STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235660	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Woodfield	5370 East Baldwin Road Grand Blanc, MI 48439

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 1) Call lights were answered in a timely manner, 2) Residents' preferences were respected, and 3) Residents were treated with dignity during the provision of care for one resident (Resident #28) and a confidential group of residents reviewed for dignity with care. Findings include: During the Facility's Monthly Resident Council Meeting held on 6/8/26 at 3:15 PM, twelve (12) residents of a confidential group of residents were present. At the meeting, the council raised the call light response time as an issue. They indicated that it has been an ongoing concern. Ten (10) confidential group of residents raised their hands when asked about the wait time experienced when they activated their call button. 10 indicated by raising their hand, experiencing an average of over 15-minute wait time for staff to respond to their call light. Eight (8) of twelve (12) residents continued to raise their hands when asked whether they had recently experienced a wait time of over 30 minutes after activating the call light. Among the 8 residents in the confidential group, two (2) residents expressed that staff do not seem to focus on providing quality care. When the surveyor asked if they could provide more specific details about the concern, one described the nursing staff as on their phones, talking to someone, or talking to each other about themselves and their personal issues. Another resident expressed that staff are not really focused on the residents here when providing care. The majority of the confidential group of residents indicated that this has been an issue raised for several months during monthly Resident Council Meetings, where they have expressed concerns about delayed responses to call lights or about call lights not being placed close to them or within their reach. or simply staff turning them off and leaving, saying they will return but do not return to address their immediate need. One said: Nothing seems to be done by the facility to resolve the issue. A review of the Resident Council Meeting Minutes dated 3/2/26, 4/20/26, and 5/11/26. The following are details of the concerns: Call light/Waiting (3/2/26)-Concern: healthcare resident council inconsistency on all shifts to put call light within reach and when returning to room. Facility action as resolution was noted: Satisfactorily-Huddles being completed with staff daily to re-educate on this topic. Also on agenda for discussion 3/8 and 3/19 CRCA meeting. There were no audits or interviews found to confirm with residents. No follow-up was documented for resolution. Call Light 4/20/26 - Concern: Healthcare resident council reports that assigned aides are not in the dining room at the assigned time; also, aides don't arrive promptly to get their residents from the dining room after meals,, causing extended wait times for residents. Resolved by re-education of (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff. No audits or interviews were found to confirm with residents. No follow-up was documented to confirm resolution. Call Light/Waiting 5/11/26 - Concern: Health Care Resident Council is noticing that aides are turning off resident call lights and stating they will return to complete the needed task. There were no audits or interviews found to confirm with residents. No follow-up was documented to confirm resolution. The Resident Council (RC) Minutes were discussed during the meeting, and it was confirmed that they remain unresolved. The Council Meeting ended on 6/8/26 at 4:09 PM. According to the Executive Director and the Administrator during the QAPI (Quality Assurance and Process Improvement) meeting held on 6/10/26 at 3:15 PM, they indicated that, there were different call light concerns each month, and they are resolved each time. A review of the Facility's policy was done on 6/10/26 at 2:30 PM: The Guidelines for Answering Call Lights Policy, date reviewed by the facility, 12/10/2025, revealed, Purpose Statement: The purpose of this policy is to respond to the resident's request and needs. Procedure: .5. Answer the call lights as quickly as possible .10. Provide the service the resident requested and turn off the call light. .11. If the service is unable to be provided, do not turn off the call light until appropriate staff are available to assist. .13. If nothing else is needed, return the call light to within reach of the resident. Resident Rights Guidelines, date reviewed: facility on 12/08/2025. Purpose Statement: The purpose of the policy is to ensure resident rights are respected and protected and to provide an environment in which they can be exercised. Precedure: .2. Our residents have the right to. a. Be treated with dignity and respect. Resident #28 (R28): A record review of R28's face sheet and Minimum Data Set (MDS) assessment indicated R28 was admitted to the facility on [DATE] with diagnoses that included: after care following digestive surgery, acute appendicitis, sepsis (extreme response to