

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/27/2025
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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
F0000 SS=	INITIAL COMMENTS Willowbrosk Manor was surveyed for a Combined Recertification/Abbreviated survey exiting on 06/27/2025. Event ID: DM8F11 Intake Numbers: MI00153340, MI00153408 Census: 108	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The	F0550		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents are treated in a dignified manner by timely call light response by staff and accessible to residents, maintain food palatability for two (2) Residents #58, #21, and a confidential group of residents resulting in residents needs not met, frustration, embarrassment and potential for skin impairment from being left soiled and wet for prolonged periods.</p> <p>Findings include:</p> <p>FACILITY</p> <p>Resident Council</p> <p>FACILITY</p> <p>On June 25, 2025, at 11:00 AM, a Resident Council Meeting was held. According to nine (9) members of a group of confidential residents, on June 25, 2025, at 11:05 AM, the Resident Council meets on the last Friday of every month. They requested to remain anonymous and to keep their identities confidential. One confidential resident stated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>that the issues brought up by the council do not get resolved and said, "It does not go anywhere. It seemed that the concerns were not followed up on. No one gets back at us."</p> <p>The following grievances were brought up by the confidential group of residents during the meeting held on June 25, 2025, from 11:00 AM to 12:05 PM.</p> <p>1. Prolonged wait times for Call Light response averaging from 30 minutes (at least). 9 out of 9 groups of confidential residents agreed; occasionally, during call light response, staff may turn off the call light and claim they are coming back with the request, but they don't. Some staff members are helpful, while others are not. They talk to other staff very loudly or on their cell phone while residents needing assistance have to wait. Staff ignore the lights because we see them at the nurse's station gathering, talking, or on their phones.</p> <p>2. Palatability of the Food Menu. Residents complained that the food does not taste good, is repetitive, and lacks variety. One resident stated: "They repeat the same menu more often. It seems like every 2 weeks. It used to be every four to six weeks. A lot of cold sandwiches, whatever the alternative, can be the leftovers from previous meals that they did not like to begin with."</p> <p>3. No HS (Bedtime) Snacks are provided or are not distributed appropriately to residents.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Residents revealed that they don't receive them unless they walk or wheel themselves to the nurse's station.</p> <p>4. Staff often make up reasons, such as equipment being unavailable or not being found, as the reason why they don't return immediately, but the equipment is available. We have identified the location of the equipment, and we know where it was stored. An example was the sit-to-stand lift. Staff would say it took them a long time to find them. Meanwhile, they've been soaking wet from waiting for prolonged periods.</p> <p>The Resident Council (RC) Meeting ended on 06/25/25 at 12:03 PM. The Activities Director and an Assistant Activities staff member were present during the meeting.</p> <p>A review of the RC Meeting Minutes from December to May 2025 was conducted on June 25, 2025, at 10:30 AM. The Resident Council Minutes revealed that the March 2025 meeting minutes were missing. There were no notes and no follow-up on previous issues discussed in the old business notes. There were no noted resolutions to some of the residents' concerns listed in the minutes from December to May. The monthly Resident Council Meeting Minutes revealed:</p> <p>> December 2024 RC Meeting Minutes, dated January 24, 2025, at 11:00 AM, were reviewed and did not discuss any old or new business. Old Business, according to their</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>minutes, refers to the list of follow-up items from last month's minutes, and Issues not resolved are moved to New Business. The Old Business section was left empty, and the New Business section was noted. See the attached form. The council discussed Nursing, Dietary, and activities concerns. The council suggested some ideas for future activities, and events were noted.</p> <p>> January 2025 RC Meeting Minutes, dated January 24, 2025, at 11:00 AM, were reviewed and did not discuss any old or new business, and the sections were left blank.</p> <p>> February 2025 RC Meeting Minutes, held on February 28, 2025, at 11:00 AM, revealed discussions about concerns regarding requesting a meeting with the Dietary Manager, including the menu, snacks sitting out and never being distributed, and the call light response on the 3rd shift being too long. The old business section was left empty.</p> <p>> March 2025- The facility did not have a March 2025 RC Meeting Minutes. When queried, the Administrator stated that the council did not meet due to the COVID-19 outbreak. When asked if the concerns and issues were resolved or followed up? The Administrator revealed there was no documentation.</p> <p>> April 2025 RC Meeting Minutes, dated April 25, 2025, at 11:00 AM, were reviewed. Issues not resolved from the February meeting were</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>noted. Additional concerns include staff being too loud, dissatisfaction with the food quality, and repetitive meals.</p> <p>> May 2025 RC Meeting Minutes, dated May 30, 2025, at 11:00 AM, were reviewed. The minutes revealed that unresolved issues, such as staff being too loud and disruptive to residents who are resting during shift changes or in the break room, as well as concerns about food quality, nursing staffing assignments, and group activities, continued to persist.</p> <p>On June 25, 2025, at 4:15 PM, the Administrator was interviewed. When queried about whether she was aware of the concerns and how to address them, she indicated that she was unaware that she was allowed to attend the council meeting. The Administrator asked the surveyor if the regulation had changed. When asked about the lack of Resident Council Meeting Minutes in March 2025, the Administrator explained that a COVID-19 outbreak had occurred in March, and therefore, they were unable to hold the meeting. When asked if they met with the RC President or if the meeting was documented as being postponed. The Administrator stated, "No, it was not documented." Was there an attempt to resolve some of the issues brought up by the council? The Administrator did not reply. The Administrator indicated that the Activities Director is new in her position, so there is still much need for improvement.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Resident #58 (R58)</p> <p>Dignity</p> <p>An interview with R58 was conducted on June 25, 2025, at 1:44 PM. R58 complained of delayed staff response to call light, and there was always a long wait for assistance in Activities of Daily Living (ADLs). When asked about how long the wait time usually was? R58 stated, "On average, over 30 minutes. At times, more so, due to staff attitude. There are times staff don't come back after shutting the call light off."</p> <p>R58's clinical record was reviewed on 6/25/25 at 2:30 PM and revealed R58 was admitted to the facility on 8/12/2021 with the diagnosis of Chronic Embolism and Thrombosis Generalized Muscle Weakness and spastic Hemiplegia affecting the right dominant side and pharyngoesophageal phase dysphagia in addition to other diagnoses. R58 Brief Interview for Mental Status BIMS Score assessed on 5/15/25 was 15/15. A score of 15 means R58 was cognitively intact. Further review of R58's care plans indicated:</p> <p>R58's Careplan: Dysphagia</p> <p>" Obtain and honor food preferences with dietary parameters.</p> <p>" Assist with meals as needed, including setting up trays.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>" Observe and report to physician PRN for s/sx of dysphagia: Pocketing, Choking, coughing-Drooling, Holding food in the mouth, Several attempts at swallowing, and pain in swallowing.</p> <p>R58's Careplan: Alteration in Musculoskeletal status r/t history rib fracture, spinal stenosis</p> <p>" Attempt to anticipate and meet needs. Call Light is within reach and respond promptly to all request for assistance.