STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CON	ISTRUCTION	(X3) D/ COMP	ATE SURVEY LETED
		634021	B. WING			8/7/20	24
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
EVERGREEN	HEALTH AND RI	EHABILITATION CENTER			19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR EFERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
F0000	INITIAL COMME	NTS	F0000				
SS=		And Rehabilitation Center was ertification survey on 8/7/24. 640. Census= 143					
F0550 SS= E	§483.10(a) Resic has a right to a d determination, ar access to person outside the facilit in this section. §4 treat each reside and care for each in an environmer maintenance or e quality of life, rec individuality. The promote the right (2) The facility m quality care rega of condition, or p must establish ar and practices reg and the provision plan for all reside source. §483.10(resident has the rights as a reside citizen or residen §483.10(b)(1) Th the resident can without interferer or reprisal from the her rights and to	enhancement of his or her ognizing each resident's facility must protect and s of the resident. §483.10(a) ust provide equal access to rdless of diagnosis, severity ayment source. A facility nd maintain identical policies parding transfer, discharge, of services under the State ints regardless of payment b) Exercise of Rights. The right to exercise his or her int of the facility and as a t of the United States. e facility must ensure that exercise his or her rights ice, coercion, discrimination, ne facility. §483.10(b)(2) The right to be free of ricin, discrimination, and facility in exercising his or be supported by the facility	F0550	environ residen been in environ residen educati a prope educati member ELEME Reside on Ann affecter residen assess promot Any de with ed ELEME The Int policy a staff ha proced and ann rooms, feeding	e practice of the facility to provide imment that promoted and enhance tis' dignity. R42, R73, and R85 h iterviewed and assessed to ensu- ment promotes and enhances its dignity. Nurse K has receive ion on providing feeding assistan er manner. Nursing staff has bee ed on intervening when family ers attempt to feed other residen ENT 2 ints that currently reside in the fa a s Place have the potential to d by this cited practice. Those its have been interviewed and ed to ensure the environment es and enhances residents dig ficiencies were corrected immed ucation provided to staff.	ed ave ure the ed cce in n ts. cility be nity. iately gnity ent and ocking ints t with	9/17/2024
		his or her rights as required			היש מתפוווףו וט ובפע טנוופו ופטעפון	.	
LABORATORY I	DIRECTOR'S OR PR	ROVIDER/SUPPLIER REPRESENT	ATIVE'S SIGNA	TURE	TITLE	(X6) DA	TE
Electronicall	y Signed					08/26	/2024

08/26/2024

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.

ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 634021			Á. BUILDII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 8/7/2024	
		034021	B. WING					
ME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE	
/ERGREEN	I HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN N SOUTHFIELD, MI 48076	IILE ROAD		
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	evidenced by: Based on observ review, the facilit environment tha residents' dignity including three (i residents reviewe Findings include: According to the "Dignity" dated S "Residents will respect at all tim and property are are expected to I themselves befor roomsDemeani of care that com prohibitedStaff cognitively impai and sensitivity" On 8/5/24 from 9 multiple observa entering the room Place (a secured announcing ther room, or waiting the residents to o	IENT is not met as ation, interview and record y failed to provide an t promoted and enhanced v for multiple residents, R42, R73, and R85) of ed for dignity. facility's policy titled, 0/21/23: be treated with dignity and esResidents' private space respected at all timeStaff knock and identify re entering residents' ng practices and standards promise dignity are are expected to treat ired residents with dignity 9:00 AM to 11:30 AM, tions included nursing staff ms of residents on Anna's unit) without knocking, nselves prior to entering the of acknowledgment from		audits t once a environ residen and an rooms, feeding membe deficier immedi the Qua review	N/designee will complete ra hree times a week for 4 week week for 4 weeks to ensure ment promotes and enhance ts□ dignity with emphasis of nouncing prior to entering re sitting when assisting a resi , and intervening when fami rs attempt to feed other resi th practice will be corrected/t ately. The results will also be ality Assurance and perform meeting.	ks, then the es h knocking sidents⊡ dent with ly dents. Any updated e taken to ance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED 634021 B. WING 8/7/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			STRUCTION	(V2) D	ATE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD			A. BUILDING	LE CONS 			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD		634021	B. WING			8/7/20	24
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EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD	NAME OF PROVIDER OR SUPPLIE	R			STREET ADDRESS. CITY. STATE	. ZIP CO	DE
	EVERGREEN HEALTH AND R	ERABILITATION CENTER				KUAD	
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during the lunch meal on 8/5/24 which included:		meal on 8/5/24 which					
At 12:56 PM, Nurse 'K' was observed standing while providing feeding assistance to R85 who was seated in a gerichair recliner in the dining room. There were several empty chairs nearby that were available to use. At approximately 1:00 PM, the family member of R42 was observed standing while at the end of the table and feeding the R42. This family member was then observed to state to R73 (who was directly across from R42 at the end of the table). "You look like you haven't had a crumb of food in years, right?". During this time, the family member was observed to touch their clothing, hair, and table multiple times. This family member was then observed to begin to feed both R73 and R42 at the same time. There was no use of hand sanitizer or washing of hands by this family member in between assisting the two residents with their lunch meal. Additionally, although nursing staff were present, no one was observed to intervene or address this family member's actions. On 8/7/24 at 845 AM, an interview was conducted with Nurse Manager (IMI 'N'). When asked about the observations during the lunch meal on 8/5/24, NM 'N' reported	At 12:56 PM, Nu while providing i who was seated dining room. The nearby that were At approximately member of R42 at the end of the This family mem state to R73 (wh R42 at the end of you haven't had right?". During this time, observed to toue table multiple tin then observed to R42 at the same hand sanitizer on family member i residents with th although nursing was observed to family member's On 8/7/24 at 8:4 conducted with When asked about	feeding assistance to R85 in a gerichair recliner in the ere were several empty chairs a vailable to use. y 1:00 PM, the family was observed standing while a table and feeding the R42. ber was then observed to o was directly across from if the table), "You look like a crumb of food in years, the family member was ch their clothing, hair, and mes. This family member was o begin to feed both R73 and time. There was no use of r washing of hands by this n between assisting the two leir lunch meal. Additionally, g staff were present, no one intervene or address this a actions. 5 AM, an interview was Nurse Manager (NM 'N'). but the observations during					

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AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	G	ISTRUCTION		ATE SURVEY PLETED
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	informed of the r nursing staff enter knocking, acknow and they reporter knocking and and the rooms. R42 Review of the clir was admitted inter readmitted on 8/ on 11/21/23 with Alzheimer's disea failure to thrive, or calorie malnutriti According to the assessment dater cognitive impair Review of the ress "Announce self explain all process with feeding, maid dayEATING: 1 p R73 Review of the clir was admitted inter readmitted on 2/ included: cerebra metabolic encept	eding. They were also multiple observations of ering the rooms without wledging prior to entering d staff should absolutely be nouncing before entering hical record revealed R42 o the facility on 7/1/20, 30/20, signed onto hospice a diagnoses that included: ase with late onset, adult unspecified severe protein- on, and anorexia. Minimum Data Set(MDS) d 5/31/24, R42 had severe nent. dident's plan of care included, when entering room and duresAssistance needed y fluctuate day to erson assist as needed" hical record revealed R73 o the facility on 2/10/21 and 23/21 with diagnoses that al palsy, bipolar disorder, halopathy, unspecified alorie malnutrition, and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634021	À. BUILDIN	IG	ČOŃ	(X3) DATE SURVEY COMPLETED 8/7/2024	
	WIDER OR SUPPLIE	EHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP C		
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	According to the dated 6/21/24, R impairment. Review of the re: "EATING: 1 per resident to join s R85 Review of the cli was admitted int readmitted on 4, included: Alzheir other behavioral and adult failure According to the 7/12/24 docume cognitive impair Review of the re: "assist w (with),	MDS assessment dated nted R85 had severe ment. sident's plan of care included,					
F0555 SS= D	Physician §483. Physician. The r choose his or he §483.10(d)(1) Th licensed to pract physician chose or does not mee this part, the fac	/Be Informed Attendg 10(d) Choice of Attending esident has the right to r attending physician. he physician must be ice, and §483.10(d)(2) If the h by the resident refuses to t requirements specified in lity may seek alternate pation as specified in	F0555	of an at has bee has bee on the p	It 1 practice of the facility to ensure choic tending physician is honored. R288 en interviewed and physician choice en updated. Dr. F has been educated process and residents right to have ar ng physician of their choice.		

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 634021	À. BUILDIN	G	STRUCTION		ATE SURVEY LETED 24
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	, ZIP CO	DE
EVERGREEN HEALTH AND REHABILITATION CENTER					19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
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	assure provision adequate care ar The facility must remains informed way of contacting primary care prof his or her care. § must inform the r determines that t resident is unable requirements spe facility seeks alte to assure provision adequate care ar must discuss the participation with resident's prefere options. §483.10 subsequently sel physician who m specified in this p that choice. This REQUIREM evidenced by: Based on observa- review, the facilit an attending phy (R288) of three re choices. Findings On 8/5/24 at 10: lying in bed. A sig Precautions'' was isolation cart was immediately outs contained persor	and (5) of this section to of appropriate and and treatment. §483.10(d)(3) ensure that each resident d of the name, specialty, and g the physician and other essionals responsible for 483.10(d)(4) The facility esident if the facility he physician chosen by the e or unwilling to meet ecified in this part and the mate physician participation on of appropriate and nd treatment. The facility alternative physician the resident and honor the ences, if any, among (d)(5) If the resident ects another attending eets the requirements bart, the facility must honor IENT is not met as ation, interview and record y failed to ensure choice of sician was honored for one esidents reviewed for include: 30 AM, R288 was observed gn announcing "Contact posted on the door and a c observed in the hallway ide R288's room which hal protection equipment olation gowns and gloves.		have the practice facility f choice Element The Inte Facility the resist attendir appropi Physici Facility on the 1 attendir Element The DC week fc weeks to physicia will be of results Assural	nts that currently reside in the fa e potential to be affected by this e. Residents that currently reside have been interviewed to ensure of attending physician is honored heets updated with the residents of attending physician. It 3 erdisciplinary Team reviewed the Admission Contract, with empha dents right to choose his or her ng physician and deemed it riate. Licensed nurses and curre ans have been educated on the Admission contract, with the em residents right to choose his or her ng physician. It 4 DN/designee will interview 5 reside or 4 weeks, then every week for - to ensure resident choice of atte an is honored. Any deficient prac- corrected/updated immediately. will also be taken to the Quality nce and performance review me ministrator is responsible for	cited in the the the d. asis on nt uphasis ler dents a 4 nding tice The	

