| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WILLOWBROOK MANOR** | **G-4436 BEECHER RD FLINT, MI 48532** |

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|---|---|---|---|---|
| E0000<br>SS= | Initial Comments<br><br>On June 24, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Willowbrook Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness. | E0000 | | |
| E0013<br>SS= F | Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization | E0013 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

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|---|---|---|---|---|
| | must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, the facility failed to develop Emergency Preparedness policies and procedures, based on the emergency plan, risk assessment and communication plan. The policies and procedures must be reviewed and updated at least annually. This deficient | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| | practice could affect all occupants in the event of an emergency.<br><br>Findings Include:<br><br>1. On June 24, 2025 at approximately 2:30 PM record review revealed the facility policy for emergency situations involving electrical Power Outage directs staff to utilize the "emergency kit" cart located in the 500 Hall. Field verification of the cart location revealed there is no emergency kit carts located in the 500 wing. The cart was moved and it not located in the 600 service hall. This may lead staff unable to locate the emergency kit cart when needed during an emergency situation.<br><br>2. On June 24, 2025 at approximately 2:45 PM record review revealed the facility severe weather policy indicates facility staff will monitor a weather radio located at the main nurse station. Field verification of the emergency response plan revealed there is not a weather radio located at the main nurse station. This may lead staff to miss important emergency weather information.<br><br>These findings were confirmed through interview with the maintenance director at the time of record review. | | | |

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|---|---|---|---|
| | 254260 | A. BUILDING _____ B. WING _____ | 6/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOWBROOK MANOR | G-4436 BEECHER RD FLINT, MI 48532 |

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|---|---|---|---|---|
| K0000<br>SS= | INITIAL COMMENTS<br><br>On June 24, 2025 a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Willowbrook Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code.<br><br>The facility is a single story building of type II (111) construction, built in 1965, with an addition of type V(111) built in 2018. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.<br><br>The facility has 130 certified beds. At the time of the survey the census was 108.<br><br>The requirement at 42 CFR, subpart 483.90(a) is NOT MET as evidenced by: | K0000 | | |
| K0211<br>SS= E | Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure aisles, | K0211 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WILLOWBROOK MANOR** | **G-4436 BEECHER RD FLINT, MI 48532** |

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|---|---|---|---|---|
| | passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7.1.10.1. This deficient practice could affect 20 occupants in the event of a evacuation emergency.<br><br>Findings Include:<br><br>1. On June 24, 2025 observation revealed the Human Recourses office exterior door is sealed shut and will not open. This will prohibit the full use of the door to any extent needed including emergency use.<br><br>2. On June 24, 2025 observation revealed an excessive amount of dialysis infusion transport chairs being stored in the emergency egress corridor outside of the dialysis treatment room. Twelve chairs were observed in storage in the corridor from approximately 10:30 AM until 2:30 PM. There is not enough dedicated accumulation space for the chairs to be placed in when removed from the corridor during an emergency evacuation.<br><br>3. On June 24, 2025 observation revealed the west emergency exit door from the main dining room is stuck closed and cannot be opened without using excessive force. This will prohibit emergency evacuation from the main dining room in the event of an emergency.<br><br>These findings were confirmed through interview with the maintenance director at the time of observation. | | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K0291<br>SS= F | Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure automatic emergency lighting is provided in accordance with 7.9. This deficient practice could affect all occupants in the event power is lost to the facility.<br><br>Findings Include:<br><br>1. On June 24, 2025, at approximately 11:00 AM observation revealed the battery back-up emergency lighting over the transfer switches is not illuminating when tested. This will leave the area in the dark should the transfer switches fail to transfer power to back-up generator power during a power loss event.<br><br>2. On June 24, 2025 at approximately 12:00 PM observation revealed the battery back-up light in the activities area over the doors does not illuminate when the test button is pushed. This may leave the area in darkness during a power loss event.<br><br>These findings were confirmed thorough interview with the maintenance director at the time of observation. | K0291 | | |

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|---|---|---|---|
| | 254260 | A. BUILDING _____ B. WING _____ | 6/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOWBROOK MANOR | G-4436 BEECHER RD FLINT, MI 48532 |

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|---|---|---|---|---|
| K0293<br>SS= E | Exit Signage Exit Signage 2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure exit signs are continuously illuminated and served by the emergency lighting system as required by 19.2.10.1. This deficient practice could affect 50 occupants in the event power is lost to the facility.<br><br>Findings Include:<br><br>On June 24, 2025 at approximately 11:00 AM to 12:00 PM testing of the battery back-up illumination of the exit signs in the old side of the facility revealed the exit signs do not illuminate when the test button is pushed. Interview with the maintenance director revealed he believed this indicated the signs were working properly. The battery exit lights should remain illuminated when tested as they transfer from regular power to emergency battery power. This could leave the area without illuminated exit signs in the event of a power outage to the facility.<br><br>These findings were confirmed thorough interview with the maintenance director at the time of observation. | K0293 | | |
| K0321<br>SS= E | Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire | K0321 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WILLOWBROOK MANOR** | **G-4436 BEECHER RD FLINT, MI 48532** |