infection), presence of colostomy (surgical opening for stool to pass externally), paraplegic (paralysis of lower body) and urinary tract infection. The MDS assessment dated [DATE] indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15/15 and required assistance with care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/08/2026 at 2:35PM, during an interview with R28 and family member E, R28 said she has a long wait time for her call light to be answered and that mornings were especially slow response. R28 said she had requested to be out of bed and dressed for the day before breakfast so that she can eat breakfast in the dining room. R28 said that she has repeatedly asked staff to get her up and that today (05/08/2026) she was not dressed until 1:30PM. Family member E concurred with the time R28 stated. R28 further stated they put me in bed naked today after my bath and said they would be right back R28 and family member E concurred that it was approximately 45 minutes before anyone returned to get her dressed. R28 further stated I ending up eating my lunch naked in my bed, so it did not get cold while she waited. On 06/09/2026 at 8:25AM, during medication administration observation of the resident she was resting in bed in green gown. R28 said she no one got her dressed as requested, and they had brought her breakfast to her room, so she had eaten it in her room today (06/09/2026). On 06/10/2026 at 9:03AM, Observed R28 call light on and entered her room to follow up, R28 was in bed in her night gown and stated they are still not getting me up for breakfast R28 said that she had made the request to the CNA's and said it is hard to remember who was who among the staff to recall, when asked. When asked, R28 said her call light had been on for about 10 minutes before SA entered her room. SA exited room of R28 at 9:05AM and continued observation of R28's room from hall. On 06/10/2026 at 9:08AM, observed MDS D enter R28's room and overheard him ask R28 'what she needed', and overheard R28's response I am still waiting to get out of bed and heard MDS D who replied, I will let your CNA know. Observed MDS D exit R28's room with R28's meal tray and observed the call light was no longer on in the hall. Observation of R28's room continued from the hall. On 06/10/2026 at 9:19AM, during the continued observation of R28's room from hall, no staff came and at 9:19AM R28's call light was turned back on and visible from the hall. On 06/10/2026 at 9:23AM, observed ADON stop at R28's door and overheard her ask 'what she needed help with' and overheard R28's response I am still waiting to get out of bed, and no one came back. Observed ADON and CNA K don (apply) personal protective equipment (PPE) enter R28's room. According to the interviews and observations R28 had used call lights and made requests for assistance to staff without assistance provided from approximately 8:53AM until 9:23AM. On 06/10/2026 at approximately 10:30AM, Family Member E was asked if she could confirm the staff that bathed R28 on 06/08/2026 and she said she was unsure because the day was such a blur now and she does not know names, maybe the therapy or CNA. On 06/10/2026 at 11:13 AM, during an interview with Occupational therapist (OT) F she said that she assisted R28 with the shower on 05/08/2026 as part of occupational therapy. OT F said that since R28 has diagnoses of paraplegia she had to do everything at bed level, and that R28 had to be in bed to get dressed, so she was in bed naked. OT F said she stepped out to let the nurse know that R28 had her shower and needed cream for dermatitis before getting her dressed. When asked if 45 minutes was acceptable for a resident who was waiting naked in bed and was upset about that they had to eat lunch that way was appropriate and she said no, that is unfortunate and that she was not sure what the delay was from, and stated I guess if I would have known it was going to take so long, I would have gone ahead and gotten her dressed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/10/2026 at 11:50AM, Executive Director (ED) C approached SA and offered that she had talked to OT and then did an investigation. ED C said she asked R28 and Family member E how long R28 had waited and they said, 'they couldn't remember because so many things were going on that day'. ED C said Nurse G reported 'that it was about 20 minutes until she treated resident and not 45 minutes.'The medication administration records (MAR), and treatment administration records (TAR) were requested from ED C for R28 on 06/08/2026. On 06/10/2026 at 2:59PM, received a return phone call from Nurse G and during the interview she said it was about 20 minutes after she was informed of the requested care, that she provided that care to R28, that she was prepped and administered an IV medication prior to that. Nurse G said she applied R28's cream but did not get R28 dressed, that the CNA and the OT got R28 dressed. On 06/10/2026 at 3:05PM, ED C was asked how often residents are assessed for preferences and care planning. ED C said they get an assessment with in 5 days of admission, if they have a significant change and quarterly. She