STATEMENT OF I AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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NAME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CC	DE		
EVERGREEN H	EALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN MI SOUTHFIELD, MI 48076	LE ROAD	ROAD		
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R c tt c w tt a e w R w d a Ir d ir R P n "" C ir E 9 R n tt tt a P P e e	288 explained t ome in the day heir PICC (peripl atheter) line and yound on their f hey told Dr. "F" n attitude" about xplained they hay yound they hay yound them as the eview of the clin yas admitted int liagnoses that in nd acute kidney herview of the clin yas admitted int liagnoses that in nd acute kidney herview for Mere lated 7/30/24, R htact cognition. Review of R288's hysician Team - tote dated 8/4/2 Patient refused Dn 8/7/24 at 9:11 herviewed by p Dr. "F" explained loves, they wan 288 would not looticed a bandag ried to move the hem for not weat sked if they wer precautions. Dr. '	about care at the facility. heir doctor, Dr. "F", had before, but was touching herally inserted central d the dressing over the foot without gloves when to put on gloves, Dr. "F" "got ut wearing gloves. R288 also ad told Dr. "F" they did not eir doctor anymore. hical record revealed R288 o the facility on 7/29/24 with hocluded: diabetes, cellulitis r failure. According to a Brief ntal Status (BIMS) exam 288 scored 14/15 indicating r progress notes revealed a H&P (health and physical) 24 at 4:08 PM that read, exam". 3 AM, Dr. "F" was hone and asked about R288. they were not wearing ted to see the PICC line, but let them touch it, then they ge on R288's foot, so they e blanket, but R288 yelled at aring gloves. Dr. "F" was re aware R288 was in Contact 'F" explained they normally ind does an evaluation of ey would need, then exits the							

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	IPLE CON	STRUCTION		ATE SURVEY LETED
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	put on a gown ai examination and was asked if R28 them as their dow was upset and have were going to see they had calmed On 8/7/24 at 9:3 Nursing (DON) wa a resident did no again, could they DON explained t the facility and a doctors at any tin R288 had told Du as their doctor, a had told them, b going to see their explained she wor facilitate a different they wanted. Wh have informed th "fired" them, the have informed th Review of the fac dated 11/2017 re has the right to co physician If the selects another a meets the require	2 AM, the Director of vas interviewed and asked if t want to see their doctor get a different doctor. The hey had several doctors at resident could change me. The DON was informed r. "F" they did not want them nd Dr. "F" had agreed R288 ut they had said they were m anyway. The DON build talk to R288 and ent doctor if that was what en asked if Dr. "F" should he facility that R288 had DON agreed Dr. "F" should					
	Choose/Be Notif	ied of Room/Roommate	F0559	F559			9/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON	STRUCTION	(X3) DA COMPI	ATE SURVEY LETED
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PRÉFIX (EACH DEFICIE TAG FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE
SS= D room with his our residents live in spouses conser §483.10(e)(5) T his or her room practicable, whe same facility an the arrangemer receive written n for the change, roommate in the This REQUIREI evidenced by: Based on obser review, the facil appropriate not room change for reviewed for roo On 8/5/24 at 11 lying in a bed d provided by the about being in 1 explained their morning, it was in, and they had Review of the cl had been admit with diagnoses abdominal wall, kidney disease. for Mental Statu	O(e)(4) The right to share a r her spouse when married the same facility and both nt to the arrangement. he right to share a room with mate of choice when en both residents live in the d both residents consent to it. §483.10(e)(6) The right to notice, including the reason before the resident's room or e facility is changed. MENT is not met as vation, interview and record ity failed to provide ice in a dignified manner of a or one (R289) of one resident om changes. Findings include: :11 AM, R289 was observed ifferent than the room census facility. R289 was asked that particular room. R289 room had been changed that the third room they had been I only been there four days. inical record revealed R289 ted into the facility on 8/1/24 that included: open wound of prostate cancer and chronic According to a Brief Interview is (BIMS) exam dated 8/2/24, /15 indicating intact		appropri room ch dignified Elemen Resider that req be affect residen ensure manner practice Elemen The Inte policy a Room/F appropri educate Notifica emphas a dignified dignified deficien immedia the Qua review n	practice of the facility to pro iate notice in a dignified ma hange. R289 has been notifi d manner with no concerned t 2 hts that currently reside in the uire a room move have the ted by this cited practice. The ts charts have been review appropriate notice in a digni has been completed. Any co- has been corrected. t 3 erdisciplinary Team reviewen nd procedure Notification of Roommate Change and deel iate. Licensed nurses have ed on the policy and procedu- tion of Room/Roommate Cha- sis providing appropriate not ed manner of a room change t 4 N/designee will complete ra- haree times a week for 4 week eek for 4 weeks to ensure the ding appropriate notification d manner of a room change. t practice will be corrected/L thy Assurance and performa- neeting. ministrator is responsible for	nner of a ed in a d voiced. e facility potential to hose ved to fied leficient d the med it been ure of ange with ification in je. undom ks, then he facility in a . Any updated e taken to ance	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		STRUCTION		ATE SURVEY
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	admission, R289 8/3/24, R289 was on 8/5/24 R289 was on 8/5/24 R289 was their current roo On 8/6/24 at 1:0 lying in bed and changes. R289 es admitted (8/1/24 moved to a diffe (8/3/24) then at night (8/4/24) st had to change ro whyR289 asked rooms, but staff to tell them the ro guestR289 asked they knew they h them the room of rightsR289 was to their current r came again that them the reason they agreed to it told them the re 2:00 AM, would room change. R2 would have mov them that it had that room, and it moved. When as	s census revealed upon was in Room 421. On s moved to Room 419, then was moved to Room 417, m. 5 PM, R289 was observed asked about their room xplained they had been t) into one room, then was rent room on Saturday 2 o'clock in the morning that aff came and told them they boms, but did not say I why they had to change told R289 they did not have reason, they were a even if they were a guest, had basic rights, but staff told thange was not part of their ed the staff if they had to call buse they knew they had asked when they had moved oom. R289 explained staff morning (8/5/24) and told for the room change, so . R289 was asked if staff had ason for the room change at they have agreed to the 289 explained they definitely ed as it was explained to been a mistake to be put in t was for health reasons to be ked if they knew the name of nted to move them at 2:00					

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AND PLAN OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTI	PLE CON G	ISTRUCTION		ATE SURVEY LETED
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	1	NFORMATION)			DEFICIENCY)		
	AM on 8/4/24 R	289 explained there had					
		nembers, and they did not					
	know their name						
		1 PM, the Director of Nursing					
		viewed and informed of the					
		h R289. The DON explained					
		d R289 had refused to be					
		4, but then agreed to be					
		4, but did not know the					
	1 '	sked if R289 should have					
		ason for the move, especially DON agreed R289 should					
	have been told th	5					
		le reason.					
	On 8/6/24 at 4:47	7 PM, Licensed Practical					
		was interviewed and asked					
		oting to change R289's room					
	at 2:00 AM on 8/	4/24. LPN "D" explained she					
		reason for the room change,					
	but R289 wanted	specific information about					
	the reasons, and	were told they could not					
	give specifics, R2	89 threatened to call their					
	attorney.						
	Review of a facilit	ty policy titled, "Notification					
		nate Change" dated 4/18/23					
		ne right to receive written					
		the reason for the change,					
		ent's room or roommate in					
		ngedDiscuss possible room					
	or roommate cha	-					
		Team. Ensure room or					
		ges meet the CMS (Centers					
		Aedicaid Services) guidelines					
		ng with the changeDiscuss					
	•						•

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY LETED
		634021	B. WING)24
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDR	RESS, CITY, STATE, ZIP CO	DE
EVERGREEN	HEALTH AND R	EHABILITATION CENTER		19933 WEST SOUTHFIELD	THIRTEEN MILE ROAD D, MI 48076	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORRECTIVE ACTIC REFERENCED TO	OF CORRECTION (EACH ON SHOULD BE CROSS- O THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	resident's represent for the change. P	the resident and/or the entative including the reason rovide the resident or ith the printed notification				
F0563 SS= F	The resident has his or her choosi choosing, subject deny visitation w manner that doe another resident, immediate access family and other subject to the res withdraw consen must provide imm by others who ar the resident, sub and safety restric right to deny or v time; (iv) The fact reasonable acce or individual that legal, or other ses subject to the res withdraw consen facility must have procedures rega residents, includi clinically necess or limitation or sa when such limita with the requirem facility may need the reasons for the restriction or limit	ss to a resident by any entity provides health, social, rvices to the resident, sident's right to deny or t at any time; and (v) The e written policies and rding the visitation rights of ng those setting forth any ary or reasonable restriction afety restriction or limitation, tions may apply consistent tents of this subpart, that the to place on such rights and ne clinical or safety	F0563	The admission packet visiting hours have be council meeting was h residents on unrestrict Element 2 Residents that current have the potential to b practice. Residents th facility and family mer notified that visitation hour visitation is avail Element 3 The Interdisciplinary T F563- right to receive have been educated of receive/deny visitors v unrestricted, 24-hour Element 4 The DON/designee w interviews every week other week for 4 week unrestricted, 24-hour Any deficient practice	visitation for residents. t has been updated and een removed. Resident held and updated the ted, 24-hour visitation. tly reside in the facility be affected by this cited hat currently reside in the mbers have been is unrestricted and 24- able. Feam reviewed the /deny visitors. All staff on the F563-right to with emphasis on visitation for residents. ill complete 5 random < for 4 weeks, then every (s to ensure that we offer visitation for residents. will be mediately. The results he Quality Assurance ew meeting.	9/17/2024

