STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235464	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Nursing Center	2532 Cadillac Drive Farwell, MI 48622

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement an effective and current system of surveillance for staff illnesses to identify possible communicable diseases and infections to prevent the spread of an illness/outbreak, resulting in the potential for an outbreak to go undetected.Findings:During an interview on 04/08/2026 at 11:37 AM, Director of Nursing (DON) reported that Infection Control Preventionist (ICP) A was off on 4/8/26 and she would review the Infection Control Program in her place. DON reported that when a facility employee called off the employee answering the phone would complete the Call off Notice form. DON confirmed that it did not need to be a licensed nurse to complete the form. Once that form was completed it was sent to Human Resources to review/document. If the call-off was illness related the Call off Notice was reviewed by ICP A.DON reported that the Employee Surveillance Log included all facility staff and was to include the symptoms and the onset date, the date last worked, and the unit worked further stating that that information is the requirement. DON reported that if the symptoms were vague, ICP A would call the staff member to obtain additional details.Review of the CDC (Centers for Disease Control and Prevention) Long-Term Care (LTC) Respiratory and Acute Gastroenteritis Surveillance Line List templates revealed, Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring. The Line List (Surveillance Log) should contain, all healthcare personnel (e.g., nurses, physicians and other providers, therapists, food services, environmental services) whether employed, contracted, consulting or volunteer.For each staff member listed, indicate the floor, unit or location where that staff member had been primarily working at the time of illness onset. Symptoms and Symptom onset date: Record the date (month/day) each person developed or reported signs/symptoms.and Symptom Resolution Date.Review of the 2026 Infection Control Binder revealed the tabs for March and April contained only the staff Call off Notice forms.On 04/08/2026 at 1:24 PM, an email was sent to the Nursing Home Administrator (NHA) which included, For the employee surveillance log I am not seeing documentation of the date they last worked, the department they are from, the unit they worked, etc. Is there any additional documentation you can find?During an interview on 04/08/2026 at 2:28 PM, DON provided a copy of the March Infection Control Map which was a printout of the facility floor plan. DON reported there was no April Infection Control Map. The Infection Control Map was located in ICP A's office (not in the infection control binder.) The map was color coordinated as follows blue-gastrointestinal symptoms, green-influenza, pink-congestion/body aches, orange-RSV, and yellow-unknown. DON reported the Infection Control Map was utilized to track the location the employee last worked. However, it did not contain any dates of symptom onset/resident exposure or the correlated staff member.During an interview on 04/08/2026 at 2:28 PM, DON confirmed that the Infection Control Maps were located in ICP A's office, the staff Call off Notice forms were located in the Infection Control Binders, and the line list was printed off from the facility charting system. Confirming all required employee surveillance documentation was not accessible in one location.Review of the March staff Call off Notice forms and the March Employee Surveillance Log revealed:Licensed Practical Nurse (LPN) U called off 3/1/26 for nausea and (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diarrhea and called off 3/2/26 for confirmed Flu. LPN U was not listed on the Employee Surveillance Log. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.Certified Nursing Assistant (CNA) V called off 3/3/26 for fever/chills. CNA V was not on the Employee Surveillance Log. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.Dietary Aide (DA) W called off on 3/3/26 for vomiting and loose watery diarrhea. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.CNA Q called off 3/7/26 for vomiting. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.CNA X called off 3/9/26 for fever/chills, congestion, body aches, and sinuses and called off 3/16/26 for sore throat and body aches. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.Housekeeper Y called off on 3/13/26 for nausea and fever/chills and called off 3/16/26 for fever/chills, body aches, and headache. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.CNA Z called off 3/11/26 for fever/chills and sore throat, on 3/12/26 with no symptoms included, on 3/14/26 for positive for RSV, and on 3/16/26 for RSV. They were not added to the line list until 3/17/26 (created date). The date of symptom onset and the unit/department they last worked was not included.CNA AA called off 3/16/26 for fever/chills and vomiting. CNA AA was not listed on the Employee Surveillance Log. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.Activity Aide (AA) BB called off on 3/18/26 for fever/chills and vomiting. The date of symptom onset and the date they last worked was not included.CNA CC called off on 3/22/26 for vomiting. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included.RN DD called off on 3/23/26 for congestion and cough. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. The Employee Surveillance Log listed the onset date as 3/24/26.CNA EE called off on 3/25/26 for puked. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.DA FF called off on 3/27/26 for congestion and cough. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.CNA V called off on 3/29/26 for vomiting. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.Review of the March Infection Control Map revealed there was no highlighted area of RSV/orange highlight despite CNA Z calling off 3/11/26 for fever/chills and sore throat, on 3/12/26 with no symptoms included, on 3/14/26 for positive for RSV, and on 3/16/26 for RSV. There were areas highlighted in yellow (unknown) but no way to determine the correlating staff member or the illness.Review of the April staff Call off Notice forms and the March Employee Surveillance Log revealed:CNA II called off on 4/1/26 for nausea and sick. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.CNA EE was sent home on 4/426 for vomiting. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.DA JJ called off on 4/4/26 for vomiting. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.CNA GG called off on 4/4/26 for nausea. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not added to the Employee Surveillance Log until 4/7/26.CNA HH called off on 4/7/26 for vomiting. The date of symptom onset, the date they last worked, and the unit/department they last worked was not included. They were not on the Employee Surveillance Log.During an interview on 04/08/2026 at 2:29 PM, Regional Clinical Nurse (RCN) R confirmed that the Employee Surveillance Log did not include the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unit the staff member last worked. RCN R reported that going forward that information would be added to the comment section on the Employee Surveillance Log. RNC R confirmed that the March Infection Control Map did not specify the dates the unit(s) were exposed to different infection types and did not adequately depict the unit the staff members last worked.Review of the Facility Assessment last completed/updated 3/9/26 revealed, .Evaluation of Infection Prevention and Control Program .IFC surveillance will identify trends, types of infections for all residents and staff. When patterns persist education maybe provided to staff to assist with minimizing any further exposure. We also use information from our QIO. The QIO offer trainings and education on various topics related to Infection prevention .Review of the facility policy Infection Prevention and Control Plan last updated March 2024 revealed, Policy: It is the policy of this facility to implement the Infection Prevention and Control Program utilizing a systematic, coordinated and continuous approach guided by OSHA regulations, and pertinent state, federal and local regulations pertaining to infection control.2. Surveillance includes HAIs among staff and residents.a. Continuously collect and screen data to identify potential outbreaks.d. The Infection Prevention Manager assumes direct accountability for the surveillance, aggregation and analysis of the data.4.Monitoring and evaluation of key performance aspects of infection control through preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted.f. Employee health trends.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review, the facility failed to ensure call lights were within reach for one of three residents reviewed (Resident #60) for accommodation of needs. Findings:Resident #60 (R60)Review of an admission Record revealed R60 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent diagnoses of dementia, high blood pressure and type 2 diabetes. During an observation on 4/06/26 at12:03 PM, R60s call light was draped over the shade of the small lamp that sat on the table near the foot of the bed, out of reach of the resident. During an observation on 4/06/26 at 1:03 PM, staff had just delivered a lunch tray to R60 in her room. After staff left the room, the call light laid over the small lamp shade at the foot of the bed, out of reach of the resident. During observation on 04/07/26 at 8:10 AM and again at 2:20 PM, R60 laid in bed and the call light was draped over the shade of the lamp that sat on the table at the foot of the bed, out of reach of the resident. During observation on 04/08/26 at 8:24 AM, R60 laid in bed and the call light was draped over the shade of the lamp that sat on the table at the foot of the bed, out of reach of the resident. Review of a Care Plan for R60 revealed .resident is able to utilize the call light for assistance.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physician orders and nursing professional standards of practice of 4 residents (Resident #1, #5, #47, and #57) out of 15 residents reviewed for medication administration.Findings: Resident #1 (R1)Review of an admission Record reflected R1 admitted to the facility with diagnoses that included atrial fibrillation, high blood pressure and biventricular heart failure. Review of R1's March 2026 Medication Administration Record (MAR) reflected licensed nurses administered Midodrine HCl Oral Tablet 10 MG (milligrams) (Midodrine HCl) Give 1 tablet by mouth three times a day for Hypotension (low blood pressure) Hold is (sic) SBP (systolic blood pressure) > (greater than) 120 outside of prescribed parameters 7 times (three times on 3/16/26, once on 3/26/26, once on 3/28/26, once on 3/29/26, and