STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure the call light was accessible to the resident for one (R32) of three residents reviewed for accommodation of needs. Findings include: On 5/6/25 at 9:28 AM, R32 was observed in bed sleeping. The call light, which was a long thin string attached to a switch, was observed behind the head of the bed on the floor. On 5/6/25 at 10:56 AM, R32 was observed in bed with the head of the bed at an incline. R32 asked for the head of the bed to be lowered. When queried about how he alerted staff when assistance was needed, R32 reported he used the call light. The call light remained behind the head of the bed on the floor. When queried about whether he could reach the call light string, R32 attempted to reach back and said he could not reach it. On 5/6/25 at 11:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 'I'. LPN 'I' reported all nursing staff were required to ensure residents had access to their call lights. At that time, an observation of R32's call light was conducted with LPN 'I'. LPN 'I' attached the call light string to R32's blanket. On 5/6/25 at approximately 2:00 PM, R32's call light was observed clipped behind the head of the bed to a bed sheet, not in reach of the resident. At that time, LPN 'I' was informed and said it should be clipped where the resident could reach it. On 5/8/25 at 3:39 PM, an interview was conducted with the Director of Nursing (DON). The DON reported all staff were required to ensure call lights were within reach of the residents. A review of R32's clinical record revealed R32 was admitted into the facility on [DATE] with diagnoses that included: heart disease, end stage renal disease, and history of traumatic brain injury. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R32 had moderately impaired cognition and required partial/moderate assistance with bed mobility, transfers, and activities of daily living. A review of a progress note dated 4/26/25 revealed R32 was not compliant with self-transferring. It was documented the nurse educated R32 on using the call light. (continued on next page)

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
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R32's care plans revealed a care plan dated 4/24/24 that noted, I am at risk for falling R/T (related to): poor safety awareness, need for assist with mobility and not waiting for help. An intervention dated 4/27/25 noted, Keep call light in reach at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0578 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure residents were given the opportunity to make decisions about their treatment for one (R32) of two residents reviewed for advance directives, resulting in R32 becoming distressed, tearful, and withdrawn after the facility attempted to petition (send to the hospital involuntarily for a psychiatric evaluation) him to the hospital when he refused dialysis, continuously expressing frustration with having a feeding tube, and not being included in conversations about his care. Findings include: On [DATE] at 9:28 AM, R32 was observed in bed sleeping. A tray containing breakfast was observed on the over bed table. A tube feeding pole with a pump was observed in the room, but was not attached to the resident or infusing. On [DATE] at 10:57 AM, R32 requested to have a conversation. R32 reported feeling frustrated with his legal guardian. R32 explained he had things to take care of outside of the facility, but his legal guardian did not return his phone calls and he had not met her or spoken with her since his admission into the facility. R32 said he was not allowed to leave the facility without the guardian's consent. A review of R32's clinical record revealed R32 was admitted into the facility on [DATE] with diagnoses that included: heart disease, prostate cancer, hypertension, end stage renal disease (ESRD), type 2 diabetes mellitus, history of traumatic brain injury, acquired absence of left leg below knee, and dependence on renal dialysis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R32 had moderately impaired cognition, no delusions or hallucinations, no behaviors including no rejection of care, required partial/moderate assistance from staff for activities of daily living, had no signs or symptoms of a swallowing disorder, and received nutrition via feeding tube and mechanical soft diet (by mouth). A review of R32's progress notes revealed the following: On [DATE], it was documented in a nursing progress note that R32 refused to go to dialysis because he wanted to wait for his daughter to go with him. The appointment was rescheduled for [DATE]. It was documented R32 attended dialysis on [DATE]. On [DATE], it was documented in a nursing progress note that R32 stated to writer that he doesn't want to go to dialysis. Nurse asked why resident stated because he supposed to go only 3 times a week. Resident stated he went yesterday and he not going to keep going back and forth every day. Nurse contacted daughter to assist with convincing resident to go for schedule dialysis appointment today and resident started using profanity saying allow him to make his own decisions for his life and hung up the phone .Nurse contacted provider made aware and stated its ok for resident to miss if refusing . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE], it was documented in a nursing progress note that R32 told the nurse hes not going to dialysis today. Nurse contacted provider stated he came by facility yesterday and saw resident regarding resident is being non-compliant with care. Provider stated resident code status needs to be changed also for manager to consult hospice r/t (related to) not being compliant w/ (with) care .Nurse contacted guardian. No answer . On [DATE], it was documented in a nursing progress note that R32's guardian called and said that since the resident was not compliant with dialysis and care multiple times she felt it will not (be) safe for resident to leave facility and she would rather for nursing staff to watch resident closely . It should be noted that there was no documentation in R32's clinical record that indicated staff or the legal guardian engaged in a conversation with the resident about why he did not want to go to dialysis at times. It was documented R32 attended dialysis on [DATE]. On [DATE] at 8:40 AM, R32 was observed seated on his bed eating breakfast. R32 was asked about his dialysis schedule. R32 reported he went to dialysis twice a week and that the physician wanted him to go three times a week. R32 said he felt better only going twice a week. R32 further explained he no longer wanted the PEG tube in his stomach. R32 reported he ate all food by mouth and stated, I told them so many times that I don't want this tube. I want it out! R32 reported he was told his legal guardian had to consent for any medical care. R32 stated, I need a patient advocate or something because I have an issue with having a guardian who doesn't return my calls. R32 further explained his guardian or the facility had never had a conversation with him about his goals and treatment preferences. R32 said he wanted to petition the court for a new guardian or to not have one at all. R32 reported the facility social worker had not talked to him about anything. On [DATE] at approximately 10:50 AM, Emergency Medical Services (EMS) was observed outside of R32's room. R32 was observed to be calm, not yelling or screaming. EMS was observed talking with Licensed Practical Nurse (LPN) 'C' and said they could not force R32 to go to the hospital if he did not want to go. At that time, Unit Manager, LPN 'A' handed LPN 'C' a completed Petition for Mental Health Treatment form (a form petitioning the court to order mental health treatment for an individual who is a danger to self or others) for R32 and LPN 'C' contacted the police and told them R32 was a danger to himself because he would not go to dialysis treatment. On [DATE] at approximately 11:00 AM, an interview was conducted with EMS staff. EMS staff said they cannot make R32 go to the hospital if he would not voluntarily go. They were not allowed to restrain the resident. EMS staff reported they believed R32 was of sound mind and made a conscious decision not to go to dialysis. At that time, an interview was conducted with LPN 'C'. LPN 'C' reported she was told by LPN 'A' to petition R32 to the hospital. LPN 'C' reported R32 was combative and agitated and refused to go to dialysis. At that time R32 was observed lying in bed calmly. A review of the petition revealed documentation that R32 .refused several days of dialysis appointments over the past two weeks and has not abided by his hemodialysis orders. Refusing to attend further sessions as well as tube feeding and medications . When queried about whether she thought R32 required psychiatric treatment, LPN 'C' reported she did not think he did. LPN 'C' reported R32's vital signs were currently stable and R32 was not in any physical distress. LPN 'C' stated, (LPN A') did the petition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:06 AM, an interview was conducted with R32. R32 was observed visibly upset and stressed and was teary eyed. R32 reported he knew the doctor's orders were to go to dialysis more often, but he already told the doctor he would only go twice a week. R32 reported he knew what dialysis was for and understood the risks of not going according to the physician's order. R32 reported he went on Monday ([DATE]) and would go again on Friday (- interview with resident. Visibly upset, teary eyed. Said he talked to the dialysis doctor already. Wants him to go three days but