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CON G		(X3) DATE SURVEY COMPLETED	
		634021	B. WING _			8/7/20	24
					-		
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
EVERGREEN HEALTH AND REHABILITATION CENTER					19933 WEST THIRTEEN MIL SOUTHFIELD, MI 48076	E ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	facility failed to evisitation for resination for resident facility. Finding several anonymouth facility's visite 8:00 PM with the that time, and we that time, and we that time, and we that they resident reported allowed to have yof 8:00 AM and 8 On 8/7/24 at 1:10 conducted with the they responded a front door lockin which is annound if the residents we right to have visit to 8:00 PM timef chose not to "spowere aware of. There may be visit facilities admission there was a scrip night when annound the they responded for the residents we right when annound for the residents we facilities admission there was a scrip night when annound the they have a scrip night when annound the they responded for the residents we have a scrip night when annound the they have a scrip night when	30 AM, during a resident with the State Agency, ous residents reported that or hours ended each night at e front door being locked at ere announced overhead. were present and each d not knowing that they were visitors outside of the hours 8:00 PM. 0 PM, an interview was the Administrator. When e facility's visitor hours were, 8:00 AM to 8:00 PM with the g at 8:00 PM each day, ced overhead. When queried vere aware that they had the tors outside of the 8:00 AM rame, the Administrator eak" for what the residents he Administrator mentioned itor hours listed in the on packet. When asked if t that was followed each puncing the end of visitor nistrator deferred to the					

TATEMENT OF DEFICIENCIE	6 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	634021	B. WING	i	8/7/20	24	
AME OF PROVIDER OR SUP	LIER		STREET ADDRESS, CITY	(, STATE, ZIP CO	DE	
VERGREEN HEALTH AN	REHABILITATION CENTER		19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076			
PRÉFIX (EACH DEFI	STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY LATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE	
 overhead an beginning at series of ann the end of vi residents and at 8:00 PM a at that time. A visitor poli facility, howe that they did Review of th packet provi- large bold pi "VISITATION LOBBY DOO F0578 Request/Ref SS= D F0578 Request/Ref SS= D F0578 Request/Ref adv Dir §483 refuse, and/c participate in experimenta advance dire this paragrag- right of the re of medical tr deemed med inappropriate must comply in 42 CFR pp Directives). (provisions to information t the right to a surgical treat 	M was queried about the ouncements, they reported that 7:45 PM each night, there is a uncements made announcing itor hours and informing visitors that visiting hours end d the front door will be locked by was requested from the rer the Administrator responded not have a formal visitor policy. first page of the admission ed by the facility revealed, in nt and in all capital letters 10 AM TO 7:45 PM DAILY. LOCKS AT 8PM". se/Dscntnue Trmnt;FormIte 10(c)(6) The right to request, or refuse to participate in research, and to formulate an trive. §483.10(c)(8) Nothing in n should be construed as the sident to receive the provision atment or medical services cally unnecessary or §483.10(g)(12) The facility with the requirements specified t 489, subpart I (Advance These requirements include nform and provide written all adult residents concerning cept or refuse medical or nent and, at the resident's ate an advance directive. (ii)	F0578	F578 Element 1 It is the practice of the facility to Not-Resuscitate (DNR) Advance order per the residents/guardia R128 no longer resides in the fi Element 2 Residents that currently reside that wish to be a Do-Not-Resus have the potential to be affecte practice. Residents that current facility charts have been review Advance Directives are in place Resuscitate wishes have been the facility s policy. Any deficie been corrected immediately. Element 3	e Directive ns wishes. acility. in the facility scitate (DNR) d by this cited tly reside in the ved to ensure e and Do-Not- executed per	9/17/2024	

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	À. BUILDIN	G	ISTRUCTION	(X3) DATE SURVEY COMPLETED 8/7/2024	
		634021	B. WING _			0,172024	
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
EVERGREEN HEALTH AND REHABILITATION CENTER					19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	facility's policies of directives and ap Facilities are peri- entities to furnish legally responsib requirements of t adult individual is admission and is information or art she has executed facility may give a information to the representative in (v) The facility is to provide this information. Follo place to provide this information. Follo place to provide to individual directly This REQUIREM evidenced by: Based on intervie facility failed to e (DNR) Advance D resident (R128) re reviewed for Adv Findings include: Clinical record re admitted from th 7/23/24. R128 red right toe gangrer to lack of blood f medical history in	view revealed R128 was e hospital to the facility on quired rehabilitation from ne (death of body tissue due low or infection). R128's		Advance appropriet departin Advance executii Advance residen Elemen The So comple for 4 we for 4 we fo	cial Work Director/designee will te random audits three times a v beeks on five residents, then ever each on five residents to ensure -Resuscitate (DNR) Advance Di re executed per the ts/guardians wishes. Any deficit will be corrected/updated ately. The results will also be ta ality Assurance and performance meeting. ministrator is responsible for	it /ork e sis on week ry week that rective ent ken to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CON		DATE SURVEY PLETED	
		634021	B. WING				
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZIP CO	ATE, ZIP CODE	
EVERGREEI	N HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076	0	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS- FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	products via the natural filter for Mental Status (B indicating R128 - On 7/29/24, a re conference sum PM documented reviewed and R1 DNR code status DNR form was c awaiting physicia On 8/6/24 at 12: Corporate Social facility failed to i DNR code status the duration of F facility. On 8/6/24 at 1:1 provided the DN dated 7/29/24, s and dated the fo "B" was aware R	eal dialysis (removal of waste lining inside the belly as a blood). A Brief Interview of IMS) score totaled 14/15 was cognitively intact. view of the health care mary held on 7/29/24 at 2:00 Advance Directives were 28 expressed their choice of 5. The facility documented the ompleted by R128 and an signature and order. 49 PM, an interview with Services "B" confirmed the mplement R128's wishes of a 5 and remained a full code for R128's residency at the 2 PM, Social Services "B" IR form signed by R128, tated the physician signed vrm 8/6/24. Social Services 128 was discharged from the se the physician signed.					
F0624 SS= D	§483.15(c)(7) O discharge. A fac document suffici orientation to res orderly transfer of This orientation	Safe/Orderly Transfer/Dschrg rientation for transfer or ility must provide and ent preparation and sidents to ensure safe and or discharge from the facility. must be provided in a form the resident can	F0624	and col resides Elemer	practice of the facility to ensure a safe laborated discharge. R29 no longer in the facility.	9/17/2024	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		634021	B. WING			8/7/20	24	
NAME OF PRO	OVIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, ST	TATE, ZIP CO	DE	
EVERGREEI	N HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN I SOUTHFIELD, MI 48076	MILE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIOI DATE	
	evidenced by: Based on observ review, the facilit collaborated disc residents review, include: On 8/5/24 at 9:4 the bathroom ur in the room wait the bathroom. R like a surveyor to finished getting AM, this surveyo was sitting in the leg elevated on d sitting in a chair interviewed and stay at the facilit been good" and getting discharg spouse interjecte know because so that we might no to a fall (that R25 9:05 AM)." R29's facility called the that R29 would b 8/5/24. R29's spo have packed up ready to go, and not leaving. So, w	MENT is not met as ation, interview and record by failed to ensure a safe and charge for one (R29) of three ed for discharge. Findings 0 AM, R29 was observed in massisted. R29's spouse was ing for them to return from 29 stated that they would or return once they were ready for the day. At 10:00 r returned to the room, R29 e wheel chair with their left the bed. Their spouse was across the room. R29 was asked how was their current y, and stated, "It has not explained that they were ed today (8/5/24). R29's ed and stated, "Well, we don't ocial work came in and stated of be getting discharged due 0 had that morning around spouse explained that the em on Friday 8/2/24 to state on discharged on Monday ouse stated, "Hence, why I her room and have her all now they are saying we are we do not know what is her way if they are making		be affed residen confere a safe a deficier immedi Elemen The Inte Transfe appropt departn Transfe on ensu includim Elemen The So comple for 4 we and col dischar will be o results Assura	at 3 erdisciplinary Team reviewe er and Discharge Policy and riate. Nursing staff and Soci nent have been educated or er and Discharge policy with uring a safe and collaborate ig holding a care conference to a safe and collaborate to a safe and collaborate to a safe and collaborate is in pla ging patients including the core conference. Any deficient will also be taken to the Qua nce and performance review ministrator is responsible fo	Those care T to ensure Any ed the deemed it ial Work n the emphasis d discharge e. ee will as a week every week sure a safe ace for completion t practice tely. The ality w meeting.		

