STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Nursing Center	600 Denmark Street Baldwin, MI 49304

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. This pertains to intake 2716089.Based on observation, interview, and record review, the facility failed to protect Resident#1 (R1) for the right to be free from verbal and physical abuse by Ancillary Service Provider the Podiatrist.Findings include:A review of the facility's Identification of Abuse, policy and procedure, reviewed/revised 3/19, revealed, abuse the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. A review of the facility's Identification of Abuse, policy and procedure, reviewed/revised 3/19, revealed, Psychological, Mental or Verbal Abuse: Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.Resident#1 (R1)Review of an admission Record reflected Resident #1 (R1) admitted to the facility with pertinent diagnoses of. ALZHEIMER'S DISEASE, DEMENTIA, OSTEOARTHRITIS, ANXIETY DISORDER, MUSCLE WEAKNESS, UNSTEADINESS ON FEET, AUDITORY AND VISUAL HALLUCINATIONS. A review of R1's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/23/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 01 which revealed R1 was severely cognitively impaired. Review of R1's record revealed she is not her own responsible party; the Resident's daughter is her DPOA and decision maker. Resident is care planned for one assist w/ ADLS, she transfers and ambulates independently. Resident uses a 4-wheeled walker. On 1/27/26 at 11:40 AM, R1 was observed to be fully dressed and had her shoes. She was sitting on the side of the bed with her walker in front of her. Resident was carrying on a conversation with herself and did not acknowledge or engage with this surveyor after several attempts to converse were made. Resident appeared calm, content, and was visibly free from bruises. During an interview on 1/27/26 at 1:05 PM, Certified Nurse's Aide (CNA) A stated, I was working in the resident room next door with PT assisting in doing a transfer. We heard, some thumping, yelling, loud male voice and another thump against the wall. Once resident was secured, I went into the hallway to go get a gait belt when I witnessed, (Name of R1) was 3 feet from the bed coming towards this guy. I am directly behind this guy, and I see him push (Name of R1) and she fell onto her bed. I couldn't intervene in time. I saw one arm make contact with (Name of R1). I'm not sure if both his arms made contact. This guy then reaches down, grabs his stuff and tries to get past me. (Name of R1) was yelling at him to get out. I had heard him tell her, Don't f*ck*ng hit me. CNA A further stated, I yelled down the hall to get administration because I had witnessed him abusing (Name of R1). CNA A stated, This guy was trying to get past me so he could get down the hallway and leave. I told him to stay, and I instructed him he was not going by other residents until he was escorted by administration. It was about that time Director of Rebab (DOR) C came in and went to check on and comfort (Name of R1) who was yelling and crying. CNA A revealed this all happened in less than a minute's time and that R1 was (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pretty agitated the rest of my shift. R1 was assessed by the nurse. During an interview on 1/27/26 at 2:28 PM, DOR C stated she was doing a therapy evaluation with Physical Therapy Assistant (PTA) D and CNA A in the room next door to R1. She stated she heard someone yelling and heard a muffled man's voice yelling and swearing when the CNA went to grab a gait belt. DOR C stated, I heard a man swearing and clearly heard him say, Do not F*ck*ng lay hands on me again. She then stated she heard male voices yelling and CNA A stating R1 needs help and that he witnessed abuse. She stated I walked in the hallway and saw CNA A blocking the Podiatrist and trying to prevent him from leaving and going down the hall. I squeezed past them and found R1 on her bed. Her glasses were strewn across her face, her arms were flailing/swinging in the air, and she was yelling, crying, physically upset. I calmed her down then went and found the (Clinical Care Coordinators CCC's) and DON. I ended up helping DON do a skin assessment on her. During the assessment she was clearly upset, she said someone was beating on her with a hammer. By the end of the day, she was back to baseline. During an interview on 1/27/26 at approximately 3:15 PM, PTA D stated she, DOR C and CNA A were assisting another resident when they heard scuffling, loud noises, and yelling when CNA A went to grab a gait belt. CNA A immediately came back and reported to DOR C as a manager that a man is abusing R1. DOR C told everyone to stay put and then CNA A was heard very firmly telling the man to stay here. PTA D then stated I know now it was a doctor that CNA A was