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	05/06/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that weights were obtained in accordance with physician orders for 3 residents (Resident #63, #26, and #35), out of 5 residents reviewed for the provision of nursing services.Findings: Resident #63 (R63) Review of an admission Record revealed R63 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure. Review of R63's Order Summary dated 5/1/26 revealed, Daily weight. See Torsemide (diuretic medication) order for weight gain 4-5lbs in a day. every day shift for CHF (congestive heart failure) and Torsemide Oral Tablet 20 MG Give 1 tablet by mouth as needed for Weight gain 1 tablet prn (as needed) for weight gain of 4-5lbs daily. Review of R63's May Treatment Administration Record revealed: On 5/3/26 R63's weight was 133.2 pounds. On 5/4/26 no weight was obtained for the reason Hold/See Progress Notes. The progress note revealed waiting on weight to be done. On 5/5/26 R63's weight was 138.2 pounds (5 pounds since previous weight). Review of R63's May Medication Administration Record revealed no doses of the as needed torsemide were administered. Review of R63's Electronic Medical Record revealed no documentation that a weight was obtained and documented for R63 on 5/4/26. There was no documentation that the provider was notified of the 5-pound weight gain. Resident #26 (R26) Review of an admission Record revealed R26 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure. Review of R26's Order Summary dated 4/8/26 revealed, Daily Weight r/t (related to) CHF every day shift for Heart failure and Bumex Oral Tablet 2 MG (Bumetanide) Give 2 mg by mouth every 24 hours as needed for weight gain of 3 pounds in a day or 5 pounds in a week. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R26's April Treatment Administration Record revealed: On 4/28/26 R26's weight was 177.5 pounds. On 4/29/26 no weight was obtained with no documentation for the rationale of the missed weight. On 4/30/26 R26's weight was 182.5 pounds (5 pounds since previous weight). Review of R26's April Medication Administration Record revealed no doses of the as needed Bumex were administered. Review of R26's Electronic Medical Record revealed no documentation that a weight was obtained and documented for R26 on 4/2926. There was no documentation that the provider was notified of the 5-pound weight gain. During an interview on 05/06/2026 at 3:16 PM, the Director of Nursing (DON) confirmed that R63 and R26 had missed weights as well as 5-pound weight gain. The DON reported that she would be reviewing the PRN (as needed) diuretic orders with the provider to ensure diuretic medications were administered safely and consistently. The DON reported she would be educating the licensed nurses on following the providers orders as they were written. On 5/6/26 at 12:52 PM a request for a policy for congestive heart failure was requested. No policy was received prior to survey exit. Review of the facility policy, Medication Administration by the Various Routes last revised December 2024 revealed, .e. Take vital signs as indicated if the medication administration is contingent upon the results. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, A weight gain of 0.9 to 1.4 kg (2–3 lb) in 1 day indicates fluid-retention problems. daily weight is measured at the same time of day and on the same scale (Ball et al., 2019). This allows an objective comparison of subsequent weights. Accuracy of weight measurement is important because health care providers base medical and nursing decisions (e.g., drug dosage, medications) or changes. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 558). Elsevier Health Sciences. Kindle Edition. R35 A review of R35's admission Record, dated 5/6/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R35's admission Record revealed they had multiple diagnoses that included congestive heart failure, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. A review of R35's Weights and Vitals Summary, dated 4/20/26 to 5/4/26, revealed R35 had a 102.4-pound significant weight gain from 4/24/26 (223.6 pounds) to 4/29/26 (326 pounds). This weight gain resulted in a 45.8% change in weight within five days. A review of the facility's Weight Management Policy & Procedure, dated April 2015, revealed that in the event of a patterned or significant weight loss or weight gain the IDT (Interdisciplinary Team) (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	team is responsible for assessing and implementing individualized interventions. A review of R35's electronic medical record (EMR), dated 4/20/26 to 5/4/26, failed to reveal any documentation that R35's weight gain was addressed and/or that R35 was assessed for a significant change in their weight and the effects it could have on their health (e.g., swelling, difficulty breathing, shortness of breath on exertion). During an interview on 5/6/26 at 10:58 AM, the DON stated someone should have done a re-weight when they noticed that R35 appeared to have a 102.4-pound weight gain in five days. She stated R35 was re-weighed last night, and they weighed 227 pounds which was more consistent with what they had been weighing prior to 4/29/26. The DON further stated R35 should have been re-weighed soon after the weight gain was recorded