resident only wants to go two. He said he understands the risks of not going all days and knows what dialysis is for. He said he went on Monday and will go on Friday ([DATE]). R32 stated, They don't get to get rid of my rights just because I'm in a nursing home. I have the right. Might as well just discharge me then. On [DATE] at 11:11 AM, an interview was conducted with LPN 'A'. When queried about why the facility had completed a petition for mental health care for R32, LPN 'A' reported R32 had a history of two cardiac arrests (prior to admission into the facility) and missed several dialysis appointments. LPN 'A' stated, I have to ask myself, 'Have I done all I can to help him?' When queried about why they petitioned R32 instead of following his wishes to not go to the hospital, LPN 'A' reported R32 had a legal guardian and they wanted him to get dialysis. When queried about how often the legal guardian interacted with the resident or when they last visited R32, LPN 'A' reported the legal guardian had not visited R32 (admitted on [DATE]). LPN 'A' reported that they had to follow what the legal guardian wanted. LPN 'A' further reported if R32 did not go to the hospital, the physician said the legal guardian had to sign R32 onto hospice services. When queried about R32's choice in signing onto hospice services, LPN 'A' did not offer a response. When queried about what conversation were had with R32 about dialysis and why he did not want to go according to physician's orders, LPN 'A' said R32 just said, You can't make me go. At that time, police entered the facility and attempted to talk with R32. R32 remained calm and did not agree to go to the hospital The police left the building around 11:20 AM. On [DATE] at approximately 11:25 AM, R32 was observed curled into a fetal position. An interview was attempted. R32 was visibly upset and said he could barely talk at the moment because he was very stressed about what just happened. R32 curled back into a fetal position and pulled the bed sheet over his face. On [DATE] at approximately 1:20 PM, R32 was interviewed further. When queried about whether anyone in the facility and/or his legal guardian had talked to him about his treatment wishes related to dialysis or his code status. R32 reported nobody talked to him. R32 reported he would only want CPR (Cardiopulmonary Resuscitation) if he could be brought right back and would not want to be hooked up to machines to breathe. When queried about whether he knew what hospice was, R32 stated, Is that like when you are about to die? R32 reported a nurse asked him if he wanted to be on hospice and he told her No. R32 reported the nurse stated, Are you sure? and left the room. R32 reported nobody had any meaningful discussion about his treatment wishes. A review of a Social Services progress note dated [DATE], written by Social Services Staff (SS 'L') revealed, Writer sent hospice recommendation letter to guardian, guardian approved of consult and gave permission for writer to speak with resident's family regarding hospice consult, writer called resident's sister and left a voicemail, resident daughter phone line was busy unable to leave message. There was no indication hospice was discussed with R32. There were no other Social Services progress notes that indicated R32's refusals of dialysis and other care were addressed by social services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:27 PM, an interview was conducted with SS 'L'. When queried about the facility's process for including residents in decision making when they had a legal guardian, SS 'L' reported both the resident and legal guardians were included in conversations about the resident's care, including discussions about code status and whether the resident wanted CPR or not. When queried about whether R32 was included in a discussed about his code status when he was admitted into the facility, SS 'L' reported R32 was not included, only the legal guardian. When queried about whether R32's legal guardian has been to the facility since R32 was admitted , SS 'L' reported the guardian had not and she did not know if they had talked on the telephone. When queried about any conversations SS 'L' had with R32 about his treatment wishes or why he had refused dialysis at time, SS 'L' reported she talked to R32 on that day because he refused dialysis, but did not talk to him before that. SS 'L' reported she had not talked to R32's legal guardian and R32 together to discuss R32's refusals of dialysis or care and stated, Now he will be having a consult for hospice. When queried about whether R32 was included in a conversation about his feeling about having a hospice consult, SS 'L' reported he was not and stated, It is just a consult. On [DATE] at 2:00 PM, an attempt was made to interview R32's guardian via the telephone using the phone number provided by SS 'L'. There was no option to leave a voice mail message. On [DATE] at 2:19 PM, an interview was conducted with the Administrator. The Administrator reported any care conference or discussion about treatment or care should including the resident and the legal guardian. On [DATE] at 1:40 PM, an interview was attempted with Physician 'K' via the telephone and a voice mail message was left. Physician 'K' was not available for interview prior to the end of the survey. A review of a facility policy titled, Residents' Rights Regarding Treatment and Advance Directives, dated [DATE], revealed, in part, the following: .The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive .Any services that would be otherwise required, but are refused, will be documented in the resident's comprehensive care plan .The facility will not initiate or discontinue any other care based on refusal of care by the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure accurate assessments were completed for four (R41, R16, R15 and R18) of 13 residents reviewed for Minimum Data Set (MDS) assessments. Findings include: According to the Long-Term Care Facility (LTCF) Resident Assessment Instrument (RAI) 3.0 User's Manual, link to the LTCF RAI User's Manual: https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf: .an accurate assessment requires collecting information from multiple sources . Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician . R41 Review of the closed record revealed R41 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: hypertension, acute kidney failure and diabetes. According to the MDS assessment dated [DATE], section A2105 which prompted the staff completing the assessment to indicate where the resident discharged to was incorrectly marked as Short-Term General Hospital. Review of R41's progress notes revealed a nursing note dated 2/11/25 at 10:57 AM that read in part, . Resident was transferred to another facility . Discharge transfer paperwork sent with resident . On 5/8/25 at 2:14 PM, the MDS Coordinator, Registered Nurse (RN) H, was interviewed by phone and asked why R41's discharge assessment was marked for the hospital when R41 was discharged to another Long Term Care facility. RN H explained it was a complete accident she had marked hospital. R16 Review of the clinical record revealed R16 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart failure, psychotic disorder with delusions and anxiety disorder. According to the MDS assessment dated [DATE], section N0450 which prompted the staff completing the assessment to answer yes or no if there had been a gradual dose reduction (GDR) of an antipsychotic was completed, and the date it was attempted. The assessment was incorrectly marked as Yes and the date entered was 01/05/2025. Review of R16's Psychiatric Evaluation & Consultation report dated 1/27/25 read in part, .Current Assessment/Plan: .GDR is not indicated at this time due to the ongoing need for symptom control . Current medication regimen will remain unchanged . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/25 at 2:20 PM, RN H was asked, during the phone interview, why R16's assessment on 2/24/25 was marked yes for a GDR. RN H explained she had seen that R16 had a psychiatric evaluation on 1/5/25 and she thought a GDR was done every time a psychiatric evaluation was done. When informed a GDR was not indicated, RN H explained she now saw that it was not done. Additional review of R16's psychiatric evaluations revealed no evaluation was completed on 1/5/25. In Resident Documents the upload date of 1/5/25 was for an evaluation completed 12/30/24. The evaluation dated 12/30/24 also documented a GDR was not indicated. 