewed and said the expectation is for psychiatric services to follow residents who are prescribed antipsychotic medications and/or exhibit behaviors at least quartetly. The DON said R6 and R8 were last seen by psychiatric services in August of 2024 and that there is not a current pscychiatric group servicing the building.</p> <p>50634</p> <p>R16</p> <p>On 4/14/25 at 11:00 AM, R16 was observed in dinning room in wheelchair. R16 had multiple bruises on the face from a previous fall.</p> <p>On 4/15/25 at 12:45 PM, R16 was observed in the dinning room crying. R16 was crying saying she did not know what she should be doing and could not remember who she was. Registered Nurse (RN) J reminded her of her name and where she was. R16 continued to repeat they did not know who they were.</p> <p>On 4/17/25 at 10:00 PM, R16 was observed in the dinning room crying. RN J was sitting next to R16 talking to her. R16 continued to cry.</p> <p>Record review of R16's Electronic Medical Record (EMR) revealed that R16 had not received Psychiatric services since 11/5/24.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of R16 (EMR) documented R16 was admitted on [DATE] with a pertinent diagnosis of Major depressive disorder, anxiety disorder, dementia and mild cognitive disorder. Review of R16, Quarterly Minimum Data Set (MDS) dated [DATE] for Brief Interview for Mental Status (BIMS) R16 was severely cognitively impaired with a score of 99.</p> <p>R9</p> <p>On 4/14/25 at 2:00 PM observed R9 in room sitting on bed in room talking with other residents.</p> <p>Record review of R9's (EMR) revealed that R9 had not seen Psychiatric services since 8/12/24.</p> <p>Record review noted R9 was admitted on [DATE] with a pertinent diagnosis of Major depressive disorder, dementia, paranoid personality disorder, adjustment disorder with mixed anxiety and depressed mood, psychotic disorder with hallucination.</p> <p>Review of R9 Quarterly (MDS) dated [DATE] for BIMS R9 was moderately cognitively impaired with a score of 9 out of 15.</p> <p>R7</p> <p>On 4/15/25 at 12:45 PM, R7 was observed in the dining room eating.</p> <p>Record review of R7's (EMR) revealed R7 had not seen since Psychiatric services since 7/15/25.</p> <p>Record review noted R7 was admitted on [DATE] with a pertinent diagnosis of Vascular dementia with mood disturbances, psychotic disorders with delusions, schizophrenia, adjustment disorder and mood disorder. Review of R7's (MDS) dated [DATE] for BIMS R9 was severely cognitively impaired with a score of 99.</p> <p>On 4/16/25 at 2:00 PM, Social Worker (SW) F was interviewed about residents not receiving Psych services. SW F said they had recently started coming back to this facility in February after a staff change and they are working on getting services established with a Psychiatric services provider.</p> <p>On 4/16/25 at 2:15 PM, the Director of Nursing (DON), was interviewed and said the previous provider would meet with her and keep her up to date on resident's care. When the new provider started coming out, they did not meet, so she was unaware the residents where not receiving services.</p> <p>On 4/16/25 at 2:15 PM, the Nursing Home Administrator (NHA), was interviewed and said if they would have noticed any changes in residents' behavior they would have communicated the changes to the provider.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>50634</p> <p>This citation includes two Deficient Practice Statements.</p> <p>Deficient Practice Statement #1:</p> <p>Based on observation, interview and record review, the facility failed to ensure proper cleaning and disposal of loose medications were conducted for one medication cart (North Hall Cart) reviewed for medication storage and cleanliness.</p> <p>Findings include:</p> <p>On 04/17/25 at 09:00 AM, an observation and an interview were conducted with Registered Nurse (RN) J on the North Hall medication cart. Upon inspection of medication cart a total of 13 loose pills were scattered on the bottom of the first and second drawers of the medication cart. The loose pills varied in shapes, colors and sizes.</p> <p>On 04/17/25 at 09:05 AM, an interview was conducted with RN J regarding the loose medications of North Hall medication cart. RN J said they were probably pills that were being popped from the packet but dropped. When asked about their policy for loose medications, RN J said the pills should have been discarded.</p> <p>On 04/17/25 at 9:15 AM, an interview was conducted with the Director of Nursing (DON) regarding the 13 loose pills found in the North Hall medication cart. The DON said that the nurses are expected to clean the cart when they take it over, because they oversee the medication cart.