STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634021	A. BUILDING _____ B. WING _____	4/8/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHABILITATION CENTER	19933 WEST THIRTEEN MILE ROAD SOUTHFIELD, MI 48076

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F0000 SS=	INITIAL COMMENTS Evergreen Health & Rehabilitation Center was surveyed for an Abbreviated survey on 4/8/25. Intakes: MI00150776 and MI00150988. Census=156	F0000		
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake Number(s): MI00150988. Based on interview and record review, the facility failed to thoroughly evaluate and timely address a foot injury for one (R802) of one resident reviewed for a change in condition, resulting in a delay in diagnosing and treating a "moderately comminuted avulsion fracture (bone broken in multiple places)" to the resident's heel (calcaneus), increased pain, and the inability to fully participate in physical rehabilitation. Findings include: A review of a complaint submitted to the	F0684	ELEMENT 1 It is the practice of the facility to thoroughly evaluate and timely address residents with foot injuries. R802 had x-ray completed on 10/21/24 per the physician order, ultrasound completed on 10/26/24 per the physician order, and was seen by a physician on 10/23/24, 10/27/24, and 10/28/24. R802 no longer resides at the facility. ELEMENT 2 Residents that currently reside in the facility and have new complaints of pain including foot injuries have the potential to be affected by this cited practice. An audit completed with current residents to ensure any new complaints of pain including foot injuries have been thoroughly evaluated and timely addressed. No other residents complained of any foot injuries at this time. ELEMENT 3 The Interdisciplinary Team reviewed the Change in Condition Notification policy and deemed it appropriate. Nursing staff have been educated on the Change in Condition Notification policy with emphasis on ensuring thoroughly evaluated and timely addressing residents with new complaints of pain, including foot injuries.	4/30/2025

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

Electronically Signed | 04/28/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	State Agency revealed an allegation that the resident sustained an injury to her foot in the facility. On 4/8/25, an unannounced onsite investigation was conducted. A review of R802's clinical record revealed R802 was admitted into the facility on 10/3/24 and discharged on 10/25/24 with diagnoses that included: orthostatic hypotension and syncope and collapse. A review of a Minimum Data Set (MDS) assessment dated 10/9/25 revealed R802 had intact cognition, received scheduled pain medication, no as needed (PRN) pain medication, and did not experience any pain during the assessment period. A review of a "Physical Therapy (PT) Treatment Encounter Note" dated 10/21/24 revealed R802 complained of pain in the right foot after being assisted with transferring into bed which was "new onset". According to the note, the nurse was notified and ice was applied. A review of a "Occupational Therapy (OT) Treatment Encounter Note" dated 10/21/24 revealed, "Upon returning patient to bed, patient sudden <sic> yelled out and grabbed her right ankle, stating that it suddenly started hurting. Not <sic> bruising identified... (Licensed Practical Nurse - LPN 'E') informed...Patient did not trip or kick any object and also did not appear to roll or twist her ankle during transfer. Unknown what exactly caused pain..." A review of a "Nursing - Progress Note" dated 10/21/24 at 12:00 PM, written by Licensed Practical Nurse (LPN) 'E'		ELEMENT 4 The DON/designee will complete random audits on 5 residents a week for 4 weeks, then 5 residents a month for 2 months to ensure nurses have thoroughly evaluated and timely addressed residents with complaints of pain including foot injuries. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance. Compliance Date 4/30/25	

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	documented the following, "Resident was working with therapy and when she stood up her foot buckled. Res (resident) right ankle is swelling res stated her pain is at a 9 (out of 10 with 10 being the worst level of pain). spoke with NP (Nurse Practitioner) she ordered a STAT (right away) xray". A review of a "Radiology Results Report" dated 10/21/25 revealed R802 had an X-ray of the right ankle and there was no fracture or significant abnormality identified at that time. A review of a "Nursing - Progress Note" dated 10/22/24 at 2:33 PM, revealed, R802 "...complains of pain, ice pack given. NP spoke with resident regarding care, pt (Physical Therapy) and ot (Occupational Therapy) to continue". A review of a "Nursing - Progress Note" dated 10/23/24 at 12:55 PM, written by LPN 'E', revealed, "Resident (R802) is complaining of pain to the right foot spoke with NP she is aware. NP ordered 1 time Dose for Norco (opiate pain medication)...she ordered...Hydroxyzine...anxiety..." A review of a PT "Treatment Encounter Note" dated 10/23/24 revealed R802 declined PT on that date. A review of an OT "Treatment Encounter Note" dated 10/23/24 revealed, "...Pt (patient) c/o (complained of) ankle pain and states she doesn't think she sure <sic> do therapy today. Therapist educated pt on the need for consistent participation in therapy to reach goals..."			