once on 3/30/26). Review of an order on R1's April 2026 MAR reflected Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth three times a day for Hypotension Hold is (sic) SBP (systolic blood pressure) > (greater than) 120 - D/C Date- 4/06/2026 revealed a licensed nurse administered the medication outside of parameters on 4/4/2026 with a blood pressure (BP) of 124/57. Review of a physician order found on R1's April 2026 MAR reflected Midodrine HCL Oral Tablet 10 MG (milligrams) (Midodrine HCL) give 0.5 (half) tablet by mouth three times a day for hypotension Hold is (sic) SBP (systolic blood pressure) greater than 120. The medication is documented as given on 4/6/26 at 10:00 AM with a BP of 126/60. Resident #5 (R5) Review of an admission Record reflected R5 admitted to the facility with a diagnosis of Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. Review of the April 2026 Medication Administration Record (MAR) reflected an order for Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 18 unit subcutaneously every morning and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC POLYNEUROPATHY (E11.42) During an observation of Medication Administration on 4/7/2026 at 7:32 AM, Registered Nurse (RN) J prepared the prescribed Insulin Glargine for R5. RN J did not prime the needle prior to injecting the resident with the medication and did not hold the pen injection against the skin for 10 seconds to ensure full delivery of the prescribed dose of medication. When asked, RN J said she was not sure if she was supposed to prime the needle and did not know she was to hold the injector next to the resident's skin for 10 seconds. During an interview on 04/08/2026 at 9:24 AM, the DON reported that she expected staff to hold the medication if the blood pressure is outside the prescribed parameters. The DON also reported that she expected nurses to prime the needle of any injection insulin and to hold the needle in place for a count according to policy. Review of a policy Medication Administration by Various Routes revised December 2024 reflected It is (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the policy of this facility to administer medication in agreement with standards of practice as well as in accordance with applicable state and federal law. 13' General Preparation: . e. take vitals as indicated if the medication is contingent upon the results. Review of a Lantus SoloStar Step-by-Step Guide_Lantus (insulin glargine injection) 100 Units_mL.pdf reflected Step 3. Perform a Safety Test, dial a test dose of 2 units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again. Always perform the safety test before each injection. Never use the pen if no insulin comes out after a second needle. Step 5. Inject your Dose, . Use your thumb to press the injection button all the way down. When the number in the dose window returns to 0 (zero) as you inject, slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.) . Resident #47 (R47) Review of an admission Record revealed R47 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain. Review of R47's Order Summary dated 5/28/25 revealed, Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Controlled Drug Give 1 tablet by mouth every 12 hours. To be administered at 6:00 AM and 6:00 PM. Review of R47's Controlled Drug Receipt/Record/Disposition Form revealed a tablet of Norco was not dispensed for the 6:00 PM dose on 4/4/26. Review of R47's April Medication Administration Record revealed the 4/4/26 6:00 PM dose of Norco was documented as administered. Review of R47's Electronic Medical Record revealed no documentation for the withholding and/or incorrect documentation of the Norco administration. Resident #57 (R57) Review of an admission Record revealed R57 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain. Review of R57's Order Summary dated 2/10/25 revealed, Norco Oral Tablet 7.5-325 MG (Hydrocodone/Acetaminophen) Give 1 tablet by mouth four times a day. To be administered at 5:00 AM, 12:00 PM, 5:00 PM, and 11:00 PM. Review of R57's April Medication Administration Record revealed that on 4/2/26 the 5:00 AM dose of Norco was not documented as administered (left blank). Review of R57's Electronic Medical Record revealed no documentation for the withholding of the Norco. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/08/2026 at 2:29 PM, Regional Clinical Nurse (RCN) R confirmed the medication errors for R47 and R57 and reported that the nurse that made the medication errors was an agency nurse. Review of the facility policy, Medication Administration by the Various Routes last revised December 2024 revealed, .6. All current medications, dosage schedules and treatment records will be noted on the residents Electronic Medication Administration Record (eMAR).n. If a dose of medication is withheld or refused, the nurse will note that on the eMAR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility policy for pressure injury prevention and management for 3 residents (Resident #32, #50, and #55) out of 5 reviewed for pressure injuries.Findings:Resident #32 (R32)Review of an admission Record revealed R32 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: muscle wasting and atrophy. Further review of the record revealed that R32 had a responsible party (guardian/decision maker).Review of R32's Skin assessment dated [DATE] revealed, Open area to right buttocks scar tissue measuring 0.3cm x 0.2cm. Area opened while providing personal