</p> <p>On 4/17/25 at 12:30 PM, an interview was conducted with the Nursing Home Administrator (NHA) about the 13 pills found in the North Hall medication cart she said the midnight nurses are responsible for cleaning the medication carts. The NHA supplied a sheet titled Medication Cart Check list which noted it is the duty of the midnight shift to clean med cart drawers and remove any loose pills.</p> <p>Review of the facility document titled Medication Administration with a revision date of 6/12/24, noted the medication cart should be kept clean and organized.</p> <p>Deficient Practice Statement #2:</p> <p>Based on observation and interview the facility failed to ensure expired medication were disposed of in a timely manner.</p> <p>Findings include:</p> <p>On 4/17/25 at 9:30 AM, an observation and interview were conducted of three of the medication rooms with the Director of Nursing (DON.) Identified expired medication in the facility's main storage room included Geri Lanta (expired 9/24) and Benadryl (expired 2/25).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>These finding were acknowledged by the DON at the time of the observation.</p> <p>On 4/17/25 at 11:00 AM, the DON was interviewed and said medication supply staff are responsible for the medication storage room. In addition, the DON said the stock is checked weekly by the medication supply staff. The DON said expired medication should be brought to them so they can be put in the drug buster (a system used to secure and destroy unused medication.)</p> <p>On 4/17/25 at 12:30 PM, the Nursing Home Administrator (NHA) was interviewed about the expired medications identified in the medication storage room. The NHA said it is the duty of the medical supply staff to review dates on medical supplies in the storage room. The NHA said the medical supply staff should be going through and checking dates monthly.</p> <p>Review of a facility document titled Medication Administration with a revision date of 6/12/24 noted if medication is expired the staff should notify the nurse manager.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>15194</p> <p>Based on observation, interview, and record review the facility failed to post revised menus and planned menus in advance for residents, resulting in the potential for a decline in nutritional status and resident dissatisfaction with meals. This deficient practice affected 27 of the 28 residents that consumed meals from the kitchen.</p> <p>Findings include:</p> <p>On 4/15/25 at approximately 10:35 a.m. posted in the dining room revealed the posted lunch menu listed: Braised Beef Tips, Parsley Noodles, Seasoned carrots, wheat rolls, Boston cream pie, coffee or tea, milk. However, during the lunch observation at 12:00 p.m. residents were instead served the following: Hamburger/Bun, lettuce, tomato, onion, pickles, ice cream, beverage of choice.</p> <p>At 1:30 p.m., an interview with Dietary Manager (DM) A was conducted regarding the inconsistency between the posted menu and the meal served. DM A explained on 4/13/25 a new dietary employee had mistakenly used the meat intended for Tuesday's lunch meal, and it was too late to place a new order from the facility's food vendor. DM A stated, whenever an item is unavailable or a situation like this arises, a meeting is held with the residents to vote on the substitute menu, with the majority determining the outcome. When further questioned about the complete menu change, including the dessert substitution, DM A stated although the Boston Cream Pie was available in the freezer, an unspecified decision was made to change the entire menu. DM A indicated that while residents in the dining room and in their rooms were consulted, no evidence could be produced to show that the menu changes were formally posted or that official meetings were documented for any of the days when substitutions occurred.</p> <p>On 4/16/25 at approximately 9:00 A.M. a request was made to review the substitution log for the current winter cycle. The review revealed on 3/28 Potato salad was to be served but was substituted with potato chip and on 4/14/25 Salmon Croquettes for the dinner meal were replaced with resident's choice of pizza and salad. The substitution Logs documenting these changes were not provided until 4/17/25 after DM A and [NAME] K said they were not aware the resident's posted menus should be changed or modified when there was a change in the planned menu.</p> <p>During interview with DM A regarding the planning of Easter Sunday menu, DM A stated the menu would probably change because it was a special occasion. DM A further explained that Saturday's planned lunch would be switched with Sunday's lunch but admitted that the residents had not been informed of the changes and that the planned menu had not yet been posted or completed.