talking to in the hallway. I heard the aggression in this doctor's voice, and I heard him yelling and swearing. PTA D further stated she heard R1 yelling and R1 was upset. Review of an interview conducted by the DON on 12/31/25 at 11:23AM, Entered (Name of R1's) room and observed her sitting on the edge of the bed hugging her stuffed dog. (Name of R1) was tearful and resistant to touch. (Name of DOR C) sat next to (Name of R1) and hugged her providing support. With (Name of DOR C's) support (Name of R1) did allow for observations of her forearms, sides, abdomen and lower left extremity. Redness was observed on her left forearm in a broad irregular shape. No observation of what appeared to be fingerprints. While assessing (Name of R1) she did not answer questions asked but continued to hug her dog and when attempting to assess other areas she would shoo me away. Towards end of the assessment (Name of R1) was asked by (Name of DOR C) if she was feeling better. (name of R1) reported to (Name of DOR C) at this time They were in here beating me with hammers (Name of R1) appeared more relaxed and less tearful at the end of the attempted interview and assessment. Review of a Short Term Care Plan dated 12/31/25, reflected a Potential for a latent injury. Assess L (left) forearm and Rt. Wrist. Record review of a progress note dated 1/2/26 at 15:26, On 12/31/25 Staff reported hearing raised voices coming from (Name of R1's) room. Upon staff approach, the podiatrist was observed yelling at (Name of R1). (Name of R1) was attempting to ambulate past the podiatrist in her room when staff reported her being pushed back onto her bed. Staff immediately intervened. The podiatrist was removed from the room and escorted to the Director of Nursing office. A post-incident assessment was completed as tolerated. (Name of R1) allowed assessment of bilateral forearms, sides, and left lower extremity. No redness, swelling, or skin alterations were observed to the face. (Name of R1) reported right wrist pain; however, she was observed to flex, extend, and rotate the wrist without signs of pain, including facial grimacing or negative verbalization. (Name of R1) accepted support and reassurance from staff. She verbalized, They were beating me with hammers. Staff provided continued emotional support and remained with (Name of R1) until agitation and anxiety resolved. Hospice was requested for a visit. Notifications were made to the Administrator, Director of Nursing, Hospice, Physician, (Name of Ancillary Service Provider Company), (Name of) DPOA, and (Name of) County Sheriff.During an interview on 1/28/26 at 11:02 AM, R1's DPOA revealed, I was aware of a verbal thing that happened between the podiatrist and my mom. They (staff) reported she (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not hurt but had a scrape on her arm. I guess my mom hit him and he pushed my mom onto the bed. I ended up talking to the sheriff and decided not to press charges. The sheriff told me that they were making a report and that the podiatrist would be banned from coming back onto the property. I think the podiatrist handled my mom's negativity wrong, I think he needs more training to deal with Alzheimer's patients or he needs another job. During an interview on 1/28/26 at 11:35 AM, the DON stated, I was pulled out of a meeting by (DOR C) and told that an incident occurred. Before I could get down the hallway, my Unit Managers (CCC's) were bringing him (doctor/podiatrist) down to my office. The doctor claimed (Name of R1) assaulted him. He said she hit and kicked him while she was still sitting on the bed, and then he tipped her leg back while she was on the bed. (CNA A) said he saw him shove her onto the bed. The doctor said she assaulted him, and I did observe some pink on the side of his head, but it went away while we were waiting for the sheriff to show up. The DON revealed that while waiting for the sheriff to show-up, the Doctor wanted to leave and wanted to know when the sheriff department would get there. He also wanted to continue to see the rest of the residents on his list or leave. The DON said she told him he had to stay there and he continued to explain why he felt what he did was appropriate. She stated that he didn't seem to think or act like it was a big deal. The DON further revealed she did not do a full skin assessment because (R1) would not allow them to and as they were attempting to assess what they could she started getting more upset and agitated. She then stated that R1 did not have any concerning behaviors receiving care by the doctor prior to this and this was the first time she was aware of a problem. The DON stated that he (doctor/podiatrist) would go into resident rooms by himself because a lot of the residents he saw were bedbound and more comfortable being seen in their rooms. The DON stated as result of this incident, all ancillary services will now have a staff member with them. During an interview on 1/28/25 at approximately 3:45 PM, the Nursing Home Administrator (NHA) revealed they only had one other resident complaint about the doctor/podiatrist the day of this incident. The other resident complained the doctor had an attitude and was rude. The rest of the residents (approximately 20) seen that day had no concerns. The NHA further revealed that she had heard from the company the podiatrist works for earlier today and they wanted to know when he could come back into the facility. The DON stated, I informed them that he would not be welcomed back to our building.