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	04/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 relates to Intake 2962105. Based on interview and record review, the facility failed to ensure a change in condition was addressed timely for one Resident (R901) of three residents reviewed for change in condition. Findings include:On 3/20/26 at 8:35 a.m., a complaint was received by the State Agency, which alleged the facility failed to respond timely to a change in condition, when R901 experienced a significant medical decline on 5/16/25 in the middle of the night. The complainant described R901 was rushed to the hospital by the daytime nurse (on 5/17/25) after they received a phone call from the night nurse, who reported R901's breathing was fluctuating, their blood pressure had fallen, and they were not responding as normal. The complainant reported they received a phone call from the daytime nurse who told them they were rushing R901 to the hospital, as when they walked into R901's room they could tell that something was wrong with him, with his eyes rolling in the back of his head and called for the ambulance immediately. The complainant alleged the nighttime nurse should have sent R901 to the hospital when the nighttime nurse called them, as all the signs were there that something was off and wrong with (R901). Review of R901's Minimum Data Set (MDS) assessment, dated 4/28/25, revealed R901 was admitted to the facility on [DATE], with diagnoses including coronary artery disease (plaque in the heart arteries), hypertension (high blood pressure), deep vein thrombosis (blood clot in deep veins of leg), kidney disease, diabetes, dementia, seizure disorder, depression, metabolic encephalopathy (brain dysfunction caused by metabolic disturbances), sepsis (severe life-threatening infection), lung disease, sarcopenia (loss of muscle mass), and cystitis with hematuria (inflammation of the bladder with blood in the urine, often after a urinary tract infection). The assessment showed R901 required supervision with eating, and maximal assistance for bed mobility and transfers. The cognitive assessment showed R901 had cognitive impairment and was sometimes able to understand others and make themselves understood, with no hearing or vision impairment. The assessment revealed R901 was on an anti-depressant medication, an anti-coagulant (blood thinner to treat/prevent blood clots), insulin (for diabetic management), and a seizure medication. The bladder section of the assessment showed R901 had a urinary catheter and was frequently incontinent of bowel. Review of R901's vitals page for pulse (heart rate) showed elevated pulses as follows: 5/17/2025 3:18 (a.m.): 123 bpm (beats per minute) - irregular - new onset.5/17/2025 3:00 (a.m.): 133 bpm - irregular - new onset.5/17/2025 at 2:34 (a.m.): 120 bpm - irregular - new onset. It was noted since admission, R901's pulses ranged from 51 to 85 bpm, so this was atypical for them, and beyond the clinically acceptable range (typically 60 to 100 bpm for a resting pulse, per professional standards of practice). Review of R901's vitals chart for blood sugar showed elevated blood sugars as follows: 5/16/2025 21:36 (9:35 p.m.): 356.05/16/2025 21:52 (9:52 p.m.): 356.0 It was noted during the week prior (back to 5/10/25), R901's blood sugar ranged from 140 at lowest to 280 at highest (with a typical range of 100 to 200 for persons with complex health, per professional standards of practice). Review of R901's assessment page showed a sepsis screening was done on 4/27/25 and 4/29/25, however no sepsis screening was done at the time of these findings. Review of R901's nursing progress note, dated 5/17/25 at 2:34 (a.m.), revealed, Writer called into residents room by CNA (unnamed), res (resident) appeared to not be at normal baseline; VS (vital (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs) obtained: 96/64 (blood pressure - in low normal range), 120 P (pulse - elevated), 20 RR (20 respiration rate of breaths per minute - high normal range), 184 BS (blood sugar). Pt (R901) responds to painful stimuli but would not vocalize any discomfort, res had a large BM (bowel movement) at this time. 0600 midodrine given (generic name of medication to increase blood pressure) and BP rechecked: 0300 (3:00 a.m.) bp 111/75 (increased). Pulse still tachycardic at 128 (pulse increased) and respiration rate increased to 28 (higher than typical range of 12 to 20 respirations (breaths), per professional standards of practice). Updraft given (breathing treatment). 0318 (a.m.). res continues to have increased RR (respiratory rate), BP 111/81, 126 P (highly elevated pulse). Left a voicemail for (name of) Nurse practitioner and on call staffing #, awaiting call back. It was unclear why midodrine was given about 3 hours before the next scheduled dose at 6:00 a.m. Review of R901's May (2025) Medication Administration Record (MAR) revealed their midodrine with 10 mg (milligram) dosing was scheduled three times a day, at 0600 (6:00 a.m.), 1100, and 1600. And to hold for systolic blood pressure of 140 or above (top number). There was no physician order found of an extra dose ordered on 5/16/25 or 5/17/25 or an additional dose added. Further review of R901's progress notes showed no documentation of any follow-up with R901, or a provider, until 5/17/25 at 6:29 a.m., which showed, NP called (back), order for CBC (complete blood count - lab)/CMP (complete metabolic profile - lab) and CXR (chest x-ray). There