</p> <p>On 4/17/25 at 10:00 A.M. and at 3:30 P.M. during the exit conference with the Corporate (Registered Dietitian) RD, the Director of Nursing, and the Administrator, no additional information or evidence was presented explaining why resident's menus were not updated or posted in accordance with changes made to the planned menu.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>15194</p> <p>Based on observation, interview and record review the facility failed to ensure hygienic practices were performed while serving resident meals, resulting in the potential for food contamination. This deficient practice had the potential to effect 27 of the 28 residents that consumed food from the kitchen.</p> <p>Findings include:</p> <p>On 4/15/25 at 12:30 P.M. during a lunch meal observation, Certified Nurse Aides (CNA's) C, D, and H were observed serving food to residents without any form of hair restraint or their hair pulled back off their faces. CNA C and CNA H were observed with (loose braided) hair extensions (approximately 50 inches long) that hung over their shoulders and reached their buttocks. CNA D natural hair extended down her back and was seen repositioning her hair behind her ears to prevent hair from touching resident's food. Additionally, CNA D was observed wrapping silverware without wearing gloves. While the silverware was positioned correctly in the cylinder CNA D manipulated the eating surfaces of the utensils while attempting to wrap them in napkins. CNA H poured beverages for resident and passed the drinks by holding them at the rim of the drinking surface instead of the base.</p> <p>During the observation Dietary manager (DM) A was interviewed regarding the handling of the silverware and glasses. DM A confirmed that while the silverware was properly positioned in the cylinders, staff should not have been handling the eating portions of the utensils at all. DM A was asked should gloves be applied? Dietary Manager A responded YES.</p> <p>On 4/17/25 at 10:00 A.M., a policy was requested regarding the use of hair restraints during dining and handling of resident's eating utensils. At 11:50 A.M. a policy titled, Dress Code was provided. However, it was not specific to food service personnel. Under the Policy Explanation and Compliance Guidelines, item #5 documented that depending on the duty assignment or work area, an employee with long hair may be required to wear a hair net.</p> <p>According to the 2009 Michigan Modified Food Code, section 2-402.11 (A) Except as provided in (B) food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils and linens; and unwrapped single-service and single-use articles.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235730	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2025
NAME OF PROVIDER OR SUPPLIER  Northville Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  520 W Main St Northville, MI 48167	

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47964</p> <p>Based on interview and record review, the facility failed to ensure one resident (R21) out of five residents reviewed for immunizations were provided pneumococcal vaccination and education, resulting in the potential for development and spread of influenza among vulnerable residents in the facility.</p> <p>Findings include:</p> <p>On 4/15/25 at 2:32 PM the Director of Nursing (DON)/Infection Preventionist (IP) was interviewed and reported R21 did not have documentation of a current influenza immunization or refusal.</p> <p>Review of the Electronic Health Record (EHR) for R21 revealed admission to the facility on [DATE] with diagnoses of adjustment disorder with mixed anxiety and depressed mood, and asthma. Further review of EHR revealed R4 did not have documentation to indicate that the influenza vaccine was offered or was contraindicated.</p> <p>On 4/17/25 at 8:52 AM the DON was interviewed and said residents and or guardians should be educated and given the opportunity to receive vaccinations. The DON agreed R21 should have been offered the influenza vaccine for the 2024/2025 flu season.</p> <p>Review of the facility policy titled Influenza Vaccination date implemented 11/1/2022 revealed in part: It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>47964</p> <p>Based on observation, interview, and record review the facility failed to provide 80 square feet of space per bed within six (2, 7, 10, 11, 12, and 14) of 15 resident rooms, resulting in the increased likelihood for resident dissatisfaction with the amount of provided living space.</p> <p>Findings include:</p> <p>On 4/17/2025 at 10:31 AM observation of resident rooms and record review of the facility bed count information with the Nursing Home Administrator (NHA) revealed the following:</p> <p>Room # Sq./Ft # Beds #Residents in Room</p> <p>2 283 4 3</p> <p>7 218 3 3</p> <p>10 225 3 3</p> <p>11 215 3 3</p> <p>12 154 2 2</p> <p>14 144 2 2</p> <p>Observations and interviews with various residents revealed no specific complaints and no specific health/safety concerns.</p>		