		· · · · · · · - · · · · · · · · ·					
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY
		634021	B. WING _			8/7/20)24
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE
EVERGREEN		EHABILITATION CENTER			19933 WEST THIRTEEN		
EVENOREER					SOUTHFIELD, MI 48076		
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TAG		TORY OR LSC IDENTIFYING	TAG	RE	FERENCED TO THE APPROI	PRIATE	DATE
	II II	NFORMATION)			DEFICIENCY)		
	[R29] stay, we wi	ll stay but if they are					
	discharging her t	hen we will leave." R29					
		eir discharge) had just been					
		mess" and that they just					
		me and stated, If they are					
		der any services, then I can					
		do the same thing." R29 and then asked did the facility					
		erence (a conference					
		ident and resident's					
		the plan of care for the					
		m and they both said, "No".					
	R29's spouse ask	ed this surveyor what a care					
		sted of. R29 stated that the					
		had talked to her from the					
		ocial worker on the day after					
	admission and th	nat Friday (8/2/24).					
	A record review r	revealed that R29 was					
		facility on 7/18/24 with a					
		e two diabetes, repeated falls,					
		anxiety disorder. R29 had a					
	brief interview fo	r mental status score of 15,					
	indicating an inta	act cognition.					
		0 AM, R29 was observed in was asked how they were.					
		at they were still in pain					
		that they had been vomiting					
		and that their head and their					
	hip were still hur						
		-					
		13 AM, R29 and their spouse					
		I. R29's spouse explained					
		ceived a call from the facility					
	and was told that	t R29 was ready to be					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		ISTRUCTION		ATE SURVEY PLETED	
		634021	B. WING _			8/7/20	024	
IAME OF PRO	OVIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE	
VERGREE	N HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN N SOUTHFIELD, MI 48076	33 WEST THIRTEEN MILE ROAD ITHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETIO DATE	
	explain that they the facility so that then). The spous arrived to the fac "another lady" cc them that we we On 8/7/24 at 11: were observed g items in their hat over to walk tow R29 then stated, nurse just came i were discharged unorganized!" R2 "continuous care going on in each nursing (DON) sa talking to this su conversation and she was. R29 rep but what did you them where they "I have been disc "No, you have no set, no follow up you need to go b set this up for you to get your shit t unacceptable, ar me to my room la	s spouse continued to were already on the way to at was okay (to discharge her e stated that when they cility around 9:30 AM, ame into the room and told re not being discharged. 33 AM, R29 and their spouse oing towards the exit with nds. R29 waved this surveyor ards door with them where "This place is a crap show. A in the room and said we so we are leaving. But it is so 29 stated that there was no " and no one knows what's o department. The Director of aw R29 and their spouse rveyor and came into the d asked R29 if she knew who lied "Yes, you are the DON of want?" The DON asked were going and R29 stated, charged". The DON replied, bt. There was no homecare appointments or anything, pack to your room so we can out." R29 stated, "You all need ogether because this is d if you are going to send do not need a psychiatrist! I ou all are just not th each other and it has						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	B. W	NG	8/7/2024
AME OF PROVIDER OR S	PLIER		STREET ADDRESS, CITY	, STATE, ZIP CODE
VERGREEN HEALTH	ID REHABILITATION CENT	TER	19933 WEST THIRTEE SOUTHFIELD, MI 4807	
PRÉFIX (EACH D	STATEMENT OF DEFICIENCI ICIENCY MUST BE PRECEDED ULATORY OR LSC IDENTIFYII INFORMATION)	D BY PREFI	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOUL REFERENCED TO THE APPI DEFICIENCY)	D BE CROSS- COMPLETIC
 conducte were aska discharge just took percent s discharge trying to was askee discharge sure, that resigned trying to On 8/7/2 resident p "psychiat resident v There wa provided F0655 Baseline Person-C Baseline facility m baseline includes effective resident t quality ca Be develu admissio healthcar care for a to- (A) Ini orders. (E 	t 11:47 AM, an interview was vith the social worker (SW). T what role they play in their an? The SW explained that s er R29's case and she was no e what happened (with the The SW explained that she was it from this point on". The S who informed the family of the SW explained that she was e social work director had 8/5/24. The SW stated, "I'm what I can." t 1:00 PM, the facility had the itioned to hospital for behaviors" that stated the e trying to "self harm." o additional information the exit of survey. re Plan §483.21 Compreher tered Care Planning §483.2 re Plans §483.21(a)(1) The develop and implement a e plan for each resident that instructions needed to prov d person-centered care of th t meet professional standard The baseline care plan musi- ed within 48 hours of a reside ii) Include the minimum nformation necessary to proj sident including, but not limi goals based on admission Physician orders. (C) Dietary fherapy services. (E) Social	They the tas tide tide tide tide perly tited t	 F655 Element 1 It is the practice of the facility to baseline care plan for tube feed longer resides in the facility. Th care plan was updated prior to l discharged. Element 2 Residents that currently reside that receive tube feeding have to be affected by this cited practic residents □ charts have been re ensure a baseline care plan is i 48 hours of admission to the fad deficiencies have been corrected 	ling. R287 no e baseline R287 in the facility the potential to e. Those viewed to n place within cility. Any

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 634021	IA (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 8/7/2024	
NAME OF PRO	VIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STAT			, ZIP CO	DE
EVERGREEN HEALTH AND REHABILITATION CENTER					19933 WEST THIRTEEN MILI SOUTHFIELD, MI 48076	E ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	applicable. §483. develop a compr of the baseline c comprehensive c within 48 hours of (ii) Meets the req paragraph (b) (2)) §483.21(a) (3) Th resident and thei summary of the b includes but is no goals of the resic resident's medica instructions. (iii) / to be administere personnel acting Any updated info of the comprehen necessary. This REQUIREM evidenced by: Based on observa- review, the facilit baseline care pla provided to one reviewed for tubo Review of a facili Baseline" dated & the policy of the plan of care to m health and safety within forty-eigh The baseline care	SARR recommendation, if .21(a)(2) The facility may ehensive care plan in place are plan if the are plan- (i) Is developed of the resident's admission. uurements set forth in this section (excepting (i) of this section). e facility must provide the r representative with a paseline care plan that of limited to: (i) The initial dent. (ii) A summary of the ations and dietary Any services and treatments ed by the facility and on behalf of the facility. (iv) rmation based on the details nsive care plan, as IENT is not met as ation, interview and record y failed to implement a n for tube feeding was (R287) of one resident e feeding. Findings include: ty policy titled, "Care Plan - 3/25/23 read in part, "It is facility to develop a baseline leet the resident's immediate r needs for each resident t (48) hours of admission e plan includes instructions le effective, person-centered		Plan-Ba approprieducate with emplans for 48 hour Element The DC audits t residen are con Any det correcte will also and pel	at 3 erdisciplinary Team reviewed the aseline policy and deemed it riate. Nursing staff have been ed on the Care Plan-Baseline prophasis on ensuring baseline care for tube feedings are completed rs of admission. At 4 DN/designee will complete rando hree times a week for 4 weeks ts, then every week for 4 weeks ts, then every week for 4 weeks ts, then every week for 4 weeks ts to ensure that baseline care inpleted within 48 hours of admis ficient practice will be ed/updated immediately. The re- o be taken to the Quality Assura- formance review meeting. ministrator is responsible for	blicy re within on five s on five plans ssion. ssults	

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	IPLE CON		DATE SURVEY IPLETED
		634021	B. WING			2024
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZIP C	ODE
EVERGREEN		EHABILITATION CENTER			19933 WEST THIRTEEN MILE ROA SOUTHFIELD, MI 48076	U
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS- FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	standards of qua the minimum he necessary to pro- On 8/5/24 at 9:5- sleeping in bed. I feeding) was bein Review of the clin was admitted int diagnoses that in depressive disord According to a B Status (BIMS) exa scored 3/15 indic cognition. Review of R287's no care plan for the On 8/6/24 at 2:39 (DON) was intervi- resident receiving care plan for tub explained there s informed R287 h	9 PM, the Director of Nursing riewed and asked if a g tube feeding should have a e feeding. The DON should be a care plan. When ad no care plan for tube N explained there should				
F0658 SS= D	Services Provide Standards §483. Care Plans The arranged by the comprehensive of professional star	ed Meet Professional 21(b)(3) Comprehensive services provided or facility, as outlined by the care plan, must- (i) Meet	F0658	medica orders	nt 1 practice of the facility to ensure tions were accurately documented an written according to professional rds of practice. R27 medications was	9/17/2024 d

FORM CMS-2567(02-99) Previous Versions Obsolete

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		634021	B. WING			8/7/2024		
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE	
EVERGREEN	I HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN M SOUTHFIELD, MI 48076	IILE ROAD		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIEN FULL REGULA II	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPI DEFICIENCY)	CROSS-	(X5) COMPLETION DATE		
	review, the facilit medications wer and orders writte standards of pra- residents. Finding R27 On 8/6/24 at 8:2 Medication Adm Practical Nurse (I prepare seven m crushed the med with applesauce. enter R27's room medications to R medications to R medications to R medications to R Medications to R medications to R medications to P leave R27's room had refused. On 8/6/24 at 9:0 "E" had prepared physician orders. marked as given On 8/6/24 at 9:1 she had gone ba medications. LPN When informed a marked as given, marked them as	5 AM, as part of the inistration task, Licensed LPN) "E" was observed to redications for R27. LPN "E" lications and mixed them LPN "E" was observed to to give the seven crushed R27. R27 refused to take the N "E" was then observed to the with the medications R27 5 AM, the medications LPN d were reconciled with R27's All seven medications were		nurse e educate medicai adminis facility. updated Elemen Resider have th practice reviewe medicai orders of standar been co Elemen The Inte Medicai Practitic appropri educate and Phy emphas accurat and ord standar Fresiden the DC audits th residen accurat and ord standar Standar Practitic appropri educate and Phy emphas accurat and ord standar tesiden residen the DC audits th residen accurat and ord standar Standar	nts that currently reside in the e potential to be affected by a. Those residents □ charts h d and residents interviewed tions were accurately docum written according to professid ds of practice. Any deficience prected immediately. t 3 erdisciplinary Team reviewed tion Administration and Phys poner Orders policy and deem riate. Nursing staff have beer ad on the Medication Adminis ysician, Practitioner Orders p sis on ensuring medications ely documented after admini lers written according to prof ds of practice. t 4 N/designee will complete ra hree times a week for 4 wee ts to ensure that medications ely documented after admini lers written according to prof ds of practice. Any deficient witten according to prof ds of practice. Any deficient witten according to prof ds of practice. Any deficient will also be taken to the Qua nce and performance review ministrator is responsible for	eeen out been es in the and e facility this cited ave been to ensure eented and onal ees have d the sician, ned it n stration bolicy with were stration essional ndom ks on five eks on five es were stration essional practice aly. The lity meeting.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED 634021 B. WING 8/7/2024 NAME OF PROVIDER OR SUPPLIER B. WING 8/7/2024 EVERGREEN HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES 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									
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE				A (X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION			
EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH (X5)) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FREFIX) PREFIX CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE			634021	B. WING _			8/7/20	24	
EVERGREEN HEALTH AND REHABILITATION CENTER 19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH (X5)) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FREFIX) PREFIX CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE									
SOUTHFIELD, MI 48076 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH (X5)) (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PREFIX CORRECTIVE ACTION SHOULD BE CROSS- COMPLETION TAG FULL REGULATORY OR LSC IDENTIFYING TAG REFERENCED TO THE APPROPRIATE DATE	NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH (X5)) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PREFIX CORRECTIVE ACTION SHOULD BE CROSS- TAG FULL REGULATORY OR LSC IDENTIFYING TAG REFERENCED TO THE APPROPRIATE DATE	EVERGREEN	HEALTH AND RE	EHABILITATION CENTER				LE ROAD		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY PREFIX CORRECTIVE ACTION SHOULD BE CROSS- TAG FULL REGULATORY OR LSC IDENTIFYING TAG REFERENCED TO THE APPROPRIATE DATE						SOUTHFIELD, MI 48076			
TAG FULL REGULATORY OR LSC IDENTIFYING TAG REFERENCED TO THE APPROPRIATE DATE									
		FULL REGULAT	ORY OR LSC IDENTIFYING	TAG		EFERENCED TO THE APPROPRIA			
should medications be marked as given. LPN									
"E" explained they should not be marked		"E" explained the	y should not be marked						
until after they have been given.		until after they ha	ave been given.						
On 8/7/24 at 8:24 AM, the Director of									
Nursing (DON) was interviewed and asked		-							
when medications should be marked as									
given. The DON explained medications									
should only be marked as given after the			5						
resident takes the medication.		resident takes the	e medication.						
R287		R287							
On 8/5/24 at 9:54 AM, R287 was observed		On 8/5/24 at 9:54	AM, R287 was observed						
sleeping in bed. Jevity 1.5 Cal (calorie) Enteral									
nutrition (tube feeding) was being delivered									
via pump at 65 ml/hr (milliliters per hour).									
Review of the clinical record revealed R287		Review of the clir	nical record revealed R287						
was admitted into the facility on 8/3/24 with		was admitted into	o the facility on 8/3/24 with						
diagnoses that included: stroke, major		diagnoses that in	cluded: stroke, major						
depressive disorder and malnutrition.									
According to a Brief Interview for Mental		-							
Status (BIMS) exam dated 8/4/24, R287									
scored 3/15 indicating severely impaired			ating severely impaired						
cognition.		cognition.							
Review of R287's physician orders revealed		Review of R287's	physician orders revealed						
an Enteral Feed order with a start date of									
8/4/24 that read, "in the evening Up at 1800									
(6:00 PM); down at 1400 (2:00 PM); 20 hours			÷ .						
total". There was no specific type of tube feed									
formula or rate the tube feed was to be									
infused in the order.									
On 8/6/24 at 8:49 AM, R287 was observed		On 8/6/24 at 8:49	AM, R287 was observed						

