STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235556	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodward Hills Health and Rehabilitation Center	39312 Woodward Ave Bloomfield Hills, MI 48304

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI00151510. Based on interview and record reviews the facility failed to address the concerns reported to the facility for one (R202) of three residents reviewed for grievances. Review of a complaint submitted to the State Agency (SA) documented multiple concerns that the complainant attempted to get resolved with the facility staff unsuccessfully. The complainant noted the facility's failure to follow up and the lack of communication to resolve any of their concerns. A review of R202's medical record revealed the resident was admitted to the facility on [DATE] and transferred out to the hospital on 3/27/25. R202 admitted with the primary diagnosis of hypokalemia and required staff assistance with all Activities of Daily Living (ADLs). A review of the progress notes revealed the following: On 3/26/25 at 9:35 AM, a Social Worker (SW) note documented in part . CM (case manager) had some concerns regarding the resident. SW asked appropriate parties to follow up . This note was documented by SW K. A review of a facility policy titled Grievance Policy And Procedure revised November 2023, documented in part . Grievances made to the Facility may be oral or in writing . The grievant may request assistance from the facility's social worker when completing a written grievance . all grievances will be investigated and reported back to the grievant within fifteen 15 days from the receipt of the grievance . On 5/28/25 at approximately 9:07 AM, the Administrator was asked to provide all grievances and concerns filed on the behalf of R202. Shortly after the Administrator stated they had no grievances for R202. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 10:50 AM, an interview was conducted with SW K. SW K was asked about the concerns reported to them by R202's CM on 3/26/25. SW K stated they could not recall. SW K was asked if they completed a grievance form regarding the concerns reported to them and SW K stated they did not. SW K stated they would look into it and see if they could find what the concerns were and follow back up. At 11:18 AM, SW K returned and stated the believed the concerns were regarding the discharge planning for R202. When asked how they came to that conclusion and what documentation they reviewed to remind them, SW K stated they had notes on their desk. SW K was asked to provide any additional documentation for review. No further explanation or documentation was provided by the end of the survey.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake #MI00151329. Based on observation, interview, and record review, the facility failed to protect the resident's rights to be free from physical abuse during two resident-to-resident incidents for two Residents (R205, R206) of three residents reviewed for abuse. Findings include: R206 Review of R206's Minimum Data Set (MDS) assessment, dated 12/13/25, revealed R206 was admitted to the facility on [DATE], with diagnoses including heart failure, lung disease, and arthritis. R206 required set up with eating, and maximal assistance with toileting and transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R206 was cognitively intact. On 5/27/25 at 12:54 p.m., R206 was observed dressed, seated in a bariatric wheelchair. On 5/27/25 at 12:56 p.m., R206 reported they had a concern with another resident. R206 reported they transferred to R205's room from another facility room a couple months ago, and the room was torn apart (messy) .so bad (unorganized) . R206 reported the facility staff turned their roommate's bed to fit their (R206's) large bariatric bed with extenders in the room, which made their new roommate (R205) angry. R206 explained their new roommate gave them dirty looks. R206 continued, The next thing I knew, (R206) was yelling and screaming .and (R205) got up and pointed at (R206) with their reacher (metal item retrieval device). (R205) had it in their hand, and (R205) got over there (to their bed) and (R205) hit my right leg and knee, and the woman in the next room heard and got everyone (staff) over here and the patient was (R205) . I said, Get the cops (police), do something, and someone (staff) came in and got (R205) . I was in shock .It (the incident) was inappropriate .Why is (R205) so nasty when I didn't say anything to (R206) .It didn't make me feel happy .(R205) reported the strikes hurt their knee at the time, and there were two small bruises, but they could not be certain they were from the incident. Review of the facility investigation report, received from the Nursing Home Administrator (NHA) on 5/27/25, revealed on 3/10/25 at 4:51 a.m., .Allegation: Assault: Substantiated . The report showed on 3/10/25 nursing staff witnessed an argument between R205 and R206, when R205 threatened R206 who turned their room light off (with assistance). The report further revealed on 3/11/25 at 9:10 p.m., R205 ambulated to their roommate's side of the room and began yelling at R206 and struck them in their legs with reaching device. R205 was reportedly loud and out of control, with their room messy, with clothing, food, and personal items thrown around their room. 911 was called and the police arrived and moved R205 out of the room into another resident room. R206 reportedly declined to press charges. The report revealed the police declined to have R205 sent to the hospital. Afterwards, R205 acknowledged the incident, expressed no remorse and felt their roommate was in the wrong. R205 clarified they did not want to have any roommates. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R205's Accident and Incident report, dated 3/11/25 at 8:00 p.m., (R206) was lying in bed when roommate (R205) in Bed A ambulated over and hit (R206) in the leg with a reacher. (R206) began to yell for staff and immediately staff came in the room and intervened . (R206 stated) (R205) hit me in the leg once or twice . The report showed staff intervened, (R205) to another resident room in the facility, and R206 had no injury. Review of Registered Nurse (RN) B's witness statement, dated 3/11/25, revealed, Writer (RN B) was at the nurse's station .Yelling was heard from down the hall in patient's room. When writer arrived, second nurse (unnamed) was in the room .as (R206) was standing at foot of roommates (R206's) bed, striking (R206) and bed with reaching device .Second nurse removed reacher from (R206's) hands. Both nurses escorted (R205) to her side of the room .(R205) was still upset, yelling .The violence was deescalated but (R205) was still yelling and upset about a room change. When writer asked (R206) if (they) were hit (R206) stated 'yes', in the right leg near the knee .911 was called and (police) arrived .(R205) was removed from room and taken to new room by head nurse (unnamed). Review of R206's full skin assessment, dated 3/14/25 (three days after the physical abuse incident), revealed no pain and no new skin concerns. Review of R206's Care Plan, accessed 5/27/25, revealed no interventions to protect R206 from approaching R205 them in their room or in facility common areas. R205 Review of R205's MDS assessment, dated 1/10/25, revealed R205 was admitted to the facility on [DATE], with diagnoses including heart failure, stroke, anxiety, and depression. The assessment revealed R205 required supervision or contact guard assistance (touching assistance with or without cues) for toileting, transfers, and walking room distances. The BIMS assessment revealed a score of 13/15, which showed R205 was cognitively intact. The sensory assessment revealed corrective lenses (glasses) were used by R205 at the time of the assessment. On 5/27/25 at 1:31 p.m., R205 was observed in their room, seated on the edge of their bed, dressed. R205 was not wearing eyeglasses. On 5/27/25 at 1:33 p.m., R205 reported they were having a problem with their roommate in their former room, and staff packed up their (R205's) personal items up and moved them out of the room. When asked why, R205 stated staff cut the lights off and I need the lights on, as they said their eyeglasses got lost and the staff never found them. R205 clarified, I didn't have nothing (any glasses) to see. R205 explained they told their roommate (R206), Don't you see me trying to do something? and R206 started cussing and turned the lights off again. R205 continued, I told the young lady (aide) I'm going to kick (their) butt, and I fell twice trying to get to (R206). I hit (R206) two to three times with the reacher, and it didn't hardly touch (them). They (staff) had me in a hold, and took me out of the room, and the police came and asked me why I was so angry .It made me feel scared . R205 had a metal reacher next to them on their bed, in a private room. R205's nurse, Licensed Practical Nurse (LPN) A, entered their room during the interview, and R205 became verbally escalated (speaking loudly and aggressively) with LPN A about finding their belongings in their room, and declined to speak with Surveyor further. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 at approximately 1:45 p.m., the Unit Manager, LPN A, confirmed there were no other resident-to-resident incidences for R205 and R206. LPN A clarified neither resident had a medical, psychosocial, or functional decline since the incident, and R206 was not injured. Review of R205's social work progress note, dated 3/07/25 at 10:14 a.m. (four days prior to the resident-to-resident incident on 3/11/25), R205 had behavioral episodes including calling 911 r/t (related to) having a roommate (R206). (R205) made it clear (they did) not want a roommate .