32568 R15 A review of R15's weights revealed on 1/6/25, R15 weighed 194.6 pounds. On 4/2/25, R15 weighed 173.2 pounds which indicated an 11 percent loss of body weight. A review of R15's progress notes between 1/6/25 and 4/2/25 revealed no documentation that indicated the weight difference was incorrect or what was done to verify that it was accurate. A review of R15's clinical record revealed R15 was admitted into the facility on [DATE] and readmitted on [DATE], 3/8/25, and 3/16/25 with diagnoses that included: normal pressure hydrocephalus, influenza, and acute cystitis. A review of R15's MDS assessment dated [DATE] revealed R15 weighed 185 pounds which indicated a 6.81 percent weight gain since the last documented weight of 173.2 pounds on 4/2/25. It was documented on the MDS assessment that R15 did not have a gain of five percent or more in the last month or a loss of 10 percent or more in the last six months. The weight documented on the MDS assessment was not consistent with the weight documented in the clinical record in the weight summary. On 5/8/25 at approximately 2:16 PM, an interview was conducted with RN 'H'. When queried about how she ensured accuracy of the nutrition assessments conducted by other staff members, RN 'H' reported she went through the assessment and was in communication with RD 'J' and CM 'K' to coordinate with them to ensure their assessments were accurate. When queried about the weight discrepancy and why R15 was coded as not having significant weight loss or gain based on the weight in the MDS and/or the documented weights in the clinical record, RN 'H' stated, I am only signing off that the assessment is done, but I do coordinate with them. RN 'H' reported as a nurse she did not know how to calculate percentage of weight loss to check for accuracy and stated, Dietary is responsible for that. I only sign off that it's complete, not that it's accurate. On 5/8/25 at 3:00 PM, an interview was conducted with the Administrator. When queried about the role of the RN MDS Coordinator in ensuring accuracy of MDS assessments, the Administrator reported RN 'H' was supposed to assess the residents in order to ensure the information entered on the MDS was accurate. If there were any discrepancies, a discussion should be had with the department who conducted the assessment. It should not be assumed that the documented assessment was correct. 47283 R18 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18 was admitted to the facility on [DATE] from another skilled nursing facility. R18's admitting diagnoses included colon cancer, liver cirrhosis, history of falls with fractures and depression. Based on MDS assessment dated [DATE], R18 had a Brief Interview for Mental Status (BIMS) of 12/15 indicative of moderate cognitive impairment. Section M of the MDS assessment revealed that R18 was admitted with a stage 3 pressure ulcer and they had pressure reducing devices for the bed. An initial observation was completed on 5/6/25 at approximately 9:40 AM. R18 was observed lying on their bed that had a regular mattress. When queried how they were doing, R18 stated I feel a lot better. R18 was able to answer questions and reported that they had surgery some time ago related to their cancer. R18 also reported that they came over here from another facility. Later that day the follow-up observations were completed at approximately 11 AM and 12:20 PM. R18 was observed in their room, sitting in a wheelchair. R18 was queried if they had any pain and or sores on their back and they reported no and they have had the same mattress since they were admitted to this facility. Review of R18's Electronic Medical Record (EMR) revealed a physician order dated 3/28/25 that wound on left upper buttock and lower buttocks. Special instructions: clean wound with wound cleaner on left upper and lower buttock and apply Calmoseptine ointment on each shift. Review of nursing admission progress notes dated 3/27/25 read in part, Resident alert oriented x 3 at this moment .skin assessment done, open wound to buttocks,, wound consult done. Further review of EMR did not reveal any wound care consultation or any new orders other than the Calmoseptine order referenced above. Review of nursing progress notes dated 3/28/25 read in part, Midnight nurse assessed resident buttocks for wounds. Resident has one small open wound on upper left buttock and small wound in healing stage on lower left buttocks . Review of admission skin assessment dated [DATE] did not reveal any pressure ulcers marked on the assessment. Review of history and physical note by attending physician dated 3/27/25 revealed R18 had pressure ulcer with no specification on any stage. Review of the facility Matrix revealed that R18 had a stage 3 pressure ulcer. Further review of EMR did not reveal any evidence of stage 3 pressure ulcer after R18's admission to the facility. An interview with Registered Nurse (RN) E was completed on 5/6/25 at approximately 2:55 PM. They reported that they had been at the facility almost 2 years and they regularly worked the floor. They added that they were familiar with the residents. They were questioned about wound treatments on the unit and if they had any stage 3 pressure ulcers. RN E reported that they did not have any resident with open areas on the unit and added that the floor nurses completed the treatments if they had any on their units. An interview with Unit Manager (UM) A was completed on 5/6/25 at approximately 3:10 PM. They reported that they oversaw the facility's wound care program. They were queried about R18 and they had reported that they were familiar with the resident. They were queried if R18 had any stage 3 pressure ulcers, and UM A reported (after reviewing EMR) that that R18 did not have stage 3 pressure ulcer and they had small hypopigmented /open areas on their left buttocks when they were admitted . They added that R18 never had a stage 3 pressure ulcer and they were just using barrier cream since admission. They were queried about the MDS assessment that indicated that R18 was admitted with stage 3 pressure ulcer and they reported that resident was admitted from one of their other facilities and the paperwork from other facility had documentation about stage 3 pressure ulcer during their stay at the other facility. They were notified of the concerns with the accuracy of MDS assessment and they reported that they understood and they would follow up with their Director of Nursing (DON). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with DON was completed on 5/6/25 at approximately 3:35 PM. During this interview Administrator and UM A were present in the office. They were notified of the findings and concerns with the accuracy of MDS assessment. DON confirmed that R18 did not have stage 3 wounds after their admission to the facility and UM A completed weekly rounds with their wound care practitioner. The DON reported that the MDS coordinator possibly obtained the information from the transfer records sent from the other facility. They reported that they understood the concern and they would follow up with their MDS coordinator. An interview with RN 'H' was completed via phone on 5/8/25 at approximately 2:15 PM. They were queried how they had completed the section M (skin conditions) under the MDS assessment. They reported that they saw all residents admitted to the facility prior to their comprehensive assessments. When queried further on the process to ensure the accuracy of assessment, they reported they were not trained to do wound staging or assessments and they relied on documentation from the nursing team/wound care team to complete their assessment. When queried about R18 and the stage 3 pressure ulcer coded on R18's MDS assessment, RN 'H' reported that they obtained the information from the documentation that was sent from the previous facility and the admission nursing note had documentation about small open areas and had completed their MDS assessment based on that information. They did not physically verify if R18 had a stage 3 pressure ulcer and did not look any further. They were notified of the concern with the MDS accuracy and they reported that they understood the concern and will submit a modification. Review of the facility provided document tiled Conducting an Accurate Resident Assessment with a revision date of 2/26/25, read in part, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Definition: 'Accuracy of assessment' means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status). Policy Explanation and Compliance Guidelines: 1. The Administrator will ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. 2. Qualified staff who are knowledgeable about the residents will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. 3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. 4. A registered nurse will coordinate the RAI completion process with the appropriate participation of health professionals. The registered nurse is responsible for certifying that the assessment has been completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Information provided by the initial comprehensive assessment establishes baseline data for the ongoing assessment of resident progress. 6. The physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon individual resident status and needs. 