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|---|---|---|---|---|
| | resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to provide hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 19.3.5.9. Doors shall be self-closing or automatic-closing. This deficient practice could affect 10 occupants in the event of a fire.<br><br>Findings Include:<br><br>On June 24, 2025, at approximately 12:00 PM observation revealed the 600 hall soiled utility rated room door does not latch when closed. This | | | |

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|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WILLOWBROOK MANOR** | **G-4436 BEECHER RD FLINT, MI 48532** |

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|---|---|---|---|---|
| | will allow smoke, heat, fire/biohazard to escape the rated space and enter the emergency egress corridor.<br><br>These findings were confirmed thorough interview with the maintenance director at the time of observation. | | | |
| K0353<br><br>SS= F | Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could affect approximately all occupants in the event of a fire.<br><br>Findings Include:<br><br>On June 24, 2025, at approximately 10:45 AM observation revealed the sprinkler escutcheon | K0353 | | |

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|---|---|---|---|
| | 254260 | A. BUILDING _____ B. WING _____ | 6/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOWBROOK MANOR | G-4436 BEECHER RD FLINT, MI 48532 |

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|---|---|---|---|---|
| | ring in the main office paper supply closet has slid down around the sprinkler head. This will not allow the sprinkler to function as designed when needed during a fire.<br><br>These findings were confirmed through interview with the maintenance director at the time of observation. | | | |
| K0363<br><br>SS= E | Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in | K0363 | | |

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|---|---|---|---|
| | 254260 | A. BUILDING _____ B. WING _____ | 6/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOWBROOK MANOR | G-4436 BEECHER RD FLINT, MI 48532 |

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|---|---|---|---|---|
| | area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure doors protecting corridor openings are capable of resisting the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could affect 50 occupants in the event of fire.<br><br>Findings Include:<br><br>On June 24, 2025, at approximately 12:15 PM observation revealed the double rated fire corridor doors outside of resident room 210 do not fully close due to a failing door arranger. This will allow the transfer to of smoke, heat, and fire from one compartment into the adjacent compartment.<br><br>These findings were confirmed through interview with the maintenance director at the time of observation. | | | |
| K0761<br><br>SS= F | Maintenance, Inspection & Testing - Doors<br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or | K0761 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 254260 | A. BUILDING _____ B. WING _____ | 6/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WILLOWBROOK MANOR | G-4436 BEECHER RD FLINT, MI 48532 |

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|---|---|---|---|---|
| | experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, the facility failed to inspect and test annually in accordance with NFPA 101, 19.7.6, 8.3.3.1 and NFPA 80, Standard for Fire Doors and Other Opening Protectives 5.2, 5.2.3. This deficient practice could affect all occupants in the event of a fire emergency.<br><br>Findings Include:<br><br>On June 24, 2025 at approximately 2:00 PM record review revealed the annual swinging type fire door inspection is not complete and does not include all rated swinging fire doors in the facility. The inspection only encompasses the 7 sets of cross corridor rated fire doors and did not include all rated doors such as storage rooms, soiled utility rooms, and other tagged rated fire doors.<br><br>These findings were confirmed through interview with the maintenance director at the time of record review. | | | |
| K0918<br>SS= F | Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to | K0918 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WILLOWBROOK MANOR** | **G-4436 BEECHER RD FLINT, MI 48532** |

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| | annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, record review and interview, the facility failed to ensure generators or other alternative power source are in accordance with NFPA 110, NFPA 99, NFPA 111 and NFPA 70. This deficient practice could affect all occupants in the event power is lost to the facility.<br><br>Findings Include: | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **254260** | A. BUILDING _____ B. WING _____ | **6/24/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **WILLOWBROOK MANOR** | **G-4436 BEECHER RD FLINT, MI 48532** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 1. On June 24, 2025, at approximately 11:45 AM observation revealed the automatic transfer switch number 2 for the facility equipment branch is not functioning. The display screen and line power indicator lights are not displaying or lighting. The maintenance director stated; it hasn't been working since last February or March, we still have lights and power when we lose power, I am waiting to hear back from our generator company. This may lead to the facility not having all available resources for residents and staff during a power outage.<br><br>2. On June 24, 2025 at approximately 2:15 PM record review revealed the facility cannot provide documentation to verify the back-up emergency generator is serviced annually and the annual load bank is conducted. The maintenance director stated; "The generator company was just out here last Tuesday, I don't have any paperwork from them yet." This may leave the facility generator issues unknown to the facility leading to generator failure when needed during a power outage.<br><br>These findings were confirmed through interview with the maintenance director at the time of observation and record review. | | | |