was no documentation of any observation of R901 at that time, or their clinical presentation. Continued review of R901's progress notes sequentially revealed no new progress note until 5/17/25 at 14:23 (1:23 p.m.), by Licensed Practical Nurse (LPN) A, which showed R901 had a marked decline: Writer went into resident's room to check his BS (blood sugar) for the morning med pass; upon going into the room, writer observed the resident lying in bed but unresponsive to commands. Resident was in bed with his eyes opened and mouth breathing. Writer got a full set of VS (vital signs) on (R901). BP (blood pressure) was 105/70, P42/125 (ranging from low of 42 to high of 125 - erratic pulse) resident pulse was going up and down when get patient. VS O2 (oxygen saturation) 92% on room air (range 92% to 100% clinically acceptable per professional standards of practice) and temperature 100.5 (fever, as 97.0 Fahrenheit to 99 F is the clinically acceptable range per professional standards of practice). Writer reached out to DR (doctor - unnamed) and supervisor on shift. Resident sent out to (name of hospital). Family was also notified of resident status. R901's next nursing progress note in chronological sequenced noted on 5/17/25 at 14:46 (p.m.): Physician team discharge note. Late entry: pt (patient) transferred to ED (Emergency Department) for unresponsiveness. R901's subsequent progress notes and census page showed they did not return to the facility. Review of R901's progress notes on 5/16/25 (the day prior to their hospitalization) showed R901 was alert and able to answer general questions during their rehab practitioner visit at 13:26 (1:26 p.m.), revealing, .Pt (R901) seen lying in bed. He stated that he is participating in therapy. He denies concerns. Denies pain. Denies SOB (shortness of breath), chest pain, and abdominal pain. Foley (catheter) is intact, but hematuria (blood in urine) is noted. Later in the day, pt was examined again. Foley is clearing up. D/w (discussed with) nursing. General: Well-developed, well-nourished (patient), who appears the stated age. Patient in no acute distress.Catheter intact with yellow urine.Neurological: Alert and oriented x 2 (name and place) with cues.Comprehension: No word finding difficulty. Following simple commands. Poor safety awareness noted.Psychiatric: Calm and cooperative. This progress note revealed R901's discharge plan was to return home and revealed R901 had a fall on 5/07/25 with no injury or hitting their head. Review of R901's next progress note, dated 5/16/25 at 19:59 p.m. (7:59 p.m.), showed, Small amount of blood observed to foley cath (urinary catheter). Writer attempted to apply securement; resident was agitated at the moment and refused. NP (name) aware of blood. Writer observed throughout shift and blood subsided. No complaints of pain during shift). There was no notation of R901's catheter being removed, or further concerns with their catheter. The next progress note was dated 5/17/25 at 2:34 a.m., earlier referenced, which showed no catheter concerns. Review of R901's progress notes showed no practitioner or physician visit during the time of R901's decline (5/17/25) before R901 was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sent out to ED emergently. Review of R901's SNF (Skilled Nursing Facility)/ NF (Nursing Facility) to Hospital Transfer Form, by LPN B, revealed R901 was full code (full resuscitation life wishes). The date of transfer showed: 5/17/2025 13:00 (1:00 p.m.). The reason for their emergent transfer was marked, Change in mental status. There was no mention of change of fluctuating vital signs, including pulse, respirations, or fever, or their unresponsiveness documented on this emergent transfer document. On 4/22/26 at 12:50 p.m., the Medical Director, Physician C, was asked about R901's incident when they were sent out emergently on 5/17/25. Physician C said they reviewed R901's medical record prior to the interview and based on the clinical judgment of what they were seeing, they would have sent R901 out earlier due to a change in condition. Physician C indicated they had not been contacted, as it was the facility protocol for an on-call provider to be contacted on the weekends (5/17/25 was a Saturday). Surveyor reviewed R901's progress notes and vitals of concern with them as well. Physician C clarified based on the clinical judgment of what they were seeing, R901 needed to go to the hospital sooner, after reviewing the nursing progress note dated 5/17/25 at 2:34 a.m., by a former nursing staff. Physician C reviewed R901's May (2025) MAR with Surveyor and concurred midodrine should have not been given early. Physician C was asked if there was anything the facility could do going forward to prevent a recurrence of a similar incident, and responded, Staff education. Upon further review, Physician C indicated it was unclear why R901 was not sent out sooner when the practitioner on call ordered a medical work up, and why there was a gap of time on 5/17/25, from 2:34 a.m. until 1:00 p.m. (per EMR), with no additional clinical presentation or reattempts to contact a provider documented. When asked about the midodrine being administered three hours earlier than the morning dose, Physician C said the former LPN probably did not have to give it (early). Physician C understood there was no documentation which showed it should have been given earlier. On 4/22/26 at 1:09 p.m., LPN A, was asked during a phone interview about the incident which occurred