

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER Woodward Hills Health and Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 39312 Woodward Bloomfield Hills, MI 48304	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>34208</p> <p>This citation pertains to intake #MI00149390.</p> <p>Based on interview and record review, the facility failed to ensure treatment in a dignified manner for one resident, (R801) of three residents reviewed for dignity, resulting in feelings of frustration and being ignored. Findings include:</p> <p>A complaint received by the State Agency alleged R801 was moved from one unit to another and staff did not retrieve and deliver their personal hygiene wipes as requested.</p> <p>A review of R801's progress notes revealed a note entered into the record by Nurse 'B' on 1/12/25 at 11:18 PM that read, .Patient needs wipes from priar <sic> room on brae burn <sic> (unit) please relay message to day shift supervisor or maintenance .</p> <p>On 3/11/25 at 2:35 PM, an interview with the facility's Director of Nursing (DON) was conducted regarding the resident's request for their wipes and the nurses progress note in response. The DON indicated the nurse should have went to R801's previous room, retrieved the wipes and delivered them to their new room.</p> <p>A review of a facility provided policy titled, Resident Rights issued 11/2024 was reviewed and read, .Right to a Dignified Existence to: Be treated with respect and dignity .</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34208</p> <p>This citation pertains to intake #MI00149390.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the State Agency for one resident (R801) of two residents reviewed for abuse. Findings include:</p> <p>A review of a complaint received by the State Agency alleged R801 was assaulted by a staff member.</p> <p>On 3/11/25 at approximately 10:30 AM, a review of a progress note entered into the record by Nurse 'D' on 12/28/24 was conducted and read, Nurse checked in with resident to see how he is doing and said he's doing better, and felt better knowing that the CNA (Certified Nurse Aide) that was working with him earlier was sent home .</p> <p>On 3/11/25 at 10:45 AM, in absence of the facility's Administrator (out of the facility) the Director of Nursing (DON) was requested to provide grievances, investigations, and facility reported incidents for R801.</p> <p>On 3/11/25 at 11:50 AM, a telephone interview was conducted with Nurse 'D' regarding their progress note on 12/28/24. They were asked about the note and why it documented a CNA had been sent home. They said R801 had a complaint about CNA 'C' and said, He (R801) didn't feel safe. Nurse 'D' said CNA 'C' had a stressful day and R801 did not want CNA 'C' caring for them anymore. They were asked what was meant about CNA 'C' having a stressful day and said R801 reported they overheard CNA 'C' say I could strangle somebody today. Nurse 'D' said they reported it to the Director of Nursing and a decision was made to send CNA 'C' home. They were asked if the police came to the building at the time of the incident and said they were, pretty sure they came out.</p> <p>On 3/11/25 at 12:17 PM, a review of numerous facility provided documents revealed an e-mail sent from R801 to a law firm. The representative at the law firm forwarded R801's e-mail to the facility's owner on 1/14/25 and it was then forwarded to the facility's former Administrator 'A' from the owner. The e-mail was lengthy and read, .Disrespectful and Verbal and Physical Abuse by Staff: On December 28, 2024, I had only had <sic> 3 to 4 hours of sleep and had wet the bed .When I woke up I was feeling cold Since I was feeling cold, I had asked the aide named (Certified Nurse Aide 'C') to turn the heat up, and from that moment on, he became super aggressive with me and assaulted me. I had texted one of the staff managers via text, and then eventually the police were called to handle the situation. (Officer 'D') came and also took my report .</p> <p>Continued review of the numerous documents did not reveal any evidence of any incidents reported to the State Agency.</p> <p>On 3/11/25 at 1:59 PM, a review of CNA 'C's personnel file was conducted and in the back of the file was a typed document signed by the facility's Director of Nursing on 1/6/25 that read,</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The following statement is in regard to a concern I was made aware of by phone from (Nurse 'D') on December 28, 2024 around 11 am that occurred between a (CNA 'C') and a current resident (R801) On the initial phone call with (Nurse 'D'), (Nurse 'D') made me aware that the resident was scared due to the verbal statements made by (CNA 'C') in response to the resident requesting help. (Nurse 'D') interviewed the resident (R801) and (R801) stated I could hear somebody in the hallway and it sounded like they said, 'I could strangle somebody'. (Nurse 'D') asked (R801) who he thinks may have said it (R801) stated, I think it was (CNA 'C'). Writer Advised <sic> (Nurse 'D') to send (CNA 'C') home and remove him from the schedule until an investigation is completed .</p> <p>Continued review of the DON's typed statement was conducted and read, .On Monday December 30th writer interviewed the resident (R801). Writer asked the resident to talk me through the events that occurred on December 28 .(CNA 'C') agreed to do a bed bath upon (R801) request, brought back supplies, an additional CNA (CNA 'E') and new bedding and began to give the bed bath. (R801) said I think it would be easier and I would feel much better if I could just be put in the shower with running water (CNA 'C') then said I'm going to strangle somebody in here at that point (R801) decided it wasn't safe and let the bed bath finish, bedding be changed, and (CNA 'C') stormed out of the room when finished .(R801) then decided to call the police to report the threats stating, There is a guy here that is threatening to strangle disabled people. Police arrived took the residents statement .In conclusion the allegations against (CNA 'C') were determined to be unsubstantiated .</p> <p>On 3/11/25 at 2:35 PM, an interview was conducted with the facility's Director of Nursing (in absence of the facility's Administrator/Abuse coordinator who was out of the facility with illness). They were asked why R801's allegations against CNA 'C' were not reported to the State Agency and said because they could not substantiate the incident happened it was not reported.