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2677566. Based on observation, interview, and record review, the facility failed to ensure the appropriate assessing, monitoring, documenting, and care planning reflected the needs, cares, and services required for one (R2) of 4 residents reviewed for quality of care. Findings include:Resident #2 (R2)Review of a Face Sheet revealed R2 originally admitted to the facility on [DATE] with pertinent diagnoses of diabetes, congestive heart failure (CHF), hernia, chronic kidney disease, benign prostatic hyperplasia (enlarged prostate), major depressive disorder, weakness, and needs for assistance with personal care. Review of the Minimum Data Set (MDS) dated [DATE] for R2 revealed he was cognitively intact. During an observation and an interview on 1/27/26 at 2:30 PM, R2 was observed sitting in a wheelchair with his hair disheveled and notable scabbing on his head. R2 reported he scratches his head because it itches. R2 reported he had been in the hospital for a hernia repair but was tired at this time to elaborate anymore. Hernia/Pain/HospitalizationReview of a Hospital emergency room notes for R2 dated 11/28/25 revealed: . presents for right inguinal hernia. I was able to easily reduce the hernia with gentle pressure. I advised continued outpatient discussion with primary care, . Strict return precautions given, discharged stable condition. No documentation or clarification in the EMR (electronic medical record) of what the strict precautions were. Review of a Nursing Progress note dated 11/29/25 for R2 revealed: After visit summary from hospital visit-[Physician] - I recommend ordering a hernia [NAME] which can be found over the counter at the pharmacy and may help keep the hernia in place. If the hernia returns reduce as soon as possible. Continue to follow-up with his outpatient providers for further monitoring and management. No documentation shows there was any follow up to R2 receiving a hernia [NAME] and no further assessments/monitoring of R2s hernia. Review of a Nursing Progress note dated 12/2/25 at 3:36 PM for R2 revealed: Resident stated his hernia is out. Physician ordered one time dose of 2 Norco 5/325 (narcotic). Resident laid down in his bed and HOB (head of bed) lowered feet raised. At this time we believe that his hernia is back in. Scrotum has returned to baseline size and area soft with palpation. Review of a Nursing Progress note dated 12/2/25 at 4:01 PM for R2 revealed: Resident stated his hernia was out again. PRN (as needed) Norco administered. Resident placed in bed with head down and feet up. Resident continues to put his feet down and head up and is requesting more Norco at this time. There was no documentation of ongoing assessments and monitoring of hernia. Review of a Nursing Progress note dated 12/29/25 for R2 revealed: Nursing noted residents abdomen distended with brown emesis. order to send resident to ED (emergency department) for eval and treatment. Review of an emergency room Hospital medical records for R2 dated 12/29/25 revealed: Diagnosis at time of disposition: 1. Small bowel obstruction 2. Right inguinal hernia 3. Pneumatosis intestinalis (gas filled cysts inside the intestinal tract) 4. AKI (acute kidney injury) . chief complaint of inguinal pain at the site of his known hernia, also with vomiting and diarrhea.He is complaining of abdominal pain, nausea. He states that his hernia has been out for a couple of days, that usually he is able to self reduce, but has been unable to get it to go back in currently. R2 was transferred to another Hospital Emergency Department. Review of an emergency room Hospital Discharge Summary with an admission date of 12/29/25 to discharge of 1/2/26 for R2 revealed: Presenting Problem: Small bowel obstruction and Right inguinal hernia. Hospital Course: . CKD 3 (stage III chronic kidney disease), prior stroke with right-sided residual deficits, type 2 diabetes, hypertension, coronary artery disease, known right inguinal hernia who presented to the emergency department on 12/29/2025 as a transfer from [Emergency Room] for small bowel obstruction and incarcerated