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI	A (X2) MULTI	PLE CON	ISTRUCTION	(X3) D	ATE SURVEY
AND PLAN OF		IDENTIFICATION NUMBER:	A. BUILDIN	G			LETED
		634021	B. WING _			8/7/20)24
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE
EVERGREEN		EHABILITATION CENTER			19933 WEST THIRTEEN		
LVENGREEN					SOUTHFIELD, MI 48076		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PRO\	I /IDER'S PLAN OF CORRECT	TION (EACH	(X5)
PREFIX TAG	(EACH DEFICIEN FULL REGULAT	ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	PREFIX TAG	COR	RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	COMPLETION DATE
	sleeping in bed. I delivered to R28	No tube feed was being 7.					
	(RD) "G" was inter R287's tube feed when a resident in the weekends lik call him and he w or use what the r in the hospital ur evaluate the resid "G" was asked if reflecting the spec- formula and the explained the ord all the required er of formula and the explained the tub were in a progress progress note was orders, RN "G" ex an order for tube Review of R287's Nursing note wri (RN) "H" dated 8, part, "Pt (patient) at 65 ml/hr" On 8/6/24 at 11:3 interviewed by pl R287's tube feed she was the Midra assisting with R25	51 AM, Registered Dietician erviewed and asked about orders. RD "G" explained is admitted at night or on e R287 was, the nurse would would give a standard order resident had been receiving ntil he could come and dent's nutritional needs. RD an order should be put in ecific type of tube feed infusion rate. RD "G" der should be complete with elements including the type he rate. RD "G" also be feed formula and rate as sufficient for tube feed kplained there needed to be e feed. progress notes revealed a tten by Registered Nurse /3/24 at 8:17 PM that read in admittedJevity 1.5 to run B6 AM, RN "H" was hone and asked about orders. RN "H" explained night Manager and had been 87's admission and had ssion progress note. RN "H"					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634021	ENTIFICATION NUMBER: A. BUILDI		STRUCTION		DATE SURVEY MPLETED 2024	
	OVIDER OR SUPPLIE N HEALTH AND R	EHABILITATION CENTER	STREET ADDRESS, CITY, STA 19933 WEST THIRTEEN M SOUTHFIELD, MI 48076					
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETIO DATE	
F0684 SS= D	infusion rate sho note. RN "H" exp should be compl and infusion rate Review of the fac (RN/LPN)" job de part, "As a men team, the unit CH responsibility an services delivered designated unit f Quality of Care § Quality of Care § Quality of Care § Quality of Care § Quality of care is applies to all trea facility residents. comprehensive a the facility must treatment and ca professional star comprehensive p and the resident This REQUIREM evidenced by: This citation has Statements. Deficient Practice Based on observ review, the facilit care for two (R35	cility's "Unit Charge Nurse escription undated read in nber of the interdisciplinary narge Nurse assumes d accountability for nursing d to all residents of a for one shift" 3 483.25 Quality of care a fundamental principle that atment and care provided to Based on the assessment of a resident, ensure that residents receive are in accordance with ndards of practice, the berson-centered care plan, s' choices. IENT is not met as 2 Deficient Practice	F0684	Elemen It is the wound of care. Ri and woi physicia Elemen Resider that rec wound of by this of have be order is physicia correcte Elemen The Inte and Woi appropri educate with em non-pre	practice of the facility to provid care for non-pressure related w 337 and R120 have been asses und care has been provided pe an order. t 2 hts that currently reside in the fa eive wound care for non-press care have the potential to be af cited practice. Those residents been reviewed to ensure wound in place and being provided pe an order. Any deficiencies have ad immediately.	round ssed r the acility ure fected charts care er the been he Skin lelines e for he	9/17/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 634021		À. ÉUILDIN	G	STRUCTION	(X3) DATE SURVEY COMPLETED 8/7/2024		
NAME OF PRO	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP COI	DE
EVERGREEN	HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	lying in bed resti their stay at the f that they were in needed to chang they (the facility) stated, "There is have not change abdominal woun proceeded to she abdominal woun drainage from th odor. A record review r admitted to the f diagnosis of hype diabetes and mill brief interview fo indicating an inta review of the reco received orders f wound to gallbla work. On 8/6/24 at 12:0 nurse was intervi process of new a surgical wounds. is supposed to be admission is com	So AM, R337 was observed ng. R337 was asked how facility had been. R337 stated pain and that someone e their wound dressings but had not done so. R337 an area on my butt that they d yet." R337 stated that the d had started to stink and ow this surveyor the d. There was blood and e wound that had a mild revealed that R337 was facility on 8/3/24 with the erlipidemia, type two d protein deficit. R337 had a r mental status score of 15, fact cognition. A further ord revealed that R337 or treatment for surgical dder in the hospital paper 20 PM, the wound care (WC) ewed and asked about the dmissions who come in with The WC explained that there e orders in once the upleted and the nurses would or treatment orders if they		Elemen The DC audits t residen pressur Any del correcte will also and per The Ad complia Deficier Elemen It is the Physica longer r Elemen Resider that hav have th practice reviewe appoint Any del immedi Elemen The Intk Physica deemed been ec Practitic followin appoint Elemen The DC audits t	N/designee will complete rando hree times a week for 4 weeks ts, then every week for 4 weeks ts to ensure that wound care for e related wounds have been pre- icient practice will be ed/updated immediately. The re be taken to the Quality Assura formance review meeting, ministrator is responsible for nnce. The Practice Statement #2 t 1 practice of the facility to follow t an consult appointment. R128 m resides in the facility. t 2 ints that currently reside in the fa ze physician consult appointmer e potential to be affected by this a. Those residents □ charts have d to ensure physician consult ments follow up has been receiviciencies have been corrected ately. t 3 erdisciplinary Team reviewed thi an and Practitioner Orders policy d to enthe Physician and oner Orders policy with emphas g up on physician consult ment.	e y and ve been we been	

ATEMENT OF DEFINIT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CON	ISTRUCTION		ATE SURVEY PLETED		
		634021	B. WING			_ 8/7/2	024		
ME OF PROVIDER	OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DDE		
/ERGREEN HEAL	TH AND R	EHABILITATION CENTER		19933 WEST THIRTEEN SOUTHFIELD, MI 48076			MILE ROAD		
PRÉFIX (EAC	H DEFICIEN	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIC DATE		
order on th would hospi R337 WC cl woun been R120 On 8/ whee vac in 7/31/ care t stated you w love c love t when their chang band suppo A rece admit diagn and h interv indica review medic	s would rer e resident. d normally f tal paper w should hav arified that d care curre some. 5/24 R120 I chair in th place as w 24. When R hey receive d its pretty o could be ab doing what o get a pay was the las hand dressi ged on the age (07/31/ osed to be o ord review i ted to the f osis of sep yperlipider iew for menting an inta- v of the rec-	peak to the doctor and the nain until wound care rounds The WC explained that they follow orders from the ork. WC nurse was asked if e wound care orders. The there were no orders for ently and there should have was observed sitting in a eir room. R120 had a wound ell as a hand dressing dated t120 was asked about the d while at the facility, R120 decent but anywhere you go le to tell the people who they do and the ones who c check. R120 was asked st time the facility changed ng. R120 stated it was date that was written on the 2024). R120 stated, "It's completed 3 times a week." revealed that R120 was facility on 7/19/24 with the sis, pressure ulcers stage 3, nia. R120 had a brief ntal status of score of 15, act cognition. A further ord revealed that in the inistration record (MAR) the as marked off as being		appoint correcte will also and per	ted for physician consult ments. Any deficient practi ed/updated immediately. The b be taken to the Quality As formance review meeting. ministrator is responsible france.	he results ssurance			