7. A registered nurse will sign and certify that the assessment/correction request is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. Whether the MDS assessments are manually completed, or computer generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review the facility failed to assess, monitor and treat a skin tear for one (R16) of one resident reviewed for wounds. Findings include: On 5/6/25 at 8:53 AM, R16 was observed sitting in a wheelchair in the dining room. An undated adhesive foam bandage was observed on R16's right forearm. Shadowing of drainage was visible on the bandage. When asked about the bandage, R16 was not able to explain why it was there. On 5/6/25 at approximately 12:00 PM, R16 was observed sitting in a wheelchair in the dining room. The bandage on R16's right forearm with the same shadowing of drainage had the date 5/6/25 written on it. Review of the clinical record revealed R16 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: altered mental status, dementia and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R16 had severely impaired cognition and required the assistance of staff for activities of daily living (ADL's). Review of R16's physician orders revealed no order for a dressing to the right forearm. Review of R16's progress notes revealed a nursing note dated 5/5/25 at 7:03 PM that read in part, Resident has a skin tear to the right forearm . Writer cleaned area left open to air . On 5/7/25 at 10:41 AM, R16 was observed sitting in a wheelchair in their room. The bandage on R16's forearm, dated 5/6/25, had the same shadowing of drainage that was observed the previous day. On 5/7/25 at 11:10 AM, Licensed Practical Nurse (LPN) C, R16's assigned nurse, was asked if she had received any report of R16 having a skin tear. LPN C explained she had not been told anything about R16 having a skin tear. When asked if there were any orders for a dressing for R16, LPN C explained there were no orders for any dressings for R16. On 5/7/25 at 12:55 PM, Unit Manager (UM) A was interviewed and asked about the dressing of R16 ' s right forearm. UM A explained she had been leaving the facility on 5/5/25 when R16 ' s nurse had told her about R16 ' s skin tear . she thought the nurse had taken care of everything, but now knew there were no physician orders for the skin tear. UM A was asked who had put the dressing on the skin tear as the progress note had said it was left open to air. UM A explained she did not know if it had been the midnight nurse or the day nurse. UM A was asked if a nurse thought a skin tear required a dressing on it, what should be done. UM A explained the nurse should call the physician an obtain orders for the dressing and wound care. When informed the dressing originally had no date, but the same dressing was dated later on in the day, UM A had no answer. Review of a facility policy titled, Wound Treatment Management dated 11/1/22 read in part, .Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change . In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number(s): MI00152212. Based on observation, interview, and record review, the facility failed to consistently monitor residents' skin according to physician's orders and appropriately implement preventative interventions for three (R15, R18, R23) of three residents reviewed for pressure ulcers, who had a history of or were at risk of pressure ulcers. Findings include: On 5/6/25 at 9:25 AM, R15 was observed partially inclined in bed, lying on her back. A specialty air mattress was observed on R15's bed which was set to normal pressure and 400 pounds. Protective heel boots were observed in the room, but not on the resident. R15's heels were observed in contact directly with the mattress. On 5/6/25 at 10:56 AM, R15 was observed in the same position in bed and the air mattress was set to 400 pounds. R15 did not appear to weigh 400 pounds. R15's heels were observed in contact directly with the mattress and the heel boots were not applied. On 5/6/25 at 4:15 PM, R15 remained in the same position in bed and the air mattress remained set to 400 pounds. R15 was not wearing the heel boots. R15's heels were observed in contact directly with the mattress. When queried, R15 reported she did not like to wear the boots and that was her choice. R15 further said she liked to stay in bed. A review of R15's clinical record revealed R15 was admitted into the facility on [DATE], and readmitted on [DATE], 3/8/25, and 3/16/25 with diagnoses that included: normal pressure hydrocephalus, acute cystitis, and diabetes mellitus. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R15 had severely impaired cognition, required partial/moderate assistance with bed mobility and transfers, was always incontinent of bowel and bladder, and was at risk of pressure ulcer development. A review of a Braden Scale assessment dated [DATE] revealed R15 was at moderate risk of developing pressure ulcers. The documented interventions included pressure reducing device for bed. A review of R15's Physician's Order revealed an order with a start date of 10/11/24 for Weekly Skin Assessment Special Instructions: Complete under observation/weekly skin assessment once a day on Tue (Tuesday) . A review of R15's weekly skin assessments under observation revealed no skin assessments completed by the nurse between the dates of 4/10/25 and 4/30/25 and 3/16/25 and 4/2/25. A review of R15's care plans revealed no specific interventions regarding the settings for the specialty pressure reducing air mattress. There was an intervention to float R15's heels with pillows or with heel boots. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 4:55 PM, an interview was conducted with Unit Manager, Licensed Practical Nurse (LPN) 'A' who was also the wound care coordinator for the facility. When queried about how nursing staff knew what settings to use for residents who had speciality air mattresses used to prevent pressure ulcers, LPN 'A' reported she trained staff to set the mattresses according to the residents' body weight. When queried about whether R15's mattress should be set at 400 pounds, LPN 'A' reported it should not because it would provide too firm of a surface for R15's weight, which was not 400 pounds. When queried about how residents' skin was monitored for any skin alterations, including pressure ulcers, LPN 'A' reported the nurses were required to complete a full head to toe skin assessment using the observation form every week. LPN 'A' reported Certified Nursing Assistants looked at residents' skin during showers and nurses signed off on the shower sheets, but those were not in place of the full head to toe skin assessments ordered by the physician. At that time LPN 'A' reviewed R15's clinical record and confirmed R15 had a physician's order for weekly skin assessments and there as no skin assessments completed between 4/10/25 and 4/30/25; and 3/16/25 and 4/2/25. A review of a facility policy titled, Skin assessment dated [DATE], revealed, in part, the following, .A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter . 47283 R18 A review of R18's clinical record revealed R18 was admitted to the facility on [DATE] from another skilled nursing facility. R18's admitting diagnoses included colon cancer, liver cirrhosis, history of falls with fractures, and depression. Based on the MDS assessment dated [DATE], R18 had a Brief Interview for Mental Status (BIMS) of 12/15 indicative of moderate cognitive impairment. Section M of the MDS assessment revealed that R18 was admitted with a stage 3 pressure ulcer on their buttocks. Based on the definition of staging from Centers for Medicare and Medicaid Services, a stage 3 pressure ulcer is full thickness tissue loss and the subcutaneous (under the skin) fat may be visible, but bone, tendon, or muscle is not exposed. R18 had pressure reducing devices for the bed. An initial observation was completed on 5/6/25 at approximately 9:40 AM. R18 was observed lying on their bed that had a regular mattress. When queried how they were doing, R18 stated I feel a lot better. R18 was able to answer questions and reported that they had surgery some time ago related to their cancer. R18 also reported that they came over here from another facility. Later that day, follow-up observations were completed at approximately 11:00 AM and 12:20 PM. R18 was observed in their room, sitting in a wheelchair. R18 was queried if they had any pain and or sores on their back and they reported no and they have had the same mattress since they were admitted to this facility. Review of R18's Electronic Medical Record (EMR) revealed a physician order dated 3/28/25 that wound on left upper buttock and lower buttocks. Special instructions: clean wound with wound cleaner on left upper and lower buttock and apply Calmoseptine ointment on each shift and weekly skin assessments: under observations. R18 also had an order for weekly skin assessments dated 4/2/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing admission progress notes dated 3/27/25 read in part, Resident alert oriented x 3 at this moment .skin assessment done, open wound to buttocks,, wound consult done. Further review of EMR did not reveal any wound care consultation or any new orders other than the Calmoseptine order referenced above. Review of nursing progress notes dated 3/28/25 read in part, Midnight nurse assessed resident buttocks for wounds. Resident has one small open wound on upper left buttock and small wound in healing stage on lower left buttocks . Review of admission skin assessment dated [DATE] did not reveal any pressure ulcers marked on the assessment. Further review of weekly skin observations revealed that they were not consistently completed as ordered. R18 had an admission skin assessment completed on 3/28/25 revealed no pressure ulcers when the initial record review was completed on 5/6/25 at approximately 1:30 PM. Later that day (after the concern was brought to the attention of facility team) during the follow up review, at approximately 4 PM the admission skin assessment was initially completed on 3/28/25 showed that a modification of assessment was in progress on the EMR. There were no weekly skin assessments for approximately over two weeks after 3/28/24, and the next skin assessment was completed on 4/17/24. Review of R18's care plan revealed a problem area dated 4/9/25 that read, I have a pressure ulcer, due to multiple underlying medical conditions, wound may not heal and formation of more wounds may be unavoidable and interventions included low air loss mattress that initiated on 4/9/25. R23 A review of R23's clinical record revealed R23 was originally admitted to the facility on [DATE] and they were recently hospitalized and readmitted back to the facility on [DATE]. R23's admitting diagnoses included brain cancer (recent finding), urinary tract infection, post COVID, dementia, and compression fracture of the lumbar vertebrae. Based on the MDS assessment dated [DATE], R23 had a BIMS of 11/15, indicative of moderate cognitive deficits. An initial observation was completed on 5/6/25 