on 5/17/25 at 1:43 p.m., when they sent R901 to ED emergently. R901's progress notes were reviewed with them, per request, because they initially did not recall the incident. After the review, LPN A stated based on what occurred prior to them coming on shift, R901 should likely have been sent out sooner, because the nurse documented a change in condition. LPN A' said with a high heart rate, they could have had sepsis going on, or something they could not treat, and noted R901 was responding only to painful stimuli. LPN A did not recall the prior nurse giving them this information at shift change and clarified they saw R901 in the morning, not in the afternoon, per their note, but they did not know a time and said they should have documented a late entry note. LPN A explained when they walked in R901's room they went out quickly to get their vitals machine, and R901's heart was going everywhere, from the 40s to the 120s (pulse 40 bpm to 120 bpm range). LPN A said they were calling R901's name and R901 was not responding to them and was staring into space. LPN A clarified they couldn't get anything out of them (a response) and immediately called 911. LPN A said they didn't reach the physician until afterwards and were not sure of the exact time. LPN A said they should have written their progress note in the morning. LPN A denied any catheter concerns and said they would have documented if removed. On 4/22/26 at 1:25 p.m., LPN B was asked about their transfer form and to explain the detail of R901's emergent hospital transfer, and their observations. LPN B said they could not recall the incident or writing the note or the timing and details. LPN B believed they were only assisting LPN A with the documentation. On 4/22/26 at 1:37 p.m., R901's EMR related to the incident, including R901's vitals, progress notes (since 5/16/25), and transfer note were reviewed with the Director of Nursing (interim DON). Based on their review, the DON acknowledged R901 should have been sent out emergently sooner, when R901 was found responsive only to pain in the 2:34 a.m. progress note, with a change of condition documented. The DON was asked to review R901's May (2025) MAR and about the early dosing of midodrine for high blood pressure, as there was no documentation of the physician being contacted or any additional as needed order. The DON concurred the midodrine was administered 3 hours early with no clinical reason, or provider contact documented and said they had concerns based on what they read had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred. On 4/22/26 at 11:47 a.m., the complainant was left a voicemail, which was not returned during the survey. On 4/22/26 at 2:10 p.m., the Administrator was asked regarding the results of the investigation, however did not wish to respond. Review of the policy, Change in Condition Notification, issued 8/09/23, revised 2/02/26, revealed, It is the policy of the facility to notify the resident, his or her attending physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident, the resident's physician/ practitioner, and the resident's designated representative when there is.a significant change in the resident's physical, mental, or psychosocial status, such as deterioration which includes life-threatening conditions or clinical complications. A need to alter the resident's medical treatment significantly, such as a new treatment, discontinuation of current treatment due to adverse consequences, an acute condition, or exacerbation of a chronic condition. A need to transfer or discharge the resident from the facility, including discharge against medical advice. A room change or roommate change. A change in resident rights. Death of a resident. The nurse will document in the resident's medical record information relative to the resident's change in medical/mental condition or status (i.e. assessment, notifications, interventions, and response). If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted.Definitions: Significant change of condition: Means that the condition will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and that it impacts more than one area of the president's health status, and required interdisciplinary review and/or revision to the care plan. Immediately: For purposes of notification, immediately is determined to be as soon as practicable after the resident has been adequately assessed, necessary emergent care or treatment is rendered, and the resident's safety has been secured. (For example, if a resident receives a laceration, the nurse should assess the resident, control the breathing, and manage the resident's pain before (they) would be required to contact the physician.) Review of the policy, Standards of Practice, revised 2/03/26, revealed, Residents at the facility will receive services, treatment, and care in accordance with professional standards of practice. Residents care policies are developed, revised, and updated as needed, to ensure they are consistent with current professional standards of care and implemented within the facility. Facility symptoms, guidelines, policies, and procedures are developed, revised, and updated as needed, to ensure they are consistent with professional standards of care and implemented within the facility. Facility staff education, training, and skills checklists are developed, revised, and updated as needed, to ensure they are consistent with current professional standards of care and implemented within the facility.