</p> <p>" Observe and document to identify the risk of falls. Educate resident, family/caregivers on safety measures that needs to be taken in order to reduce risk of fals.</p> <p>R58's Careplan: Risk for fall related injury and falls r/t decreased mobility, spinal stenosis, medication side effects.</p> <p>" Put resident's call light within reach and encourage him/her to use it for assistance as needed.</p> <p>Resident #21(R21)</p> <p>Dignity</p> <p>On June 24, 2025 at 2:46 PM, R21 was observed in his room talking alone, saying, "it's not right! I can't get anything done here. No one helps me around here." R21 was asked if he tried pressing his call light for help. He replied, "I don't know where it is."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0578 SS= D	<p>When the surveyor searched around R21's room, it was noted that R21's call light button was on the floor, between R21's bed and the roommate's bed, and not within R21's reach from his seated position. Meanwhile, the housekeeping staff went in and out of the room but did not notice that the call light was on the floor. CNA "K". On 6/24/25 at 3:00 PM, Nurse Aide " K" entered the room and acknowledged that R21's call light was on the floor and clipped the call light on his pillow.</p> <p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive</p>	F0578			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure Code Status was assessed, documented and accessible in the medical record for one resident (#209) and signed by the physician for one resident (#43) of 4 residents reviewed for Advance Directives, resulting in the potential for the resident's lack of informed knowledge related to options for code status and miscommunication of code status which could lead to a lack of appropriate interventions for care.</p> <p>Findings Include:</p> <p>Resident #209:</p> <p>Advance Directives</p> <p>A record review of the Face sheet t indicated Resident #209 was admitted to the facility on 6/10/2025 with diagnoses: History of a stroke, right sided weakness, hypertension,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>weakness, anxiety, aphasia (difficulty with speech), and dysphagia (difficulty swallowing). The Minimum Data Set assessment was not yet completed.</p> <p>On 6/24/2025 at 12:07 PM, Resident #209 was observed sitting in a chair in her room. She was alert and talkative.</p> <p>A review of Resident #209's electronic medical record revealed the following:</p> <p>"Full Code" on the Face sheet.</p> <p>"Full Code" on the Medication Administration Record/MAR and Treatment Administration Recor/TAR for June 2025.</p> <p>A review of the Care Plans for Resident #209 identified there was no Care Plan for Code Status. It did not indicate the resident wanted to be a Full Code (if the resident were to stop breathing and/or their heart stopped beating, CPR/ Cardiopulmonary resuscitation would be provided).</p> <p>A review of the "Documents" tab in the electronic medical record/emr did not include a document/assessment for Code Status preferences.</p> <p>On 6/25/2025 at 1:47 PM, Social Worker "C" was interviewed related to lack of an assessment for Code Status for Resident #209. The Social Worker identified she had placed a Code Status assessment in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>"Documents" tab of the emr that day 6/25/2025 The form said "Full Code" but was not signed by the resident; the Social Worker had signed it and dated it 6/25/2025. The Social Worker was asked who was responsible to complete the Code status assessment form and she said either nursing or Social Work. When asked when the Code status assessment should be completed, she stated, "Within 5-7 days of admission. It was missed."</p> <p>On 6/25/2025 at 2:30 PM, Unit Manager "B" was interviewed about the Code status assessment forms, and she said the nurse would look at the admission documents from the hospital and copy the code status into the nurses admission assessment. Then the Social Worker talked to the resident, reviewed the code status with the resident and had them choose their option, "Full code or DNR/Do Not Resuscitate" and then signed the assessment form.</p> <p>On 6/27/2025 at 12:11 PM, during an interview with the Director of Nursing/DON related to resident Code status, she said nurses would ask the resident on admission. The DON said many of the admissions were in the evening and the resident would often be full code by default until the form was reviewed with them. She said the Social Worker would do that.</p> <p>A review of the facility policy titled, "Advance Directives- Michigan" origination date</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>7/11/2023 provided, " ... On admission, the Facility will determine whether the Resident has executed advance directives and if not, whether the Resident would like to execute advance directives. The Facility will also determine whether there was a DNR Order signed in another setting and whether the Resident would like a DNR Order issued while in the facility. A Code Status Form will be signed to reflect the decision regarding CPR/DNR ..."</p> <p>Resident #43:</p> <p>Advance Directives</p> <p>A record review was conducted on 6/25/25 at 10:15 AM. According to the Electronic Medical Record (EMR), R43 was 73 years old, admitted to the facility on 11/07/2022, with the primary diagnosis of Cerebral Infarction, dysphagia Type 2 Diabetes Mellitus, Hemiplegia, and Hemiparesis affecting Right dominant side and vascular dementia in addition to another diagnosis. R43 was enrolled in hospice services and has an appointed guardian. R43's Minimum Data Set (MDS) assessed on 5/20/2025 revealed that her Brief Interview for Mental Status score is 00/15. A score of zero generally indicates severe cognitive impairment. MDS section GG indicated that R43 was dependent on all Activities of Daily Living (ADLs), especially personal hygiene tasks and mobility. A care plan related to dementia revealed that the guardian was in place for all medical and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>treatment decisions, as R43 is no longer able to follow directions and does not communicate with others. A Care Plan for DNR and Hospice services was initiated on May 24, 2024.</p> <p>On 6/25/25 at 10:15 AM, during a review of R43 Advanced Directives status, R43 was a Do-Not-Resuscitate status., R43 has a legal guardian-signed DNR (Do Not Resuscitate) Order form that expired on May 15, 2025. The currently uploaded DNR Order Form, dated June 2, 2025, in R43's medical record, was also reviewed. The DNR Order Form dated June 2, 2025 was found to lacked a physician's signature which was required. The physician's signature line was blank and undated.</p> <p>An interview with the assigned social worker was conducted on June 25, 2025, at 2:00 PM. The social worker agreed that R43's DNR order was not signed by the physician as of 6/2/25. After reviewing R43's records, the social worker indicated that the last DNR order form was signed on 5/15/2024, had expired, and according to the facility policy, it must be done annually. The MD did not sign the form; therefore, there was no current DNR order. The social worker explained that it is their responsibility to ensure that all DNR Order forms are accurately filled out and signed.</p> <p>The facility policy dated 7/11/2023 entitled "Advanced Directives was reviewed on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>6/25/25 at 2:15 PM. The policy revealed:</p> <p>". . . B. Obtain Documents. Copies of all advance directives will be obtained from the Resident and/or family and placed in the medical record. If applicable, a DNR Order will be signed and placed in the medical record. . . D. Code Status Form. If the initial facility cognitive evaluation (Nursing Comprehensive Evaluation and/or BIMS) indicates cognition to be intact, a Code Status Form will be completed by the resident and a DNR order signed by the resident, 2 witnesses and the physician, if a DNR is requested. . ."</p> <p>Additionally, the same facility policy for Advanced Directives specified: "Cognitively Impaired Resident Unable to make Medical Decisions with Duly Executed Advance Directives and/or DNR.