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	06/15/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 relates to Intake 3003663. Based on interview and record review, the facility failed to prevent an avoidable fall for one Resident (R903) of two residents reviewed for falls. This resulted in R903 sustaining a brain bleed, a fractured humerus, and a fractured femur, which required surgery and resulted in increased pain and a functional decline. Findings include:A complaint was received by the State Agency on 5/05/26, which revealed R903 was admitted to the facility during April 2026, had a prior traumatic brain injury, and wore a yellow bracelet showing they were at high risk for falls. The report alleged R903 had a fall at the facility on 4/09/26 which resulted in fractured ribs, and a second fall on 4/19/26, which resulted in a brain bleed, fractured left hip, and a fractured left distal (lower) radius (wrist fracture). It was reported R903 was wandering in and out of residents' rooms on the night of their fall, in the early morning (on 4/19/26), which contributed to the major injuries. The complainant reported R903 was in extreme pain at the time of the fall and the nurses said they had to call the physician first, so the family called an ambulance themselves. It was alleged the nurse delayed sending R903 to the hospital which concerned them. It was further reported that the facility did not place R903's sensor alarm consistently and there was no alarm observed in R903's room after their fall. The complainant said R903 underwent hip surgery at the hospital due to their new fracture. Another concern noted was R903's family said they attempted to obtain more specific details about R903's fall from the facility however no additional information was provided. Review of R903's accident and incident report, dated 4/19/26 at 5:00 a.m., revealed, Patient son stated to nurse that his dad reported to him that he had a fall during the night shift. Patient was never found on the floor by staff during the night. Staff reported that he was only seen wondering (sic) during the night shift. Staff also reported to son that patient (R903) has had multiple behaviors including yelling out and hitting the walls and skin in room.Son called 911 prior to full evaluation being completed by nursing staff. Patient sent to hospital for evaluation. The report showed R903 was confused and had memory impairment. Review of the facility census showed R903 had been discharged from the facility on 4/19/26. Review of R903's Minimum Data Set (MDS) assessment, dated 4/08/26, revealed R903 was admitted to the facility on [DATE], with diagnoses including sepsis (severe systemic infection), urinary tract infection, kidney disease, osteoporosis (weak or fragile bones), dementia, rheumatoid arthritis (inflammatory arthritis), lupus (an autoimmune disorder), anxiety, and depression. The assessment revealed R903 was able to eat with set up, required moderate assistance with bed mobility and transfers, and they used a walker for mobility. The Brief Interview for Mental Status (BIMS) assessment showed a score of 8/15, which showed severe cognitive impairment. Review of R903's hospital neurosurgical consult, dated 4/19/26, revealed they were consulted because R903 had a head injury as was on a blood thinner with an intracranial hemorrhage (brain bleed). The report showed R903 was admitted to the hospital on [DATE] after an unwitnessed fall around 5:30 a.m., which required two staff to assist R903 back up. The report revealed R903 had a left distal radial fracture which was casted and a displaced femoral neck fracture (hip fracture). The report showed the bleed was not present on prior imaging at the hospital on 4/09/26 with no surgery indicated. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R903's trauma surgery consult, dated 4/19/26, revealed R903 presented with pain after a presumed fall, and per reports from family and facility R903 was confused overnight and was walking around knocking hard on doors, and patient remembered falling at some point and requiring assistance to get up and called his son and complained of pain. This prompted his son to go him, and he presented with left hip and left wrist pain, with the left wrist, left hip, and brain bleed diagnosed at hospital. Review of R903's physical therapy hospital document, dated 4/22/26, revealed R903 required max assistance of two people for bed mobility and was unable to transfer, showing a decline in function prior to second fall. On 6/15/26 at 11:47 a.m. Family Member (FM) G was asked about R903's care at the facility during a phone interview. FM G shared about a week after R903 arrived at the facility he fell in the bathroom and hit his neck, which