was asked how the care plan was updated and she said it was updated from conversations and interactions, they are not documented in progress notes unless the social worker or interdisciplinary team reviewed them. She said she was made aware today (06/10/2026) when she interviewed the resident and that she updated her care plan, that if R28 had told staff they should have updated the care plan, and if R28 had requested it to staff and it was not addressed that was a problem. According to a record review of the MAR/TAR it indicated that treatment or medication was completed and did not have time stamp associated. When requested the specific time stamped MAR/TAR for R28, she said it was not available. According to a review of R28'd plan of care (POC) medical record: 'activities of daily living (ADL's) bathing dated 06/08/2026 at 12:04PM R28 received a shower.' A record review of R28's care plan revealed: Dated 05/27/2026 Focus: Resident has impairment in functional status. with Interventions: Provide assistance as needed with self-care and mobility functional tasks. Not found in care plan residents' preference was to be up and dressed for breakfast in the dining room daily. According to a record review of the facility policy labelled call lights the Policy: guidelines for answering call lights: procedure: 5. Answer the call light as quickly as possible; 10. Provide this service the resident requested and turn the call light off; 11. If the service is unable to be provided do not turn the call light off until the appropriate staff is available to assist.No specific policy was provided on Dignity to review as requested. According to a record review of the facilities policy titled Residents rights guidelines:Procedure. 2. Our residents have the right to.; a. Be treated with dignity and respect; b. Be given the information necessary to participate in decisions which affect them both individually.; t. Which means they're probably be consulted and encouraged to have input into their care which guides the services delivered.;

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interviews, and record review, the facility 1) Failed to ensure that medications and related supplies were properly labeled, stored, and discarded upon expiration and, 2) Failed to secure chemical medication destroyers, chemical sanitation cloths, and alcohol˜based hand rubs out of residents' reach. These deficiencies were identified in two of two medication carts, one of two medication rooms, and in three of three resident units reviewed for medication storage.Findings include: On 06/10/2026 at 9:16AM, an observation of the resident living room / nursing station area on unit 300 revealed that on top of the nurse's station at mid chest level (~ approximately 4 feet high) were two large bottles of RX (prescription) medication destroyer with a label that read: always store in a secure location and out of reach of children; warnings: if ingested, contact poison control. if solution comes into contact with eyes, flush with cool water for 15 minutes and consult position immediately. Also locate at the nurse's station at midthigh level (~ approximately 3 feet high) was an 8-ounce bottle of purple spray with a label perineal and skin cleanser. On 06/10/2026 at 9:20AM, during an observation and interview with the ADON she was asked if the RX (prescription) medication destroyer and perineal and skin cleanser should be stored in the resident common areas and within reach. ADON said no they should not be and said they should be kept in the secure medication room behind the desk. ADON took the items and stored them in the medication room. According to a review of the safety data sheet (SDS) for (brand name) perineal care: individual protection measures, such as personal protective equipment; Eye/Face Protection Avoid contact with eyes. General Hygiene Considerations: Do not get in eyes. Keep away from food and drink.On 06/10/2026 at 09:23 AM, during a walkthrough of resident unit 100 an observation of 75 count (brand name) sanitation wipes with bleach and 160 count (brand name) germicidal sanitation wipes both were on top of nurse's station at mid chest level (~ approximately 4 feet high). Also observed on resident's hall handrail was one 8-ounce pump style bottle of ABHR, with warning label: do not use in eyes. Observed in the living room area of 100 hall on a side table (~ approximately 2 feet high) between the couch and chair was one 160 count (brand name) germicidal sanitation wipes and one 8-ounce pump style bottle of ABHR. According to a record review of the brand name sanitation wipes SDS warnings: avoid skin or eye contact; keep out of reach of children and unauthorized personnel.; 7.1. Precautions for safe handling Precautions for safe handling Hygiene measures: Ensure good ventilation of the workstation. Wear personal protective equipment: Do not eat, drink or smoke when using this product. Always wash hands after handling the product.On 06/10/2026 at 09:26 AM, during a walkthrough or resident unit 200 an observation of 8-ounce pump style bottle of ABHR was sitting on top of a personal protection equipment (PPE) cart at knee height (~ approximately 2 feet high) within residents reach in residential hallway. Also observed on top of a cart at mid chest level (~ approximately 4 feet high) were two 8-ounce pump style bottles of ABHR, with warning labels: do not use in eyes. On 06/10/2026 at 09:30 AM, during a requested walkthrough of the facility with the ADON she verified locations and removed all the chemicals mentioned in above-mentioned observations. When queried the ADON said none of these should be within the resident's reach. On 06/10/2026 at 09:50 AM, during medication storage with the ADON, observed in medication room on unit 200 in the IV-treatment cart were two 24 gauge IV start needles with the expiration date of 03/01/2025. ADON said she didn't know where they were from, and she took them to discard. Additionally, an observation of medication cart on 200 (front hall) revealed one resident Novolog insulin pen label on a bag that contained another resident's Humalog Kwik pen inside. ADON said she didn't know how that happened and that only one of the residents was in that part of the unit. Observed a bottle of Timolol maleate eye drops with peeled label stored in a bottle with a resident label and date 05/04/2026. When asked how they would be identified when they were removed from the bottle, ADON and Nurse I said they could not be easily. Observed 3 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	separate residents' Lanaprost eye drops with open dates: 04/19; 04/23 and 04/27. Nurse I was asked how long the eye drops are good for once opened and she looked it up and said 45 days. The ADON was asked if according to the expiration schedule any of these were still ok to use, she responded no. the ADON Verified that the latest dated one 04/27 would have expired on 06/08/2026. Continued observation on the 300 unit and the medication cart was observed a loose Albuterol inhaler with black marker labelled 311A (no name) opened 05/05/2026. ADON and Nurse J agreed that was not a sufficient resident identified label and could easily lead to an error. On 06/10/2026 at ~03:00 PM When asked EDC said they had no specific policy on chemical storage and was asked for safety data sheets for each; they were not supplied by facility but were obtained online after the survey. A record review of the (facility pharmacy) expiration dates revealed: Timolol maleate eye drops expired 30 days after opening; Lanaprost eye drops expired 6 week/42 days after opening. A record review of the facilities policy titled Medication storage in the facility revealed: Policy: medications and biologics are to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed facility personnel, pharmacy personnel, or facility personnel lawfully authorized to administer medications. With Procedures: C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label; G. Potentially harmful substances are clearly identified and stored in a locked area separately from medication; H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of.; expiration dating: c. Certain medications or package types, such as four solutions, multiple dose injectable vials, ophthalmic, nitro glycerin tablets. once opened require an expiration date shorter than the manufacturers to ensure purity and potency; d. The medication administration personnel will check the expiration date of each medication before administering it; e. No expired medication will be administered to a resident. F. Call expired medications will be removed from the active supply and destroyed in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 06/08/2026 at 9:18AM during the initial kitchen tour with Assistant Manager A, salmon packaged in separate plastic bags with a prep date of 5/20/26 and use by date of 5/26/26 was observed in the walk-in cooler. During this observation, Assistant Manager A stated it was taken out of the freezer this weekend and continued to throw out the salmon. On 06/08/2026 at 9:28AM interior walls of microwave were observed to be visibly soiled with food debris. During this observation, Assistant Manager A said oh gosh when she saw the dirty microwave and stated that they clean it every day. On 06/08/2026 at 9:34AM two cans of baked beans with dents on the seams were observed on the can rack in the dry storage room. During this observation, Assistant Manager A was interviewed on the process of eliminating dented cans from storage and she stated the dented cans are thrown out, and they receive credit for them, then she proceeded to throw out the dented cans. In addition, Assistant Manager A stated she will re-check cans during stock on Tuesdays and Fridays. During this time, Assistant Manager A observed another dented can that contained hot fudge and proceeded to throw out that can as well. On 06/08/2026 at approximately 11:45AM interviewed Assistant Manager A on whether there is a log or documentation on thawing of foods, particularly for the salmon that was found in the walk-in cooler earlier this morning, and she stated there wasn't any documentation or logs for thawing. During this time, Assistant Manager A presented a labeling sticker that is used to date mark food and said that staff probably