inguinal hernia. Patient was high risk for procedure and conservative management was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pursued. Patient was prescribed scrotal support belt which helped with the abdominal discomfort. Also of note, Nephrology was consulted for AKI on CKD, this is likely prerenal in the setting of small-bowel obstruction, this did improve and he was started on Lasix as well as Farxiga for GDMT for heart failure with reduced ejection fraction. Review of a Practitioner Progress note dated 1/6/26 for R2 revealed: SBO (small bowel obstruction) 2/2 Recurrent incarcerated (right) inguinal hernia (a hernia that won't move back) . [NAME] (lower extremities) 1-2+ edema bil [NAME] (bilateral lower extremities) below knees . The Practitioner documented the A/P (assessment and plan) for R2 was 1. SBO and incarcerated right inguinal hernia, 2. CHF. Review of a Nursing Progress Note dated 1/7/26 for R2 revealed R2 went to the hospital with complaints of pain due to his hernia and had a solid hard scrotum that was larger than usual and painful. No documentation in the EMR indicates ongoing assessments of R2 hernia prior to hospitalization on 12/29/25. In an interview on 1/29/26 at 10:42 AM, the Director of Rehab (DR) C reported R2 has severe arthritis with limited range of motion in his shoulders, knees, and wrists. It was hard for him to do therapy because of it and his complications with his hernia popping out with activity. R2 has had several hospitalizations that interfered with making progress. In December R2 was fitted for a reclining wheelchair to ease the pressure from his hernia that would also cause pain and discomfort. Review of the Care Plan for R2 revealed a Focus for: .has some areas of concern including a (history) Hernia with repair, .Diabetes, Congestive Heart Failure and (R2) is healing from a wound. The medications associated with the above Diagnosis can contribute to weight, Fluid and Intake Fluctuations for the resident. Congestive Heart Failure can raise fluids levels for (R2) and cause weight shifts. Constipation and the bowel obstruction can effect (sic) (R2's) intake levels due to him feeling full or not wanting to eat. Last revised 6/23/25. This Care Plan is not focused or clear on the specific concern/condition.Interventions: No interventions for R2's hernia, and no update since return from hospital on 1/11/26 post hernia repair. LabsReview of laboratory results dated [DATE] for R2 revealed a high level of potassium at 6.0 (normal 3.4-5.0) and an eGFR (glomerular filtration rate) of 39 (normal is >=60), indicating stage III kidney disease. On 9/19/25 labs were redrawn and R2's potassium was 5.0 and eGFR was 5.0. Review of a Practitioner Progress note dated 9/23/25 for R2 revealed: . a/p (assessment and plan): Hyperkalemia (high potassium): Added Lokelma (a potassium lowering drug) 5 mg . CKD3b. This is the last potassium monitoring in the medical records. Review of a Nursing Progress note dated 12/28/25 for R2 revealed: Stated he is feeling a little better but still didn't want to take Lokelma. Review of an Order Summary for R2 revealed several orders for Lokelma from July 2025 to January 2026. No potassium labs in the EMR to reflect ongoing monitoring and stability of this medication. Review of the January Medication Administration Record (MAR) Orders for R2 revealed the following active orders unless otherwise indicated:Sodium Chloride- Give 1 gram by mouth one time a day for hyponatremia.Lokelma- 5 GM (grams), Give 1 packet by mouth one time a day for elevated potassium. No documentation indicating ongoing assessment/monitoring of sodium and potassium levels with altering medications and no indication R2 is stable on these medications. In an interview on 1/29/26 at 12:43 PM, the Director of Nursing (DON) was asked about R2s high potassium last checked in September the DON reported R2 had been in and out of the hospital frequently and the physician has access to the labs done in the hospital. The Physician will direct when a recheck is to be done. Skin/WoundsReview of a Skin Assessment dated 1/21/26 for R2 revealed BLE (bilateral lower extremities) are red and dry with scratch marks on them. Bilateral heels are boggy and blanching and are floating with blue boots on. Surgical area on abdomen is healing well with no concerns to note. Posterior thighs are red and excoriated. Review of the January Medication Administration Record (MAR) Orders for R2 revealed the following active orders unless otherwise (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA (Certified Nursing Assistant) and does cares for R2. MT I reported R2 has a suprapubic catheter and was not sure why the MAR shows R2 has a foley catheter. MT I reported R2 did not have any excoriation at his catheter exit site. In an interview on 1/28/26 at 10:30 AM, an