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CONST G	TRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		634021	B. WING _			8/7/20	24
NAME OF PRO	VIDER OR SUPPLIE	R		s	TREET ADDRESS, CITY, STATE,	ZIP COI	DE
EVERGREEN HEALTH AND REHABILITATION CENTER					9933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORRE	DER'S PLAN OF CORRECTION (E/ ECTIVE ACTION SHOULD BE CRO ERENCED TO THE APPROPRIATI DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	completed on 08	/02/2024.					
	asked how the tr being completed bandage on R120 7/31/24 and that the last time it w. stated, "I am not wound. The floor (R120) wounds o Director of Nursi that the nurse (N the treatment wa have them come surveyor. Nurse " on a treatment th Nurse "R" stated, miscommunication and explained the treatment. No addition infor exit of survey. Deficient Practice Based on intervie facility failed to for consult appointmo one reviewed for	w and record review, the ollow up on a Physician ent for one resident (R128) of physician consults, resulting or missed or delayed new					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 634021		À. BUILDIN	IG	ČOŃ	(X3) DATE SURVEY COMPLETED 	
	VIDER OR SUPPLIE	I R EHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP C 19933 WEST THIRTEEN MILE ROA SOUTHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS- FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	admitted from th 7/23/24. R128 rec right toe gangrer to lack of blood f medical history ir hypertension, end required peritone products via the l natural filter for b Mental Status (Bl indicating R128 w On 8/6/24 at 4:38 (DON) was quest dated 7/30/24 th a doctor's appoir of an after-visit si DON acknowledge appointment was acknowledged th the physician cor On 8/6/24 at 4:44 coordination of c	d stage renal disease and eal dialysis (removal of waste ining inside the belly as a blood). A Brief Interview of MS) score totaled 14/15 as cognitively intact. B PM, The Director of Nursing ioned of a progress note at the daughter took R128 to itment and no documentation ummary was identified. The ged the process for outside "not done correctly" and e facility did not follow up on					
F0686 SS= D	Ulcer §483.25(b) Pressure ulcers. comprehensive a the facility must receives care, co standards of pra	to Prevent/Heal Pressure 9 Skin Integrity §483.25(b)(1) Based on the assessment of a resident, ensure that- (i) A resident onsistent with professional ctice, to prevent pressure not develop pressure ulcers	F0686	care or with pre reviewe	It 1 practice of the facility to ensure woun ders are in place for new admissions essure ulcers. R337 chart has been ad and order updated to include wound ders for pressure ulcers.		

STATEMENT OF DEFICIENC	ES (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED _ 8/7/2024		
	634021			8/7/20			
NAME OF PROVIDER OR SU	PPLIER		STREET ADDRESS, CIT	Y, STATE, ZIP CO	DE		
EVERGREEN HEALTH AI	ID REHABILITATION CENTER		19933 WEST THIRTEI SOUTHFIELD, MI 480		MILE ROAD		
PRÉFIX (EACH DEF	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY ULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUL REFERENCED TO THE APP DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE		
demonstrat and (ii) A re receives ne consistent to practice, to infection an developing. This REQU evidenced I Based on of review the f wound care (R337) of tv ulcers. Find On 8/5/24 a lying in bec stay at the f they were in to change t had not do an area on changed ye abdominal proceeded area to this drainage or that came f On 8/5/24 a performed that time R	Idividual's clinical condition as that they were unavoidable; sident with pressure ulcers sessary treatment and services, ith professional standards of promote healing, prevent d prevent new ulcers from REMENT is not met as y: servation interview and record acility failed to ensure there were orders placed for one resident o residents reviewed for pressure ngs include: t 9:15 AM, R337 was observed rest. R337 was asked how their acility had been. R337 stated that pain and that someone needed heir wound dressings but they e so yet. R337 stated, "There is ny butt that they have not " R337 explained that the wound had started to stink. R337 o show the abdominal wound surveyor. There was blood and the bancage with a mild odor om the site. t 9:20 AM, the certified nurse aid noontinence care for R337. At 37's coccyx area was observed. presented with a reddened a greenish yellow slough base.		Element 2 Residents that are admitted to pressure ulcers have the poten affected by this cited practice. The residents is charts have been re- ensure wound care orders are admissions skin assessments in completed to ensure any press wound care orders in place. And have been corrected immediate Element 3 The Interdisciplinary Team revi- and Wound Guidelines and devi- appropriate. Nursing staff have educated on the Skin and Wout with emphasis on ensuring wou- are in place for newly admitted pressure ulcers. Element 4 The DON/designee will comple audits three times a week for 4 residents, then every week for residents to ensure wound care place for newly admitted patient pressure ulcers. Any deficient pressure ulcers. Any deficient pressure ulcers and performance review meetin The Administrator is responsibl compliance.	titial to be Those eviewed to in place. New have been sure ulcers have by deficiencies ely. weeked the Skin emed it been and Guidelines und care orders patients with ete random weeks on five 4 weeks on five 4 weeks on five 5 with oractice will be 7. The results 7 Assurance ng.			

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STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIF A. BUILDING	PLE CON G	ISTRUCTION	\ - /	ATE SURVEY LETED
		634021	B. WING _			8/7/20	24
NAME OF PRO	VIDER OR SUPPLIE	iR			STREET ADDRESS, CITY,	STATE, ZIP CO	DE
EVERGREEN	HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN		
					SOUTHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	There were two c	dime sized stage two					
		n the left gluteal cheek.					
		-					
		revealed that R337 was					
		facility on 8/3/24 with the					
		erlipidemia, type two					
		d protein deficit. R337 had a protein deficit. R337 had a protein deficit.					
	indicating an inta						
		ce cognition.					
	A review of the n	nedical record revealed					
	further that there	e were no admission wound					
	care orders place	ed for R337 on the day of					
	admission on 8/3	3/24.					
		00 PM, the wound care (WC)					
		ewed and asked who is					
		outting in orders upon houd there be treatment					
		ntil wound care rounds on					
		C explained that there are					
		orders in place on admission					
		d by the nurses if the WC					
	nurse was not ab	ble to assess the resident. The					
		plained that the admitting					
		nsible for calling the doctors					
		atment order put in place					
		can round on the residents.					
		en asked was R337					
		e wound care orders, WC here was not orders put in					
		there have been orders put					
	in place.	and a nave been orders put					
		ditional information					
	provided by the	exit of survey					

	ATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 634021		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 8/7/2024	
	/IDER OR SUPPLIE	R R EHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
F0689 SS= D	Accidents. The fa §483.25(d)(1) The remains as free of possible; and §44 receives adequat assistance device This REQUIREM evidenced by: Based on observa- review the facility a fall for one (R24 accidents. Finding On 8/5/24 at 9:40 the bathroom un- in the room waiting the bathroom. R2 like this surveyor finished getting in AM, this surveyor was sitting in the leg elevated on t sitting in a chair asked about their explained that the (8/5/24). R29 stat and they hit their when they fell, the A record review r admitted to the factors.	sion/Devices §483.25(d) acility must ensure that - e resident environment of accident hazards as is 83.25(d)(2)Each resident te supervision and es to prevent accidents. IENT is not met as ations, interview and record / failed assess promptly after 9) resident of reviewed for	F0689	residen resides comple Elemen Resideu and hav affected residen ensure prompti family immedi Elemen The Inte Manage appropti educate with em assess comple residen Elemen The Inte Manage appropti educate with em assess comple residen residen prompti comple residen residen residen residen sesses comple residen the DC audits t	practice of the facility to assest ts promptly after a fall. R29 no in the facility. Assessment wa ted prior to R29 discharge. It 2 Ints that currently reside in the i we a fall have the potential to b d by this cited practice. Those ts charts have been reviewent the residents have been assest ly and interventions completed ly with notification to resident a Any deficiencies have been co ately. It 3 erdisciplinary Team reviewed the end the Fall Management Gu ophasis on ensuring the resident ed promptly with interventions ted promptly with notification to t and family. It 4 DN/designee will complete rando hree times a week for 4 weeks ts, then every week for 4 weeks ts, then every week for 4 weeks ts to ensure residents are assest y after a fall with interventions ted promptly with notification to ts and family. Any deficient pro- will also be taken to the Quality nce and performance review of ministrator is responsible for	longer s facility e d to ssed and rrected he Fall it it idelines nt is o dom o five ssed o actice . The y	9/17/2024

		1					
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		634021	B. WING _			8/7/20)24
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
EVERGREEN	HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN MIL	E ROAD	
					SOUTHFIELD, MI 48076		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PRO\	I /IDER'S PLAN OF CORRECTION (EACH	(X5)
PRÉFIX		ICY MUST BE PRECEDED BY	PREFIX		RECTIVE ACTION SHOULD BE CI		COMPLÉTION
TAG		FORY OR LSC IDENTIFYING NFORMATION)	TAG	K	EFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
		ized anxiety disorder. R29 riew for mental status score					
		and intact cognition. A					
		the record revealed that R29					
		get assisted when using the					
	restroom.						
		AM D20 was absorved					
		0 AM, R29 was observed was asked how they were					
		ed that there were sick to					
		ey had been vomiting, and					
		29 stated they were					
		was then asked did they tell					
		e vomiting and pain? R29					
		did tell the facility. R29					
		e started having those day, while visiting with her					
	spouse.	day, while visiting with her					
	l .						
		nedical record revealed with					
		dated for 8/5/24 at 2:44 PM					
		rrse who cared for R29 tated " Resident was					
		n their left side around 9:05					
		hat they was trying to get					
		I fell on their bottom.					
	Resident was qui	ckly assessed and the team					
		then to the bed. Resident					
		no pain at this time. Vital					
		pulse 72, temperature 98.1 00 on room air. Spoke with					
		ioner(NP) she was in the					
		s the patient and she					
	J	ubic centimeters) bolus for					
	hypotension. And	d she ordered Neurochecks,					
	waiting assess fo	r peripheral IV (intravenous)					

						()(0) D	
AND PLAN OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDING	GECON	ISTRUCTION	(X3) D/	ATE SURVEY LETED
		634021	B. WING _			8/7/20	24
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
		EHABILITATION CENTER			19933 WEST THIRTEEN MILE		
EVERGREEN		ERABILITATION CENTER			SOUTHFIELD, MI 48076	KUAD	
			-				
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX		/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR		(X5) COMPLETION
TAG	FULL REGULAT	FORY OR LSC IDENTIFYING	TAG		FERENCED TO THE APPROPRIA		DATE
	1	NFORMATION)			DEFICIENCY)		
	placement"						
		5 AM, the Unit Manager					
		ewed and asked how does					
		up with residents after a					
		ed they use a neuro check					
		d not complain of anything					
	1	nting the neuro check sheet). blained that R29 had stated					
	· · ·	pain yesterday as well as					
		added that they feel sick to					
	-	d had started to vomit					
	yesterday. The U	M explained that R29 never					
	complained of ar	nything. The UM was then					
		29 with the surveyor and					
		n, R29 stated that they were					
		to stomach and explained					
		arted after the fall and the iting after lunch on 8/5/24.					
		29 were they still sick to					
		9 stated, "Yes." After we left					
		1 stated that she would call					
	the doctor to let	them know that R29 was in					
	pain to order x-ra	ays, labs and to order Zofran					
	for the nausea.						
	$0 = 9/7/24$ at 10^{-1}	12 AM D20 and their spause					
		13 AM R29 and their spouse I about the fall that resident					
		on the morning of 8/5/24					
		were feeling. R29 stated that					
		nd that the facility finally					
		heir leg, but did not					
		they did not take one of					
		se stated that no one from					
		called them to let them know					
	R29 had a fall an	d no one mentioned the fall					

