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	02/19/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include: On 02/18/2026 at 8:44am during the initial kitchen tour with Corporate Dietician F observed the drain line to the ice machine sitting directly in the drain. According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).On 02/18/2026 at 12:25pm during lunch observation, observed a tray with purees individually stored in bowls on the tray line. Puree green beans were temped at 123 F and puree chicken was temped at 127 F using Thermapen. During this observation, [NAME] G was interviewed on what the temperature should be while hot holding, and she answered 135 F. Corporate Dietician F was also interviewed on whether there is a facility policy on hot holding, and she stated the facility follows the FDA Food Code.According to the 2022 FDA Food Code, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, Except during preparation, cooking, or cooling, or when time is used as the public health control . time/temperature control for safety food shall be maintained .at 57 C (135 F) or above.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents' Advanced Directives' code status was documented and accessible in the medical record for 2 residents (Resident #3 and Resident #5) of 8 residents reviewed for Advanced Directives. Findings Include: Resident #3 (R3):A record review of R3's [NAME] Data Set assessment (MDS) dated [DATE] revealed a brief interview mental status (BIM's) score of 11 of 15, which indicated R3 was moderately cognitively impaired. R53 was admitted to skilled nursing on [DATE] with diagnoses of Inflammatory disorder of scrotum, diabetes mellitus type 2, chronic atrial fibrillation (irregular heartbeat), malignant neoplasm of left main bronchus (left lung cancer), need for assistance with personal care and spinal stenosis of cervical and lumbosacral regions.A record review of R3's physician determination of decision-making capability dated [DATE] revealed that R3 was capable of making medical treatment decisions. A record review of R3's face sheet revealed an Advance directive document link with no code status of CPR or DNR. A review of R3's Advanced directives link revealed no identifiable code status or preferred treatment option (PTO). It revealed the physician determination of decision-making capability signed [DATE] with no clear code status of CPR or DNR listed.A record review of R3's orders dated [DATE] revealed: Refer to Preferred Treatment Option for Advanced Directives.A record review of R3's care plan revealed: Initiated: [DATE]; Focus Potential with acute condition change with cardiopulmonary, metabolic or infectious complications. Intervention: Review advanced directives and know residents wishes for treatment.Resident #5 (R5):A record review of R5's [NAME] Data Set assessment (MDS) dated [DATE] revealed a brief interview mental status (BIM's) score of 15 of 15, which indicated R5 was cognitively intact. R5 was admitted to skilled nursing on [DATE] with diagnoses of displaced intertrochanteric fracture of right femur (right hip fracture), multiple sclerosis and need assistance with personal care.A record review of R5's physician determination of decision-making capability dated [DATE] revealed that R5 was capable of making medical treatment decisions. A record review of R5's face sheet revealed an Advance directive document link revealed no identifiable code status of CPR or DNR and no PTO. A review of R5's Advanced directives link revealed no code status or PTO. It revealed the physician determination of decision-making capability signed [DATE] with no clear code status of CPR or DNR listed.A record review of R5's orders dated [DATE] revealed: Refer to Preferred Treatment Option for Advanced Directives.A record review of R5's care plan revealed: Initiated: [DATE]; Focus: (R5) has the potential with acute condition change with cardiopulmonary, metabolic or infectious complications. Intervention: Review advanced directives and know residents wishes for treatment.----------On [DATE] at 2:50 PM, During an interview with the contract interim SW C she was asked about resident's code status/advance directives and who is responsible for getting them. SW C said it was a combination or responsibilities between the nurses and SW that ensure the code status for resident was put in place for residents, she said nurses or SW can complete the care plans.On [DATE] at 11:35 - 12:55 PM, The DON was queried about code status for R3 and R5 and where information could be found in the chart. The DON said it was under advanced directives and advanced care planning in the resident's chart. The DON was asked about the code status on face sheet, care plan and orders referencing the advanced directives to find PTO and code statuses, but they were filed under advanced care plan not was not in advanced directive (the link to find code status in the chart), she did not have an explanation.The DON said all updated code statuses are kept in a red binder at the nurse's station. The binder is updated as needed by the nurses and weekly by the scheduler. The DON said the scheduler will upload the documents to the medical chart after they are signed by the doctor. The DON said the red book labelled Resident Code Status- Preferred treatment option is the up-to-date code status and residents preferred treatments and where the staff find residents code status and not in the resident's chart. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said that in an emergency, staff would grab the red binder and look up the resident, it is alphabetized. When asked if the code book was not at the nurse's station and nothing had been uploaded into the medical chart, how would the staff know the code status of a resident, The DON said the book is always kept at the nurse's station and up to date. The DON agreed the red book is not a part of the residents' medical record and the medical chart does not reflect residents code status until the doctor signed it.Observation of the red book with DON revealed that R3 has a different PTO in the red book than in his chart that has handwritten DNR on it dated [DATE], the DON said that it was pending signature but was the resident's active status. Reviewed that the residents chart reflect a different PTO than the red book because the updated one int the red book was not signed and uploaded into the medical chart. The DON was asked could that lead to confusion, she said I see what you're saying. R5 had a PTO signed [DATE] with no distinction of code status CPR or DNR written on it. When the DON was asked about the handwritten code DNR on the PTO form for R3's and no distinction on R5's, the DON said they changed the practice of handwriting in the code status since November or December, to clarify either CPR or DNR on the PTO. The DON was asked why they not updated all the residents in the red book to reflect the clarity since it is updated weekly and admitted ly what the staff used as the code status, she did not have an answer. Clarified with the DON, the resident's medical records had no PTO or code status identified until it was signed by the physician and then uploaded into residents' chart and staff relied on the red book only. Also, clarified that nowhere in facilities written policies or procedures or in the resident's charted care plan, orders or advanced directives was the red code - PTO book referenced to identify residents' code status; Nor is there a written clarification of the preferred treatment option statuses to reflect clear coded statuses of CPR or DNR. The practice of not readily and clearly identifying a resident code status in an emergency could cost valuable time and or mis interpretation of the immediate response desired. A record review of the facilities policy and procedure titled Cardiopulmonary Resuscitation. revealed: Purpose: this facility will provide basic life support, including CPR - cardiopulmonary resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the residence advance directives.A record review of the facilities policy and procedure Advanced directives revealed: Policy: It is the policy of this facility to honor the health care decisions made by residents with decision making capacity or the resident's legal representative if the resident has not been made deemed of making decisions. a resident who lacks decision making capability and legal representation may require a preferred treatment option status 4. Purpose: to define the rights of residents to establish decisions concerning their medical and psychiatric care comma including the right to formulate advanced directives and the right to refuse unwanted medical treatment.Definitions: Advanced directives: an oral or preferably written statement by a resident with decision making capacity expressing his/her preferences for health care agent and or for future medical care in the event that he/she becomes unable to participate in medical decision making. Decision making capacity: the capacity of a resident to 1. understand his/ her medical condition. 2. appreciate the consequences of various treatment options including non-treatment. 3. judge the relationship between the treatment options and his or her personal values, preferences and goals. 4. reason and deliberate about his or her options and 5. Communicate his or her decision in a meaningful manner . Cardiopulmonary resuscitation (CPR): a procedure performed to attempt to support and restore ventilation and circulation in a resident experienced cardiac arrest or respiratory arrest. It includes establishment and maintenance of an airway, assisted ventilation, trust compressions, call to 911 emergency medical technicians and paramedics to provide establishment of intravenous access, cardiac monitoring, administration of medications, Defibrillation or other controlled arrhythmias, and immediate care after resuscitation. Do not resuscitate (DNR): an order written on the preferred treatment options form that indicates the residence or health agent's decision to refuse cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. A DNR order only becomes effective when the resident has experienced A cardiac (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or respiratory arrest. Clear and convincing evidence: generally, means it has to be in writing when referencing to advanced directives.Procedure: 1. admitting personnel assess whether the resident is capable of making decisions or has a legal medical decision maker. This information is documented on the preferred treatment option form. 2. An inner query is made upon a mission as to whether the resident possesses or wishes to execute an advanced directive. 