was bruised, went to the hospital and afterwards R903 complained of pain in his chest and rib, which was discovered a few days later to be rib fractures. FM G reported on 4/19/26, R903 called them just before 6:30 a.m., and said he was in tremendous pain after falling while sitting in a chair. R903 explained R903 said they called for staff and said, Girls; come help me., and no staff came. FM G told R903's spouse to call the facility, who said they could not reach anyone and so FM G headed over to the facility themselves. FM G said they found R903 in his room alone and clarified they had visited R903 the night before and R903's bed was still made, and it appeared R903 was not in bed all night. FM G reported feeling distressed because they had purchased a bed alarm for R903's bed and said they could not find it in the room or underneath R903 in their chair, a green padded reclining chair. FM G believed if the sensor alarm had been in place, it may have alerted staff to R903's fall. FM G said R903 was in too much pain to move and they saw R903's wrist was swollen and Certified Nurse Aide (CNA) F came into R903's room at that point to assist. FM G said they had not seen any staff prior. FM G stated staff were not aware R903 fell and learned from staff R903 was up all night wandering to other residents' rooms. FM G said CNA F could also not move R903 as he was in tremendous pain. FM G said they went to the nurses and said, You need to do an assessment (on R903 urgently), and the nurse (unnamed) said she had to finish her rounds on her beds and then they would call the physician to send R903 if needed. FM G told the nurse R903 was in extreme pain and said R903's wrist was very swollen. FM G said they called their family who agreed with them R903 was in acute distress and needed to go out as soon as possible, so after attempts at nursing intervention they called the ambulance themselves, as they were concerned as nursing staff declined to assess R903, declined to administer pain medications, and declined to call the doctor when R903 he was in 9 - 10/ 10 pain (with 10 the highest pain) on his entire left side. FM G said they were present when EMS (Emergency Medical Services) arrived and the EMS staff had a horrible time trying to get R903 on the stretcher. FM G reported the hospital found R903 had a left hip fracture, a wrist fracture, and a brain bleed. FM G said they let the Nursing Home Administrator (NHA) and facility know about the findings afterwards and requested video footage of what occurred that night, which was not received, and denied receiving a reply. FM G said the staff told them on 4/19/26 R903 was found wandering around and banging on people's doors when they asked further but received no formal explanation. On 6/15/26 at 2:21 p.m., LPN B was asked about any incident on 4/19/26 with R903 when they were working. LPN B said R903's family said he fell and confirmed R903 was wandering on the unit during their shift at night and early morning. LPN B described they and an aide heard R903 yelling and pushing the call light, and said they repositioned R903 in his room, as he was found seated on the footrest of the recliner instead of on the seat, and said he was not positioned well, between 5:00 and 6:00 a.m. LPN B said due to R903's behaviors and steady wandering that night, they had called the Unit manager and asked for a 1:1 sitter (staff for supervision) of R903. LPN B reported they were told, No, as the facility did not do 1:1 sitters and they could not assist, as they were training a new nurse. LPN B stated, I felt like (R903) needed a 1:1 (for safety and supervision due to behaviors). LPN B said R903's unit held up to 20 residents but they were uncertain of how many were there that night. It was unclear with R903's ongoing wandering behaviors at night why he was in his room alone, since he was in their positional chair, which could (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	have been moved outside the room in nursing line of sight, given their wandering behaviors, agitation, and need for increased supervision. On 6/15/26 at 2:36 p.m., Certified Nurse Aide (CNA) F reported during a phone interview there was only one nurse on shift and one nurse acting as an aide the night before when they arrived for the day shift. CNA F said by the time they got there with another aide, they understood why R903's family needed to call an ambulance themselves, because R903's wrist and leg looked broken and they could not move him, around 7:00 a.m. CNA F said they told the nurse and didn't know what the nurse did but R903's family called because no nurse came and assessed R903 for an urgent situation. CNA F said the midnight nurse wasn't doing anything and they and the other aide were