Agency Licensed Practical Nurse (LPN) H was questioned to clarify R2's catheter. LPN H reported R2 did have very dry skin and reported R2 has a Foley catheter and not a suprapubic catheter. LPN H verified the electronic medical records (EMR) reflected R2 had a Foley catheter. R2 was out of the facility at this time, but LPN H later clarified that R2 did have a suprapubic catheter. Review of the January Medication Administration Record (MAR) Orders for R2 revealed the following active orders unless otherwise indicated:Foley Catheter (urinary catheter) care every day shift, change the Foley Cath securement device weekly and as needed, ordered 1/12/26.Foley Cath Care every shift, empty drainage bag every shift and record output.Foley Cath Care as needed ___ (no size documented) French Foley Catheter with 30 cc (cubic centimeters) saline balloon, change as needed.Suprapubic Cath Care. Securement device on left anterior thigh. Drainage tubing to be run down pant leg when up in chair. Every shift empty catheter drainage bag and record output.Cleanse suprapubic site with soap and water, pat dry and apply T-sponge every day shift for skin integrity, discontinued 1/11/26. In an interview on 1/28/26 at approximately 10:35 AM, R2 lifted his shirt where a suprapubic catheter was observed with no T-sponge in place and the surrounding skin was red and excoriated. R2 reported he just has very dry skin. R2 went on to talk about his past hospitalizations due to his hernia that would not go back in. The last hospitalization R2 said he had a high-risk surgery done to hopefully fix the problem. R2 verified a long time ago he did have sepsis from an infected catheter and not too long ago he had swelling in his groin area that was very painful. Review of the Care Plan for R2 revealed a Focus for:ADL's (Activity of Daily Living) last revised 1/12/26 revealed: TOILETING/ELIMINATION: Foley catheter to drainage. Maintain drainage bag placement below bladder. Catheter care with soap and water with AM/PM care and PRN. Maintain a closed drainage system; report diminished output to the Charge Nurse and any skin integrity concerns. Avoid dependent loops in the drainage tubing. Initiated 12/1/25. Review of the medical record reveals R2 does not have Foley catheter. Review of the elimination Care Plan for R2 revealed a Focus for: has the potential for altered elimination related to: (R2) has a diagnosis of obstructive reflux uropathy resulting in impaired bladder emptying. A suprapubic catheter is in place to ensure continuous bladder drainage and prevent overdistention, reflux, or renal complications. Despite adherence to infection prevention protocols, aseptic catheter care and routine monitoring, the presence of an indwelling urinary catheter inherently increases the risk for UTI (urinary tract infection), bacteriuria, and urethral irritation. This risk is considered unavoidable due to the residents underlying medical condition that necessitates catheter use for bladder management and comfort. Last revised 10/29/26. No interventions for a suprapubic catheter. In an interview on 1/29/26 at 12:43 PM, the Director of Nursing (DON) was asked about R2's suprapubic catheter. The DON reported R2 should have had a T-sponge in place and if the skin surrounding the area was excoriated, staff should start with soap and water to clean the area first and then move up to other options if that was not working. The DON expects staff to monitor, assess and document findings. If there is anything abnormal, then she would expect a short-term care plan to be in place. The DON was informed about the conflicting orders for a Foley catheter instead of a suprapubic catheter and the Care Plan reflecting a Foley catheter. The DON reported that it should not be that way as we discussed the importance of Agency Staff being able to know how to care for a resident based on appropriate orders, care planning, and documentation. In an interview on 1/29/26 at approximately 1:15 PM, the DON reported she followed up with R2 and verified R2 did not have any wounds on his heels. R2's suprapubic catheter site (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235499	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Oaks Nursing Center	600 Denmark Street Baldwin, MI 49304

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be documented and monitored. Any labs for residents are resident specific and depends on how long they were on a medication and the residents' baseline. Review of R2's Care Plans revealed they are showing incorrect information or missing information pertaining to the resident's current medical status and do not include pertinent interventions per medical orders. Further review of R2's Care Plans reveals no Care Plan for Chronic Kidney Disease (CKD) for R2, hyperkalemia, hyponatremia, and prostatic hyperplasia.