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	A review of a progress note written by Physical Medicine and Rehabilitation (PM&R) Physician (Physician 'G') on 10/23/24 at 4:30 PM revealed, R802 "...had no complaints today. She feels well. She continues to have some difficulties with blood pressure during therapy...Inspection of the...BLE (bilateral lower extremities) revealed no acute swelling...tenderness...gait not tested...Pain: Reasonably controlled. Continue gabapentin (a pain medication used to treat neuropathy - nerve pain) which she takes at home for some neuropathy..." There was no mention in Physician 'G's note regarding R802's potential ankle injury and that R802's right foot was evaluated specifically for that reason as R802 had complained of pain that day and declined PT and OT due to the pain. A review of an OT "Treatment Encounter Note" dated 10/24/24 revealed R802 "refused to do any standing today. C/O right ankle pain". A review of a PT "Treatment Encounter Note" dated 10/25/24 revealed, "...Pt with NEW RT ANKLE swelling, X rays negative for any fractures, swelling present..." A review of an OT "Treatment Encounter Note" dated 10/25/24 revealed, "...pt only able to take one-step this day as she is reporting Max ankle pain. Nurse and PMR Dr (doctor) aware of pt's c/o's...Pts fear of ankle pain impeding optimal performance. 'I know the doctor said the x-rays were fine, but still." On 10/26/24 at 1:03 AM, it was documented in a "Nursing - Progress Note" that R802 "...has edema to the rle (right lower extremity), cool to touch, pain to the heel, np			

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	notified new orders for rle venous arterial us (ultrasound)". A review of an OT "Treatment Encounter Note" dated 10/26/24 revealed, "...Pt states she hurt her ankle stating that her leg collapsed when she was standing. 'It just collapsed suddenly'. Her leg is wrapped in ace wrap and she states it is painful. Xrays taken and negative..." It should be noted that upon further review of R802's complete clinical record, as of 10/26/24, five days after R802 first complained of pain to the right ankle/foot, there was no documentation that R802's right foot was evaluated by a medical provider after complaints of pain, swelling, and inability to participate in therapy, other than Physician 'G's note which did not address the potential injury and/or pain experienced that day. A review of an OT "Treatment Encounter Note" dated 10/27/24 revealed R802 declined OT on that day. On 10/27/24 at 1:09 PM, six days after R802 first complained of pain to the right ankle/foot, R802's attending physician, Physician 'H', documented, "...CHIEF COMPLAINT: Right ankle injury...The patient stated that she inured her right ankle, moving inside of her room from the wheelchair to the bed. The patient had x-ray done secondary to significant amount of discomfort. It did not show the fracture, X-ray shows no significant abnormalities including soft tissue being intact. Arterial Doppler was also done reveals to abnormalities. At this point, the patient is complaining that she is unable to put pressure on the ankle. It is swollen with			

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	significant bloody bruising involving the inner side of the right ankle going down to the sole...Positive for inability to ambulate, significant pain in the right ankle, swelling and tenderness...Examination of the right ankle appears to be swollen in the outer area with significant amount of bruising and tenderness...ASSESSMENT AND PLAN:...Injury to the right ankle, no fracture of the bones. The patient definitely has some injury of the soft tissue involving swelling and bruising. At this point, I strongly encouraged the patient to be no weightbearing...I do not believe the patient should walk on these extremities...The patient is no weightbearing status on the right lower extremity until evaluated by podiatrist..." A review of a PT "Treatment Encounter Note" dated 10/27/24 revealed, "Pt declined gait training today due to new R ankle swelling (it should be noted that R802 first injured her ankle on 10/21/24); stating 'they don't want me walking or standing on it'. Writer unable to find documentation on (electronic medical record)...Declined gait training today due to R ankle swelling..." On 10/28/24 at 7:30 PM, PM&R Physician 'G' documented, "...Since last evaluation, she does complain of right ankle pain (It should be noted that R802 although she did not exhibit pain during the last evaluation by Physician 'G' on 10/23/24, she did exhibit pain during therapy and according to the nursing progress note at which time pain medication was administered). She stated this started when she stood up but does not remember any overt trauma. She had been placed NWB (non weightbearing) by the primary team. She had an x-ray, which did not show any acute process. She is pending			

