| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on interview and record review the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) were provided and completed for one (R26) of three residents reviewed for beneficiary notification, resulting in the resident not being informed timely of private pay charges for continued services at the facility, and the inability to file an appeal.<br><br>Findings include:<br><br>Review of the beneficiary notification documentation provided for three randomly selected residents included R26. Upon further review of the documentation for R26, concerns were identified that the facility issued a NOMNC (Notice of Medicare Non-Coverage) on 9/11/24, which was the same date of the resident's last covered day. R26 and/or their responsible party were not provided adequate notice of the non-coverage, in the event the responsible party wanted to request an appeal of this decision.<br><br>Additionally, R26 remained in the facility following the facility's decision to end skilled services, without the facility providing a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). The SNFABN provides information to the beneficiary so that they can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.<br><br>On 1/22/25 at 11:00 AM, the Administrator reported they had previously identified a Past Non-Compliance (PNC) regarding R26's SNFABN. They were requested to provide any additional documentation for review and consideration of PNC.<br><br>Review of the documentation provided for the facility's PNC revealed the PNC identified only a concern that the SNFABN was not provided. They did not identify or address concerns with the lack of timely notification of the NOMNC in any of the education, or audits.<br><br>On 1/22/25 at 12:20 PM, an interview was conducted with the Administrator. At that time, they were informed of the concern with the missing component of the PNC as mentioned above and they expressed understanding of the findings. |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set (MDS) assessment timely for two (R1 and R37) of eight residents reviewed for resident assessments.<br><br>Findings include:<br><br>According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Link to the LTCF RAI User's Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/M<br><br>.At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days .<br><br>Review of the triggered resident assessment task identified there were eight resident MDS assessments noted as having an MDS record over 120 days, which meant they were either not completed and/or submitted as required. Two of the eight residents identified these were comprehensive assessments.<br><br>R1<br><br>On 1/21/25, review of the Resident Assessments revealed an annual (comprehensive) MDS with an Assessment Reference Date (ARD) of 12/12/24 was not completed. On 1/22/25, further review revealed the assessment was noted as production accepted. Review of the signature by RN (Registered Nurse) assessment coordinator verifying assessment completion by RN 'D' was not signed until 1/21/25. Sections A, B, C, D, E, H, I, J, J-Interview, K, L, M, N, O, P, Q were completed by the MDS Coordinator (Nurse 'E') on 1/14/25; sections F, GG, Z were completed by Nurse 'E' on 1/15/25; and sections B, C, E were completed by RN 'D' on 1/21/25. The last completed MDS assessment was a quarterly MDS with an ARD of 9/13/24.<br><br>R37<br><br>On 1/21/25, review of the Resident Assessments revealed a significant change (comprehensive) MDS with an ARD of 11/14/24 documented sections B, D, E, Q were completed by RN 'F' on 11/18/24; sections A, C, F, GG, H, I, J, J-Interview, K, L, M, N, O, P, and Z were completed by RN 'F' on 1/9/25, and section A was completed on 1/13/25 by RN 'D'. The last completed MDS assessment was a quarterly MDS with an ARD of 8/19/24.<br><br>On 1/22/25 at 11:20 AM, an interview was completed with RN 'D' and Nurse 'E'. Nurse 'E' reported they were the MDS Coordinator and RN 'D' was their support nurse. When asked when comprehensive assessments should be completed, RN 'D' reported per the RAI manual, should be completed every 92 days and within 15 calendar days from the ARD date. When asked about the system-triggered MDS assessments that had gone beyond 120 days since their last completed assessments, RN 'D' reported they also received that information and had completed a lot of assessments just last night. When asked for the reason for the delayed MDS assessments, both RN 'D' and Nurse 'E' reported concerns with the staff person (social worker) responsible for completing those sections and reported most of those incomplete<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | sections were triggered from assessments completed by the social worker and the facility lost their previous social worker, the new one wasn't aware and needed further training on the importance of timely assessments. When asked if they identified that as a concern, why weren't other staff able to complete those assessment sections since they were completed last night by RN 'D' and RN 'D' reported they were aware of the concerns, they should've been completed timely and were doing the best they could.<br><br>On 1/22/25 at 12:22 PM, the Administrator was informed of the concerns with the untimely Resident Assessments and details of discussion of concerns and they expressed understanding. They also reported there was no policy for timely MDS, they followed the RAI manual. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure that each resident's assessment is updated at least once every 3 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment timely for six (R8, R16, R17, R40, R41, and R44) of eight residents reviewed for resident assessments.