care. Clinical coordinator notified, treatment ordered.Review of a handwritten entry in the Physician Communication book dated 3/31/26 revealed, open area to right buttocks. There was a handwritten line through the entry and noted was printed. There was no date or initials documented to reflect when the entry was reviewed or by whom.Review of R32's Electronic Medical Record (EMR) revealed no documentation that RP S was notified or that R32's practitioner was notified via in person or telephone of the newly identified pressure injury. Additionally, there was no comprehensive wound assessment completed (description of the pressure injury location, dimensions, description of wound bed, exudate type, exudate amount, presence of odor, wound edges, peri-wound assessment, tunneling/undermining, and pain.)During an interview on 04/07/2026 at 10:23 AM, Responsible Party (RP) S reported that she was not aware of any recent skin breakdown or newly implemented treatments.Review of R32's Order Summary dated 3/31/25 revealed, wound care - Cleanse open area to right buttocks, pat dry, apply collagen, and cover with foam dressing. Change every three days and prn (as needed) until resolved. Monitor dressing integrity every shift.During an observation and interview on 04/08/2026 at 11:12 AM, R32's skin was observed with Clinical Care Coordinator (CCC) B. CCC B pointed out an area of thin fragile intact skin (scar tissue) where R32's pressure injury had been located. CCC B reported that the nurse that had identified the pressure injury implemented a treatment order at the time using the facility's wound care guide.Review of R32's Treatment Administration Record revealed the wound care order was transcribed for the assessment of the dressing integrity every shift but was not transcribed to reflect the dates the dressing was to be changed.Review of R32's EMR revealed no documentation of the dates R32's dressing was changed.Review of R32's Health Care Provider Visit note dated 4/3/26 revealed no documentation that the provider was made aware of or assessed R32's pressure injury.Review of R32's Order Audit Report for the pressure injury treatment revealed that on 4/5/26 R32's treatment was discontinued for Reason: resolved.Review of R32's EMR revealed there had not been an additional Skin Assessment since 3/31/26 and there had been no Wound Measurement assessments. There was no documentation that a licensed nurse had reassessed the pressure injury and observed it as resolved.During an interview on 4/8/26 at 10:25 AM, Director of Nursing (DON) reported that CCC B was responsible for the oversight of R32's pressure Injury. CCC B reported that she assessed her buttocks on Sunday (4/5/26) and there were no open areas identified on R32's buttocks. DON communicated to CCC B that the assessment of the resolution of R32's pressure injury should have been documented at that time. CCC B reported that staff should have notified RP S and the physician of R32's pressure injury at the time it was discovered and reported that the physician communication book was not a sufficient method to communicate pressure injury concerns.Resident #50 (R50)Review of an admission Record revealed R50 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of buttocks stage 2.Review of the facility policy Skin at Risk Assessment Documentation, Staging & Treatment revealed, .9. Re-assess and measure a pressure ulcer a minimum of weekly.Review of R50's Wound Measurement assessment revealed the last assessment was completed on 3/30/26.Review of R50's EMR revealed no documentation that a comprehensive wound assessment had been conducted on 4/6/26.During an (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview via email on 04/08/2026 at 1:49 PM, Nursing Home Administrator (NHA) confirmed R50's Wound Measurement had not been completed and stated the CCC is completing wound measurement currently.Resident #55 (R55)Review of an admission Record revealed R55 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral palsy and muscle wasting and atrophy.Review of R55's Order Summary dated 2/24/26 revealed, MASD (moisture associated skin damage) to bilateral buttock - wash, pat dry and apply zinc ointment to affected areas q (every) shift and PRN.Review of R55's April Treatment Administration Record revealed that on 4/1/26 the treatment was not completed.Review of R55's EMR revealed no documentation for the rationale of the missed treatment.During an interview on 04/08/2026 at 2:29 PM, Regional Clinical Nurse (RCN) R confirmed R55's treatment had not been documented as completed in the EMR on 4/1/26 and reported the agency nurse believed another nurse had completed the treatment.Review of the facility policy Skin at Risk Assessment Documentation, Staging & Treatment last revised January 2020 revealed, Policy: It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools. It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient's skin condition have occurred. Weekly measurements and narrative assessments are conducted on existing pressure injuries. Purpose: To provide prompt identification and intervention for residents at risk of impaired skin integrity corresponding to risk factors. To limit the development of avoidable pressure ulcers and provide evidenced based guidance on effective strategies to promote pressure ulcer healing.Stage II: Partial-thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising. May also present as an intact or open / ruptured