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	a podiatry evaluation...Inspection of the...BLE revealed no acute swelling...tenderness...The patient does have ecchymosis (bruising) with increased swelling over the lateral right ankle. The patient does have tenderness to palpitation over the fibula (leg bone) as well as the fifth metatarsal (foot bone)...IMPRESSION/PLAN:...Right ankle pain: Anticipate that this is related to an ankle inversion injury (sprain)...Will obtain a CT (computed tomography) scan of the ankle and foot to rule out small fracture. The patient is currently NWB with pending podiatry evaluation. This will likely be a barrier to the patient's rehab..." Further review of R802's progress notes revealed R802 was transferred to the hospital for issues with orthostatic blood pressure on 10/29/24. A review of a DR (Digital Radiography - X-ray) of the right ankle dated 10/21/24 revealed, "There is a small ossific density which projects in the region of the superior calcaneus (heel bone). This is indeterminate, but could relate to an avulsion type injury. Recommend further dedicated radiographs of the calcaneus". A review of a DR of the right foot dated 11/1/24 revealed, "...Minimally displaced likely avulsion-type fracture of the posterosuperior calcaneus (heel bone) at the Achilles tendon (tendon on the back of the foot) insertion, correlating with torsion (torsion) included suspicious findings on the left <sic> ankle series one day earlier..." A review of R802's hospital records revealed an "Orthopedic Foot and Ankle Surgery			

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	Consult Note" dated 11/1/24 that read, "...Reason for consultation/Indication: Right heel pain...reports having twisted her ankle 1 week ago which has been painful and difficult to bear weight on...She reports her ankle pain is worse with weightbearing, improved with rest...Assessment/Plan: ...closed avulsion type fracture of the R (right) calcaneus (heel bone) after a twisting injury 1 week ago...Placed into a well padded bulky posterior mold splint...please no pressure is <sic> on the heel at any time...Maintain the RLE elevated...CT of the R hindfoot ordered for further evaluation...NWB RLE..." A review of a CT of R802's right lower extremity dated 11/2/24 revealed, "...Moderately comminuted avulsion fracture at the posterior superior calcaneus at the attachment of the Achilles tendon with numerous avulsed and displaced bony fragments..." On 4/8/25 at 1:38 PM, a telephone interview was attempted with LPN 'E' to inquire about how R802's foot was assessed, which NP was contacted, and what information was given to the NP, as the progress notes did not address level of pain, a visual assessment of R802's right foot, or documentation that R802 had trouble with therapy due to the ankle pain. LPN 'E' was not available for interview prior to the end of the survey. On 4/8/25 at 2:11 PM, an interview was conducted with the Director of Nursing (DON). When queried about whether R802's right foot should have been physically evaluated by a medical provider after continued pain, swelling, and the inability to participate in PT and OT, despite a negative			

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	X-ray, the DON reported the nurse notified the NP and therefore they did what they were supposed to do. At that time, the nursing notes related to R802's right ankle were reviewed with the DON and the DON was asked about the lack of documented assessment of R802's foot. The DON reported when the nurse called the NP (it was unknown which NP was contacted either time) the NP would ask more questions even if it was not documented. The DON reported a physical evaluation of R802's foot/ankle probably should have been done, but she would review the clinical record and follow up. On 4/8/25 at 3:08 PM, the DON followed up and reported it was documented on 10/22/24 that the NP "talked" to R802 and on 10/23/24 R802 was seen by PM&R Physician 'G'. When queried about where it was documented that Physician 'G' documented an evaluation specifically of R802's injured ankle, the DON reported Physician 'G' documented R802's pain was "reasonably controlled". However, it should be noted that the pain assessment was related to R802's chronic neuropathy and did not address the new and acute pain R802 had been experiencing, even if she did not experience it at that time (while at rest). On 4/8/24 at 3:40 PM, a telephone interview was conducted with Physician 'G'. When queried about whether he evaluated R802's right ankle/foot on 10/23/24 specifically to address the potential injury and new onset pain that began on 10/21/24, Physician 'G' reported he did not recall R802 and said if he documented there was no pain, swelling or tenderness then that was going on at that time. Physician 'G' stated, "Pain can come			