at approximately 10:15 AM. R23 was observed in their bed. R23 was receiving their nutrition and hydration through Percutaneous Endoscopic Gastrostomy (PEG) tube/feeding tube. R23 also had a Foley catheter (a thin, flexible tube used to drain urine from the bladder) and the bag was connected to their bed frame. R23 was observed laying on their back and they had a specialty low air loss mattress. Review of R23's recent Braden assessment (tool used by healthcare professionals to assess a patient's risk for developing pressure ulcers/bedsores) dated 3/3/25, revealed a score of 14, indicative of moderate risk for pressure ulcer. Review of R23's admission note dated 1/24/25 revealed that R23 was admitted to the facility with two stage 2 pressure ulcers on their sacrum and wounds on their left scapula (shoulder blade). R23's EMR revealed a physician order dated 2/1/25 that read weekly skin assessment. Review of R23's care plan initiated on 2/3/24 read, I have a pressure ulcer. Due to multiple underlying medical conditions wounds may not heal and formation of more wounds may be unavoidable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R23's skin assessments revealed that weekly skin assessments were not completed as ordered. Review of weekly assessments after 2/1/25 revealed assessments dated: 2/5/25. No assessment on 2/12. R23 was admitted to hospital between 2/14/25 and 3/2/25. They were readmitted to the facility on [DATE]. After the initial assessment that was done on readmission there were no weekly skin assessments until 4/3/25 (approximately one month). There was no assessment for the week of 4/11- 4/17. The shower sheets that were provided later by the facility revealed R23 had multiple weeks with areas of redness or open areas marked by the CNAs and signed by the nurse, with no further follow-up nursing assessment. The shower sheets dated 3/19/25, 3/22/25, 3/26/25, 3/29/25, 4/9/25 and 4/12/25 that had red area or open area checked on shower sheet with no further skin assessment/follow-up by the nurse. An initial interview with the DON was completed on 5/7/25 at approximately 9:45 AM. They were questioned about the weekly skin assessment process and they reported that they added the skin assessments orders to Medication Administration Record (MAR) section for the nurses to give weekly alerts and the nurses completed the assessments under the observation sections of the EMR. The DON also added that the CNAs completed their skin checks during the shower and they were verified and signed off by the nurses. They were questioned why the weekly skin assessments as ordered by the physician were not consistently completed by the for R18 and R23. They reviewed the EMR and agreed that they were completed weekly and understood the concerns and reported that they would check and report back. An initial interview with Unit Manager, LPN A was completed on 5/7/25 at approximately 9:35 AM. They reported that they oversaw the facility's wound care program. They were queried about the weekly skin assessment process. They reported that they were completed weekly by the floor nurses under observation section of their EMR. Certified Nursing Assistants completed weekly skin checks during showers/bed baths and they were completed on paper by the CNAs and signed off by the nurses. They were questioned about the low air loss mattress that was on R18's care plan and they reported that they were not sure why it was recommended and did not believe that R18 needed one. LPN A was reported that they would check and provide the shower sheet for the R18 and R23. An interview with LPN B was completed on 5/7/25 at approximately 12:10 PM. They were questioned about the facility's weekly skin assessment process. They reported that the nurses completed the skin assessment on shower days. They signed off on the shower sheets and documented their assessment under weekly skin assessment observations in the EMR. They were questioned what their process was if they identified any skin concerns during skin checks on shower days. LPN B reported that they would notify the physician after they complete further assessment on the identified area of concern and document under the weekly skin assessment. During a follow up interview completed with the DON on 5/7/25 at approximately 11:10 AM, they reported that paper shower sheets that were used by CNAs were signed off by the nurses and they were also considered as the weekly skin assessments. They were queried further about the discrepancies between shower sheets and skin observations. They were asked to explain how R18's admission nursing note completed on 3/28/25 had a reflected small open area with treatment orders and wound consult and skin was marked clear on shower sheet dated 3/29/25. Also, they were queried further about multiple shower sheets for R23 dated 3/19/25, 3/22/25, 3/26/25, 3/29/25, 4/9/25 and 4/12/25 that had red area or open area checked on the shower sheet with no further skin assessment/follow-up by the nurse on where the redness or open areas were. When queried further, the DON did not have any further explanation and they reported that they understood the concerns. On 5/07/25 at approximately 04:00 PM, the Administrator was notified of the concerns with the skin assessments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility provided document titled Skin assessment dated [DATE], read in part, Policy: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury . 2. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review facility failed to thoroughly investigate and do a root cause analysis of a fall; and failed to consistently implement fall/accident prevention interventions as recommended for one (R34) of one resident reviewed for falls. This deficient practice has the potential for further falls with/without injury and resulted in hospital transfer of R34 for evaluation after fall. R34 R34 was a long-term care resident of the facility, originally admitted to facility on 9/24/24. R34's admitting diagnoses included dementia, personality disorder, schizoaffective disorder, and drug induced movement disorder, and unsteady gait with history of falls. Based on Minimum Data Set (MDS) assessment dated [DATE], R34 had a Brief Interview for Mental Status (BIMS) score of 3/15 indicative of severe cognitive impairment. An initial observation was completed on 5/6/25 at approximately 9:55 AM. R34 was observed sitting in the dining room in their wheelchair eating a snack. R34 had no shoes and had gripper socks on. Follow-up observations were completed on 5/7/25 at approximately 8:35 AM and 9:30 AM. R34 was sitting up in wheelchair, in their room. They had their bedside table in the front with their breakfast tray. R34 had a non-skid socks. Later that day, at approximately 12:15 PM, R34 was observed sitting in the dining room with their socks. At approximately 1:20 PM, they were observed trying to propel their wheelchair in front of the nursing station with their socks on. Review of R34's Electronic Medical Record (EMR) revealed a nursing progress note dated 03/09/2025 at 08:31 AM, read in part, During shift change, resident fall out of bed, Writer immediately assessed resident, small laceration noted on right-side of head neuro checks in place . Writer contacted MD (Medical Doctor) notified of situation writer also informed MD that resident is currently on Eliquis(blood thinner) writer ordered to send resident to hospital for evaluation. Further review revealed a nursing progress note dated 3/10/25 at 6:50 PM that read in part, Writer received resident from [local hospital] accompanied by two attendees post fall. Resident alert, verbally responsive. No s/s (signs-symptoms) acute distress. Denies sob (shortness of breath). Denies pain. Pupils equal and reactive. Able to move all extremities. Incontinent of bowel and bladder. Abrasion to the right side of forehead. Bed in lowest position . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was sent via e-mail to the facility administrator on 5/06/25 at 3:05 PM to provide Incident and Accident (IA) reports for R34 between 9/24/24 and 5/6/25. Three sets of event reports (incident and accident) and investigation reports were received. The reports revealed R34 had events on 10/21/24, 11/22/24, and 11/29/24. Review of the IA report dated 10/21/24 revealed that R34 had a fall in the room while they were attempting to self-transfer and they were sent to an emergency room for further evaluation due to an abrasion to their forehead. The IA report for the 11/22/24 fall revealed R34 had a fall from their bed. Review of the investigation reports and R34's care plan did not reveal a thorough investigation of the incident or any immediate interventions that were implemented after the fall. Review of the IA report dated 11/29/24 and progress notes revealed that R34 was sitting in the day room and another resident wheeled over their right foot and their right great toenail was partially detached from the nail bed. Intervention read Certified Nursing Assistant (CNA) educated on importance of proper footwear. The facility did not provide any IA report or investigation report for R34's fall on 3/9/25 when they were transferred out to the hospital with a laceration to their forehead. An interview with License Practical Nurse (LPN) B was completed on 5/7/25 at approximately 2:41 PM. LPN B was assigned to care for R34 during that shift. They were queried about how the resident information/plan of care was shared with the CNAs. LPN B reported they had a Kardex (care card for CNAs) book/binder for the CNA's and nurses shared the information as needed. LPN B provided the Kardex book