blister. This stage should not be used to describe moisture associated skin damage, including incontinence associated dermatitis, intertriginous dermatitis, medical adhesive related skin injury, or traumatic wounds (skin tears, burns, or abrasions).8. Individualize the resident goals and interventions as documented on the plan of care. 9. Re-assess and measure a pressure ulcer a minimum of weekly .10. Document the appearance of the wound with considerations to the physical characteristics as applicable to the resident; a. Location b. Stage c. Size d. Color e. Peri-wound condition f. Wound edges g. Sinus tracts or tunneling h. Exudate i. Odor.Review of the facility policy, Change in Resident Condition Physician/Family Notification last revised January 2026 revealed, Policy: It is the policy of this facility to inform the resident; consult with the residents health care practitioner, and notify the residents authroized (sic) representative according to the minimum guidelines established in this procedure and more frequently at the discretion of the licensed nurse or member of the interdisciplinary team. 1. The health care practitioner will be promptly notified when.c. A resident assessment indicated the need to alter the treatment significantly i.e.commence a new treatment. 2. The resident, or authorized representative will be notified when. c. There is a significant change in the physical, mental or psychosocial status. 3. Immediate attempts at notification will occure (sic) with all medical emergencies, in other instances notification will occure as soon as possible and as soon as prudent given the time of day and nature of event. 5. Objective observations of changes in a resident's condition, including emotional changes as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be recorded in the resident's record.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, For patients experiencing acute or chronic illnesses, diseases, or trauma, patients' family members and surrogate decision makers become active partners in decision making and care .When possible, patients and family caregivers want to participate in shared decision making about treatment options and ongoing symptom management. Incorporating a patient's and family's cultural beliefs, values, and communication patterns is essential to provide individualized patient/family-centered care. When developing a plan of care, consider all resources available to patients. The family plays a key role .Engaging the family or designated surrogate is a fundamental (continued on next page)

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	235464	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Nursing Center	2532 Cadillac Drive Farwell, MI 48622

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skill of patient-centered care [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain general cleanliness and repair of the premises. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living for residents. Findings include: On 04/07/2026 at 10:12AM, observed the drain line for the ice machine in the Nourishment room, had a whitish gel-like substance coming out of the drain line. Dietary Manager (DM) D, present at time of observation, stated that maintenance department was responsible for the cleaning and maintenance of the ice machines. On 04/07/2026 at 3:04PM, Maintenance Supervisor (MS) C observed the gel-like substance coming out of the drain line. MS C noted that this had happened before after the ice machine had been cleaned and believes it might be the cleaning product interacting with minerals in the well water. On 04/07/2026 at 3:05PM, observed in the Nourishment room, a piece of coving (1 foot long) missing from wall, floor juncture next to the ice machine and paint bubbling on wall behind the ice machine. MS C confirmed condition of the surfaces in vicinity of the ice machine. On 04/07/2026 at 3:07PM, observed in the Housekeeping/Mechanical closet on main hall, paint chipping (12-inch by 10-inch section) on the wall, about 3 feet off the floor, next to the mop sink in the housekeeping room. MS C confirmed there is chipping paint on the wall.

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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** Based on observation, interview, and record review, the facility failed to safely transport residents in wheelchairs for 2 residents (Resident #7 and #5) out of 15 residents reviewed for accidents and hazards.Findings:Resident #7 (R7)Review of an admission Record revealed R7 was an [AGE] year-old female, admitted to the facility on [DATE].During an observation on 04/06/2026 at 11:00 AM, Certified Nursing Assistant (CNA) Q was observed propelling R7 in her wheelchair without foot pedals from room [ROOM NUMBER] to the nurses' station.Resident #5 (R5)Review of an admission Record revealed R5 was a [AGE] year-old male, admitted to the facility on [DATE].During an observation on 04/08/2026 at 8:13 AM, CNA L was observed propelling R5 in his wheelchair into his room, his left foot was behind the foot pedal. During an observation on 04/07/2026 at 4:45 PM, while exiting the building with 2 other healthcare surveyors, a facility staff member was observed propelling a resident in her wheelchair down the 100 unit with her feet behind the foot pedals.During an interview on 04/08/2026 at 12:39 PM, Nursing Home Administrator (NHA) reported the facility staff were to push residents in their wheelchairs with foot pedals on and with their feet on the foot pedals. NHA reported pushing residents without their feet on foot pedals was not safe practice.A copy of the facility's policy for wheelchair safety/foot pedals was requested on 4/8/26 at 12:32 PM via email. A copy was not received prior to survey exit.