3. If the resident already possesses an advance directive a copy of the advance directive will be placed with the preferred treatment option in the resident's clinical record.A record review of the facilities document named preferred treatment option (PTO) revealed status options labelled 0-4 defined as: Status 0: the resident is to be treated only in the nursing home. Interventions are limited to enduring comfort. No treatments are to be given beyond those necessary to relieve or prevent pain. Such treatments are not to include resuscitation; Status 1: the resident is to be treated only in the nursing home and is to receive interventions to promote comfort and treatments for presumed infection are limited to medications. Therapeutic testing may be performed, no diagnostic testing is to be performed, nor tube feedings. Such treatments are not to include resuscitation; Status 2: the resident is not to be hospitalized but is to be treated in the nursing home and to receive all interventions necessary to promote comfort and treat illness. Such interventions are limited to their availability in the nursing home, but include diagnostic tests, hydration through tube feedings, IV fluids if available, and IM or IV antibiotics. Such treatments are not to include resuscitation; Status 3: the president is to be hospitalized for any treatments that exceed the nursing home's capabilities and that are necessary to extend life or maintain comfort. Such treatments are not to include resuscitation. Surgical intervention is limited to conditions with a high probability of successful outcome; Status 4: a resident is to be hospitalized for any treatments that exceed the nursing home's capabilities and that are necessary to extend life or maintain comfort. Such treatments are to include resuscitation and surgical intervention.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate notice of non-coverage and maintain documentation for three residents (#56, #58, #59) of five residents reviewed, resulting in the lack of full disclosure related to Medicare rights and the inability to appeal the discharge in the time frame allotted by Medicare. Findings include: Record review of the facility 'Advanced Beneficiary Notice' policy, dated 11/2022, revealed that it is the policy of the facility to prepare and deliver to the resident or resident authorized representative an Advanced Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC) when the utilization review entity expects that Medicare probably will not pay for or will not continue to pay for extended care items or services . In an interview and records review on 02/18/2026 at 1:48 PM, Staff A Admissions Director reviewed 5 residents records with the state surveyor for Advanced Notice (ABN) and Notice of Medicare Non-Coverage (NOMNC):Resident #56:Record review of Resident #56 who was discharged home on 9/19/2025, did not have an ABN/NOMNC 2025 documentation found in the medical record. Staff A went through Resident #56's documents in the electronic medical record and doubled checked. Staff A stated that the only one the facility had dated for 2024, a previous stay that the resident had discharged from. Staff A stated that the facility did not have an admission director at that time. and that there was no 2025 NOMNC/ABN. Resident #58:Record review of Resident #58 who was discharged home on [DATE] did not have an ABN/NOMNC 2025 documentation found in the medical record. Staff A went through Resident #58's documents in the electronic medical record and doubled checked. Resident #58 was a Medicare Part A recipient. Staff A stated that the facility did not have an admission director at that time. and that there was no 2025 NOMNC/ABN for Resident #58's stay/discharge.Resident #59:Record review of Resident #59 who was discharged home on 9/24/2025 did not have an ABN/NOMNC 2025 documentation found in the medical record. Staff A went through Resident #59's documents in the electronic medical record and doubled checked. Resident #59 was a Medicare Part A recipient. Staff A stated that the facility did not have an admission director at that time. and that there was no 2025 NOMNC/ABN for Resident #59's stay/discharge.Record review of the facility 'Advanced Beneficiary Notice' policy, dated 11/2022, revealed that the facility will provide a completed copy of the notice of Medicare Non-Coverage (NOMNC) to enrollees receiving skilled care no later than two days prior to the termination of services. The NOMNC conveys notice to the beneficiary of his or her rights to an expedited review of a service termination

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that diabetic foot care was provided for one resident (R34) of one resident reviewed for ancillary services. Findings include: Resident #34 (R34):A record review of R34's [NAME] Data Set assessment (MDS) dated [DATE] revealed a Brief Interview Mental Status (BIMS) score of 15 of 15, which indicated R34 was cognitively intact. R34 was admitted to long term care (LTC) on [DATE] with diagnoses of diabetes mellitus type 2 with diabetic polyneuropathy (nerve damage), difficulty walking, need for assistance with personal care, history of falling, abnormalities with gait and mobility and lack of coordination. On [DATE] at 11:03AM, During an interview with R34 she said that she had asked to be seen by the podiatrist several times and stated that she felt he doesn't have enough time for me. R34 said the podiatrist ?pops in when he gets time' otherwise the staff told me that I needed to be on the calendar to be seen. R34 stated my nails are getting so long. R34 pulled off her socks and revealed her feet, an observation of R34's feet displayed a long and thickened toenail on the little toe of the left