for the unit. Review of Kardex for R34 revealed an intervention dated 11/29/24 that read proper foot ware and LPN B was queried about what it meant for R34 and they reported that he had tendency to scoot/sit himself on the floor and R34 needed non-skid socks or shoes. When queried if socks were ok they reported yes. An interview with Unit Manager (UM) A was completed on 5/7/29 at approximately 9:30 AM. They were queried about the post fall follow up and investigation process. They reported that the nurse initiated the process and they would call and notify them or Director of Nursing (DON). The nurse would implement immediate interventions and the leadership completed the investigation and further follow up as needed. They were queried about the IA and investigation report for 3/9/25 fall and they reported that they would follow up with the DON. An interview with the DON was completed on 9/7/25 at approximately 9:50 AM. They were queried about the process and they reported that the nurse would notify them or the unit manager of a fall event and they would make recommendations on implementation of immediate interventions. The DON also added that they were involved with handling the fall management program for the facility. DON was queried about the IA and investigation report for the fall event on 3/9/25. The DON reported that they were unaware of the fall event from 3/9/25 and they were not notified that R34 was transferred out to hospital. The DON reviewed the EMR and progress notes from 3/9/25 and 3/10/25. They reported that they would find out more information and would get back. They were queried about staff expectations on R34's intervention dated 11/29/24 proper footwear. The DON reported that R34 should have their shoes on when they were up because of the incident. The DON was notified of the multiple observations when R34 was observed with their socks on in the dining room and hallway. They reported that they would follow up with their staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at approximately 11:10 AM, the DON came back and reported that they did not have any IA reports for this fall and they were trying to reach the nurse and the nurse was taking their exam and they were unable to reach them. They confirmed that they were unaware of the event. They reported that they understood the concern. On 5/7/25 at approximately 4 PM, the facility Administrator was questioned about the fall investigation process. The Administrator notified that the nurse initiated the IA report and notified the DON or the unit manager and the DON followed up after completing the investigation and implemented plans. They were notified of the concern with fall incident on 3/9/25 with IA and investigation, the administrator agreed with the concern. Review of the facility provided document titled Incidents and Accidents with a date of 11/1/22, read in part, Policy: It is the policy of this facility for staff to utilize Incident Reports to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines: 1. Incident/accident reports are part of the facility's performance improvement process and are confidential quality assurance information. 2. Licensed staff will utilize Incident Reports, falls assessments and Neuro Check Protocol to report incidents/accidents and assist with completion of any investigative information to identify root causes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Incidents or accidents involving employees or visitors will be documented on the following forms/systems: Incident Reports 6. In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk of harm. 7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until it is safe to do so. First aid will be given for minor injuries such as cuts or abrasions. 8. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview and record review facility failed to ensure a resident admitted with an indwelling catheter was assessed for removal; failed follow-up with urologist as ordered and failed to have orders for catheter care for one (R23) of two residents reviewed for urinary catheter. This deficient practice has the potential to cause Urinary Tract Infections (UTI) and loss of normal bladder function. Findings include: Review of R23's clinical record revealed R23 was originally admitted to the facility on [DATE] and they were recently hospitalized and readmitted back to the facility on [DATE]. R23's admitting diagnoses included brain cancer (recent finding), urinary tract infection, post COVID, dementia, and compression fracture of the lumbar vertebrae (stable). Based on a Minimum Data Set (MDS) assessment dated [DATE], R23 had a Brief Interview of Mental Status (BIMS) of 11/15, indicative of moderate cognitive deficits. An initial observation was completed on 5/6/25 at approximately 10:15 AM. R23 was observed in their bed. R23 was receiving their nutrition and hydration through Percutaneous Endoscopic Gastrostomy (PEG) tube/feeding tube. R23 also had a foley catheter (a thin, flexible tube used to drain urine from the bladder) and the bag was connected to their bed frame. R23 was observed laying on their back and they had a specialty low air loss mattress. Multiple follow up observations were completed on 5/7/25 (at approximately 8:30 AM and 12:35 PM) and 5/8/25 (at approximately 8:35 AM), R23 had their foley catheter during all the follow-up observations. Review of R23's Electronic Medical Record (EMR) revealed a diagnosis list, with the diagnosis of urinary retention dated 1/24/25 (upon admission to the facility). Further review of discharge summary from the hospital dated 1/23/25 revealed the following diagnoses: acute back pain, dementia, essential hypertension (high blood pressure), history of seizure, cranial neoplasm (brain cancer), sinus bradycardia (slower heartbeat/rhythm), leukocytosis (high white blood cell count), COVID infection, multiple vertebral compression fractures, and severe protein calorie malnutrition. The hospital records did not reveal a diagnosis of urinary retention or any urologist consultation. Review of physician orders did not reveal any orders for the foley catheter use and care, since admission to the facility. Review of Care Area Assessment under the MDS assessment dated [DATE] revealed the following indicators for catheter use: Restricted mobility, urinary urgency and need assistance for toileting and did not have any other clinical rationale/diagnoses for the use of the indwelling catheter. The supporting documentation section for use of foley catheter was blank. Review of physician progress notes revealed a note dated 4/3/25, with recommendation to follow up with urology regarding urinary retention. There was no evidence in the EMR that R23 had any urology follow-up and it was later confirmed by Director of Nursing (DON) on 5/7/25. Review of R23's care plan revealed an intervention that read change catheter per MD (Medical Doctor) order and use a Fr. (size), type per MD order but there were no physician orders for foley catheter use and care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) B was completed on 5/7/25 at approximately 2:35 PM. They were assigned to care for R23 during that shift. They were queried about the facility process to care for foley catheter. LPN B reported that they followed the physician order for catheter use and the standards for nursing care. They were unaware that R23 did not have any physician orders for the foley catheter use and care. An interview with the DON was completed on 5/7/25 at approximately 3:45 PM. They were queried about the rationale for foley catheter use for R23 and the facility process. The DON shared the facility process and reviewed the EMR for R23. After reviewing the records, the DON agreed that R23 did not have any orders for foley catheter use/care and they were unable to locate the diagnosis of urinary retention based off hospital records. They also confirmed that R23 did not have any urology appointment. They reported that they understood the concern. A facility provided document titled Appropriate Use of Indwelling Catheters' with a date of 11/1/22, read in part, Policy: It is the policy of this facility to ensure that a resident who is continent of bladder on admission receives services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. An indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates that catheterization is necessary . 1. It is the policy of this facility to ensure each resident with urinary incontinence: a. Who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. b. Who is admitted with an indwelling urinary catheter, or each resident who subsequently receives an indwelling catheter, will be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. c. Who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible . 3. Any decision regarding the use of an indwelling urinary catheter will be based on the resident's condition and goals for treatment. The resident and/or representative will be included in discussions about the indications, use, potential benefits and risks of urinary catheters, and alternatives to help support the resident's right to make an informed decision. 4. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change (if applicable). 5. Examples of appropriate indications for indwelling urethral catheter use: a. Resident has acute urinary retention or bladder outlet obstruction. b. Need for accurate measurements of urinary output. c. To assist in healing of open sacral or perineal wounds in incontinent residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Resident requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures). e. To improve comfort for end-of-life care, if needed. 