(R205) has had issues with past roommates and continues to call the family upset (about having a roommate) . Review of R205's behavioral progress note, dated 3/10/25 at 4:51 a.m., revealed R205 was upset R206 wanted to turn the room lights off when they (R206) were attempting to sleep. The writer entered the room when R205 was yelling, and stated, I can't see (vision) . Writer explained to R205 how R206 had a right to sleep with the room lights off so they could fall sleep. In response R205 reportedly became aggressive, and stated, How come it's all about that b@tch? and I don't care what (R206) says; I was in this room first. Writer also heard R205 threaten R206 if they attempted to turn the lights off. The note showed they intervened and notified their supervisor on duty who reported they would contact the Director of Nursing (DON). Review of R205's census form showed R205 was in room [ROOM NUMBER], Bed A, from 1/03/25 to 3/11/25. Review of R206's census form showed R206 was in room [ROOM NUMBER], Bed B, from 3/06/25 to 3/14/25. On 5/27/25 at approximately 3:25 p.m., Social Worker (SW) D reported they were aware there had been verbal allegations by R205 towards R206 prior to the physical abuse incident on 3/11/25. SW D reported they spoke to both residents, who were both their own responsible parties, and neither resident would change (relocate) rooms. SW D said they reported this to the NHA and DON, as they had concerns about both residents remaining in the shared room prior to the resident-to-resident incident on 3/11/25. SW D explained they were concerned as nursing staff had reported R205 threatening words to R206. SW D reported the concerns were R205 wanted their room lights to remain on, and R206 wanted the lights off, and they did not know why. SW D confirmed the resident-to-resident incident occurred on 3/11/25 when R206 reported R205 hit them with their reacher, and confirmed the police were called. SW D reported they and nursing management believed R205 should have been taken to the hospital emergently, however, the police declined, and assisted staff to relocate R205 to another resident room on the other side of the facility. SW D confirmed this was a physical abuse resident-to-resident incident, as when interviewed R205 reported they attempted to hit R206 and expressed no remorse. SW D reported they were not aware R205 had glasses, or had reported they could not see to them or staff and said they would follow-up. Review of the Electronic Medical Record (EMR) including R206's progress notes with SW D revealed no progress note describing the incident itself. SW D reported their expectation would be there would be a progress note describing the resident-to-resident physical abuse incident on 3/11/25 would be in R206's medical record. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident investigation file revealed a verbal reeducation in service with LPN C, dated 3/11/25, signed by the NHA. The document revealed LPN C had not reported the alleged verbal abuse in a timely manner to the NHA or DON, when floor staff reported to their supervisor, LPN C, R205 made a verbal threat to their roommate (R206). The abuse policy was reportedly reviewed with LPN C at that time. On 5/27/25 at 3:44 p.m., the afternoon supervisor, (LPN) C, confirmed the resident-to-resident physical abuse incident between R205 and R206 occurred, as they were working. LPN C reported they were sitting at the desk when they heard the nurse and aide yelling and they observed R205 standing over R206. LPN C described they had not known R205 stood and walked, as they had only seen them using their manual wheelchair. LPN C reported RN B was standing there when R205 struck R206 on their shin with their reacher, and since R206 was physically assaulted, they called the police. LPN C stated the DON wanted R205 sent out to the hospital, and the police declined. LPN C explained R205 admitted to the police they hit R206, and R206 declined to press charges. LPN C confirmed this was physical abuse. LPN C reported they got an Xray of R206's knee and clarified R206 was not injured. On 5/27/25 at 3:50 p.m., the verbal review in service education form dated 3/11/25 was reviewed with LPN C, who denied recalling a phone in service or reeducation by the NHA regarding not reporting verbal abuse prior, and said they only learned of this when the 3/11/25 incident occurred. On 5/28/25 at 10:04 a.m., during a phone interview, Registered Nurse (RN) B stated on 3/11/25 they observed R205 hit R206 on their legs with a reacher, using it as a weapon, and they and another nurse had to intervene. RN B reported R206 was not upset or fearful after the incident. RN B reported the police were called and called this a violent incident. On 5/28/25 at 11:48 a.m., the Medical Director, Physician F, reported they had been made aware resident-to-resident incidents occurred between R205 and R206, and they were reviewing the incidents in their QAPI (Quality Assurance and Performance) program. Physician F conveyed they understood the residents declined to change rooms prior to the incident, and deferred documentation expectations to the NHA. Physician F reported R206 was under their care, and they had not been made aware of any reported vision concerns for R205. On 5/28/25 at 12:21 p.m., room [ROOM NUMBER] (R205 and R206's former room) was observed, where the incident occurred. It was noted when the room light switch was activated, a circle overhead ceiling light lit above both Bed A and Bed B simultaneously. It was further observed each bed had a bright fluorescent light over the head of bed, and the room ceiling lights activated in tandem, making the room well-lit when the room light switch was on. On 