foot and long unkempt toenails throughout all five toes on the right foot.On [DATE] at 2:43PM, During an interview R34 said that she needed to see the podiatrist. R34 said that she was afraid she would not be seen by the podiatrist because she wouldn't be included on the podiatry schedule. R34 said she had seen the podiatrist several months ago, and when she asked the staff about being placed on the schedule for the next visit they said, ?they did not know when he was coming next or if she was on his schedule'. R34 verbalized that she was upset staff did not follow up with her on the information she had requested. R34 said she was concerned because she is diabetic and she needed regular foot care. R34 said when her kids visited that they occasionally trimmed her toenails, however her kids were afraid to clip them and shouldn't need to. A record reveal of R34's medical record revealed an active order dated [DATE] for dental, optometry, podiatry, audiology, or psychiatric / behavioral consult per consent.A record review of R34's chart revealed a request for services and consent for services through (facilities contracted company) for Podiatry services dated [DATE].A record review of R34's documents revealed a Podiatry visit note dated [DATE] revealed an initial and routine foot care exam was completed. On [DATE] at ~(approximately)10AM, The Director of Nursing (DON) was asked to provide (facilities contracted company) active census into (electronic document system).A record review of the summary of benefits page in the contract to residents enrolled in (facilities contracted company) under podiatry services revealed: Upon requesting services the podiatrist will perform an initial exam to evaluate the podiatric conditions of the patient and determine a plan of continued care for any outstanding issues; Routine foot care: a patient is eligible for routine foot care every 60 calendars days. Nail care is performed when the nails are elongated; Additional Podiatry exam: subsequent exam for a specific podiatric complication, complaint or issue.A record review of the (facilities contract company) NHQA report with R34's podiatry services listed revealed that on [DATE]: R34 had ?nail debridement of 6 or more nails and an initial visit with diagnoses of Tinea Unguium (toenail fungus and thickening) and generalized Atherosclerosis (buildup of plaque inside of arteries)'. The report also revealed the status of R34 as discharged .On [DATE] at 11:35AM, during an interview, the DON was asked how residents received services from (facilities contract company) for ancillary services and she said residents or responsible parties get the information in their admission packet and they sign a consent that they wish to receive the outside services or decline the outside services, she confirmed that consent/declination was kept in residents medical charts as part of admissions. The DON was asked to review the NHQA report provided by (facilities contract company) and clarify if the census was active residents enrolled in services. The DON called the (facilities contract company) for clarification. The DON advised that the report included every resident that was enrolled in (facilities contract company) services at the time it was printed. The DON confirmed the date the report was printed was [DATE]. The DON was asked and clarified that if a service was (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	listed it was performed, if it was offered and not performed it indicated the service was refused. The DON was queried on the abbreviations use in the resident services census, she stated DNT = do not treat resident ?on hold'; DEC = deceased resident and DIS = discharge resident. The DON was asked to review R34's chart and was asked if there was an order for R34 to have Podiatry services and she said yes there was one in the chart as a batch order and everyone gets that order, and said that it said per consent so one would have to go to the consents and see if the resident accepted or declined the services.The DON was asked if R34 had seen Podiatrist and she said yes, in June of 2025 there was a consent, a Podiatry visit and confirmed that R34 was also present on the NHQA report received from the (facilities contract company) that indicated a completed visit. The DON was asked to why R34 had not seen podiatry since June of 2025 for routine foot care, she replied I think it was an oversight. The DON said that R34 was originally at facility for skilled nursing and had left the facility for a hospital stay and that when R34 returned to the facility she changed from skilled to LTC status. The DON said the facility would have had to re-enroll R34 in the (facilities contract company) program with readmission. The DON was asked about the re-admission and if there was a different consent/declination present in R34's chart for the original dated [DATE], she agreed there was not. After we consulted with the admissions staff, the DON agreed they could not produce any documentation that differed from the original consent to services in R34's chart nor that R34 received a new (facilities contract company) agreement to accept or decline upon her readmission, the DON stated that is a problem and agreed the resident had consented to and requested Podiatry services originally. The DON said that she would reinstate R34's enrollment to (facilities contract company) for Podiatry services and make sure was seen on the next scheduled visit which was for [DATE].