</p> <ul style="list-style-type: none"> > Code Status Form completed with the legal decision-maker > Complete a DNR form if necessary. > Place copies of all paperwork in the Resident's chart. > Review the Resident's advance directives quarterly and capacity at least annually and with any significant mental status changes. > If a DNR was requested it is re-signed annually, if still requested. . ." 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0585 SS= E	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement	F0585			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide prompt efforts to resolve complaints pertaining to prolonged call light response times, food palatability, bedtime (HS) snack distribution, group activities, and staff availability and attitude to assist and to ensure the process to address grievances was understood for nine (9) confidential group of residents resulting in unresolved grievances and potential for further frustration.</p> <p>Findings include:</p> <p>Resident Council:</p> <p>FACILITY</p> <p>On June 25, 2025, at 11:00 AM, a Resident Council Meeting was held. According to nine (9) members of a group of confidential residents, on June 25, 2025, at 11:00 AM, the Resident Council meets on the last Friday of every month. They requested to remain anonymous and to keep their identities confidential. One confidential resident stated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>that the issues brought up by the council do not get resolved and said, "It does not go anywhere. It seemed that the concerns were not followed up on. No one gets back at us." A confidential group of residents expressed a lack of awareness about the grievance process and were unaware of a grievance form that could be filled out. Any complaint or issue raised by a group or individual must be filed using the designated form. Depending on the type of concern or issue, it is handled, followed up on, and addressed during the next group meeting or individually. The group of confidential residents stated that this was the first time they had heard about the process and wondered where the forms could be obtained and to whom they should report their grievances. They were unaware of the process for putting concerns in writing using a grievance form. When the Grievance form was presented and read to the council, some residents indicated that they had never seen the grievance form or had any idea it existed.</p> <p>The following were grievances brought up by the confidential group of residents during the meeting held on 6/25/25, from 11:00 AM to 12:05 PM:</p> <p>1. Regarding activities, they have not had a field trip since the COVID-19 pandemic. The council went into specific details about the facility, sold the bus, and since they don't have transportation for group activities. Activities have been redundant, and choices</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>were limited and not individual-centered. This was asked for in previous council meetings.</p> <p>2. Prolonged wait times for Call Light response averaging from 30 minutes (at least). 9 out of 9 groups of confidential residents agreed; occasionally, during call light response, staff may turn off the call light and claim they are coming back with the request, but they don't. Some staff members are helpful, while others are not. They talk to other staff very loudly or on their cell phone while residents needing assistance have to wait. Staff ignore the lights because we see them at the nurse's station gathering, talking, or on their phones.</p> <p>3. Palatability of the Food Menu. Residents complained that the food does not taste good, is repetitive, and lacks variety. One resident stated: "They repeat the same menu more often. It seems like every 2 weeks. It used to be every four to six weeks. A lot of cold sandwiches, whatever the alternative, can be the leftovers from previous meals that they did not like to begin with."</p> <p>4. No HS (Bedtime) Snacks are provided or are not distributed appropriately to residents. Residents revealed that they don't receive them unless they walk or wheel themselves to the nurse's station. The Resident Council expressed concern for other residents who were unable to reach the nurse's station or could not speak on their behalf. One resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>with a diagnosis of diabetes never received an HS snack and was unaware that one was available.</p> <p>5. Staff often make up reasons, such as equipment being unavailable or not being found, as the reason why they don't return immediately, but the equipment is available. We have seen where the equipment is kept, and we know its location. An example was the sit-to-stand lift. Staff would say it took them a long time to find them. Meanwhile, they've been soaking wet from waiting for prolonged periods.</p> <p>The Resident Council Meeting ended on 06/25/25 at 12:03 PM. The Activities Director and the Assistant Activities staff member were present during the meeting.</p> <p>The Activities Director, on June 25, 2025, at 12:05 PM was interviewed. She indicated that there had been no field trip activities because the group lacked a means of transportation. They only have a van that could fit only two wheelchairs. They don't go on field trips for that reason.</p> <p>A review of the RC Minutes from December to May 2025 was conducted on June 25, 2025, at 10:30 AM. It was revealed that the March 2025 RC Meeting Minutes were missing. There were no notes and no follow-up on previous issues discussed in the old business notes. There were no noted resolutions to some of the residents'</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>concerns listed in the minutes from December to May. The monthly Resident Council Meeting Minutes revealed:</p> <p>> The December 2024 RC Meeting Minutes, dated January 24, 2025, at 11:00 AM, were reviewed and did not discuss any old or new business. Old Business, according to their minutes, refers to the list of follow-up items from last month's minutes, and Issues not resolved are moved to New Business. The Old Business section was left empty, and the New Business section was noted. See the attached form. The council discussed Nursing, Dietary, and activities concerns. The council suggested some ideas for future activities, and events were noted.</p> <p>> The January 2025 RC Meeting Minutes, dated January 24, 2025, at 11:00 AM, were reviewed and did not discuss any old or new business. Old Business, according to their minutes, refers to the list of follow-up items from last month's minutes, and Issues not resolved are moved to New Business. The Old Business section and the New Business were left empty. The Activities Director noted that the Council approved the Administrator's attendance at the February meeting.</p> <p>> The February 2025 RC Meeting Minutes, held on February 28, 2025, at 11:00 AM, revealed discussions about concerns regarding requesting a meeting with the Dietary Manager, including the menu, snacks sitting out and never being passed, and the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>call light response on the 3rd shift being too long. The old business section was left empty, and the new business is indicated to "see the attached form."</p> <p>> March 2025 RC Meeting Minutes were unavailable. When queried, the Administrator stated that the council did not meet due to the COVID-19 outbreak. When asked if the concerns and issues were resolved or followed up? The Administrator stated there was no documentation.</p> <p>> The April 2025 RC Meeting Minutes, dated April 25, 2025, at 11:00 AM, were reviewed. Issues not resolved from the February meeting were noted. Additional concerns include staff being too loud, dissatisfaction with the food quality, and repetitive meals. Various activities are suggested by the residents to be included in the activities calendar.</p> <p>> The May 2025 RC Meeting Minutes, dated May 30, 2025, at 11:00 AM, were reviewed. The minutes revealed that old business, such as staff being too loud and disruptive to residents who are resting during shift changes or at the breakroom, Food Quality, Nursing staff assignments, and group activities, continued to be unresolved. Residents requested outings requiring transport to and from.