instead of six days later. She stated based on what R35's weights were and what their weight was yesterday, she thought that the nurse must have fat fingered the weight when she entered it on 4/29/26. The DON stated she thought R35's 326-pound recorded weight was inaccurate and R35 probably weighed 226 pounds on 4/29/26 instead of the recorded 326 pounds since R35 had not shown any physical signs of a sudden significant weight gain (e.g., difficulty breathing; increased shortness of breath with exertion; increased sudden swelling in the arms, legs, face). During a second review of R35's Weights and Vitals Summary, dated 5/6/26, verified that R35 weighed 227-pounds on 5/5/26 at 5:11 PM. In addition, it was noted after they were weighed on 5/5/26 that R35's weight for 4/29/26 had been struck out with the reason being Incorrect Documentation. Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/27/25).

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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. Based on observation, interview and record review, the facility failed to implement interventions and complete treatments for 1 resident (R16) with an unstageable pressure ulcer out of 2 residents reviewed for pressure ulcers. Findings Include:Resident #16 (R16)Review of an admission Record reflected R16 admitted to the facility with abnormal posture, weakness, muscle wasting and atrophy and dementia. Review of a Care Plan initiated 12/01/2025 reflected R16 had Altered functional mobility and ADLs (Activity of Daily Living) with interventions that included SKIN CARE INTERVENTIONS: . Heel boots at all times Date Initiated: 12/01/2025, revised on 5/4/2026. During an observation on 05/04/2026 at 10:00 AM, R16 was observed in her wheelchair in the common area and appeared to be sleeping. Heel boots were not in place. During an observation on 05/04/2026 at 11:40 AM, R16 was still sleeping in the wheelchair in the common area, heel boots were not in place. During an observation on 05/04/2026 at 1:19 PM, R16 was observed seated in the common area on the unit, and heel boots were not in place. During an observation on 05/06/2026 at 9:17 AM, R16 was observed in the common area seated in her wheelchair, heel boots were not in place. Review of Interdisciplinary Documentation dated 4/28/2026 reflected Resident appears to have PI (pressure injury) to right heal (sic); 6cm x 3.5cm. It appears to have had a large blister open. Center has dark discoloration with blanchable redness surrounding. Area is tender to touch. 4x4 foam border dressing applied. Message left for CCC (Clinical Care Coordinator).Review of Interdisciplinary Documentation dated 5/4/2026 reflected R16's responsible party was notified of the newly identified pressure ulcer, six days after the discovery of the pressure ulcer. Review of the April 2026 Medication Administration Record/Treatment Administration Record (MAR/TAR) reflected Cleanse right heel, pat dry. Apply betadine and heel cup. Secure with kerlex every day shift for PI (Pressure Injury) starting 4/30/26, two days after the pressure injury was identified. The treatment was NOT documented as done. Review of the May 2026 MAR/TAR reflected Cleanse right heel, pat dry. Apply betadine and heel cup. Secure with Kerlex every day shift for PI (Pressure Injury) starting 4/30/26. The treatment was NOT documented as done until 5/5/2026. During an observation on 05/06/2026 at 9:21 AM, the Director of Nursing (DON) removed the dressing from R16's right heel and assessed the wound. Certified Nurse Aide (CNA) E assisted the DON by elevating R16's right foot during the procedure. The DON used wound cleanser to clean the area and reported the wound had progressed from a stage 2 pressure injury to an unstageable wound due to the presence of eschar (a thick, dry, black or brown layer of dead tissue that covers a severe wound such as a third degree burn or pressure ulcer) covering the majority of the wound bed. The wound measured 3 centimeters (cm) x 3 cm x 0.2 cm. The DON applied Betadine and a new heel cup, secured with kerlix. Upon completion of the procedure, R16's heel boots were not applied. During a follow-up interview on 5/6/2026 at 9:40 AM, the DON reviewed the clinical record and confirmed that R16's April and May 2026 MAR/TARs did not reflect the dressing changes had been done as ordered until 5/5/2026. The DON speculated that the order had been entered incorrectly and did not show up on the TAR. The DON reported that her expectation is that residents and/or resident's responsible party are notified by the end of the nurse's shift if the clinical change was not an emergency.