6. Documentation to support decision making will be included in the medical record, including but not limited to: a. Clinical or medical conditions demonstrating the need for an indwelling urinary catheter. b. Assessment of incontinence, including the type, frequency, duration, and complicating factors associated with the incontinence. c. Assessment of psychosocial and functional factors affecting urinary continence status. d. Services provided to restore normal bladder function to the extent possible. e. Response to interventions prior to the decision to use an indwelling catheter. f. Resident's wishes and prognosis. 7. Indwelling urinary catheters will be used on a short-term basis, unless the resident's clinical condition warrants otherwise. The interdisciplinary team, with the support and guidance from the physician, will assure the ongoing review, evaluation, and decision making regarding the insertion, continuation, or removal of an indwelling urinary catheter. 8. Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to identify and address a significant weight loss in a timely manner for one (R15) of one resident reviewed for nutrition. Findings include: On 5/6/25 at 9:25 AM, R15 was observed in bed eating her breakfast meal. A plate cover was observed over the plate and a bowl of cereal appeared eaten. When queried about the food in the facility, R15 opened the cover that was placed over the plate and said Yuck! The plate was observed to contain scrambled eggs and toast that were not eaten. R15 reported she did not like the food in the facility and did not ask for anything different when served something she did not like. R15 stated, I don't believe in that. When queried about whether she lost any weight, R15 reported she did not know. On 5/6/25 at approximately 12:00 PM, R15 was observed in bed eating her lunch meal. R15 was observed attempting to eat peaches from a bowl which fell into her lap when she tried to eat it. When queried about how the food was, R15 stated, Yuck! Yuck! Yuck! A review of R15's clinical record revealed R15 was admitted into the facility on [DATE], and readmitted on [DATE], 3/8/25, and 3/16/25 with diagnoses that included: normal pressure hydrocephalus, acute cystitis without hematuria, influenza A, bradycardia, hypertension, type 2 diabetes mellitus, and frontotemporal neurocognitive disorder. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R15 had severely impaired cognition, required setup or clean-up assistance for eating, and weighed 173 pounds with no weight loss or gain (five percent over 30 days or 10 percent over 120 days). A review of R15's progress notes revealed multiple hospitalization s, a history of poor appetite, and gastrointestinal (GI) issues that included vomiting over the past several months. A review of a summary of R15's weights since her admission into the facility on [DATE] revealed the first weight taken was on 1/6/25 and was 194.6 pounds. The next recorded weight was on 2/27/25 and was noted to be 172.6 pounds which was an 11.31 percent loss of body weight within 30 days. Subsequent weights were recorded as follows: 3/3/25 - 171.5 pounds 4/2/25 - 173.2 pounds 5/1/25 - 174.7 pounds According to the weights recorded in R15's clinical record, as noted above, R15 had an 11 percent loss of body weight between 1/6/25 and 4/2/25. A review of an Admission Observation for R15 dated 10/12/24 revealed no documented weight for R15. A review of two Nursing progress notes written on 10/10/24 (R15's day of admission into the facility) revealed no documented weight for R15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Nursing progress note dated 12/27/24 revealed, Resident refused breakfast and lunch, staff encouraged resident to eat and drink resident refused . It was documented in a Nursing progress note that R15 was sent to the hospital on 2/18/25 due to coffee ground emesis (vomiting) to rule out a GI bleed. R15 returned to the facility on [DATE]. A review of a Admission Nursing Comprehensive Evaluation dated 2/24/25 revealed a (re)admission weight of 199.9 pounds. It should be noted that three days later, R15's weight was recorded as 172.6 pounds. A review of a Admission Nursing Comprehensive Evaluation dated 3/8/25 revealed a readmission weight of 199 pounds. A review of a Admission Nursing Comprehensive Evaluation dated 3/26/25 revealed a readmission weight of 172 (pounds) per d/c (discharge) paper work. Further review of R15's progress notes revealed no documentation from the dietary department or physician regarding the significant weight loss documented. There was no evidence that it was reported to anyone or addressed. There was no evidence that a re-weigh was conducted to confirm the accuracy of the 11.31 percent loss of body weight. A review of a Nutritional Assessment note dated 4/18/25 (the first note after the documented weight loss), written by Certified Dietary Technician (DT) 'M', revealed, .Resident's CBW (current body weight) is 173 lbs (pounds), no significant wt (weight) changes noted . There was nothing documented that addressed the weight loss that was noted between 1/6/25 and 2/27/25. A review of a progress note written by Registered Dietitian (RD) 'J' on 4/19/25 revealed, .there have been no significant weight changes observed . A review of a progress note written by RD 'J' on 5/4/25 revealed, CBW 174.7 lbs. last month's weight at 173. 2 on 4/2. Weight in the past 4 months ranges between 171 lbs-175 lbs. Weight loss triggers related to erroneous weighing in January at 194.6 lbs . There was no evidence in the clinical record that the documented weight loss that occurred between 1/6/25 and 2/27/25 was evaluated by the RD or physician to determine if it was erroneous. Further review of R15's full clinical record revealed no documentation of R15's initial weight when admitted into the facility on [DATE]. A review of R15's Nutritional Assessments revealed the first assessment was completed on 1/16/25 (three months after R15 was admitted into the facility) and noted R15 weighed 195 pounds with no weight changes in 30 days. The next Nutritional Assessment was completed on 4/18/25 and noted R15 weighed 173 pounds with no weight change in 30 days, but did not acknowledge the weight loss that occurred within that assessment period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/25 at 10:25 AM, an interview was conducted with DT 'M'. DT 'M' explained she was a Certified Dietary Manager, but had certification as a dietary technician which allowed her to conduct dietary assessments. DT 'M' explained RD 'J' was the Registered Dietician for the building and she handled all high risk residents such as residents who required tube feeding or dialysis and she (DT 'M') handled the basic residents and conducted assessments on them. When queried about how residents were monitored for significant changes in weight, DT 'M' reported if she found a significant weight change, it was reported to RD 'J'. Staff who took residents weights also reported any changes to RD 'J' or herself. When queried about the documented significant weight loss for R15 between 1/6/25 and 2/27/25 and how that was addressed, DT 'M' reported the Director of Nursing (DON) was working on looking into weight discrepancies at that time so it might have had to do with that. DT 'M' did not have any additional information on how R15's weight loss was addressed. On 5/8/25 at 10:36 AM, an interview was conducted with RD 'J'. RD 'J' reported she was hired as a Corporate Dietitian and covered six facilities for the past year. RD 'J' reported she was currently the RD for the facility and covered high risk residents and DT 'M' was able to assess and monitor the non-high risk residents with her oversight. When queried about how resident's weights were monitored for any significant changes, RD 'J' reported the documented weights in the Electronic Medical Record (EMR) were reviewed and if there were any significant weight losses or gains she requested a re-weight to confirm the accuracy of the weight changes. When queried about whether she was informed or if she identified R15's significant weight loss between 1/6/25 and 2/27/25, RD 'J' reported the facility had erroneous weights taken before I came in and I noticed a lot that did not seem right or consistent with how the resident looked. RD 'J' reported they hired a new person to take weights because they were not being done correctly. When queried about how an actual weight loss was ruled out for R15 given the documented appetite changes and medical issues during that time, RD 'J' reported she should be contacted regarding significant weight loss. On 5/8/25 at 11:07 AM, an interview was conducted with the DON. The DON reported monthly weights were taken on residents, as well as on admission and for the first couple weeks after admission, they were done weekly. Any significant changes in weights were reported to RD 'J'. When queried about what RD 'J' should do if a significant weight loss was identified, the DON reported she would let the staff know if a reweigh was needed and then make recommendations for additional interventions. When queried about R15's weight loss and the lack of documentation to address it, the DON reported they identified a lot of discrepancies with weights and discovered the person who used to weigh residents was not doing it correctly or consistently so they hired someone new. When queried about how it was known that R15 did not actually lose weight given her medical conditions, no weight taken on admission, and inconsistent documentation of weights in the clinical record, the DON reported she