5/28/25, the police report, dated 3/11/25, received from the NHA, was reviewed. The police report showed simple, non-aggravated assault and battery occurred by R205 towards R206. The report described how R206 reported R205 was complaining because they wanted their room lights turned off to sleep, while R205 wanted them on. R205 reportedly became angry about the lights being turned off, and whacked R206's legs with an extended grab claw reacher. R206 denied any injuries, and said they only wanted R205 removed from the room, and did not want to press charges. The report further revealed R205 reported they wanted the lights on as they were having difficulty seeing when they were awake and walked over to R206's bed to yell them but denied hitting R206. The report described R205 was relocated to room [ROOM NUMBER] (a different facility room) with no further issues. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/18/25 at approximately 1:10 p.m., the NHA confirmed the resident-to-resident incident on 3/11/25 was a physical abuse assault incident between R205 and R206. The NHA confirmed there was a delay in staff reporting the alleged verbal abuse incident on 3/10/25 to them and the DON, and clarified the incident was reported and investigated upon discovery. The NHA understood the concern there was no progress note for R206 regarding the resident-to resident incident on 3/11/25 in the EMR. The NHA confirmed R206 was not injured right after, and no injuries were found a few days after the incident. The NHA reported they explained their staff had not been found aware of R205 reporting their vision was impacting their perceived ability to feel comfortable with the lights off in their room, and they had already begun follow-up. This Surveyor shared with the NHA R205's progress notes showed R205 was reporting vision concerns to their staff, law enforcement noted a concern in their report, and R205's MDS assessment on 1/10/25 showed they corrective lenses were used. Review of the policy, Abuse, dated 4/13/25, revealed, Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property The facility will develop and implement policies that include: Screening potential employees and prospective residents, training new and existing staff on prohibiting, preventing, and identifying abuse, neglect, exploitation, mistreatment, and misappropriation of resident property, reporting procedures, dementia, and behavior management. Prohibiting, preventing, and identifying abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Reporting all allegations of abuse, neglect, mistreatment, exploitation, and misappropriation of resident property including reporting a reasonable suspicion of a crime to the State Survey Agency and other officials in accordance with State law. Investigating allegations of abuse, neglect, misappropriation, mistreatment, and exploitation to include protecting residents during the investigation, and taking necessary actions as a result of the investigation. Establishing coordination with the QAPI (Quality Assurance Process Improvement) program. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: MI00152670 Based on interview and record review facility failed to investigate (and follow-up) on an injury (skin tear) of unknown origin for one (R207) of three Residents reviewed for abuse resulting in the potential for further unidentified instances of injuries of unknown origin. Findings include: Review of the complaint received to the State Agency revealed that a family member/emergency contact regularly visited R207 during their stay at the facility. On 4/28/25 the family member discovered that R207 had a bandage on their arm when they removed the resident's jacket. When they removed the bandage they found bruises and a gash. They reported they were handling and assisting R207 with all their affairs. They did not receive any calls from the from the facility on how R207 sustained this injury. Record review revealed R207 was admitted to the facility on [DATE] for short-term skilled rehabilitation and nursing care. R207's admitting diagnoses included atrial fibrillation (irregular heartbeat), stroke, urinary tract infection, hearing loss, and dementia. Based on Minimum Data Set (MDS) assessment dated [DATE], R207 had a Brief Interview for Mental Status (BIMS) score of 8/12, indicative of moderate cognitive impairment. Review of R207's Electronic Medical Record revealed that R207 was admitted to the facility on [DATE] and they were discharged home with family on 5/20/25. Review of admission nursing progress notes dated 4/4/25 read that R207 had healed scratch marks on both thighs and skin tags to back and chest. Note read Resident has no wounds . Review of R207's admission nursing assessment did not reveal any open injuries/skin tear on their arms. Review of skin assessments dated 4/9/25, 4/16/25, and 4/23/25 did not reveal any skin tear/lesions. Further review of skin assessment dated [DATE] revealed a note that read right ante-cubital (area of forearm in front of the elbow joint), healing skin tear to right forearm'. Skin assessment dated [DATE] also had the same note as above. Further review of R207's nursing, practitioner and physician progress notes did not reveal any documentation of any incidents and or injuries/lesions. Review of R207's physician orders did not reveal any orders for treatment for any injuries/skin tear. Review of the discharge summary and order did not reveal any documentation on the skin tear on the the forearm. Review of R207's MDS (discharge) assessment dated [DATE] did not reveal documentation of any skin tear. A request was sent via email to the facility administrator on 5/28/25 at 9:02 AM requesting all incident/accident reports and facility investigations for R207 throughout their stay at the facility. The Administrator replied and noted that they did not have any incident and accident reports and or any investigations for R207. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R207's shower sheets were completed with Unit Manager H on 5/28/25 at approximately 1:10 PM. The shower sheets dated 4/26/25, 4/30/25, 5/7/25, 5/14/25 and 5/17/25 signed by the Certified Nursing Assistants (CNA) and nurse (s) did not indicate any skin tears. An interview with the complainant was completed on 5/28/25 at approximately 11:10 AM. The complainant reported that they came in to visit R207 and they were sitting on the courtyard and they had removed R207's jacket and observed the bandage on their forearm. They reported that R207 was not able to explain what happened. They had approached the facility staff at the desk. One staff member had mentioned that it might have happened in the shower room and did not provide any further details. They were notified that someone from the facility would contact and follow-up with them. The facility did not provide any further details. Prior to the review of R207's shower sheets (at approximately 12:45 PM), an interview was completed with Unit Manager H. They were asked about R207. UM H reported that they remembered the resident. When queried if they recall R207 having incidents and they reported R207 having a skin tear on their arm and might have been the right arm and they need to check the EMR. When queried further about what facility investigation process and what happened, UM H reported that the nurses completed an incident report and it was under their risk management and they added that the physician and responsible party were notified as part of their process. They added that treatment orders would be placed and it would also reflect in nursing progress notes and they would notify the facility's wound care team. They were asked to check R207's EMR to provide documentation/additional information. UM H reviewed the EMR and reported that they did not find any incident/accident report or progress notes and or treatment orders related to the right forearm skin tear. They were notified of the concern and they agreed on the concern and did not provide any further explanation. They reported that they would follow with the staff. An interview with facility Administrator was completed on 5/28/25 at approximately 1:35 PM. During the interview Regional Clinical Services Director (RCD) I was present in the office. The Administrator was asked about the facility process on investigation of skin tears. The Administrator reported that they would complete a nursing assessment, incident and accident report/risk management report and completed an investigation. They added that the physician and responsible parties were notified and treatment orders were implemented. They were queried about R207 and skin tear investigation and follow up, that were noted on skin assessment dated [DATE]. The Administrator reviewed the EMR and reported that they would check further and report back. The Administrator was notified of the follow up with Unit Manager H and notified of the concern. Prior to exit, the Administrator replied via e-mail and notified that they did not have any additional information or investigation for the skin tear on R207's right forearm. Review of the facility provided document titled Abuse - Policy and Procedure with a revision date on 5/24/23 read in part, Key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse. It is the Center's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source to ensure that all individuals who report such incidents and allegations are free from retaliation or reprisal for reporting the incident. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of all investigations to the administrator or designee and to the State Agency in accordance with State law. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation process includes: • Identifying staff responsible for the investigation. • Determining the purpose of the investigation and issue(s) to be investigated, whether or not the alleged violation has occurred, the extent, and cause. • Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (such as other residents, family members, staff who worked closely with the alleged perpetrator and/or alleged victim). • Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents as applicable. • Identifying and reviewing all relevant medical records and facility documentation as applicable. o If the alleged perpetrator is a staff member, review their employment records. • Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence). o Providing complete and thorough documentation of the investigation .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235556	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodward Hills Health and Rehabilitation Center	39312 Woodward Ave Bloomfield Hills, MI 48304