</p> <p>On June 25, 2025, at 4:15 PM, the Administrator was interviewed. When queried</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0684 SS= D	<p>about whether she was aware of the concerns and how to address them, she indicated that she was unaware that she was allowed to attend the council meeting or that she had invited herself to discuss and find appropriate solutions to some of the council's concerns. The Administrator asked the surveyor if that was something new or if the regulation had changed. When asked about the lack of Resident Council Meeting Minutes in March 2025, the Administrator explained that a COVID-19 outbreak had occurred in March, and therefore, they were unable to hold the meeting. When asked if they met one-on-one with the RC President or if the meeting was documented as being postponed. The Administrator stated, "No, it was not documented." Was there an attempt to resolve some of the issues brought up by the council? The Administrator did not reply. The Administrator indicated that the Activities Director is new in her position, so there is still much need for improvement.</p> <p>Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p>	F0684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Based on observation, interview and record review, the facility failed to ensure that blood pressure medications were administered as ordered for one resident (#209) of 6 residents reviewed for medications and a wound treatment was administered per physician's recommendation for one resident (#42) with a facility acquired wound of 2 residents reviewed for skin conditions.</p> <p>Findings Include:</p> <p>Resident #42:</p> <p>Pressure Ulcer/Injury</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #42 was admitted to the facility on 5/9/2025 with diagnoses: Osteomyelitis (bone infection) of the right foot and ankle, Pressure ulcer sacrum unstageable, history of lung cancer, COPD, Morbid obesity, weakness, Chronic pancreatitis, and Gout. The MDS assessment dated 5/15/2025 revealed the resident had a Brief Interview for Mental Status/BIMS score of 12/15 indicating mild cognitive loss and the resident needed assistance with care.</p> <p>On 6/24/2025 at 10:25 AM, Resident #42 was observed lying in bed, awake and readily answered questions. He said he had sores on his ankles, heels, legs, and on his sacrum. The resident said he had some when he was admitted to the facility, but the ones on his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>left foot were new since admission. Resident #42 said he had been receiving IV antibiotics for infected wounds on admission.</p> <p>On 6/25/2025 at 1:55 PM, Unit Manager "B" was interviewed about Resident #42's wounds. She said the nurses on the floor performed the routine wound care, but Wound Nurse "D" saw the resident's weekly with the Wound Care Practitioner.</p> <p>On 6/25/2025 at 1:57 PM, Wound Nurse "D" was interviewed about Resident #42's wounds. She said the resident had several wounds present on admission, including the Sacral wound Stage 3 pressure ulcer and the right foot wound/ right heel Stage 3 pressure ulcer. The Wound Nurse said the resident had a facility acquired wound on the left lateral malleolus/ankle. Th Wound Nurse "D" said Resident #42 had been going to a Wound Clinic weekly since admission for the right foot and sacral wounds. She said the Wound Clinic would assess, debride (remove dead tissue from) the wounds, and make treatment recommendations for the wounds.</p> <p>On 6/25/2025 at 2:00 PM, wound care for Resident #42 was observed with Wound Nurse "D". She said she had recently changed the dressings on the resident's feet and sacrum. His feet were observed in heel boots while the resident was in bed. Both feet were wrapped with kerlix that was dated 6/25/2025. She said the treatment recommended by the Wound clinic was a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>collagen silver combination, but the facility was not able to consistently complete the dressing as ordered because they had only received a small supply of the collagen/silver dressing. The Wound Nurse said the supplier had said there was a shortage of the product. The Wound Nurse was asked if the Wound Clinic placed a collagen/silver treatment on the resident when they changed his dressing and she said they did. Wound Nurse "D" said the Wound clinic had said if they were unable to obtain the combination product then a collagen product without silver could be used. Resident #42 said he was worried about this because he was worried his wounds would not heal.</p> <p>On 6/25/2025 at 2:25 PM, Wound Nurse "D" was further interviewed about the collagen/silver treatment for Resident #42's facility acquired pressure ulcer on the left lateral malleolus. She was asked if the facility had attempted to obtain the treatment from a different supplier and she said she didn't know.</p> <p>A review of the progress notes identified the following:</p> <p>5/28/2025 at 10:13 AM, a Nurses Note, "Spoke with ... Wound Clinic and ok to use collagen sheets until collagen and silver are delivered. Orders updated per consultation sheet after getting clarification on specific orders."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>6/5/2025, a Wound Care Note, " ... being seen today for follow-up on wound care assessment and evaluation ... Wounds are being managed by "Wound Clinic" Continue orders as prescribed from wound care clinic ... Left lateral malleolus; Treatment: Prism according to wound care clinic ... Location: Left Lateral malleolus; Stage: unstageable; Type: pressure ... Length: 1.85 cm; Width: 0.94 cm; Drainage Type: sanguineous bloody Drainage; Amount: light; Granulation: Slough, 50 ..."</p> <p>6/12/2025, a Wound Care Note, " ... seen and examined at the bedside for wound care evaluation and treatment. Continue wound care orders as prescribed by "Wound Clinic" ... Location: Left Lateral Malleolus; Stage: unstageable; Type: pressure ... Length: 1.92 cm; Width 0.92 cm; Drainage type: serosanguineous; Drainage amount: light ..."</p> <p>6/18/2025, a Progress Note, "Patient is a 73 year old male being seen today for pain ... Pt (patient) reports shooting sharp pain in LLE (left lower extremity). He states it started a couple days ago after wound clinic assessed and dressed his wounds to left foot. Pt states pain is intermittent ..."</p> <p>6/19/2025, a Wound Care Note, " ... Location: left Lateral Malleolus ... Length: 2.31 cm; Width: 1.40 cm ..."</p> <p>6/26/2025, a Wound Care Note, " ... " ... Location: left Lateral Malleolus ... Length: 1.69</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>cm; Width: 0.84 cm ..."</p> <p>A review of the June 2025 Medication Administration Record/MAR and Treatment Administration Record/TAR for Resident #42 identified the following:</p> <p>"Left lateral Malleolus: Cleanse the area with wound cleanser and allow to dry. Apply calcium alginate with silver to the wound bed. Cover with gauze and wrap with Kerlix. Daily and PRN (as needed) every day shift for Wound Care," start date 5/29/2025. This was not a collagen treatment.</p> <p>A review of the Wound Clinic consultation reports revealed the following:</p> <p>5/27/2025 at 9:30 AM, "(Resident #42); Note: Findings and Recommended Treatment- ... left ankle (malleolus)- Calcium alginate w/silver, gauze and Kling daily ..."</p> <p>6/2/2025 at 9:00 AM, "(Resident #42); Note: Findings and Recommended Treatment- ... Left ankle (malleolus) Prisma (collagen/silver) gauze, ABD and wrap daily ... Silver Collagen: Cut to the size of wound and apply directly to wound base ... Change dressing every day; dressing supplies for 30 days ..."</p> <p>6/16/2025 at 8:30 AM, "(Resident #42) Continue with Prisma (collagen/silver) ... Wound #2 Left Ankle: Silver Collagen ... Change Dressing Every Day; dressing supplies for 30 days ..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>On 6/2/2025 and 6/16/2025, both Wound Consultations indicated the treatment for the resident's left Lateral ankle/malleolus was to be Prisma a collagen/silver combination dressing. Both consultations also said, "dressing supplies for 30 days." The facility continued with the orders for Calcium Alginate with silver (a seaweed-based dressing) vs. a Collagen/silver dressing per the Wound Clinics recommendations. It was unclear if the Wound Clinic had provided a 30-day supply of the recommended dressings.</p> <p>A review of the Care Plans for Resident #42 identified the following:</p> <p>"(Resident #42) has actual impairment r/t (related to) Right foot osteomyelitis, sacral decub (pressure ulcer), left heel, left lateral malleolus, left lateral lower leg, left second toe, left thigh, right second toe, right lateral fourth toe, right third toe," created and initiated 5/9/2025 and revised 6/25/2025 with Interventions including: "Treatment to skin impairment per order," date initiated 5/26/2025.