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure controlled drugs were administered in accordance with physician orders and nursing professional standards of practice for 4 residents (Resident #52, #17, #26, and #68) out of 15 residents reviewed for medication administration.Findings:Resident #52 (R52)Review of an admission Record revealed R52 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: restlessness and agitation.Review of R52's Order Summary dated 4/22/26 revealed, Ativan Gel Apply to wrists topically every 4 hours as needed for anxiety.Review of R52's Controlled Drug Receipt/Record/Disposition Form revealed that a dose of the Ativan gel was dispensed on 4/28/26 at 6:19 PM. There was no documentation that the Ativan gel had been wasted (would include a note of wasted with a secondary nurses signature).Review of R52's Electronic Medication Administration Record (EMAR) revealed that the dose of Ativan gel dispensed on 4/28/26 at 6:19 PM was not documented as administered.Review of R52's Electronic Medical Record revealed no documentation indicating an additional nurse had witnessed the disposal of R26's Ativan gel. Resident #17 (R17)Review of an admission Record revealed R17 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: weakness and difficulty in walking.Review of R17's Order Summary dated 2/17/26 revealed, traMADol HCl Oral Tablet 50 MG Give 1 tablet by mouth every morning and at bedtime for pain.Review of R17's Controlled Drug Receipt/Record/Disposition Form revealed:On 4/22/26 a dose of Tramadol was dispensed at 7:05 AM. There was no additional dose of Tramadol dispensed on 4/22/26.On 4/30/26 a dose of Tramadol was dispensed at 8:03 AM. There was no additional dose of Tramadol dispensed on 4/30/26.On 5/2/26 a dose of Tramadol was dispensed at 8:09 AM. There was no additional dose of Tramadol dispensed on 5/2/26.Review of R17's April EMAR revealed that on 4/22/26 and 4/30/26, 2 doses (morning and bedtime) were documented as administered.Review of R17's May EMAR revealed that on 5/2/26 2 doses (morning and bedtime) were documented as administered. Resident #26 (R26)Review of an admission Record revealed R26 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain. Review of R26's Order Summary dated 4/3/26 revealed, LORazepam Oral Tablet 0.5 MG (Ativan) Give 0.25 mg by mouth one time a day for anxiety. To be administered at 4:00 PM.Review of R26's Controlled Drug Receipt/Record/Disposition Form revealed:On 4/17/26 at 3:47 PM a dose of Ativan was dispensed. There was no documentation that the Ativan had been wasted.On 4/28/26 at 3:36 PM a dose of Ativan was dispensed. There was no documentation that the Ativan gel had been wasted.Review of R26's April EMAR revealed that on 4/17/26 and 4/28/26 the doses of Ativan had been refused by R26.Review of R26's Electronic Medical Record revealed no documentation indicating an additional nurse had witnessed the disposal of R26's Ativan. Resident #68 (R68)Review of an admission Record revealed R68 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: right femur fracture.Review of R68's Order Summary dated 4/23/26 revealed, oxyCODONE HCl Oral Tablet 5 MG Give 1 tablet by mouth every 4 hours as needed for pain take one tablet by mouth every 4 hours as needed for pain.Review of R68's Controlled Drug Receipt/Record/Disposition Form revealed:On 4/27/26 (no documented time) a dose of Oxycodone was dispensed. There was no documentation that the Oxycodone had been wasted.On 4/29/26 at 8:35 AM a dose of Oxycodone was dispensed. There was no documentation that the Oxycodone had been wasted.On 4/29/26 at 5:53 PM a dose of Oxycodone was dispensed. There was no documentation that the Oxycodone had been wasted.Review of R68's April EMAR revealed that the doses of Oxycodone dispensed on 4/2726 (no documented time), 4/29/26 at 8:35 AM, and 4/29/26 at 5:53 PM were documented as administered.During an interview on 05/06/2026 at 3:16 PM, the Director of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (DON) confirmed the medication errors/discrepancies for R52, R17, R26, and R68. The DON reported that the expectation was for the licensed nurses to follow professional standards of nursing practice for medication administration and reported she had recently completed an in-service/education regarding medication administration with them. The DON reported she would be reeducating the licensed nurses regarding following the providers' orders as they are written as well as administering medications following the facility protocol and professional standards of nursing practice.Review of the facility policy, Medication Administration by the Various Routes last revised December 2024 revealed, .3. Documentation of as needed or p.r.n. medication will occur in the e-MAR directly after administration and include indicated clinical assessment, pain scale if indicated, and therapeutic effectiveness.l. Document after administering the medication and before proceeding to the next resident.n. If a dose of medication is withheld or refused, the nurse will note that on the eMAR (electronic medication administration record.Review of the facility policy, Controlled Medication Storage, Security & Disposition last revised March 2024 revealed, .2. When a dose of controlled medication is removed from the container for administration but is refused by the resident or not given for any reason, it is not placed back into the container. It is destroyed in the presence of two licensed nurses. The disposal is documented on the narcotic count verification sheet.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The seven rights of medication administration include the right medication, right dose, right patient, right route, right time, right documentation, and right indication. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 705). Elsevier Health Sciences. Kindle Edition.