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NAME OF PROVIDER OR SUPPLIER  Northville Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  520 W Main St Northville, MI 48167	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22050</p> <p>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 28 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and potential cross-connections between the potable (drinking) and non-potable (non-drinking) water supplies.</p> <p>Findings include:</p> <p>On 04/14/25 at 01:25 P.M., A common area environmental tour was conducted with Director of Maintenance I. The following items were noted:</p> <p>Resident Restroom [ROOM NUMBER]: The overhead clear plastic light lens cover was observed soiled with (dust, dirt, numerous dead insect carcasses). Director of Maintenance I indicated he would have staff clean and sanitize the light lens cover as soon as possible.</p> <p>Shower Room: The shower wand assembly was observed missing an atmospheric vacuum breaker. Director of Maintenance I indicated he would install an atmospheric vacuum breaker as soon as possible.</p> <p>Resident Restroom [ROOM NUMBER]: The hand sink faucet assembly was observed (etched, scored, particulate, corroded). Director of Maintenance I indicated he would install a new faucet assembly as soon as possible.</p> <p>On 04/14/25 at 01:50 P.M., An interview was conducted with Director of Maintenance I regarding the facility maintenance work order system. Director of Maintenance I stated: We have a manual work order system. Director of Maintenance I also stated: The maintenance logbook is located at the Nurses Station.</p> <p>Nursing Station: The black vinyl padded chair was observed (etched, scored, particulate), exposing the inner Styrofoam padding. The damaged black vinyl surface measured approximately 3-inches-wide by 30-inches-long. Director of Maintenance I indicated he would replace the worn chair as soon as possible.</p> <p>The Hallway Corridor carpeting was observed (stained, worn, buckled). One large red colored carpet stain was also observed directly beneath the resident call system panel. The stained carpet surface measured approximately 12-inches-wide by 12-inches-long.</p> <p>On 04/14/25 at 02:07 P.M., An interview was conducted with Nursing Home Administrator (NHA) regarding a replacement plan for the facility hallway corridor carpeting. (NHA) stated: No, not at this time.</p> <p>The Day Room carpeting was observed (stained, worn, pilled).</p> <p>On 04/14/25 at 03:50 P.M., An environmental tour of sampled resident rooms was conducted with Director of Maintenance I. The following items were noted:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Northville Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  520 W Main St Northville, MI 48167	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2: The Bed 1 and Bed 3 overbed light shades were observed heavily soiled with accumulated and encrusted dust/dirt deposits.</p> <p>7: The Bed 1, Bed 2, and Bed 3 overbed light shades were observed heavily soiled with accumulated and encrusted dust/dirt deposits.</p> <p>11: The Bed 3 stationary desk fan was observed heavily soiled with accumulated and encrusted dust/dirt deposits. Director of Maintenance I indicated he would have housekeeping thoroughly clean and sanitize the desk fan as soon as possible.</p> <p>14: The Bed 1 and Bed 2 overbed light shades were observed heavily soiled with accumulated and encrusted dust/dirt deposits. Director of Maintenance I indicated he would have housekeeping thoroughly clean and sanitize the soiled light shades as soon as possible.</p> <p>On 04/17/25 at 08:00 A.M., Record review of the Policy/Procedure entitled: Preventative Maintenance Program dated 11/02/2022 revealed under Policy: A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Record review of the Policy/Procedure entitled: Preventative Maintenance Program dated 11/02/2022 further revealed under Policy Explanation and Compliance Guidelines: (1) The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p> <p>On 04/17/25 at 08:15 A.M., Record review of the Policy/Procedure entitled: Cycle Cleaning dated 10/26/2022 revealed under Policy: It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain scheduled environmental service tasks. Record review of the Policy/Procedure entitled: Cycle Cleaning dated 10/26/2022 further revealed under Policy Explanation and Compliance Guidelines: (1) Routine cleaning of environmental surfaces and non-critical resident care items shall be performed according to a predetermined schedule and shall be sufficient enough to keep surfaces clean and dust free.</p>		