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	and go, if medicated, even with a small fracture". Physician 'G' clarified that he did not recall who R802 was or if he was notified by the therapy department of R802's pain and declination of therapy due to the pain.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F0690	ELEMENT 1 It is the practice of the facility to provide timely incontinence care. Incontinence care and skin assessment has been completed for R801 with no concerns noted. ELEMENT 2 Residents that currently reside in the facility that require incontinent care have the potential to be affected by this cited practice. Those residents have been assessed to ensure incontinence care has been provided in a timely manner. Any deficient practice has been corrected immediately. ELEMENT 3 The Interdisciplinary Team reviewed the Incontinence Care - Urinary and Fecal policy and deemed it appropriate. Nursing staff have been educated on the Incontinence Care - Urinary and Fecal policy with emphasis on ensuring incontinence care has been provided in a timely manner. ELEMENT 4 The DON/designee will complete random Audits on 5 residents per a week for 4 weeks than 5 residents per month for 2 months to ensure incontinent care has been provided in a timely manner. Any deficient practice will be corrected/updated immediately. The results will also be taken to the Quality Assurance and performance review meeting. The Administrator is responsible for compliance.	4/30/2025

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	This citation pertains to intake #MI00150776. Based on interview and record review, the facility failed to provide timely incontinence care for one (R801) of two residents reviewed for bowel and bladder. Findings include: Review of a complaint filed with the State Agency included allegations that they were not provided with timely incontinence care and were left wet and soiled for approximately 11 hours. On 4/8/25 at 9:30 AM, R801 was observed in bed, asleep. Upon entry, the resident woke up and participated in an interview about their care. R801 reported concerns that they were left over eight hours before they got changed or repositioned. R801 further reported that unless they put their call light on, the staff on midnights don't come in to check or reposition them, they wait for the resident to put the call light on. R801 reported if they aren't changed on midnight shift, then they have to wait until after breakfast. The resident was asked if they had reported these concerns to anyone at the facility and they indicated they did, but concerns remained. Review of the clinical record revealed R801 was initially admitted into the facility on 5/19/21 and readmitted on 8/6/21 with diagnoses that included: unilateral primary		Compliance Date 4/30/25	

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	osteoarthritis, unspecified injury at unspecified level of cervical spinal cord, morbid obesity, scoliosis, bipolar disorder, and paraplegia. According to the Minimum Data Set (MDS) assessment dated 2/19/25, R801 had a low Brief Interview for Mental Status (BIMS) score of 00/15 (which indicated severe cognitive impairment, however this was due to the resident not responding verbally to questions asked per the social service quarterly assessment on 2/20/25 - during the interview with this surveyor, they were alert and oriented to person, place and time and recalled staying up late last night to watch a championship game of the March Madness basketball). The resident was dependent for toileting, did not have a bowel and bladder program and was always incontinent of bowel and bladder. Review of the care plan for "ALTERATION IN ELIMINATION r/t (related to): incontinent bowel and bladder debility and generalized weakness RESIDENT MAY OFTEN REFUSE HYGIENE/INCONTINENCE CARE" date initiated 5/19/21. Interventions included: "Incontinent care per facility policy. Keep resident clean and dry." Date initiated 7/15/24. Review of the social work quarterly assessment dated 2/20/25 included, "...Social Work (SW)completed a cognitive screening			

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	and current BIMS score is 0/15, resident did not respond verbally to questions, she stared and waved goodbye. SW asked if she wanted to participate in her quarterly assessment, resident waved goodbye again to SW ...Previous BIMS score was 15/15..." On 4/8/25 at 10:50 AM, the Director of Nursing (DON) provided a large binder of R801's concern forms and follow-up. Review of these concerns included one dated "2/27/25" initiated by the resident to the DON which read, in part: "...CENA involved was educated & disciplined ...On 2/28/25 attempt to discuss follow up with [R801]. Pt (patient) is not a good mood. Request writer to leave and don't come back..." Included with the facility concern form was the original email sent by R801 to the DON on 2/27/25 at 6:45 AM which read, in part: "...On Feb 26, 2025, I turned on the call light, at 9:45 AM, to ask for my brief to be changed & have my breakfast tray picked up & removed because I was finished with my breakfast. I DIDN'T get a responds <sic> to the call light until 10:15 AM, an <sic> half hour later. The receptionist from the Hickory Unit nurse's station was dressed in an aide's uniform. She responded to the call light. She removed my breakfast tray & said she'd tell the aides I needed to have my brief changed. I turned the call light on AGAIN at a quarter to noon (11:45AM) because I STILL HAVEN'T got my brief changed. The receptionist from the Hickory Unit nurse's station AGAIN			