<br><br>Findings include:<br><br>According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Link to the LTCF RAI User's Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/M<br><br>.The Assessment Reference Date (ARD) of the Quarterly MDS is within 92 days (ARD of most recent OBRA assessment +92 days) after the ARD of the previous OBRA assessment (Quarterly, Admission, Annual, Significant Change in Status, Significant Correction to Prior Comprehensive or Quarterly assessment) AND The MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) .<br><br>Review of the triggered resident assessment task identified there were eight resident MDS assessments noted as having an MDS record over 120 days, which meant they were either not completed and/or submitted as required. Six of the eight residents identified these were quarterly assessments.<br><br>R8<br><br>On 1/21/25, review of the Resident Assessments revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/16/24 had a status that was In process. On 1/22/25, the assessment was now noted as production accepted (completed). The last completed MDS assessment was quarterly with an ARD of 9/17/24. Review of the signature for completion for the MDS dated [DATE] revealed Registered Nurse (RN 'D') signed as completed on 1/21/25. Section Q was completed by Nurse 'E' on 11/27/24; sections A, B, C, D, D-Interview, GG, H, I, J, J-Interview, K, L, M, N, O, P, Z were completed by Nurse 'E' on 1/10/25; sections B, C, D, E, and Q were completed by RN 'D' on 1/21/25.<br><br>R16<br><br>On 1/21/25, review of the Resident Assessments revealed the quarterly review dated 12/4/24 showed the status was In process. The last completed MDS assessment was an annual with an ARD of 9/4/24. Further review of the MDS dated [DATE] revealed sections B, C, D, E, Q, and Z were not completed. Section Q was completed by Nurse 'E' on 11/27/24; sections A, C, D, D-Interview, GG, H, I, J, J-Interview, K, L, M, N, O, P, Z were completed by Nurse 'E' on 1/9/25; and sections B, C, D, E, O, and Q were completed by RN 'D' on 1/21/25.<br><br>R17<br><br>On 1/21/25, review of the Resident Assessments revealed the quarterly MDS dated [DATE] showed the status was In process. The last completed MDS was a significant change MDS with an ARD of 8/30/24. For the MDS dated [DATE], sections A, GG, H, I, J, K, L, M, N, O, P, Z were completed by Nurse 'E' on 1/10/25 and sections B, C, D, E, Q, and Z were completed on 1/21/25 by RN 'D'.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R40<br><br>On 1/21/25, review of the Resident Assessments revealed the quarterly MDS dated [DATE] showed the status was In process. The last completed MDS was an annual MDS with an ARD of 9/3/24. For the MDS dated [DATE], sections A, GG, H, I, J, J-Interview, K, L, M, N, O, P, Z were completed on 1/9/25 by Nurse 'E' and sections B, C, C-Interview, D, D-Interview, E, Q, Z were not completed until 1/21/25 by RN 'D'.<br><br>R41<br><br>On 1/21/25, review of the Resident Assessments revealed the quarterly MDS dated [DATE] showed the status was In process. The last completed MDS was an annual with an ARD of 9/11/24. For the MDS dated [DATE], sections C, C-Interview, D-Interview, Q were completed on 12/11/24; sections A, B, D, E, GG, H, I, J, J-Interview, K, L, M, N, O, P, Z were completed on 1/14/25 by Nurse 'E'. The signature of the RN Assessment Coordinator Verifying Assessment Completion was not done until 1/15/25 by RN 'D'.<br><br>R44<br><br>On 1/21/25, review of the Resident Assessments revealed a quarterly MDS dated [DATE] showed the status was In process. The last completed MDS was a quarterly MDS with an ARD of 9/3/24. For the MDS dated [DATE], sections C-Interview, D-Interview were completed on 12/3/24 by Nurse 'E'; sections B, and Q were completed on 12/15/24 by Nurse 'E'; sections A, D, GG, H, I, J, J-Interview, K, L, M, N, O, P, Z completed by Nurse 'E' on 1/9/25; and sections A, B, C, D, E, O, Q were completed on 1/21/25 by RN 'D'.<br><br>On 1/22/25 at 11:20 AM, an interview was completed with RN 'D' and Nurse 'E'. Nurse 'E' reported they were the MDS Coordinator and RN 'D' was their support nurse. When asked when assessments should be completed, RN 'D' reported per the RAI manual, should be completed every 92 days and within 15 calendar days from the ARD date. When asked about the system-triggered MDS assessments that had gone beyond 120 days since their last completed assessments, RN 'D' reported they also received that information and had completed a lot of assessments just last night. When asked for the reason for the delayed MDS assessments, both RN 'D' and Nurse 'E' reported concerns with the staff person (social worker) responsible for completing those sections and reported most of those incomplete sections were triggered from assessments completed by the social worker and they lost their previous social worker, the new one wasn't aware and needed further training on the importance of timely assessments. When asked if they identified that as a concern, why weren't other staff able to complete those assessment sections since they were completed last night by RN 'D' and RN 'D' reported they were aware of the concerns, they should've been completed timely and were doing the best they could.<br><br>On 1/22/25 at 12:22 PM, the Administrator was informed of the concerns with the untimely Resident Assessments and details of discussion of concerns and they expressed understanding. They also reported there was no policy for timely MDS, they followed the RAI manual. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>On 1/22/25 at 8:53 AM, an observation of a small refrigerator for resident food items on the 200 hallway was conducted. The following was revealed: an iced coffee drink with half the contents gone and no open date, a cup of yogurt with an expiration date of 1/5/25, a container labeled mushroom herb dip that appeared to contain a mashed sweep potato with no date, and a salad kit with a use by date of 1/22/25, however; it was observed the lettuce was wilted and brown.