</p> <p>On 6/27/2025 at 12:45 PM, during an interview with the Director of Nursing/DON, she was asked about Resident #42's facility acquired pressure ulcer and the facilities inability to obtain the recommended wound treatment. She said she wasn't sure if the facility had tried different vendors. The DON</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>was asked if the facility contacted other corporate facilities to see if they had the collagen/silver treatment and she said she didn't know.</p> <p>Resident #209</p> <p>A record review of the Face sheet indicated Resident #209 was admitted to the facility on 6/10/2025 with diagnoses: History of a stroke, right sided weakness, hypertension, weakness, anxiety, aphasia (difficulty with speech), and dysphagia (difficulty swallowing). The Minimum Data Set assessment dated 6/16/2025 revealed the resident needed some assistance with care.</p> <p>On 6/24/2025 at 12:07 PM, Resident #209 was observed sitting in a chair in her room. She was alert and talkative. She said one of her medications ran out. She said she was told by the nurse that they did not have it. Resident #209 said she was receiving the medication 4 times a day and then it stopped, and stated "I'm worried about that. It is for my blood pressure. I've been waiting 2 days for that." The resident started to cry,</p> <p>A record review of the June 2025 Medication Administration Record/MAR identified a medication "Nifedipine oral Capsule 100 mg; Give 3 capsule by mouth four times a day for HTN (hypertension/high blood pressure). Hold if SBP (systolic blood pressure/top number) less than 110 or HR/heart rate below 60," start date 6/10/2025.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The blood pressure medication for Resident #42 was documented by the nurses as not given on 6/10/2025, 6/11/2025, 6/12/2025, 6/13/2025, 6/23/2025, 6/24/2025, 6/25/2025.</p> <p>A record review of the progress notes identified the following:</p> <p>6/10/2025, a Nurses Note from pharmacy related to the dosing of the Nifedipine.</p> <p>notes,</p> <p>6/10/2025 at 6:32 PM, an eMAR Note, "Waiting on pharmacy not in backup notified NP (Nurse Practitioner) and family."</p> <p>6/10/2025 at 9:43 PM, an eMAR Note, "Nifedipine ... medication is not available, and not in back up."</p> <p>6/11/2025, an Advance Care Planning Note, "... Essential (Primary) Hypertension: Continue BP medications; monitor blood pressure ..."</p> <p>6/11/2025, a Progress Note, "General: Patient is a 56 year old female with past medical history of Intracranial hemorrhage (bleeding) CVA (stroke) with hemiplegia and hemiparesis right side, HTN (hypertension) ... Patient was recently hospitalized and treated for intracranial hemorrhage ... Patient was transferred to (the facility) for continuation of care and rehab services ... Essential Hypertension: Monitor BP. Continue ..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Nifedipine ..."</p> <p>6/11/2025, Encounter note, "Telehealth ... Situation: Nifedipine Oral Capsule 10 mg (Nifedipine) not available. BP 155/91, HR 64. Treatment: hold until pharmacy delivers. Clonidine 0.1 mg PO (by mouth) x1 dose., by Nurse Practitioner/NP "E"</p> <p>The resident had nine additional notes from 6/11/2025-6/25/2025 related to Nifedipine being unavailable and waiting for pharmacy to deliver it.</p> <p>On 6/25/2025 at 10:03 AM, a Nurses Note, "Elevated BP- pharmacy did not send nifedipine (10 mg). The pharmacy stated it has already been requested to be sent to the facility stat."</p> <p>On 6/25/2025 at 3:40 PM Nurse "F" and Unit Manager "B" were interviewed about the Nifedipine for Resident #209. Unit Manager "B" stated, "The pharmacy said it would be here tonight about 9pm." Nurse "F" said she had made several notes and contacted the pharmacy. Unit Manager "B" said the medication had to be ordered by the pharmacy because the capsule was not in a common dose that the pharmacy had on stock. Reviewed that this had been ongoing since admission and the resident was upset about it. Nurse "F" said if the medication did not arrive that night, it would arrive early in the morning.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>A record review of the Care Plans for Resident #209 identified the following:</p> <p>"(Resident #209) is at risk for complications r/t (related to) recent intracranial hemorrhage, " date created and initiated 6/18/2025 with Interventions including: "Observe/document/report to nurse/physician s/sx (signs and symptoms) of CVA (stroke) such as: ... elevated blood pressure ..."</p> <p>"(Resident #209) is at risk for cardiac complications r/t HTN (high blood pressure) ..." date created and initiated 6/10/2025 and revised 6/11/2025 with Interventions including: "Administer medications per order ..." date created and initiated 6/10/2025.</p> <p>On 6/27/2025 at 9:10 AM, Unit Manager "B" was interviewed about Resident #209's blood pressure medication Nifedipine; she said the resident's medication was delivered to the facility the night of 6/25/2025. She said the resident received the first dose on 6/26/2025 in the morning; reviewed the June 2025 MAR with the Unit Manager "B".</p> <p>On 6/27/2025 at 9:15 AM, Resident #209 was interviewed. She said she received her medication. When asked if she knew why she did not receive it, she said no one told her, just that it was ordered.</p> <p>On 6/27/2025 at 12:35 PM, during an interview with the Director of Nursing, she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0692 SS= D	<p>was asked about Resident #209 not receiving her blood pressure medication Nifedipine. She said she had just become aware of it and the resident should have received her medication.</p> <p>Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g) (2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure that dietary care plans were revised for weight loss and failed to follow dietary orders for two residents (R36, R81) of seven residents reviewed for nutrition, resulting in the potential for continued weight loss.</p> <p>Findings include:</p>	F0692			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Resident #36:</p> <p>R36 is 91 years old and admitted to the facility on 11/22/2024 with diagnoses that include major depressive disorder, hyperlipidemia, congestive heart failure and anxiety.</p> <p>On 06/24/25 at 11:07AM, an interview was conducted with R36. R36 was asked if she has lost weight while at the facility. R36 stated she has lost weight and is concerned with as fast as she is losing it.</p> <p>On 06/26/25 at 09:43AM, record review of weights revealed that R36 weighed 224lbs on 12/17/24 and weighed 203.4lbs on 6/11/25. This represents a 10.1% weight loss in six months.</p> <p>On 06/26/25 at 9:45AM, review of dietary progress notes revealed that significant weight loss triggered on 3/19/25.</p> <p>On 06/26/25 at 09:48AM, record review revealed there was no care plan present that addresses "actual weight loss". A care plan was present with a focus of, "R36 has potential for alterations in nutritional/hydration status," it was last revised on 04/11/2024.</p> <p>On 06/26/25 at 01:43PM, an interview was conducted with Registered Dietitian (RD) "A". RD "A" was asked if there should be a care plan for actual weight loss? RD "A" stated, yes there should be. Typically, I would add it to my weight loss care plan. I see it says potential for and doesn't say anything about actual weight loss. RD "A" was asked what interventions were put in place to help slow down the weight loss. RD "A" stated, I would update preferences when I speak with her and during the at-risk meeting. I don't believe I put anything additional in place for her. I updated her preferences and added her to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>weekly weights and the weight loss has slowed a bit.