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that oxygen was ordered, and care planned for 1 resident (Resident #9) of 2 residents reviewed for respiratory care. Findings Include: Resident #9: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #9 was admitted to the facility on [DATE] with diagnoses: Heart failure, history of a stroke, left side weakness, hypertension, hypothyroidism, COPD, diabetes, depression and anxiety. The MDS assessment dated [DATE] revealed the resident had mild cognitive decline with a Brief Interview for Mental Status/BIMS score of 12/15 and needed assistance with all care. On 2/17/2026 at 3:39 PM, during a tour of the facility Resident #9 was observed lying in bed awake, an oxygen concentrator was running with oxygen set at 3 liters per minute. The resident was asked if that is what it was normally set at and she said she didn't know.On 2/17/2027 at 3:50 PM, Nurse H was interviewed about Resident #9's oxygen and asked what the oxygen should be set at. Upon entering Resident #9's room, the nurse looked at the oxygen concentrator for Resident #9 and said she wasn't sure, but she would check the order. Nurse H proceeded to the Nurse's desk and after looking at the resident's chart in the computer, she said there was no order for oxygen. Nurse H said the resident was supposed to have oxygen, and she wasn't sure why there was no order. Nurse H called another nurse, and she advised her to obtain an order for the oxygen.A review of the physician orders for Resident #9 identified an order for oxygen dated 2/17/2026 at approximately 4:30 PM, Respiratory distress: Check oxygen saturation prn (as needed), start oxygen at 2 L per minute per nasal cannula. Recheck oxygen saturation prn and titrate oxygen to maintain oxygen saturation > 90%. Notify Health Care Practitioner prn.A review of the Care Plans for Resident #9 revealed, (Resident #9) has the potential with acute condition change with cardiopulmonary, metabolic or infectious complications., date initiated and revised 4/21/2025 with Interventions including: check oxygen saturation levels SAO2% and capillary refill prn, initiate O2 as ordered, 4/21/2025.On 2/18/2026 at 9:35 AM, the Director of Nursing was interviewed about the oxygen order for Resident #9, she said there should have been a physician order.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure that Certified Nursing Assistants (CNA) yearly performance reviews were conducted for two of five CNA's reviewed, resulting in the lack of yearly education training. Findings include: Record review of the facility 'Facility Staffing Template' policy, dated 6/2019, revealed it is the policy of the facility to conduct, document and annually review a facility-wide assessment, which included both the residents' population and the resources the facility needs to care for the residents. (c.) Facility resources needed to provide competent care for residents including staff, staffing plan, staff training/education and competencies, education and training . Record review of the facility 'Facility Assessment', dated 10/13/2025, revealed the facility used computerized training assigned specialized training with lessons to address Alzheimer's disease and pertinent communication strategies with the resident experiencing behavioral health needs. Individualized training will further assist with interventions to specifically address behavioral training and meaningful interventions. Annual CNA/Nurse skills training is performed by the Corporate Clinical Educator. PCC Behavioral Care Assessment and Infection Prevention features have been implemented to better identify and track resident associated behaviors and infections and trends. Current CNA/Nurse training courses are sufficient and address our residents' needs. As changes in population occur, our interdisciplinary team meets to determine the best plan of care for their specific needs. Our Corporate, Clinical Nursing Educator, assists and oversees training and assesses annually, and as needed.An interview and records review were conducted on 02/19/2026 at 10:58 AM with the Human Resource Staff B of employee files during the staffing task of the annual survey. Staff B stated that the annual employee performance evaluations/competencies start with the human resource tracking and forwarding the annual performance evaluation forms, names of the employees that are to have the evaluations. The Director of Nursing (DON) and/or Clinical Care Coordinator E oversee the annual