understood the concern. When queried about whether the significant weight loss should have been addressed at the time it was identified, even if it was erroneous, the DON reported it should have been addressed right away and any discrepancy should have been documented at that time. A review of R15's care plans revealed a care plan initiated on 10/16/24 that read, Resident is at risk for nutrition-related declines . Interventions initiated on 1/16/25 revealed, .Obtain weight per policy. Observe and report to physician/responsible party significant weight changes . There were no additional interventions implemented after the documented weight loss on 2/27/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Weight Monitoring, revised 3/27/24, revealed, in part, the following: .The facility will utilize a systemic approach to optimize a resident's nutritional status .Identifying and assessing each resident's nutrition status and risk factors .Evaluating/analyzing the assessment information . Developing and consistently implementing pertinent approaches .Monitoring the effectiveness of interventions .A weight monitoring schedule will be developed upon admission for all residents .Resident with weight loss - monitor weekly .A significant change in weight is defines as .5% change in weight in 1 month (30 days) .7.5% change in weight in 3 months (90 days) .10% change in weight in 6 months (180 days) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure irregularities identified by the consultant pharmacist and signed by the physician were completed for one (R16) of five residents reviewed for monthly medication regimen reviews. Findings include: Review of the clinical record revealed R16 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart failure, dementia and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R16 had severely impaired cognition and required the assistance of staff for activities of daily living (ADL's). Review of a Note To Attending Physician/Prescriber by a Consultant Pharmacist dated 3/11/25 revealed a recommendation that read, .Please consider ordering the following labs: Lipid Panel, TSH (thyroid-stimulating hormone) levels . The Physician/Prescriber Response was marked AGREE and signed 3/13/25. Review of a Note To Attending Physician/Prescriber dated 4/15/25 revealed a recommendation that read, . Please consider ordering the following labs: Lipid panel, TSH levels, Vitamin D levels . The Physician/Prescriber Response was marked AGREE and signed 4/17/25. Review of R16's laboratory results revealed the Lipid panel, TSH level and Vitamin D levels were drawn on 4/17/25. No results were found for the 3/11/25 recommendation. On 5/7/25 at 3:40 PM, Licensed Practical Nurse (LPN) C was asked where it was documented when labs were ordered for a resident. LPN C explained the nurse would fill out a requisition order and place it in the lab book. LPN C was asked if a record was kept of what labs were ordered. LPN C explained since lab would take the requisition form, she would usually write a progress note that labs were ordered, but not everyone did that. On 5/7/25 at 3:43 PM, the Director of Nursing (DON) was interviewed and asked if the Lipid panel and TSH level had been ordered after the pharmacy recommendation on 3/11/25. The DON explained there was no way to see if a lab was ordered or not. Review of a facility policy titled, Medication Regimen Review dated 11/1/22 read in part, .Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39592 Based on observation, interview and record review, the facility failed to ensure medications and biologicals were appropriately stored in a safe/sanitary manner in one medication cart reviewed. Findings include: On 5/8/25 at 10:40 AM, observation of the 2nd floor medication cart was made with Licensed Practical Nurse (LPN) D. In the top drawer on the left, money was observed folded in the back right hand corner. LPN D was asked whose money it was. LPN D explained she did not know whose money it was. LPN D was asked how much money was there. LPN D unfolded the money to reveal four one dollar bills. When asked what she was going to do with the money, LPN D explained she would give it to the manager. Continued observation of the medication cart revealed in the third drawer on the left, an open bottle of hand sanitizer with a pump was in the same compartment as a nebulizer treatment for inhalation. LPN D was asked about the hand sanitizer. LPN D immediately removed the bottle of hand sanitizer and said it should not be there. On 5/8/25 at 12:09 PM, the Director of Nursing (DON) was informed of finding money in the medication cart. The DON explained they would keep it in the office until either a resident or staff member asked about it. When asked if money should ever be kept in a medication cart, the DON said no. The DON was informed of a bottle of hand sanitizer in the same compartment as nebulizer medication. The DON explained cleaning supplies should never be in the same space as medications. Review of a facility policy titled, Medication Storage revised 9/27/23 read in part, .External Products: Disinfectants and drugs for external use are stored separately from internal and injectable medications .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure accurate tracking and administration of the pneumococcal vaccinations for three (R143, R16 and R10) of five residents reviewed for vaccinations. Findings include: Review of a facility policy titled, Pneumococcal Vaccine (Series) revised 1/8/25 read in part, .Each resident will be offered a pneumococcal immunization upon admission . The type of pneumococcal vaccine (PCV15, PCV20, PCV21 or PPSV23) offered will depend upon the recipient's age, having certain risk conditions, and previously received pneumococcal vaccines, in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations . R143 Review of the clinical record revealed R143 was admitted into the facility on [DATE] with diagnoses that included: fracture of right femur, chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. Review of a facility provided Michigan Care Improvement Registry (MCIR) report dated 4/23/25 revealed there was no record of R143 receiving any pneumococcal vaccination. The MCIR report indicated R143 was Overdue for PCV15/PCV20/PCV21 vaccinations. According to (CDC) guidelines, R143 was due for a dose of PCV15, PCV20, or PCV21. R16 Review of the clinical record revealed R16 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: heart failure, dementia and anxiety disorder. Review of a facility provide MCIR report dated 6/16/23 revealed R16 had received a Pneumococcal Adult vaccination 3/28/19 and was Overdue for PCV20/PPSV23 vaccinations. Review of R16's Preventive Health Care record revealed no Pneumococcal vaccinations had been given by the facility. According to CDC guidelines, R16 was due for a dose of PCV15, PCV20 or PCV21. R10 Review of the clinical record revealed R10 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: diabetes, acute respiratory failure with hypoxia and liver transplant status. Review of a facility provided MCIR report dated 6/16/23 revealed R10 had received Pneumococcal Adult vaccinations 12/22/09 and 3/26/15, and was Overdue for PCV15/PCV20 vaccinations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R10's Preventive Health Care record revealed a Pneumococcal Vaccine was given to R10 on 8/18/18 outside of this building. It should be noted this dose was not listed on R10's MCIR dated 6/16/23. According to CDC guidelines, R10 was due for PCV20 or PCV21. On 5/8/25 at 11:21, Licensed Practical Nurse (LPN) A, who served as the Infection Control Nurse, was interviewed and asked about Pneumococcal vaccinations. LPN A explained she followed CDC guidelines for vaccinations. LPN A was asked about why R143 had not received any vaccinations even though they had been admitted for two weeks. LPN A explained the consent for vaccinations was included in the admission paperwork, and she did not have that paperwork yet. When asked if she ever went to the resident herself and asked if they wanted to get the vaccination, LPN A explained she did not, she would wait for the paperwork. LPN A was asked why R16 had not received a Pneumococcal vaccination. LPN A explained R16 was due this year as it was five years since their last vaccination. When informed that was not the CDC guideline for vaccination, and the MCIR listed the vaccination as overdue on 6/16/23, LPN A explained she must be using outdated guidelines. LPN A was asked why R10 had not received a vaccination as it had been well over five years since their last dose. LPN A explained they thought if the vaccine was given after the age of 65, no more doses were required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235322	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakridge Manor Nursing & Rehab Center LLC	3161 Hilton Rd Ferndale, MI 48220

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 22960 Based on observation and interview, the facility failed to provide 80 square feet per resident for 7 of 20 multiple resident rooms and failed to provide 100 square feet per resident for 3 of 4 single bed resident rooms, resulting in the potential for inadequate space and resident dissatisfaction with their living conditions. Findings Include: On 5/07/25 at 11:00 AM, the following Medicare/Medicaid resident rooms were observed: Room # Square Ft. Beds 102 227 3 103 93 1 107 222 3 109 222 3 110 231 3 111 83 1 203 93 1 204 230 3 205 224 3 207 225 3 The health and safety of the residents were not affected by the room size. Interviews revealed residents had no problems with their rooms.