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI00151510. Based on observation, interview and record reviews the facility failed to consistently complete wound treatments (R202), failed to timely identify a left heel wound, timely implement treatment to the left heel wound and consistently completed weekly skin assessment (R209) for two of three residents reviewed for wounds. Findings include: R202 A review of a complaint submitted to the State Agency (SA) noted concerns of the facility failure to provide adequate and appropriate interventions to prevent and care for R202's wounds. A review of the R202's medical record revealed the resident was admitted to the facility on [DATE] and transferred out to the hospital on 3/27/25. R202 admitted with the primary diagnosis of hypokalemia and required staff assistance with all Activities of Daily Living (ADLs). A review of an admission Evaluation dated 3/13/25 at 12:38 AM, documented the following in part, . Sacrum- unstageable . Left heel- Dry . Coccyx- 2 stage twos next to unstageable wound . A review of the March 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed the following treatments: Start Date 3/13/25 - Santyl External Ointment. Apply to Sacrum topically one time a day for wound on sacrum and right buttock. Although the order was prescribed once a day the facility staff documented applying the ointment twice a day. A second order for the same site noted the following: Start Date 3/14/25- Sacrum/Right Buttock- cleanse wound with dakins solution, pat dry with gauze, apply santyl to affected area, cover with ABD (abdominal) or dry dressing, tape (date and initial). Every day shift for wound care. Start Date 3/14/25- Left Heel- cleanse wound with NS (normal saline), pat dry with gauze, wipe with skin prep (allow to dry) every day shift for wound care. This treatment was omitted and not completed on 3/17/25 and 3/21/25 for both the Sacrum/Right Buttock and Left Heel. R209 On 5/28/25 at 8:40 AM, R209 was observed sitting up in bed eating breakfast. Their left foot was observed wrapped in white gauze and elevated off the bed. When asked how their left heel was doing, R209 replied they weren't really sure but hoped that it was improving. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medical record revealed R209 was admitted to the facility on [DATE] with the primary diagnosis of a traumatic subdural hemorrhage without loss of consciousness and required staff assistance for all ADLs, except bed mobility. A review of an admission assessment dated [DATE] revealed no documentation of any identified pressure wounds. A review of the progress notes revealed the following: On 4/16/25 at 2:08 PM, a Physical Medicine and Rehabilitation note documented in part, . Pt (patient) is seen laying in bed. He states therapy has been good. He complains of pain to his left heel. He denies any trauma or injury. Possible pressure ulcer forming on left heel . Pt was on Tylenol 650 bid (twice a day). Increased Tylenol to TID (three times a day) due to increased heel pain . Pt may be developing pressure ulcer on left heel. Ordered for pt to have heels elevated while in bed. Will discuss with nursing to monitor closely. Wound care consult placed . A Skin & Wound Evaluation dated 4/18/25 at 1:03 PM, documented in part . Pressure . Deep Tissue Injury . Left Heel . In-House Acquired . Area 4.3 cm2 (centimeters squared) . Length 2.8 cm . Width 2.1 cm . Depth Not Applicable . Intact blister . Treatment . generic wound cleanser . skin prep . This note was documented two days after the initial identification of the wound. Review of the April 2025 MAR and TAR and Physician orders revealed the following treatment: Start Date: 4/22/25 - Left Heel, cleanse wound with NS (normal saline), pat dry with gauze, wipe with skin prep (allow to dry), cover with ABD, wrap in kerlix, tape (date and initial) every day shift for wound care. The treatment was implemented six days after the initial identification of the wound. A review of the Physician orders documented the following in part, . Skin Evaluation weekly, every day shift every Sat (Saturday) . A review of the skin assessments revealed assessments completed on 4/5/25 and the next one completed on 4/18/25, with one week omitted in between the two assessments. Review of the April 2025 MAR and TAR, revealed a nurse documented on 4/12/25 a check mark that a weekly skin assessment had been completed, however a review of the medical record revealed no documentation of the assessment. On 5/28/25 at 9:05 AM, the Administrator and Assistant Director of Nursing (ADON E - who filled in for the Director of Nursing in their absence) was interviewed and asked about R202's omitted wound orders. The Administrator and ADON E were also asked about R209's left heel wound to have been identified by the PMR clinician on 4/16/25, however not acknowledged by the nursing staff until 4/18/25 and the delayed implementation of treatment orders on 4/22/25. The Administrator and ADON E was also asked about the documentation of the skin assessment that was signed as completed on 4/12/25. The Administrator and ADON E stated they would look into it and follow back up. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 9:26 AM, Wound Nurse (WN) J was interviewed and was asked if they were responsible to complete the wound treatments for the residents in the facility. WN J explained that they would usually complete the treatments for the major wounds- Stage III's and up, vascular wounds and usually any pressure wounds. WN J explained when they are off the wound treatments are covered by the resident's assigned nurses. WN J was asked the facility's protocol if a skin impairment is identified and WN J stated they would usually be informed and a treatment would be ordered as well as a wound consult. WN J was asked about R202's omitted wound orders and asked about R209's left heel wound to have been identified by the PMR clinician on 4/16/25, however not acknowledged by the nursing staff until 4/18/25 and the delayed implementation of treatment orders on 4/22/25. WN J was also asked about the documentation of the skin assessment that was signed as completed on 4/12/25. WN J stated regarding R202 the omitted days treatments were supposed to be completed by the resident assigned nurse. WN J stated regarding R209, they were informed by the nurse on 4/18/25 of the skin impairment identified to R209's left heel. A treatment was provided to that nurse to implement, however they reviewed the record and seen that the ordered was not put in until 4/22/25. WN J stated the residents in the facility receive weekly skin assessments that are supposed to be documented under the assessment tab. A review of a facility policy titled Skin and Wound Guidelines with the revised date of 3/20/2024, documented in part . Body audits are completed: By the licensed nurse routinely and documented in the resident's electronic medical record . any new areas of skin breakdown for evaluation and documentation . Treatment options are selected and based upon the type of wound . The individualized comprehensive care plan addresses the resident's problem . the goal for prevention and/or treatment, and individualized interventions to address the resident's specific risk factors and the plan for reduction of risk . No further explanation or documentation was provided by the end of the survey.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI00151510. Based on interview and record reviews the facility failed to ensure an initial comprehensive consultation was completed by a Physician for one (R202) of three residents reviewed for quality of care. Findings include: A review of the R202's medical record revealed the resident was admitted to the facility on [DATE] and transferred out to the hospital on 3/27/25. R202 admitted with the primary diagnosis of hypokalemia and required staff assistance with all Activities of Daily Living (ADLs). Review of the medical record revealed the following: A Physician Team - Progress Note dated 3/13/25 at 4:16 PM, that documented in part . DATE OF EXAM 3/12/2025 . initial visit post hospitalization . of multiple medical problems . This progress note contained an assessment and evaluation of care for the resident. The progress note was documented by Nurse Practitioner (NP) L. Further review of the medical record revealed no documentation of an initial comprehensive visit to have been completed by the assigned Physician. The medical record was reviewed in its entirety and no documentation was found of a written approval and/or recommendation by the Physician for R202's admission. Review of the Physician orders revealed the following order dated 3/31/25 at 10:03 AM, . Admit resident to Skilled Level of Care. Physician/Provider has reviewed and agrees with current Care Plans, Diagnosis list, and Physician Orders . This note was signed by the Physician on 4/3/25 at 7:23 AM. This order was signed when the resident was no longer under the care of the facility staff. A review of a facility policy titled Physician Services with the revision date of 3/20/24, documented in part . A physician is responsible for the resident's first initial comprehensive visit . On 5/28/25 at approximately 9:10 AM, the Administrator and Assistant Director Of Nursing (ADON) E who was filling in for the Director of Nursing (DON) in their absence was interviewed and asked why a Nurse Practitioner completed the first initial comprehensive visit for R202 instead of the Physician. The Administrator and ADON E stated they would look into it and follow back up. Shortly after the Administrator stated the Physician had a consult for the resident that some how did not transfer the facility's Electronic Medical System (EMR). Review of the provided Physician consult was back dated to 3/14/25, this consultation was completed after the NP initial consultation visit. No further explanation or documentation was provided by the end of the survey.