performance evaluations, and they are to perform the evaluations. They are to return the forms to human resources and then track the dates and upload them into the employee file. Staff B stated that there was a spread sheet that tracks all staff for the whole building, and that goes by the hire date, and then whenever the annual performance was completed. Record review of employee files: Certified Nurse Assistant G had a Hire date of 10/12/2021 and the last documented annual Performance/competency was dated 11/8/2024 with recommendations to increase personalization and communication. There were no annual 2025 performance/competency evaluation documents found in the employee file. In an interview and records review on 02/19/2026 at 11:38 AM Staff B human resource stated that there was no 2025 annual performance/competency evaluation for employee CNA G. Staff B stated the reminders sent out. No other documents were presented to the state surveyor during the annual survey for employee G annual performance evaluation.Certified Nurse Assistant/Medication Tech F had a Hire date of 2/22/2002 and the last documented annual Performance/competency was dated 8/13/2024. There were no annual 2025 performance/competency evaluation documents found in the employee F file. In an interview and records review on 02/19/2026 at 11:38 AM Staff B human resource stated that there was no 2025 annual performance/competency evaluation for employee F. Staff B stated the reminders sent out. No other documents were presented to the state surveyor during the annual survey for employee F annual performance evaluation.

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	02/19/2026

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to implement an effective in-service nurse aide training program, that ensured continued compliance with educational training of 12 hours required annually for aides employed at the facility for 1 of 5 certified nursing assistants (CNA) resulting in continued non-compliance. Findings include: Record review of the facility 'Facility Assessment', dated 10/13/2025, revealed that the facility used computerized training assigned specialized training with lessons to address Alzheimer's disease and pertinent communication strategies with the resident experiencing behavioral health needs. Individualized training will further assist with interventions to specifically address behavioral training and meaningful interventions. Annual CNA/Nurse skills training is performed by the Corporate Clinical Educator. PCC Behavioral Care Assessment and Infection Prevention features have been implemented to better identify and track resident associated behaviors and infections and trends. Current CNA/Nurse training courses are sufficient and address our residents' needs. As changes in population occur, our interdisciplinary team meets to determine the best plan of care for their specific needs. Our Corporate, Clinical Nursing Educator, assists and oversees training and assesses annually, and as needed.Record review of the facility 'Facility Staffing Template' policy, dated 6/2019, revealed it is the policy of the facility to conduct, document and annually review a facility-wide assessment, which included both the residents' population and the resources the facility needs to care for the residents. (c.) Facility resources needed to provide competent care for residents including staff, staffing plan, staff training/education and competencies, education and training . An interview and records review were conducted on 02/19/2026 at 10:58 AM with the Human Resource Staff B of employee files during the staffing task of the annual survey. Staff B stated that the facility used a computerized staff training system that issued required training for Certified Nurse Assistance to get the required 12 hours of continuing education annually. Record review of employee Certified Nurse Assistant G had a Hire date of 10/12/2021 and the last documented annual Performance/competency was dated 11/8/2024 with recommendations to increase personalization and communication. There were no annual 2025 performance/competency evaluation documents found in the employee file. In an interview and records review on 02/19/2026 at 11:38 AM Staff B human resource stated that there was no 2025 annual performance/competency evaluation for employee CNA G. Staff B stated the reminders sent out. No other documents were presented to the state surveyor during the annual survey for education training for employee G.