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI	A (X2) MULT	IPLE CONSTRUCTION		ATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		IG		LETED
		634021	B. WING		8/7/20	24
	VIDER OR SUPPLIE	R		STREET ADDRESS, CITY, S		DE
EVERGREEN		EHABILITATION CENTER		19933 WEST THIRTEEN I SOUTHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	facility all day no incident."	use stated, "I was at the one ever mentioned the ormation was provided at				
F0812 SS= F	Sanitary §483.60 requirements. Th (1) - Procure foo considered satisf local authorities. items obtained d subject to applica regulations. (ii) T prohibit or prever produce grown ir compliance with food-handling pra does not preclud foods not procure (2) - Store, prepa in accordance wi food service safe This REQUIREM evidenced by: Based on observa- review, the facilit ventilation hood failed to ensure t sanitizing, and fa machine in a san practice had the	e facility must - §483.60(i) d from sources approved or actory by federal, state or (i) This may include food irectly from local producers, able State and local laws or his provision does not nt facilities from using n facility gardens, subject to applicable safe growing and actices. (iii) This provision e residents from consuming ed by the facility. §483.60(i) irre, distribute and serve food th professional standards for ity. IENT is not met as ation, interview, and record y failed to maintain the filters in a sanitary manner, he dish machine was iled to maintain the dish itary manner. This deficient potential to affect all nsume food from the	F0812	F812 Element 1 It is the practice of the facility to may ventilation hood filters in a sanitary and to ensure the dish machine is and to maintain the dish machine is and to maintain the dish machine h repaired to ensure sanitizing with t log updated and the dish machine cleaned. No residents were affected deficient practice. Element 2 Residents that currently reside in th have the potential to be affected by practice. Residents that currently r facility have been assessed, no res have been affected by this deficient Element 3 The Interdisciplinary Team reviewed Cleaning policy and the Warewash and deemed it appropriate. Kitcher been educated on the Hood Clean and the Warewashing policy with e maintaining the ventilation hood filt sanitary manner, ensuring the dish sanitizing, and to maintain the dish a sanitary manner. Element 4 The Food Service Director/designed complete 3 random audits weekly ithen every week for 4 weeks to em	manner, sanitizing, n a sanitary s have as been he sanitizer has been d by this he facility / this cited eside in the sidents it practice. ed Hood ing policy mphasis on ers in a machine is machine in ee will for 4 weeks,	

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ISTRUCTION	(X3) D	ATE SURVEY
AND PLAN OF		IDENTIFICATION NUMBER:	A. BUILDIN	G			LETED
		624021				0/7/20	24
		634021	B. WING _			8/7/20	124
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE
EVERGREEN		EHABILITATION CENTER			19933 WEST THIRTEEN M		
LVENGREEN					SOUTHFIELD, MI 48076		
	I						
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	ID PREFIX		IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	FULL REGULAT	FORY OR LSC IDENTIFYING	TAG		FERENCED TO THE APPROP		DATE
	1	NFORMATION)			DEFICIENCY)		
	On 8/5/24 at 9·3(0 AM, the cookline hood		ventilat	ion hood filters are maintain	ed in a	
		were observed with a			/ manner, dish machine is s		
		e. Certified Dietary Manager			dish machine is maintained		
		kitchen staff were			y manner. Any deficient praced with the second s A second s		
	responsible for cl	leaning the hood vent.			be taken to the Quality As		
					formance review meeting.		
		2017 FDA (Food and Drug		complia	ministrator is responsible fo	r	
		Food Code Section 4-601.11		oompile			
		I-Contact Surfaces, Nonfood- , and Utensils. "(C)					
		FACT SURFACES of					
		ll be kept free of an					
		dust, dirt, FOOD residue, and					
	other debris."						
		0 AM, a plate simulating					
		r was sent through the dish					
		k the sanitizing properties of					
		temperature dish machine. mperature recorded on the					
		as noted to be 152 degrees					
	1.	50 AM, the plate simulator					
		nrough the dish machine,					
	-	m temperature noted on the					
		vas 153 degrees Fahrenheit.					
	At that same time	e, the digital temperature					
	display unit on th	ne dish machine noted the					
		rature to be 146 degrees					
		n queried about what					
		rinse temperature should be					
	to ensure sanitiza	ation, CDM "O" stated "150-					
	100.						
	On 8/5/24 at 9.4	5 AM, the "Temperature Log"					
		nine was reviewed and noted					
	the following:						

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 634021		À. BUILDIN	G	ISTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 8/7/2024	
	OVIDER OR SUPPLIE	EHABILITATION CENTER			STREET ADDRESS, CITY, STAT 19933 WEST THIRTEEN MII SOUTHFIELD, MI 48076	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETIO DATE	
	documented on temperature log made aware of t dish machine. CI provide an expla continued to use logging inadequ On 8/5/24 at 10: observed using t soiled dishware. dishwasher teste machine, and rec temperature of 1 final rinse temper digital display ur degrees Fahrenh	bout the low temperatures the dish machine . CDM "O" stated he was not he low temperatures for the DM "O" was unable to nation as to why staff e the dish machine after ate temperatures. 00 AM, kitchen staff was he dish machine to clean The plate simulating r was again sent through the corded the maximum 47 degrees Fahrenheit. The rature on the machine's nit was noted to be 155 eit. At that time, dietary staff asher temperature on the as 151/155.						
		10 AM, Maintenance as observed working on the						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CON		DATE SURVEY	
		634021	B. WING			_ 8/7/2024	
NAME OF PRO	OVIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STATE, ZIP		
EVERGREEI	N HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN MILE ROA SOUTHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS- FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	Supervisor "P" st that were blockin machine needed the inside of the coils, were obser buildup. According to the section 4-703.11 After being clear CONTACT SURF, SANITIZED in: "(I operations by be EQUIPMENT tha §§ 4-501.15, 4-50 achieving a UTEI 71°C (160°F) as r registering temp According to the section 4-501.11 Equipment, Hot Temperatures, "(of this section, ir temperature of t SANITIZING rins may not be more than: Pf (1) For a temperature ma	Then queried, Maintenance trated there were forks inside ing the sensor and that the cleaning inside. At that time, dish machine as well as the ved with a thick, slime e 2017 FDA Food Code Hot Water and Chemical, ned, EQUIPMENT FOOD- ACES and UTENSILS shall be B) Hot water mechanical eing cycled through t is set up as specified under 01.112, and 4-501.113 and NSIL surface temperature of measured by an irreversible perature indicator; P" e 2017 FDA Food Code 2 Mechanical Warewashing Water Sanitization A) Except as specified in ¶ (B) n a mechanical operation, the he fresh hot water e as it enters the manifold e than 90°C (194°F), or less stationary rack, single chine, 74°C (165°F); Pf or (2) chines, 82°C (180°F). Pf".					
F0880 SS= D	Infection Control and maintain an	tion & Control §483.80 The facility must establish infection prevention and designed to provide a safe,	F0880	F880 Elemer It is the	nt 1 practice of the facility to ensure prop	9/17/2024 er	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	À. BUILDIN	NG	ISTRUCTION	ĊOMP	(X3) DATE SURVEY COMPLETED	
		634021	B. WING			8/7/20)24	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DDE	
EVERGREE	N HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN I SOUTHFIELD, MI 48076	MILE ROAD		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIEN FULL REGULA II	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIO DATE		
	help prevent the transmission of o infections. §483. and control prog establish an infe program (IPCP) minimum, the fol (1) A system for reporting, investi infections and co residents, staff, v other individuals contractual arrar facility assessme §483.70(e) and f standards; §483 policies, and pro which must inclu A system of surv possible commu infections before persons in the fa possible incident or infections sho Standard and tra precautions to be of infections; (iv) should be used f not limited to: (A the isolation, dep agent or organis requirement that least restrictive p under the circum circumstances u prohibit employe disease or infect contact will trans hand hygiene pro-	nfortable environment and to development and communicable diseases and 80(a) Infection prevention ram. The facility must ction prevention and control that must include, at a lowing elements: §483.80(a) preventing, identifying, gating, and controlling ommunicable diseases for all volunteers, visitors, and providing services under a ngement based upon the ent conducted according to following accepted national .80(a)(2) Written standards, cedures for the program, de, but are not limited to: (i) reillance designed to identify nicable diseases or they can spread to other toilty; (ii) When and to whom is of communicable disease uld be reported; (iii) numsission-based e followed to prevent spread When and how isolation for a resident; including but) The type and duration of bending upon the infectious m involved, and (B) A the isolation should be the possible for the resident astances. (v) The nder which the facility must es with a communicable ed skin lesions from direct dents or their food, if direct ismit the disease; and (vi)The ocedures to be followed by direct resident contact.		includir transmi regardi equipm R73, R any infe no sign change Elemer Reside have th practice assess protocco hygiene precau protecti placem deficier immedi Elemer The Int Hygien and Tra and Su Equipm When C and de been ee Infectio Transm Summa (PPE) I Caring emphae protocco hygiene protocco the precau protocco and de been ee Infectio Transm Summa (PPE) I	nts that currently reside in the potential to be affected by e. Those Residents □ have be ed to ensure proper infection ols and practices including h e during meals, transmission tions (TMP) regarding perso ive equipment (PPE) and ro- ents are being followed. An incies have been corrected ately. It 3 erdisciplinary Team reviewe e policy, Infection Control □ ansmission-Based Precaution mmary of Personal Protection thent (PPE) Use and Room F Caring for Residents in Nurse emed it appropriate. Nursing ducated on Hand Hygiene p in Control □ Standard and hission-Based Precautions p ary of Personal Protective E Jse and Room Restriction V for Residents in Nursing Ho sis on ensuring proper infec- ols and practices including h e during meals, transmission tions (TBP) regarding use o ive equipment (PPE) and ro- ent with those on precaution	als, BP) /e nent. R42, ssessed for tems with oom was vey. he facility y this cited been n control and n-based oral bom y ed the Hand Standard ons policy, ve Restriction sing Home g staff have bolicy, and quipment When orne with tion control and n-based f personal bom		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CON	STRUCTION		ATE SURVEY LETED
		634021	B. WING		_ 8/7/2024		
AME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
VERGREE	N HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN SOUTHFIELD, MI 48076		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
	incidents identifi and the corrective facility. §483.800 handle, store, pr so as to prevent §483.80(f) Annu conduct an annu update their prop This REQUIREN evidenced by: Based on observe review the facilite infection control including hand f transmission-base regarding use of equipment (PPE) four (R42, R73, F residents review Findings include Dining Observat On 8/5/24 at 1:0 R42 was observe table and feedin This family mem state to R73, "Ye crumb of food ir During this time observed to toue table multiple time	ion: 0 PM, the family member of ed standing at the end of the g the R42 by the spoonful. ber was then observed to bu look like you haven't had a		audits ti residen residen control hygiene precaut protecti placem deficien immedia the Qua review	N/designee will complete hree times a week for 4 we ts, then every week for 4 we ts to ensure residents prop protocols and practices ind e during meals, transmissic ions (TBP) regarding use even ve equipment (PPE) and r ent with those on precaution t practice will be corrected ately. The results will also ality Assurance and perform meeting. ministrator is responsible f ince.	eeks on five weeks on five ber infection cluding hand on-based of personal oom ons. Any J/updated be taken to mance	