</p> <p>A review of a facility provided policy titled, Abuse issued 4/2022 was conducted and read, .Initial Reporting: The facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes are reported immediately to the Administrator and: Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>This citation pertains to intake #MI00149390.</p> <p>Based on interview and record review, the facility failed to prevent an avoidable fall for one resident (R801) of three residents reviewed for falls, resulting in the resident rolling out of bed. Findings include:</p> <p>On 3/11/25 at 8:50 AM, a review of R801's clinical record revealed they admitted to the facility on [DATE] and discharged [DATE]. R801's diagnoses included: paraplegia, spinal cord injuries, bipolar disorder, pain, foot drop, and post traumatic stress disorder. A Minimum Data Set assessment dated [DATE] revealed R801 had intact cognition, was non-ambulatory and dependent on staff for rolling left to right. R801's care plan for activities of daily living included an intervention dated 12/25/24 that read, .BED MOBILITY: 2 person assist .</p> <p>On 3/11/25 at 9:00 AM, a review of R801's progress notes revealed a note entered into the record by Nurse 'F' dated 1/27/25 at 6:13 AM that read, .Cena <sic> (Certified Nurse Aide) reports resident turning self for incontinence care and fell off the bed .Skin tear noted to Right knee</p> <p>On 3/11/25 at 12:00 PM, a review of a facility provided document signed by Assistant Director of Nursing (ADON) 'G' dated 1/29/25 was conducted and read, The writer was notified that the CENA, (CNA 'H') had taken care of the resident, (R801) and the resident fell out of the bed with the CENA was changing him. The writer called and spoke to (CNA 'H') and she confirmed that she was caring for the resident .She state that he rolled out of the bed onto the floor .The writer educated (CNA 'H') about making sure that she observed the Happy Feet sign and if it states x2 for bed mobility, that she uses 2 people. The writer also educated her about making sure that she is safe with transfers and that she should always roll the patient towards her and not away from her .</p> <p>On 3/11/25 at 1:40 PM, a telephone interview was conducted with CNA 'H'. They were asked if any other staff were assisting them at the time of R801's fall and said there was not. They were then asked if they were aware R801 required two staff members for bed mobility and said they were, not aware. Finally, CNA 'H' was asked if they turned R801 toward or away from them and they replied, I am ending this conversation and hung up the phone.</p> <p>On 3/11/25 at 2:35 PM, an interview was conducted with the facility's Director of Nursing regarding R801's fall. They confirmed R801 required two staff members for bed mobility at the time of the fall and CNA 'H' provided the care contributing to the fall without a second staff member.</p> <p>A review of a facility provided document titled, Fall Management Guidelines dated 12/2023 was conducted and read, .Fall management goals: Reduce the risk of falls by intervening in modifiable risk factors .The facility staff .will implement a resident-centered comprehensive care plan that addresses the fall management program, the goal for fall management, individualized interventions to address the resident's modifiable fall risk factors, interventions to try to minimize the consequences of risk factors that are not modifiable, and the plan for reduction of risk and or risk for injury related to falls .</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>This citation pertains to intake #MI00149390 and #MI00151121.</p> <p>Based on interview and record review, the facility failed to ensure pain was treated per resident request and physician's orders for one resident (R801) of two residents reviewed for pain, resulting in complaints with care and untreated pain. Findings include:</p> <p>A complaint received by the State Agency alleged the resident's pain was not treated per their request and physician's orders.</p> <p>On 3/11/25 at 8:50 AM, a review of R801's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: paraplegia, spinal cord injury, wounds, bipolar disorder, adjustment disorder, and post traumatic stress disorder. A review of R801's physician's orders revealed an order dated 12/31/24 for oxycodone (narcotic pain medication) 20 mg (milligrams) every four hours as needed for pain. R801's Medication Administration Record (MAR) for February 2025 was reviewed and revealed they received a dose of the medication on 2/16/25 at 10:47 AM.</p> <p>A progress note entered into the record by Nurse 'I' on 2/16/25 at 7:16 PM was reviewed and read, .Resident requested pain medication, which resident was completely out of. Writer notified on call doctor, no answer . Writer notified (Pharmacy name) whom contacted the on-call doctor for new script. Writer contacted (Pharmacy name) later on that day to see when medication would arrive and they stated 9pm.</p> <p>Continued review of the record revealed R801 was administered their pain medication at 11:01 PM, approximately 12 hours after their previous dose and approximately four hours after Nurse 'I' entered their note into the record. The MAR further revealed R801 reported their pain rating as a 10, where zero is no pain and 10 is the worst pain when they were administered the medication at 11:01 PM. The MAR's for R801 for December 2024, January 2025, and February 2025 were reviewed and revealed R801 very frequently requested and received their pain medication every four hours per the physician's order.</p> <p>On 3/11/25 at 2:35 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R801 running out of their supply of pain medication and the delay in treatment for R801's pain on 2/16/25. The DON said the medication should have been re-ordered prior to running out and if they were out, the nurse could have called for an order for alternate treatment or could have called for an order to pull a dose from the facility's back-up medication supply.</p> <p>On 3/11/25 at approximately 3:45 PM The DON was asked to confirm oxycodone was kept in the facility's back-up medication supply and provided documentation that indicated oxycodone was stocked in five, ten, and fifteen milligram doses.</p> <p>A review of a facility provided policy titled, Medication Administration dated 8/2023 was reviewed and read, . If a pharmacy supplied medication is not available, refer to the pharmacy policy and procedures related to emergency pharmacy delivery and emergency supply kit usage .</p>		