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	08/05/2025

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

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2577284.Based on observation, interview, and record review, the facility failed to provide a safe, clean, homelike environment, in multiple resident rooms and throughout the hallways on the 100, 400, 500, 600, and 700 units. Findings include:Review of concerns reported to the State Agency on 7/31/25 included: the building smells like mildew, the facility is dirty, rain is coming down from the second-floor ceiling, which was not a new issue and happened every time it rains, and there was black mold on the pipes and in the ceiling.On 8/5/25 between 8:30 AM - 10:05 AM, observations of the facility revealed the following environmental concerns:At 8:30 AM, upon entry into the facility's main lobby, there was a strong mildew odor present, as well as in hallway towards the conference room.At 9:11 AM, there were three ceiling tiles off the main dining room towards the long-term care side of the facility that were heavily stained with water damage. At 9:15 AM, the end of the 500 hallway had a build-up of cobwebs in the corner of the window ledge under the window, with the surrounding walls had peeling wallpaper; the fabric window valance was stained in darker brownish color (water damage) and five ceiling tiles along the ceiling directly in front of the window valance were observed to have brown stains (water damage) and the area to the right of the window valance had a ceiling tile with dark brown and black colored mold-like substance on the tile and surrounding tile grid. Throughout this hallway and in the window area, there was a strong musty/mildew-like odor.At 9:20 AM, the main elevator to access the second floor did not work. There was no signage to indicate this was not in working order, or where to go to access a secondary elevator. When staff were asked, they reported the elevator had not been working for several days and thought there used to be a sign indicating it was out of order but wasn't sure what happened to it.At 9:21 AM, upon exiting the service elevator to the second floor 600 hallway, there was a very strong musty/mildew-like and urine odor.At 9:23 AM, an interview was conducted with Nurse ‘A'. When asked about the elevator, Nurse ‘A' reported that had not been working for about three weeks or so. When asked how visitors and residents knew it was out of order and/or where to access the other elevator since there was no sign posted, Nurse ‘A' reported there used to be a sign, but confirmed there was none now.At 9:24 AM, the ceiling tile outside the elevator on the 700 hall was heavily water damaged with brown/colored stains.At 9:25 AM, while walking throughout the 500 hallway, there was a significant musty, mildew-like odor throughout most of the hallway. The ceiling tiles in the hallway across from room [ROOM NUMBER] had a large area of water damage (brown colored stain) and was observed to be sagging down in the center of the ceiling tile.At 9:27 AM, the 600-hall lounge/dining area was observed to have four ceiling tiles with water damage (varying brown colored stains) and a broken wall outlet cover with cracked/sharp plastic edges.At 9:28 AM, room [ROOM NUMBER] was observed to have one ceiling tile in the center of the ceiling between the two occupied beds with a water damage (round brownish colored water stain).At 9:29 AM, the 600 hall was observed to have five ceiling tiles missing outside of rooms [ROOM NUMBER]. The carpet was significantly stained darker in color in several areas and there was a very significant musty/mildew-like odor present. The surrounding walls had peeling wallpaper directly under the area of the removed ceiling tiles and extended down past room [ROOM NUMBER].At 9:31 AM, room [ROOM NUMBER] was observed to have a ceiling tile in the center of the room with a large area of water damage (brown colored stain).At 9:32 AM, room [ROOM NUMBER] was observed to have a ceiling tile directly over the end of their bed that was occupied with a large area of water damage and the center of the ceiling tile was sagging down.At 9:33 AM, room [ROOM NUMBER] was observed to have a ceiling tile directly above the head of the bed with a small circular water stain. On 8/5/25 at 9:31 AM, a Resident was observed seated in a wheelchair next to their bed, eating breakfast. When asked about their room and if there were any concerns, the resident pointed to the bathroom door and above their bed. The ceiling tile located just above the resident's bed was observed to have an area of small water damage (brown colored stain). Upon opening the door to the bathroom, there were three ceiling tiles missing and there was a strong musty/mildew-like odor present. Additionally, there was a toilet commode with bilateral arm rests that was placed on top of the toilet. The left arm rest was observed broken with cracked plastic and had sharp, jagged edges on the top portion of the arm rest. The resident pointed to the bathroom ceiling and stated, That's pretty bad huh?.At 9:40 AM, Nurse ‘A' was asked about the missing ceiling tiles at the end of the 600 hallway and reported the issue had been going on for a long time and further reported, Whenever it rains really hard, the ceiling leaks terribly and it smells like mold and mildew. We had to move a resident a couple weeks ago

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is or complaint # 2573833Based on observations, interviews, and record reviews, the facility failed to follow a transfer status and fall protocol for one resident (R303) of three residents reviewed for falls, resulting in R303 obtaining a serious injury.Findings include:A record review revealed that on 7/8/25 R303 fell from bed while being changed and sustained a head injury and required a higher level of care. According to the incident report R303 was being changed by one certified Nursing assistant (CNA) and rolled out of bed and hit their head. R302 care planned as a two person assist for actives of daily living (ADLs). On 8/5/25 at 10:40 AM, R303 was interviewed, and asked did they remembered how they fell from the bed. R303, report that they rolled out of bed and remembered hitting their head but that was it, R303 could not recall the staff that was around. A record review revealed that R303 was re-admitted to the facility on [DATE] with the medical diagnosis of Traumatic Subarachnoid Hemorrhage without loss of consciousness, contusion of eyeball and orbital tissues, left eye and fall. A further review of the record showed that R303 was a two person assist with ADLs.On 8/5/25 at 12:22 PM, the administrator was interviewed and asked about the fall for R303, and reported that it happened and the CNA who was involved was terminated for that reason, the CNA had been educated on proper transfer status of residents. The administrator was then asked about the facilities fall protocol, the Administrator reported that staff is supposed to follow the policy and complete all required documentation. The administrator was then asked for the incident and accident reports for R303 and R302, and agreed that required documentation was missing from the report. A review of the Employees file who was terminated revealed that the CNA had dropped three different residents and all were improper transfers. No additional information was provided by the exit of survey.