	DEFICIENCIES				ISTRUCTION	(Y2) D	
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (A2) NOLTH A. BUILDING	G	ISTRUCTION		ATE SURVEY LETED
		634021	B. WING			8/7/20	24
			_				
NAME OF PROVID	DER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
EVERGREEN H		EHABILITATION CENTER			19933 WEST THIRTEEN MILE		
					SOUTHFIELD, MI 48076	NOAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
S nr a w f C C V V t I t t t t t t t t t t t t t t t t	sanitizer or washi member in betwe residents with the although nursing was observed to i family member's On 8/7/24 at 8:45 conducted with N When asked about the lunch meal or they had observe to that family me asked why no one observed continu unable to offer ar R42 Review of the clin was admitted into readmitted on 8/ on 11/21/23 with Alzheimer's disea failure to thrive, u calorie malnutrition According to the assessment dated cognitive impairn Review of the res 'Announce self explain all proced	5 AM, an interview was Nurse Manager (NM 'N'). Let the observations during In 8/5/24, NM 'N' reported d the same, and had spoken mber as well that day. When e intervened if they used actions, they were my further explanation. An ical record revealed R42 to the facility on 7/1/20, 30/20, signed onto hospice d diagnoses that included: use with late onset, adult unspecified severe protein- on, and anorexia. Minimum Data Set(MDS) d 5/31/24, R42 had severe					

STATEMENT O		(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTI	PLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
		634021				8/7/20	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
EVERGREEN	EVERGREEN HEALTH AND REHABILITATION CENTER				19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORF	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR(FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	dayEATING: 1 p	erson assist as needed"					
	R73						
	was admitted int readmitted on 2/ included: cerebra metabolic encept severe protein-ca unspecified intell According to the dated 6/21/24, R impairment. Review of the res "EATING: 1 pers resident to join s According to the Hygiene" dated 2 "SITUATIONS IN WATER OR ALCC CAN BE USEDBr residentsAfter h objects, equipme R288 On 8/5/24 at 10:3 lying in bed. A sig Precautions" was isolation cart was	hical record revealed R73 o the facility on 2/10/21 and (23/21 with diagnoses that al palsy, bipolar disorder, halopathy, unspecified alorie malnutrition, and lectual disabilities. facility's MDS assessment 73 had severe cognitive sident's plan of care included, son assistEncourage mall dining for meals" facility's policy titled, "Hand 4/14/2023: N WHICH USING SOAP AND DHOL BASED HAND RUB etween direct contact with handling contaminated ent, dressings, etc"					

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A	(X2) MULTIF A. BUILDING	PLE CON	ISTRUCTION	(X3) DA COMPI	ATE SURVEY LETED
		634021		B. WING $_$			8/7/20	24
						-		
NAME OF PROVIDER OR S	JPPLIE	R				STREET ADDRESS, CITY, STATE	, ZIP CO	DE
EVERGREEN HEALTH A	EVERGREEN HEALTH AND REHABILITATION CENTER					19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
PRÉFIX (EACH DE	FICIEN	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)		ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
 (PPE) inclu R288 was a R288 expla come in the their PICC catheter) I wound on they told I an attitude explained want them they would them. Review of was admit diagnoses and acute Interview fi dated 7/30 intact cogin Review of Physician note writte PM that refine On 8/7/24 interviewe Dr. "F" exp gloves, the R288 would noticed a li tried to motion 	ding is asked ined t e day (perip me and their f or. "F" " aboot they h as the f not p they h as the f not p the clii ted int that ir kidney or Me 0/24, R nition. R288's Feam - at 9:1 d by p lained y wan d not to partage f and to partage f and to to partage f and to to partage f and to to partage f and to to partage f and to to to to to to to to to to to to to	nal protection equipment solation gowns and gloves. about care at the facility. their doctor, Dr. "F", had before, but was touching herally inserted central d the dressing over the foot without gloveswhen to put on gloves, Dr. "F" "got ut wearing gloves. R288 also ad told Dr. "F" they did not eir doctor anymore because but on glove before touching nical record revealed R288 to the facility on 7/29/24 with heluded: diabetes, cellulitis / failure. According to a Brief ntal Status (BIMS) exam t288 scored 14/15 indicating s progress notes revealed a - H&P (health and physical) Dr. "F" dated 8/4/24 at 4:08 atient refused exam". 3 AM, Dr. "F" was hone and asked about R288. They were not wearing ted to see the PICC line, but let them touch it, then they ge on R288's foot, so they e blanket, but R288 yelled at aring gloves. Dr. "F" was						

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI			STRUCTION		ATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		COMP	LETED
		634021	B. WING _			8/7/20	24
NAME OF PRO	VIDER OR SUPPLIE	R	•		STREET ADDRESS, CITY, STATE	, ZIP CO	DE
EVERGREEN	HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (I RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	Precautions. Dr. ' enters the room what supplies the room to gather t would put on a g examination and otherwise they w just to take it off they would need when going back asked in a Conta R288's gown ove blanket over thei infectious organi answer. On 8/7/24 at 9:24 "B", who served a Nurse, was interv going into a Con explained everyo and would have in the room muss all times. On 8/7/24 at 9:32 Nursing (DON) w physicians were to Contact Precautia all staff, including	re aware R288 was in Contact 'F" explained they normally and does an evaluation of ey would need, then exits the he supplies and then they yown and gloves to do the look at the wound, rould have to put on the PPE again to go get the supplies and then put on PPE again c into the room. Dr "F" was ct Precaution situation, could er the PICC line and the ir wound potentially have the sm on them. Dr. "F" did not 8 AM, Registered Nurse (RN) as the Infection Control <i>riewed</i> and asked about tact Precaution room. RN "B" one who entered the room contact with R288 or objects t wear a gown and gloves at 2 AM, the Director of <i>ras</i> interviewed and asked if required to wear PPE in a on room. The DON explained g physicians must wear PPE <i>r</i> with a resident or objects in a on room.					

		i					
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTI A. BUILDIN	PLE CON G			ATE SURVEY PLETED
		634021	B. WING _			_ 8/7/2	024
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
EVERGREEN	HEALTH AND R	EHABILITATION CENTER			19933 WEST THIRTEEN SOUTHFIELD, MI 48076	MILE ROAD)
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	lying in a bed dif provided by the f about being in th explained their ro- morning. Review of the clin had been admitte with diagnoses th abdominal wall, p kidney disease. A dated 8/2/24, R2 intact cognition. Review of R289's admission, R289 8/3/24, R289 was on 8/5/24 at 11: (RN) "B", who ser Nurse, was interv R289 being put in Precaution room	oom 419 revealed a Contact on the door and an isolation he hallway directly outside v of the census revealed the a 419 had been admitted been on Contact a admission. 14 AM, Registered Nurse rved as the Infection Control riewed and asked about n Room 419, a Contact . RN "B" explained R287 been put in the Contact					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634021	À. BUILDING	G	ISTRUCTION	(X3) DATE SURVEY COMPLETED 8/7/2024	
ME OF PRO	R EHABILITATION CENTER			STREET ADDRESS, CITY, S 19933 WEST THIRTEEN SOUTHFIELD, MI 48076			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B :FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE
	as the Midnight I phone and asked Contact Precaution R287 requested for was not a Contact door to Room 41 that room. On 8/6/24 at 11:- interviewed and a moved into a Co DON explained F moved into that moved into that moved into that moved out again would monitor the Review of a facili Control - Standa Precautions" revi "Transmission b for residents who be infected with require additional standard precaut transmission whi precautionsCor most frequent m healthcare associ direct contact transmission	AG AM, RN "H", who served Manager, was interviewed by I why R287 was put into a on room. RN "H" explained to change rooms and there tt Precaution sign on the '9, so they moved R287 into 46 AM, the DON was asked about R287 being intact Precaution room. The R287 should not have been room, but they had been to another room and they nem closely. ty policy titled, "Infection rd and Transmission-Based sed 3/4/24 read in part, based precautions are used to are known or suspected to infectious agents that al control measures above cions to effectively prevent ch included: Contact ct or indirect contact with Employees, residents, and onsible for complying with tact transmission is the ode of transmission of tated infections. It includes insmission (where there is a in physical transfer of					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 634021	1			STRUCTION	(X3) DATE SURVEY COMPLETED 8/7/2024	
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP CO	DE
EVERGREEN HEALTH AND REHABILITATION CENTER						19933 WEST THIRTEEN MILE SOUTHFIELD, MI 48076	ROAD	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID REFIX TAG	CORI	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	transmission (wh microorganisms l object and a pers Provide a private							