</p> <p>Review of the policy titled, "Weight Management," revealed:</p> <p>6. An initial care plan is developed upon admission and a comprehensive care plan should include:</p> <ul style="list-style-type: none"> -Identified causes of impaired nutritional status -Reflects the resident's goals and choices -Identifies resident-specific interventions and a time frame -Parameters for monitoring <p>11. A "Resident at Risk" meeting will be conducted at least monthly by the Interdisciplinary Team and any changes documented in the care plan at the meeting. Residents that will be reviewed during the meeting are as follows (the following criteria is also up to the discretion of the clinician, supported by clinical documentation as to why a resident is not being reviewed in IDT meeting and a care plan with current interventions):</p> <ul style="list-style-type: none"> -Residents identified with significant weight changes as determined by the CDM, RD, and/or diet tech -Residents with slow steady weight changes as determined by the CDM, RD, and/or diet tech -Residents receiving TPN or a tube feeding that do not have a stable weight -Any other resident identified by the IDT 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Resident #81:</p> <p>Nutrition</p> <p>A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #81 was admitted to the facility on 6/5/2025 with diagnoses: Heart failure, COPD, mild protein-calorie malnutrition, anxiety, and difficulty walking.</p> <p>On 6/24/2025 at 11:20 AM, Resident #81 was observed sitting in his room in bed. When asked about his meals at the facility, he said he was supposed to receive double portions of meat, but did not always receive them. He said he had talked to the Nurse Practitioner/NP and Unit Manager about it, but it didn't change anything.</p> <p>During the interview with Resident #81 on 6/24/2025 at 11:20 AM, he said the previous night, there were no hotdogs or hamburgers as an alternative to the regular menu. He said he was told by the staff they were "out" of them. The resident said he had to eat "very greasy, grilled cheese". He said they gave him 2 grilled cheese, but he could only eat 1, because of the grease. The resident read the menu for 6/24/2025 and stated, "Tonight they are having noodle casserole. How am I supposed to get double meat with that?" The resident said he did not need double noodles, because he had low albumin levels and needed more protein.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>A review of the physician orders for Resident #81 identified a diet order dated 6/5/2025: "Regular diet, regular texture, Thin Consistency, Large Protein portions, cranberry juice x 2." On further review the order was modified on 6/6/2025 to include "Double protein portions" then again modified on 6/6/2025 to indicate "Large protein portions" and on 6/9/2025 "cranberry juice x2" was added.</p> <p>A review of the document scanned into the "Documents" tab in the electronic medical record titled "Baseline Care Plan" did not mention additional protein in the resident's diet, "Dietary-Diet: Type: Regular; Texture: Regular; Consistency: Thin."</p> <p>A review of the Comprehensive Care Plan for Resident #81 identified the following:</p> <p>"(Resident #81) has alteration in nutritional and/or hydration status r/t (related to) dx (diagnoses): heart disease, CHF (congestive heart failure), GERD, COPD, blind right eye," date initiated and created 6/6/2025 and revised 6/11/2025. A goal included, "(Resident 381) will maintain adequate nutritional status as evidenced by maintaining weight within 2% of 220 (lbs.) and Albumin levels to be WNL (within normal limits), through review date," date created and initiated 6/6/2025 and revised 6/18/2025.</p> <p>Care Plan Interventions included: "Provide</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>diet as ordered: Regular diet, regular texture, thin liquids, Large portion protein," dated created and initiated 6/6/2025; "Obtain weekly weights x 4 weeks, then monthly, if stable," date created and initiated 6/6/2025; Obtain lab/diagnostic work as ordered. Report abnormal results to MD and follow up as indicated," dated created and initiated 6/6/2025; "Offer an alternate when 50% or less of meal is consumed," date initiated and created 6/6/2025; "Obtain and honor food preferences within dietary parameters," dated created and initiated 6/6/2025.</p> <p>A review of the weights for Resident #81 indicated 3 weights in the electronic medical record "Weights and Vitals" tab. The weights were dated 6/5/2025 at 6:30 PM: 218.8 lbs., 6/6/2025 at 9:24 PM: 218.8 lbs., and 6/6/2025 at 11:50 PM: 218.8 lbs. Each weight was exactly the same. There were no additional weights.</p> <p>A review of the lab results for Resident #81 identified 2 results for Albumin levels: 6/9/2025- 3.2 low (normal 3.50-5.70) and 6/18/2025- 2.9 low. The residents Albumin levels were declining while in the facility.</p> <p>A review of a "Nutritional Evaluation" dated 6/11/2025 for Resident #81 identified the following: "Summary/Recommendations: Resident admitted with dx: heart disease, CHF, GERD, COPD, blind right eye. Receives a regular diet with large portions. Eating 75-100% of meals. Skin is intact. Labs reviewed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>RD (Registered Dietitian) to follow." The evaluation did not mention extra portions of protein.</p> <p>A review of the progress notes indicated one progress note addressing Resident #81's concern about not receiving double portions of protein: a nurses note, dated 6/25/2025 at 11:13 AM provided, " ... (the resident's significant other) also expressed concern that the resident was not receiving double portions of protein, as requested. Dietary was notified to ensure the resident is receiving double portions of protein servings per his preference ..."</p> <p>On 6/25/2025 at 4:27 PM interviewed Registered Dietitian/RD "A" about Resident #81's diet, she said he was supposed to receive double portions of food, reviewed resident said his albumin was low and he was concerned it would be lower without extra protein. RD said she was not aware of his recent albumin levels, reviewed most recent was 2.9 (6/18/2025) and prior 3.2 (6/9/2025)- both obtained at the facility. She said she would further review his chart.</p> <p>On 6/25/2025 at 5:05 PM, the RD was interviewed about Resident #81's diet. She provided information that protein does not help low Albumin levels, asked if this had been explained to the resident. She said she didn't know. Reviewed the resident was very focused on his albumin levels and asked if his physician could have encouraged him to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>increase his protein intake. She said she didn't know. Reviewed the progress notes and assessments. There was no dietary note and one Nutritional Eval dated 6/11/2025. The RD provided a copy of the Diet order used for meal preparation in the kitchen; it indicated "Give double meat, Large portion entrée".</p> <p>On 6/27/2025 at 8:55 AM, Resident #81 was observed lying in bed, awake. His Breakfast tray was on the bedside table. He said he received eggs, a cinnamon roll, oatmeal, carton of milk, cranberry juice. He said there was no meat. "It's the first day they didn't give me any meat for breakfast." He said someone from dietary came to talk to him about his diet orders to explain about the extra protein, but he said he prefers the meat. Asked the resident about his albumin levels and he said his albumin had been low for years and he was told he was supposed to eat more protein.</p> <p>On 6/27/2025 at 9:10 AM, Unit Manager "B" was interviewed about the resident's diet and his belief that he is to receive double portions of protein vs. the diet that said large portions of protein. Reviewed that the resident is upset and worried about this, as he feels it could prevent him from getting better if he does not receive the extra protein. Unit Manager "B" said she had spoken to the resident on 6/25/2025, during the survey, about this and documented a note. Reviewed the resident was concerned about his</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0790 SS= D	<p>breakfast and wanted to talk to someone about it.</p> <p>A review of the facility policy titled, "Resident Rights," dated origination 9/1/2013 and revised 5/14/2024 provided, "Policy: The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility ..."</p> <p>Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a) (4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the</p>	F0790			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by:</p> <p>This Citation pretains to Intake Number MI00153408.</p> <p>Based on observation, interview and record review, the facility failed to obtain dental services timely for a Resident who received a partial denture for the bottom teeth that were ill-fitting, and unable to be used by the resident who had problems with chewing some foods for one resident (#84) of two residents reviewed for dental services.