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure Binding Arbitration was explained in a manner understood by residents and/or resident representatives and obtain adequate informed consent prior to entering into a binding arbitration agreement for 1 resident (R62) out of 3 residents reviewed for arbitration. Findings Include:Review of an admission Record reflected R62 admitted to the facility from a hospital on 4/26/2026 for orthopedic aftercare. R62 was listed as their own responsible party. During an interview on 05/06/2026 at 1:20 PM, R62 reported that he had no idea what a binding arbitration agreement was. R62 did not recall signing the agreement and said his son handles all these matters and these things are over his head.Review of a Voluntary Binding Arbitration Agreement reflected that R62 signed the agreement on 4/27/2026 and reflected R62 initialed agreement with 20. Understand the Binding Agreement to Arbitrate. The Resident or his/her Representative acknowledges that they fully understand this Binding Arbitration Agreement. During an interview on 05/06/2026 at 1:42 PM, the Nursing Home Administrator (NHA) reviewed arbitration agreements with the surveyor, and it was identified that R62 signed both the acceptance and the declination of the binding arbitration agreement. During the interview with the NHA on 5/6/2026 at 1:42 PM, Administrative Assistant (AA) G reported that she was responsible for explaining binding arbitration to Residents and/or Resident Representatives upon admission. AA G said she did not know she needed to tell Residents/Resident Representatives they had 30 days to change their mind about agreeing to binding arbitration in writing. Both the NHA and AA G reported that they believed the binding arbitration could be reversed at any time and reported they didn't know a whole lot about it (Binding Arbitration). AA G said a binder with admission contract details included a copy of the Binding Arbitration agreement, however, upon review of an admission Binder, a description of binding arbitration was not found. The NHA reported the facility needed to do a much better job at educating staff and residents when offering binding arbitration agreements. Review of an unsigned copy of the facility Voluntary Binding Arbitration Agreement reflected, You are strongly encouraged to consult with an attorney or a trusted advisor before signing this agreement. You have the opportunity to ask questions before signing this document. Please do not hesitate to ask any questions that you may have. The Resident/Resident's Legally Authorized Representative, by signing this agreement, also acknowledges that he/she has been informed and understands the entire agreement including that: a. Care, diagnosis, or treatment will be provided whether or not the Resident signs the agreement to arbitrate; b. The agreement may not be submitted to a Resident for approval when the Resident has been deemed incompetent by two physicians; c. The decision whether or not to sign the agreement is solely a matter for the Resident's (or the Resident's legally authorized representative) determination without any influence; d. The agreement waives the Resident's right to a trial in court for any future malpractice claim the Resident may have against the healthcare provider, absent revocation of the agreement consistent with state law.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement Enhanced Barrier Precautions for 1 resident (R16) out of 15 residents reviewed for infection control. Resident #16 (R16)Review of an admission Record reflected R16 admitted to the facility with diagnoses that included a stage 2 pressure ulcer. Review of R16's entire Care Plan initiated on 12/01/2025 did not reflect R16 was in Enhanced Barrier Precautions (EBP).Review of Interdisciplinary Documentation dated 4/28/2026 reflected Resident appears to have PI (pressure injury) to right heal (sic); 6cm x 3.5cm. It appears to have had a large blister open. Center has dark discoloration with blanchable redness surrounding. Area is tender to touch. 4x4 foam border dressing applied. Message left for CCC (Clinical Care Coordinator). Further review of the Progress Notes did not reflect R16 had been placed in EBP due to having an open wound. Review of R16's Orders in the Electronic Medical Record (EMR) did not reflect R16 required EBP. During an observation on 05/06/2026 at 9:21 AM, the Director of Nursing (DON) removed the dressing from R16's right heel and assessed the wound. Certified Nurse Aide (CNA) E assisted the DON by elevating R16's right foot during the procedure. The DON used wound cleanser to clean the area and reported the wound had progressed from a stage 2 pressure injury to an unstageable wound due to the presence of eschar (a thick, dry, black or brown layer of dead tissue that covers a severe wound such as a third degree burn or pressure ulcer) covering the majority of the wound bed. The wound measured 3 centimeters (cm) x 3 cm x 0.2 cm. The DON applied Betadine and a new heel cup, secured with kerlix. The DON and CNA E did not don the required personal protective equipment (PPE) required for EBP during the high contact resident activity. During a follow-up interview on 5/6/2026 at 11:00 AM, the DON acknowledged R16 would require EBP due to the presence of a wound. Review of the facility policy and procedure for Enhanced Barrier Precautions revised March 2025 reflected, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).