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Another area of fall risk includes wheelchair-related falls involving older adults or patients with disabilities. Patients who use wheelchairs can experience falls .Transporting patients without proper application or engagement of safety features .may lead to patient ejection. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to change and store oxygen tubing per physician orders and facility policy for three of five residents residents (Resident #42 , Resident #52, and Resident #73) reviewed for oxygen storage.Findings: Resident #42 (R42) Review of an admission Record revealed R42 was a [AGE] year-old female, last admitted to the facility on [DATE] following a four day hospitalization after a fall and was found to be positive for RSV (respiratory syncytial virus). During an observation on 04/06/26 at 10:41 AM, R42 laid in bed resting with her eyes closed. A disposable nebulizer (a machine that converts liquid medicine into fine inhalable mist to treat respiratory conditions) mouthpiece and tubing, dated 03/23/26, laid on the mattress next to R42's pillow. Clear liquid sat in the disposable medication cup. Review of a physician order reflected an order for the breathing treatment .albuterol sulfate inhalation nebulization solution 1.25 mg(milligrams)/3ml (milliliters), inhale 3ml orally every 6 hours as needed for dyspnea (difficulty breathing). Start date 03/23/226. Review of the facility policy Small Volume Nebulizer Treatment and Care, last reviewed June 2022, revealed .tubing and nebulizer delivery systems are changed weekly and as needed. According to this policy, R42's nebulizer delivery mouthpiece and tubing was to have been changed on 03/30/26. Review of an Electronic Medication Administration Record (Emar) dated 03/31/26 to 04/06/26 revealed R42 received a nebulizer breathing treatment with the disposable mouthpiece and tubing that was to have been changed on 03/30/26. Resident #52 (R52) Review of an admission Record reflected R52 admitted to the facility with diagnoses that included chronic heart failure, chronic obstructive pulmonary disease (COPD) and permanent atrial fibrillation. Review of the form CMS 802 - MDS (Minimum Data Set) Resident Matrix printed on 4/6/2026 reflected R52 admitted to the facility on [DATE] and triggered for excessive weight loss and pulmonary infection. Review of a Care Plan initiated on 3/16/2026 reflected R52 has potential for acute condition change with cardiopulmonary, metabolic or infectious complications, atrial fibrillation, CHF (congestive heart failure), COPD and CKD (chronic kidney disease). Interventions included Check oxygen saturation levels (SAO2%) and capillary refill prn (as needed), initiate O2 as ordered. Review of Interdisciplinary Documentation dated 4/1/2026 indicated R52 was diagnosed with pneumonia and prescribed an antibiotic based on the results of a chest xray and recent shortness of breath. During an observation on 04/06/2026 at 10:45 AM, Oxygen tubing for R52 was lying on the bed, not (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contained in a clean plastic bag, oxygen concentrator running. Resident #73 (R73) Review of an admission Record reflects R73 admitted to the facility with diagnoses that included chronic systolic (congestive) heart failure, atrial fibrillation and anxiety. Review of a Care Plan initiated on 3/31/2026 reflected R73 had the potential for acute condition change with cardiopulmonary, metabolic or infectious complications related to chronic systolic heart failure, abdominal aortic aneurysm, and paroxysmal a fib (atrial fibrillation). Interventions included Check oxygen saturation levels SAO2% and capillary refill prn, initiate O2 as ordered. Review of the April 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) reflects an order for Oxygen at 2 liters PRN (as needed) to maintain an oxygen saturation of > (greater than) 87% every shift. Further review of the entire MAR/TAR did not reveal orders for storage of oxygen tubing or to change oxygen tubing every week. During an observation on 04/06/2026 at 11:37 AM, oxygen tubing that was not in use for R73 was wrapped around a portable oxygen tank. The oxygen tubing was not dated and was not secured in a clean bag. During an interview on 04/08/2026 9:14 AM, the DON reported that she expects oxygen tubing that is not in use is to be secured in a clean bag with the date written on the tubing. The DON reported that oxygen tubing is dated and changed weekly. Review of a policy Oxygen Use; Storage & Handling of Concentrators & Compressed Gas Cylinders revised November 2010 reflected .Concentrator Use, . 6. Change the cannula and humidifier bottle weekly and prn (as needed). 7. Date the cannula and humidifier bottle when changed.Safety, Cleaning & Maintenance of the Concentrator: .4. A receptacle should be available to attach to the concentrator to store the oxygen tubing when not in use. Oxygen Cylinders . 9. Attach the dated oxygen device to the cylinder (Change devices weekly and prn) .13. A receptacle should be available to attach to the E tank to store the oxygen tubing when not in use.