<br><br>On 1/22/25 at 9:30 AM, an interview with Nurse 'B' was conducted. They indicated food in the fridge on the unit should be labeled with a resident name, route, and date it was placed in the refrigerator.<br><br>On 1/22/25 a facility document titled Food Labeling and Dating was reviewed and revealed the following: POLICY-Any food product removed from its original container, has a broken seal, has been processed in any way must have a label. PURPOSE: To have food product properly labeled and dated.<br><br>PROCEDURES: Any food product removed from its original container, has a broken seal, has been processed in any way must have a label that contains the following: 1. Item Name. 2. Date and Time the food was labeled. 3. Use by date. 4. Initials of the person labeling the item. 5. Securely cover the food item. FOOD STORAGE TIME - use by date. Laminate the card and post it in the kitchen food production areas as reference .<br><br>Based on observation, interview and record review the facility failed to appropriately store and label food items in the kitchen and a reach-in refrigerator. This deficient practice had the potential to affect all residents that consume food in the facility out of a total census of 55. Findings include:<br><br>On 01/21/25 at approximately 8:53 a.m., a tour of the facility kitchen was conducted with kitchen manager A (KM A) and the following was observed:<br><br>1. A tray of uncovered/unprotected apple cinnamon deserts was observed in the walk-in refrigerator with a preparation date of 1/16/25 and use by date of of 1/19/25.<br><br>2. A tray of uncovered/unprotected and dried out meat patties was observed in the walk-in refrigerator.<br><br>3. A tray of previously cooked personal sized pizzas were observed uncovered and had no dating/labeling on them in the walk-in refrigerator.<br><br>4. An uncovered pan of Blueberry desert that had a preparation date of 1/16/25 with a use by date of 1/18/25 was observed in the walk-in refrigerator.<br><br>On 1/21/25 at approximately 9:03 a.m., during a conversation with KM A, KM A was queried if the observed food items in the walk-in refrigerator should have been covered and labeled and they indicated that they should have. KM A was queried regarding the food that was date past their use by date and they reported it should have been discarded.<br><br>According to the 2017 FDA (Food and Drug Administration) Food Code section 3-501.17: Ready-to-eat,<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to utilize proper personal protective equipment (PPE) for COVID-19 transmission-based precautions (TBP) and ensure signage outside of the room included accurate instructions for PPE for two (R6 and R210) of two residents reviewed for TBP. Findings include:<br><br>On 1/21/25 at 9:41 AM, signage was observed on the door of R6's room that indicated R6 was on droplet precautions. The sign noted that those who entered R6's room must clean their hands, and ensure eyes, mouth, and nose were fully covered before entry into the room. The visuals on the signage showed a person wearing a surgical mask and either a face shield or goggles. A bin was observed outside of R6's room that contained gloves, goggles, surgical masks, and KN95 masks. There were no N95 respirator masks located in the bin. At that time, Registered Nurse (RN) 'G' was observed exiting R6's room wearing a surgical mask. At that time, RN 'G' was queried about why R6 was on droplet precautions and reported they were positive for COVID-19.<br><br>On 1/21/25 at 10:35 AM, R6's call light was observed to be on. RN 'G' was observed donning a gown, goggles, gloves, and a surgical mask prior to entering R6's room.<br><br>On 1/21/25 at 1:20 PM, an interview was conducted with the Infection Control Preventionist (ICP) 'H'. When queried about PPE required when entering a resident's room who was on TBP for COVID-19, ICP 'H' reported an N95 respirator mask, face shield or goggles, gown, and gloves were required. When queried about the signage on the door that indicated only a surgical mask and eye wear were needed, ICP 'H' reported they got the sign from the Centers for Disease Prevention and Control website and they did not have one specifically for COVID-19, but staff were to follow the facility's policy.<br><br>A review of R6's clinical record revealed R6 was admitted into the facility on [DATE] with diagnoses that included: COVID-19.<br><br>A review of an Event Report for R6 dated 1/20/25 revealed R6 tested positive for COVID-19 on that date and was placed into precautions.<br><br>According to Centers For Disease Prevention and Control (https://www.cdc.gov/covid/hcp/infection-control/index.html), Infection Control Guidance: SARS-CoV-2 (COVID-19), dated 6/24/24, HCP (Healthcare Personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a .particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) .<br><br>On 1/21/25 at 10:42 AM and 1/22/25 at 8:40 AM, an observation of R210's room was conducted. A sign on the door indicated they were on droplet transmission based precautions and instructed anyone entering to don a mask and eye protection. The sign did not include the donning of any specific type of mask, isolation gown, or gloves.<br><br>On 1/21/2510:50 AM, Nurse 'C' was asked why R210 was on isolation precautions and they said it was because R210 was positive for COVID-19.<br><br>On 1/22/25 at 10:19 AM a review of R210's clinical record revealed they admitted to the facility on<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235707 | A. Building<br>B. Wing | 01/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Willows at Howell | 1500 Byron Road<br>Howell, MI 48855 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | [DATE] had begun exhibiting respiratory symptoms, tested positive for the COVID-19 virus on 1/19/25, and had an order for transmission based precautions on 1/20/25. |