concerned. CNA F said the situation happened on the night shift, not on the day shift when they arrived. On 6/15/26 at 2:56 p.m., Registered Nurse (RN) C said on 4/19/26 at shift change they went to assist another resident when R903's family member came out of R903's room and said, Did (R903) have a fall? . RN C clarified they did not receive information about a fall. RN C said many residents were having behaviors that night and they were short staffed. RN C explained there was one aide and one nurse on the unit where R903 resided, and there was supposed to be one nurse and two aides. RN C said this occurred at about 7:10 a.m. and they left at 7:30 a.m., and the facility called them and asked what had occurred. RN C said there was not adequate staff when R903 fell and due to R903's behaviors reported to them R903 could have fallen and needed increased supervision. RN C said it was not possible to get a 1:1 supervision for R903 as there were many residents with behaviors and no extra staff were available. On 6/15/26 at 3:20 p.m. Physician D was asked about R903's falls with injury during their stay. Physician D acknowledged R903 had two falls with injury, and reported R903's first fall was when they fell walking out of the bathroom which resulted in bruising on their left side. Physician D explained initially R903's hospital x-ray showed no fracture but it was redone (a few days later) due to ongoing discomfort and showed fractures (of the ribs). Physician D said R903 had many behaviors when they were in the facility, and R903's family had asked them about R903's medications, especially at night since they were confused and agitated most at night. Physician D said R903's family had asked about adding an antipsychotic medication however they did not want to put R903 on one due to his earlier fall and put R903 on Melatonin (a natural sleep aide) at night, which was safer. Physician D indicated R903 was on a steroid and had an appointment the day before his fall (which the medical record confirmed on 4/17/26) which might have contributed by causing an acute mental status change, which they believed contributed to the fall on 4/19/26 however earlier acknowledged R903 had behaviors at night during their stay. Physician D clarified they believed R903 must have fallen, as they sustained a hip fracture, and noted R903 had a diagnosis of osteoporosis (weak and fragile bones). On 6/15/26 at 3:39 p.m., LPN E said during a phone interview they were told when they arrived for their shift on 4/19/26 by LPN B that R903 had wandered all night and said he fell and explained they did not know what the earlier shift had done. LPN E said they learned from LPN B that R903 was found hanging off their (positional) chair and an aide and nurse had pulled R903 back into the chair. LPN E said R903 was complaining of pain, said he fell, and CNA F said R903's wrist was swollen and said they had mentioned it to several nurses. LPN E acknowledged they did not do a nursing assessment as R903 was injured on the night shift, and their expectation would have been for the prior nurse to complete an assessment. LPN E explained the typical process would be when a resident went to the hospital a transfer assessment form would have been completed. LPN E clarified 20 minutes after their arrival on shift EMS services came to pick up R903, who FM G called, and explained had not been made fully aware of what occurred by the prior shift nurse, LPN B. LPN E said LPN B had told them R903's sensor alarm was missing at the time of their fall, and they knew R903 had a sensor alarm during their stay for safety. On 6/15/26 at approximately 3:46 p.m., LPN E was asked about staffing. LPN E reported on the night shifts there was typically only one nurse and one aide working, and there were typically supposed to be two nurses working on the unit. LPN E said on the morning of 4/19/26 they needed more staff, as when they arrived they were tossed everything from the previous shift which should have been done, (continued on next page)

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It is believed this writer that when the patient was found sliding in his chair that this is when he was attempting to get himself back up, as the patient reported to the son that the fall occurred around 5:30 a.m. Patient did not report any pain from his hip or arm to the staff when staff were in the room repositioning the patient. It was validated that all the patient care plan interventions were in place at the time of his reported fall. Signed by the NHA. Review of R903's fall risk evaluation, dated 4/09/26, showed fall risk factors including incontinence, history of recent falls, occasional incontinence, minimal unsteadiness, requiring supervision or steadying