STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235592	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huron Woods Nursing Center	1395 South Huron Road Kawkawlin, MI 48631

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 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 pertains to intake Number 2796974. Based on interview and record review, the facility failed to implement physician's orders for one resident (Resident #1) of three residents reviewed, resulting in a chest x-ray not being performed. Findings include:Resident #1 (R!): R1 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction, dysphagia, chronic cough and the need for assistance with personal care. Record review of a progress note from Licensed Practical Nurse (LPN) H, dated 1/14/2026 at 22:40pm, revealed that nursing staff were called to the room of R1. The daughter was observed feeding R1 Tic-Tacs and stated she was checking R1's swallowing abilities. The daughter stated that R1 did seem to be having some issues with swallowing and her lungs sounded bad. At this time the daughter requested a chest x-ray be ordered. The nurse present in the room assessed R1's lungs sounds and noted the lungs were clear to auscultation (CTA) but diminished throughout. The nurse made the Director of Nursing (DON) aware and R1 will be seen by the nurse practitioner (NP). Record review of an assessment titled, Health Care Practitioner Progress Note- [NAME] Woods, dated 1/15/26 at 13:56pm, revealed that the NP saw R1 and ordered a chest x-ray to evaluate for possible aspiration of acute pulmonary process. The NP reinforced the continuation of the pureed diet with nectar thick liquids due to aspiration risk. The NP stated to monitor for cough, fever, hypoxia or respiratory distress. Record review of physician orders for R1 revealed two orders were placed for a chest x-ray. One order was placed on 1/15/26 at 16:53pm and another order was placed on 1/15/26 at 17:37pm. Record review of a progress note from Registered Nurse (RN) D, dated 1/16/26 at 10:25am, revealed that the daughter of R1 phoned the facility, an update was given on the condition of R1. The daughter was upset that she was not told that R1 had vomited. The daughter also stated she was in the facility during the week was concerned that R1 had aspiration pneumonia because her lungs sounded bad and she had a productive cough. A chest x-ray was ordered, All-Stat (diagnostic company) was contacted and they stated they did not have an order for an x-ray, but that the nurse could place one. The health care practitioner was present in the building and saw R1, the daughter was pleased with this. The nurse stated she would contact the daughter once the x-ray results came back. The nurse assessed R1 and noted that her bilateral breath sounds were clear but diminished. R1's temperature was 97.1 and her oxygen saturation was 92% on room air. R1 received normal saline at 75ml/hr until 500cc's were completed due to not taking in as many fluids recently. Record review of a progress note dated 1/16/26 at 23:28pm, revealed that a speech therapy evaluation was completed per the daughters request due to thinking R1 was having difficulty swallowing. The speech therapist completed the bedside evaluation and believed that R1 should not have anything by mouth. The physician was notified of the findings and asked that the family be notified and for them to make a decision on further care or to have R1 sent to the hospital. The daughter wanted to keep R1 in the facility until they could speak with additional family members. Record review of a progress note dated 1/17/26 at 10:15am, revealed that the daughter wanted R1 sent to the hospital for evaluation and treatment. Record review of a progress note dated 1/19/26 at 8:54am, revealed that R1 was admitted to the 5th floor, neurosurgery of the hospital.On 5/27/26 at 11:40am, an interview was conducted with the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON). The DON was asked about the family request for a chest x-ray on 1/14/26. When the family requested a chest x-ray be ordered, should the nurse have notified the practitioner and had it ordered? The DON stated, typically, if a family is requesting some care we would notify the practitioner and go off their recommendations. Why was there a delay in getting the chest x-ray ordered? The DON stated, I know there was an issue with us placing orders and receiving faxes. I believe there is a communication gap between us and All-Stat. Our systems are integrated now, but at the time of this chest x-ray request, the nurses would have to enter an order into Point Click Care (PCC) and then enter an order into All-stat to have the x-ray done. The nurse didn't enter the order on the all-stat portal. Prior to the order on 1/17/26 were any other orders placed on All-Stat for R1? The DON stated, no, that was the only CXR that was ordered.The DON provided the order for the chest x-ray for R1 from All-Stat; it indicates that the service date was 1/17/26. R1 had already been discharged to the hospital for other reasons. The All-Stat portal revealed there were no results from the chest x-ray, which indicates the chest x-ray was never completed.On 5/27/26 at 12:43pm, an interview was conducted with RN D. RN D was asked what day did you place the order for a chest x-ray for R1? RN D stated, I believe I placed it on 1/16/26 after speaking with All-Stat. When you placed the order for the chest x-ray, did the company say when they would be out? RN D stated, no, they don't say when they will be out. I believe the tech told me they will send this order out, then they would call me with an approximate time. They never called back with an approximate time by the end of my shift. Did you listen to the lung sounds of R1? RN D stated, yes, I did and they were clear but diminished. If a family was requesting any kind of care what is your process? RN D stated, typically we look at their code status, to see the wishes of the resident, then I would do an assessment and notify the physician and receive orders and then we would call the family and let them know.On 5/27/26 at 12:57pm, an interview was conducted with LPN H. LPN H was asked what they did after the family requested the chest x-ray for R1? LPN H stated, I believe when something like that happens and there is no clinical indication (LPN H didn't think R1's lung sounds were bad based on assessment) that I will contact my on-call person and give them a report. I do believe that the on-call person said that they will contact the daughter the next day. The other thing I could have done was put a note in the communications book to the doctor so they could follow up the next time they are in. Whether or not I did that I cannot remember.