STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23E104	A. Building B. Wing	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gilbert Residence	203 S Huron Street Ypsilanti, MI 48197

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen. Findings include: On 10/06/2025 at 09:00 a.m. during an initial tour of food services was conducted with Certified Dietary Manager (CDM) “E”, the following items were observed: Cooler was observed to have red substance on the back wall and on the floor-CDM “E” explained that it was possibly spilt Jello from the weekend. Freezer was observed to have two individual containers of ice cream on the floor. Dry storage was observed to have particles on the floor which CDM “E' explained that it was possibly spilt oatmeal. The top of the enclosed stove appeared to be soiled with food particles and dust. Inside of the same stove appeared soiled with multiple layers of burn on food. End of the dish counter appeared soiled with multiple layers of old food and the back of the splash wall was observed to have black substance in the caulk. The dishwasher appeared to have multiple layers of lime deposits on the sides and front door. On 10/06/2025 at 9:45-10:24 AM during the kitchen tour with the Kitchen Manager I, observed the can opener visibly soiled. The Kitchen Manager I, removed the can opener and put it in the dishwashing area. When interviewed, the Kitchen Manager I stated that the can opener is cleaned once a week. On 10/06/2025 at 9:45-10:24 AM observed the slicer visibly soiled with orange debris, located in the main kitchen. When interviewed, the Kitchen Manager I stated that the slicer is cleaned after every use. On 10/06/2025 at 9:45-10:24 AM observed the mixer visibly soiled, located in the main kitchen. When interviewed, the Kitchen Manager I said the mixer is cleaned after every use, but that it definitely needs to be deep cleaned now. On 10/06/2025 at 9:45-10:24 AM observed the drain line to the ice machine sitting directly inside the drain, located in the main kitchen. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/06/2025 at 9:45-10:24 AM observed black residue on the inside wall of the ice machine, located in the nursing kitchen. When interviewed, the Kitchen Manager I stated that the ice machine is cleaned once a month. On 10/06/2025 at 9:45-10:24 AM observed the drain line to the ice machine sitting directly inside the drain and multiple dirty plastic cups and lids on the floor behind the ice machine, located in the nursing kitchen. On 10/06/2025 at 9:45-10:24 AM observed the inside walls of the microwave visibly soiled, located in the nursing kitchen. When interviewed, the Kitchen Manager I said that the microwave should be cleaned once a week, but it doesn't look like it's been done. On 10/06/2025 at 11:45AM-12:34PM during the lunch observation with the Kitchen Manager I, reviewed the temperature logs for hot and cold holding. On 10/2, garden salad was temped at 45 degrees Fahrenheit at dinnertime. On 10/3, potato salad was temped at 60 degrees Fahrenheit during dinnertime. On 10/4, seafood salad was temped at 56 degrees Fahrenheit and broccoli salad was temped at 52 degrees Fahrenheit. On 10/06/2025 at 11:45AM-12:34PM during lunch observation, observed the Kitchen Manager I take the cold holding temperature for chicken salad, and the temperature was 50 degrees Fahrenheit. When interviewed, the Kitchen Manager I stated they try to keep the cold holding temperatures at 40 degrees Fahrenheit. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the facility policy on Cleaning of food contact surfaces and nonfood contact surfaces, To prevent cross contamination, kitchenware and food contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred. According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). According to the 2022 Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control, time/temperature control for safety food shall be maintained: .at 5°C (41°F) or less.

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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** Based on interview, and record review the facility failed to ensure accurate advance directive (legal documents that allow a person to identify decisions about end-of-life care ahead of time) information was in place for two residents (#7 and 33) of two residents reviewed for advance directives from a total sample of 9 residents. Resident #7 Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident #7 (R7) was admitted to the facility on [DATE] with diagnosis that included vascular dementia and hypertension. The MDS revealed R7 had long and short-term memory impairment and severely impaired decision-making skills. A statement of decision-making capacity, signed by the Physician on 7/30/25 and signed by a psychologist on 7/22/25 revealed R7 was unable to fully participate in medical treatment decisions due to vascular dementia. Further review of R7's medical record reflected R7's Durable Power of Attorney (DPOA) signed an advanced directive for Do Not resuscitate (DNR), meaning if the heart and breathing should stop, no attempts were to be made to resuscitate R7. R7's legal agent signed the Advance Directive form on May 15, 2025. R7's DPOA signature was no be witnessed by two persons. The form did have one witness signature and was dated May 15, 2025, the other witness signature was dated June 2, 2025. Resident 33 Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] revealed Resident #33 (R33) was admitted to the facility 01/11/22 with diagnoses that included dementia and diabetes. The MDS revealed R33 also had long and short-term memory impairment. The clinical record revealed R33 had an activated DPOA. R33's advanced directives form revealed the DPOA's signature was dated 01/06/2022 with one witness signature dated 01/06/22. The other witness signature was dated 1/10/2022. On 10/07/2025 8:28 AM during an Interview with Director of Nursing (DON) B she reported the facility Social Worker (SW) C handled the Advanced Directives, however the SW C had an emergency and was not at the facility and was unable to be interviewed. Review of R7 and R33's advanced directive documents were reviewed with DON B acknowledged the witness section of both R7's and R 33's advanced directive forms did not have the two required witnesses.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review the facility failed to ensure that residents were free from significant medication errors for one resident (#28) of four residents reviewed during medication administration. Findings Included:Resident #28 (R38)Review of the medical record revealed R28 was admitted to the facility 09/23/2025 with diagnoses that included atrial fibrillation, hyperlipidemia, sleep apnea, congestive heart failure (CHF), hypertension, muscle wasting, ischemic cardiomyopathy (damage of heart muscle), gastro-esophageal reflux disease, anxiety, and cerebral infarction (CVA). The most recent Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 09/23/2025, revealed R28 had Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. On 10/07/2025 at 08:56 a.m. Registered Nurse (RN) D was observed preparing medication to provide to R28. R28 was observed sitting at a dining room table. RN D provided six medications to R28 who then was observed to orally consume the six medications. One of the medications observed to be provided to R28 was Digoxin 125 mcg (micrograms). During medication reconciliation and record review it was revealed that R28's physician order for Digoxin 125mcg (micrograms), one orally once per day, was written 09/25/2025 and was discontinued on 10/03/2025. No further order for Digoxin 125mcg was observed in R28s' medical record.In an interview on 10/07/2025 at 09:22 a.m. Director of Nursing (DON) B was asked review R28's medication orders. She was asked why R28 was observed to have been provided Digoxin 125mcg (microgram) one tab orally during the morning medication administration. DON B confirmed that R28 should not have been provided Digoxin 125mcg because the order had been discontinued on 10/03/2025. DON B explained that medications are delivered to the facility once per month, for a thirty day supply, called ATP (around the clock pack). DON B explained that it is the nurses responsibility to verify the list of medication in the ATP against the computerized medication administration record (MAR) and if medications were provided in the ATP, the nurse would discard that medication and not provide it to the resident. DON B could not explain why Registered Nurse (RN) D had not followed the process and why R28 had received Digoxin 125mcg (micrograms) one tablet during morning medication administration.