assistance, attempts to self-transfer, impulsivity, lack of understanding of physical and cognitive limitations, the use of at-risk for falls medications, and forgetting or not always using their assistive device, as well as predisposing medical conditions. There was no documentation of ongoing behaviors being a fall risk factor. Review of R903's Accident and Incident report, dated 4/09/26, revealed they had a fall on 4/09/26 and were sent out emergently on 4/09/26, with wearing improper footwear listed as one of the contributing factors. The improper footwear was not clarified further. Review of R903's progress note, dated 4/16/26, revealed R903 went to the hospital on 4/16/26, and returned with a diagnoses of rib fractures, which may have been attributable to the fall on 4/09/26, as they remained in pain after the fall on 4/09/26. Review of R903's physical restraint evaluation, dated 4/10/26, revealed R903 had a bed (sensor) alarm in place, which was not considered as a restraint. This may be used on a bed or in a positional chair, to alert staff when a resident attempted to stand up. Review of R903's nursing progress note, dated 4/19/26 at 8:20 a.m., LPN B, revealed, (R903) was wandering around throughout the night into other pts (residents) rooms. (R903) was redirected many times but continued to wander. Pt (R903) was also in room hitting on room walls, yelling and screaming, '(female name) is evil'. This was not reported in the camera footage description. Review of R903's nursing progress note, by LPN E, dated 4/19/26 at 7:50 a.m., revealed, Upon arriving on shift, previous nurse notified writer that resident (R903) had been up throughout the night wandering down the hallway and into patient rooms. She (nurse) stated that the resident told her he had fallen. She stated that when she went into the room herself, and the aide, (they) had seen him practically out of the chair and they lifted him back into the seat. She (nurse) also stated that he had been banging on the walls. When writer observed patient (R903), he was sitting in his recliner calmly with son in the room. The son had asked the morning aide if there was a physician on duty and the aide asked the writer (nurse). Writer stated that there aren't typically physicians (available) over the weekend. He (R903's son) then asked about getting an x-ray for his father because his wrist was swollen and how long it would be. He also asked to have his father (R903) sent to the hospital because he was in pain. Writer notified son that I would have to contact the physician and I would be in to assess the resident's (R903's) status. The son had called 911 to transport his father himself. At this point, the first responders were walking down the hallway before the writer could assess the patient. Resident was transferred to (name of hospital) at approx. 8:15 a.m. with son at bedside. Wife and (Physician D) notified of transfer. Review of R903's nursing progress note, dated 4/17/26 at 15:16 (4:16 p.m.), revealed, Patient (R903) returned from appointment alert and verbal. Consult report, x-ray show severe RA (Rheumatoid arthritis) Rt (right) shoulder. Cortisone injection given. Follow up as needed. Pain assessment endorsed to another nurse on the unit. Review of R903's nursing progress note, dated 4/16/26 at 00:48, revealed, R (right) rib 5th and 8th rib has nondisplaced fracture. MD (physician) is notified and aware. Orders for pain relief already in place. Will continue to monitor for safety. Review of R903's physician team progress note, (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and their presentation. The NHA explained they verified via camera footage there were three staff on the unit that night (4/19/26) and three were scheduled however denied having camera footage available when asked for review. The NHA respectfully disagreed with the supervision concerns respective to R903's ongoing and increased behaviors on and prior to 4/19/26, which resulted in two avoidable falls with injury. Review of the policy, Fall Management Guidelines, revised 2/03/26, revealed, The purpose of this policy is to provide guidelines to assist with fall risk identification and fall management of residents in the facility. Policy overview: .To provide guidelines to assist with fall risk identification and fall management of residents in the facility.General guidelines.Intrinsic factors that may increase the risk of falls include but are not limited to:.cognitive impairment, delirium.Extrinsic factors that may increase the risk of falls include, but are not limited to: assistive devices,.personal clothing or footwear.the MDS (assessment) identifies several possible indicators for falls or fall risk, including: fell in the past 30 days,.wandering.