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	634021	A. BUILDING _____ B. WING _____	4/8/2025

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	answered/responded to the call light. I told her I'm STILL waiting to get my brief changed. I've been waiting almost 2 HOURS to have it changed. She said if the aides don't change my brief she'll come back & change it. The aides DIDN'T change my brief. She didn't come back to change my brief, either. The lunch tray came...I told the aide who brought by lunch tray to me that I had been waiting almost 3 HOURS to get my brief changed. All she said was wow. She made NO effort or attempt to change my brief. For the 3RD TIME today, I AGAIN turned on the call light. This time NOBODY responded to the call light until the shift changed with evening shift (3PM to 11PM) starting. Thank GOD & heaven! My evening shift aide & the Hickory Unit nurse's station receptionist dressed in an aide's uniform, FINALLY, changed by brief & my urine soaked bed linen. After waiting 5 HOURS to have my brief changed my bed linen was urine soaked. The last time I had by brief changed was 4AM earlier this morning. So I was in my brief for a total of 11 HOURS (4AM to 3PM) before it was changed. WHAT A DAMN DISGRACE!!..." The assignment sheets from 2/26/25 identified Certified Nursing Assistant (CNA 'A') had been assigned to R801. The DON's interview with nursing staff from 2/26/25 revealed the room assignments had changed and CNA 'A' had been informed that R801's room was under their assignment around 9:00 AM on 2/26/25. The DON's			

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	interview with the Unit Clerk 'D' (who was also a CNA) denied being told by R801 they needed to be changes or that the call light was not answered for a long time (which conflicted with R801's recollection of events). Review of an employee counseling and corrective action record dated 3/4/25 documented, in part: "...2nd Written Warning...CENA didn't provide care to [R801]on 2/26/25 7A-3P. Education given..." the form was noted as "refused to sign". The educational in-service by the DON to CNA 'A' read, "OBJECTIVE/OUTLINE: CENAs reeducated on importance to check assignment at the beginning of the shift and freq (frequently). throughout the shift...TEACHING METHOD/EQUIPMENT: lecture..." A text message to all nurses included, "ATTENTION ALL NURSES: When you make changes to the CNA assignment after start of shift you MUST let them know of the changes and update the assignment sheet, Thank you ...". On 4/8/25 at 12:53 PM, a phone interview was conducted with CNA 'A'. When asked about R801 and what they could recall from 2/26/25, CNA 'A' reported that specific day they were not assigned to R801 and didn't know they swapped the assignment until the end of their shift (approximately 3:00 PM). CNA 'A' further reported they were familiar			

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	with R801 and when they are assigned to the resident they make them the first one to get done, and reported the resident "tolerated them". When asked how they document when incontinence or toileting care is completed, CNA 'A' reported they document in [electronic system] and will do that at the end of the shift. That's when they told me about R801, they didn't tell me earlier. On 4/8/25 at 2:10 PM, an interview was conducted with the DON. When asked when should staff be expected to check for incontinence care, or toileting needs, the DON reported the standard of care is every two hours. The DON was informed of the discrepancies between what R801 reported and what the facility's documentation reflected and the DON reported on that day, there was no documentation of refusals. When asked if they were able to provide a call-light report for that specific day, the DON reported they didn't think so, but would see as they periodically monitored call lights using an actual "hard" form (not electronic). (There was no additional documentation or follow-up regarding the call-lights provided by the end of the survey.) The DON was requested to provide the ADL documentation for the resident's bladder and bowel (B&B) elimination from 2/26/25 as this information was not available to the surveyor in the electronic medical record (EMR). On 4/8/25 at 3:38 PM, the DON provided the ADL documentation which revealed the "B&B			

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	- Bladder Elimination and Bowel Elimination" for the Day shift (7:00 AM - 3:00 PM) were incomplete (blank). The DON was informed of the concern that incontinence care was not provided to R801 on 2/26/25. According to the facility's policy titled, "Incontinence Care - Urinary and Fecal" dated 4/22/2024: "...Residents who are incontinent of bowel and/or bladder will be provided incontinent care assistance as needed based on resident request and/or check and change, or as per resident preference or need..."			