</p> <p>Findings include:</p> <p>Resident #84:</p> <p>On 6/24/25 at 12:27 PM, an interview was conducted with Resident #84 who was in his room, seated in a wheelchair. The Resident was asked about food services and reported he had issues with eating some of the foods that included chicken and hamburgers. The Resident was asked about issues with eating and the resident reported he had dentures that were made for the bottom teeth that when he received them, they did not fit properly. The Resident reported he can not wear the dentures at all because "They don't fit." An observation was made of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>resident's mouth with two teeth observed and the Resident explained that the denture was to fit around the remaining teeth, but they never fit from the time he first got them. When asked how long ago he had the dentures, the Resident was unsure but thought it was around December or before that and it had been a problem since last year. When asked if they modified his diet to adjust for not having teeth on the bottom, the Resident reported he was on a regular diet, but there were foods he could not eat that was served to him. The Resident reported that staff knew he did not wear the bottom denture. The Resident reported that the dentist was supposed to make adjustments, but they never came back to do that.</p> <p>A review of Resident #84's medical record revealed an admission into the facility on 2/13/23 with diagnoses that included dementia, contracture and hemiplegia and hemiparesis following a stroke affecting left non-dominant side. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 13/15 that indicated intact cognition, and the Resident needed setup or clean-up assistance with eating, and substantial/maximal assistance with toileting hygiene, shower/bathe self, upper body dressing, mobility and transfers.</p> <p>A review of Resident #84's dental group visit documents revealed the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>-Exam date 8/5/24, Treatment notes, " ...does not wear his lower partial denture due to discomfort ... lower partial denture is painful to wear, he does not wear it at all"</p> <p>-Exam Date 2/18/25, Treatment notes, " ...He states "I can't eat. I've been waiting 20 years for dentures." He told me at the last prophylaxis that his lower partial denture was too painful to wear ... patient is requesting dentures."</p> <p>-Exam Date 3/13/25, Reason for visit: "RTBS by Hygienist; Initial Exam; lower partial is too tight." Treatment notes, " ... Requesting PA's (xray)to determine if teeth are restorable. Decay appears to be superficial. Patient's lower partial does not fit and needs relief around both teeth he has not worn it in so long and the teeth have shifted since then. Before adjustment, waiting on xrays, because perhaps the teeth are not restorable and need to come out and be replaced with an LCD. Patient is fine with that treatment plan, should it be needed." S-ray was scheduled for 3/14/25.</p> <p>-Exam Date 4/7/25, Reason for visit: XRAY. Treatment notes, " ...2 PA's taken of tooth #22 and #27 ..."</p> <p>On 6/26/25 at 1:14 PM, an observation was made of Resident #84 in his room with the lunch meal tray on the table. The Resident complained that he did not get enough protein that he could eat. The Resident reported he had chicken that he could not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>chew that was still on his plate. The Resident reported not always having soft foods that he could chew. The Resident reported that he wanted the dentures on the bottom fixed and that it had been an issue for a long time.</p> <p>On 6/26/25 at 2:49 PM, an interview was conducted with the Registered Dietitian (RD) "G" regarding Resident #84's dental concerns of the lower partial denture not fitting and difficulty eating some foods. When asked if she was aware that the Resident was not wearing his dentures and had difficulty eating, the RD stated, "I don't have that he told me that. If he told me he was having issues, then I would have offered a soft diet." The RD reported that she might have been told that he was not wearing them (dentures) in the care conference, but she would have asked him if he wanted a diet change. When asked if she would get the dental visit notes, the RD stated, "I don't get them straight to me, but I do have access to them.</p> <p>On 6/26/25 at 3:21 PM, the Registered Dietitian "G" reported that she had spoken to Resident #84 and stated, "He is good with changing his diet to ground meats."</p> <p>On 6/26/25 at 3:23 PM, an interview was conducted with Unit Manager, Nurse "H" (UM) regarding dental services for Resident #84. A review of the August 2024 dental notes was reviewed of the issues with the dentures not fitting and the Resident not wearing the dentures. When asked what the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>facility should have done, the UM stated, "He should have been added to see the dentist at that point and seen by dietary." The Unit Manager was asked if the XRAYs were completed and she reported they had been done on April 7th. When asked about feedback on the x-rays or a plan set up, the UM stated, "just that they were completed." When asked if the dentist has seen the resident since the March dental visit, the UM reviewed Resident #84's medical record and stated, "I don't see a consult from him." When asked if the dentist had been in since the x-rays were taken, the UM was unsure. It was reviewed with the UM of the time from August 2024 with the identification of issues with the partial denture for Resident #84, and the dentures had not been adjusted or fixed to meet the Resident's needs in the span of 10 months.</p> <p>On 6/27/25 at 10:47 AM, a list of dental visits made to the facility was received by the facility. The document listed "Dentist" with the dates of 8/13/24, 9/6/24, 10/30/24, 11/11/24, 12/19/24, 2/4/25, 2/28/25, 3/13/25, 3/17/25, 4/18/25, 5/13/25 and 6/4/25.</p> <p>A review of facility policy titled, "Dental Services," effective 11/4/2024, revealed, "Policy: The facility will provide or obtain from an outside resource, routine and twenty-four (24) hour emergency dental services to meet the needs of the resident and also when requested by the resident ... 7. Within three (3) days of lost or damaged</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0809 SS= E	dentures/partials, the social worker/designee will make a referral for dental services. 8. If a consult is not completed within three (3) days following the report of lost/damaged dentures, the CDM/RD/therapy will document in the medical record to ensure that the resident is able to eat and drink in an adequate and safe manner while awaiting dental services, and what circumstances led to the delay. The residents diet will be adjusted as necessary ... 10. The social worker/designee will maintain contact with dental services, the resident, and/or the resident representative until the problem is resolved and the dentures are replaced. Documentation must reflect this communication and the verification that the resident is able to eat and drink adequately in the interim ... F. The residents' physician, family, and/or resident representative should be informed of the results of the service and any recommendations should be reviewed with the physician. A physician's order is obtained for changes in the plan of care ... H. Follow up visits will be scheduled as needed."	F0809			
	Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interviews and record review, the facility failed to ensure that a substantial HS (evening) snack was consistently offered and appropriately distributed to a group of confidential residents that attended the Resident Council Meeting, potentially affecting all residents who receive meals in the facility with 14 or more hours between last evening meal and breakfast the following day, resulting in resident dissatisfaction, frustration and potential for uncontrolled blood sugars, signs and symptoms of hypoglycemia, feeling of hunger, and weight loss.</p> <p>Findings include:</p> <p>FACILITY</p> <p>Resident Council:</p> <p>On June 25, 2025, at 11:00 AM, a Resident Council Meeting was held. According to nine (9) members of a group of confidential residents, on June 25, 2025, at 11:00 AM, the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Resident Council meets on the last Friday of every month. They requested to remain anonymous and to keep their identities confidential. There were numerous grievances brought up by the confidential group of residents during the meeting held on 6/25/25, from 11:00 AM to 12:05 PM. One of the issues brought up was pertaining to HS (Bedtime) Snacks were not provided or are not distributed appropriately to residents. Residents at the meeting revealed that they don't receive them unless they walk or wheel themselves to the nurse's station. The Resident Council expressed concern for other residents who were unable to reach the nurse's station or could not speak on their behalf. One resident with a diagnosis of diabetes never received an HS snack and was unaware that one was available.</p> <p>The Resident Council Meeting ended on 06/25/25 at 12:03 PM. The Activities Director and the Assistant Activities staff member were present during the meeting.</p> <p>A review of the RC Minutes from December to May 2025 was conducted on June 25, 2025, at 10:30 AM. It was revealed that the March 2025 RC Meeting Minutes were missing. Upon review, there were no notes and no follow-up on previous issues discussed in the old business notes. There were no noted resolutions to some of the residents' concerns listed in the minutes from December to May. The Resident Council Meeting Minutes held on February 28, 2025,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>at 11:00 AM, revealed discussions about concerns regarding requesting a meeting with the Dietary Manager, including the menu, snacks sitting out and never being passed, and the call light response on the 3rd shift being too long."</p> <p>There was no follow-up noted the following month in March 2025 because there was no meeting held in March 2025. No notes or documentation from the facility that the February 2025 concerns and issues were addressed followed up or any efforts of resolutions were implemented.</p> <p>On June 25, 2025, at 4:15 PM, the Administrator was interviewed. When queried about whether she was aware of the concerns and how to address them, she indicated that she was unaware that she was allowed to attend the council meeting or that she had invited herself to discuss and find appropriate solutions to some of the council's concerns. The Administrator asked the surveyor if that was something new or if the regulation had changed. When asked about the lack of Resident Council Meeting Minutes in March 2025, the Administrator explained that a COVID-19 outbreak had occurred in March, and therefore, they were unable to hold the meeting. When asked if they met one-on-one with the RC President or if the meeting was documented as being postponed. The Administrator stated, "No, it was not documented." The Administrator was asked if there was an attempt to resolve some of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F0812 SS= E	<p>issues brought up by the council last February meeting? The Administrator did not reply. The Administrator however, indicated that the Activities Director is new in her position, so there is still much need for improvement.</p> <p>Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i) (1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i) (2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to maintain a clean and sanitary kitchen that included: 1.) outdated food in the refrigerator; 2.) maintaining proper temperature of refrigerators and freezers; 3.) proper labelling of food items with a use by date; 4.) ensure dented cans were removed from supply; 5.) ice scooper not placed appropriately at the ice machine; and 6.) ensure the temperature</p>	F0812			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>log for refrigerator and freezer were not documented in advance. This deficient practice has the potential to affect all residents who consume food prepared by the facility of a census of 108.</p> <p>Findings include:</p> <p>Kitchen:</p> <p>On 06/24/25 10:05 AM, during Initial tour with the Dietary Manager (CDM) "I".</p> <p>The following observations were validated with the Dietary Manager:</p> <p>1. The walk-in refrigerator temperature was at 40 degrees fahrenheit as shown in the digital screen. Inside the refrigerator there was a bin containing pre-made sandwiches labeled with used by date and some did not have a label at all.</p> <p>Seven sandwiches were found with use by date that varied from 6/19/25- 6/23 and were removed from the sandwich bins. The CDM removed and discarded the sandwiches that were over the discard date and the ones with no label. The CDM revealed that the staff should be checking on the dates everyday.</p> <p>2. In the walk-in freezer an observation was made of several cooked foods that were expired:</p> <p>a. Dish #1: A metal baking tray with frozen</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>dish (unidentified) labeled with a use by date of 5/20/25 noted. The CDM reported he could not tell what dish it was. The unidentified dish #1 was observed in a metal baking pan without a tight seal cover/lid. Although it had a plastic clear cling wrap that was not entirely covering the top of the baking metal dish all the way.</p> <p>b. Dish 2: The second dish observed was also in a metal pan, also an unidentified cooked dish (#2) with a use by date 6/20/25 on the sticker.</p> <p>c. Polish/sausage links were in a plastic container with a used by date of 6/3/25.</p> <p>d. A labeled tray Mac & Cheese was dated 6/19/25 and use by date of 6/22/25.</p> <p>All these frozen food items were gathered by the CDM as they were found and verified by the CDM that he will discard them immediately because they were all out of date.</p> <p>3. The Walk-in Freezer Temperature screen (outside thermostat) was 10 degrees Fahrenheit and inside Freezer thermometer was between 6-7 degrees Fahrenheit. The CDM revealed he was unaware it was not reading below 0 degrees Fahrenheit. When asked for the June Freezer Temp. Log, the CDM gave the surveyor the log hanging on the posted board in the kitchen.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 6/27/2025
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The June Freezer Temperature Log posted on the board was examined and the log was not filled completely. The Facility Name, Uni/ Location and Month/Year were left blank.</p> <p>Findings were: all days in June were noted zero (0) degrees or less EXCEPT:</p> <p>6//7/25 AM shift 10 degrees</p> <p>6/8/25 AM shift 6 degrees</p> <p>6/12/25 AM shift 18 degrees *comment: Tells (a system to inform the maintenance department of an issue).</p> <p>6/15/25 PM shift 10 degrees * comment: Tells</p> <p>6/17/25 PM shift 6 degrees</p> <p>The Freezer Log instruction was noted that Freezer should be less or equal to zero (0) degrees Farenheit. Report Abnormal temperatures to the dietary manager or dietitian immediately.</p> <p>4. Dented cans observed. There were 3 dented cans found: one of corn beef hash 10 ounces can was mixed with the other cans that were not dented. 2 were on the counter and were put away by the CDM immediately to be discarded.</p> <p>5. Two (2) scoopers, one was in a case on top of the ice machine and the second one (blue) was placed on top of the ice machine bare</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 254260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 6/27/2025
NAME OF PROVIDER OR SUPPLIER WILLOWBROOK MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>(no cover) set on top of the machine.</p> <p>6. Temperatures in the temperature log for the Refrigerator and the Freezers wer filled in before the shift started. At 10:15 am, 6/24/25 the evening shift temperature were already filled. The CDM did not have an explanation.</p> <p>7. A spider on a web was found on the top of the grill during hot tray observation at 11:48 AM on 6/24/25. During tray line, the cook was shocked when she saw the spider and called the CDM attention.</p> <p>All concerns had been discussed with the CDM during the observation on 6/24/25 between 10:00-12:00 noon.</p> <p>Policies were requested and reviewed for Temperature monitoring for both freezer and refrigerator, leftover food, Kitchen sanitation.</p> <p>On 6/24/25 at12:15 PM. The surveyor discussed the kitchen findings to the Administrator regarding all the findings noted above.</p>				