didn't replace the sticker when the salmon started to thaw. According to the 2022 Food Code, 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, Time/temperature control for safety refrigerated foods must be consumed, sold or discarded by the expiration date. According to the FDA 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the FDA 2022 Food Code, 3-101.11 Safe, Unadulterated, and Honestly Presented, Food shall be safe, unadulterated, and, as specified under S 3-601.12, honestly presented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an active plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in allowing waterborne pathogens to exist and spread in the facility's plumbing system with an increased risk of respiratory infection among all residents in the facility. Findings include: On [DATE] at approximately 1:00PM the environmental tour was conducted with Maintenance Director B. When interviewed on chlorine residual testing, he stated the chlorine test strips are expired, and he will have more coming in today. The chlorine test strips were observed to have an expiration date of 6/2023. During this observation, Maintenance Director B was interviewed on what range the chlorine is kept at and he stated it's usually pretty low, and it's tested monthly. Record review of facility's chlorine logs show multiple free chlorine results at zero, dated [DATE], [DATE], [DATE], and [DATE]. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated [DATE]rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3011265. Based on interview and record review, the facility failed to ensure an appropriate, complete and thorough investigation was conducted for one (1) resident (Resident #77) of 3 residents reviewed for discharges when Resident #77 became unresponsive while receiving a shower done by a family member with unknown training for performing safe Activities of Daily Living (ADL) and no other nursing staff member was present to witness the unusual event resulting in R77 hitting her head on the grab bar, exhibiting a significant change in condition during the shower and being immediately transferred to the hospital for evaluation.Findings include: Resident #77 (R77):A review of R77's progress notes dated [DATE] at 1:27 PM described: Resident R77 was receiving a shower by daughter when she became unresponsive. The resident hit her head on the grab bar. The resident was breathing with a faint pulse. Resident's face and lips cyanotic. The resident was transferred from a wheelchair to bed. When the resident was transferred to bed, she returned to consciousness but continued to close her eyes while the staff was talking to her. Resident's BP was 75/54. The resident's pulse continued to be faint and irregular. The resident was placed in the Trendelenburg position. EMS was contacted. Family at the bedside is visibly upset. ADHS was present at the time, and the resident was taken to the nearby hospital (hospital name mentioned).According to the facility face sheet, R77 was [AGE] years old, admitted on [DATE], and was discharged on [DATE].R77 had a list of diagnoses and received treatment for Type 2 Diabetes Mellitus with hyperglycemia, essential hypertension, gastro-esophageal reflux disease without esophagitis, adjustment disorder, and anxiety disorder, in addition to other diagnoses. R77's Brief Interview for Mental Status (BIMS) Score, assessed on [DATE], was 14/15. A score of 14 means that the person is cognitively intact. The Minimum Data Set (MDS), GG section, assessed on [DATE], coincided with the Care Plan for ADLs created on [DATE] at 11:11 AM and indicated that Resident (77) requires staff assistance to complete self-care and mobility functional tasks safely and completely. GOAL: Resident's functional needs will be met safely by staff. R77 did not have a care plan specifying that the family can provide R77's ADLs, particularly showers.An attempt to call the family member via phone was made on [DATE] at 3:30 PM. Family returned the call on [DATE] at 3:39 PM and stated that they were present during the incident. When asked who they were? Family #1 stated, My sister and I were giving mom a shower, and, according to Family #1, they did not receive any training or an in-service from the facility on how to provide showers. Staff asked them if they could give it, so they did. They were not aware of any training requirement. They were alone with their mother when it happened, and no staff was available when their mother started to pass out. There were no other staff present during the shower when she slumped over and hit her head on the shower bar. Family #1 further described that they activated the call light immediately but could not leave to yell for help, and it took a very long time for staff to respond. Family #1 said, It was the maintenance man who came first on the scene, and no nurse or aide responded to the call. When staff finally responded, they laid her flat on the floor, and an ambulance was called. We held her in the shower chair, so she did not fall, but she was moved to the ground by staff to assess her breathing and pulse. She was on the floor when the ambulance came. Family #1 was unsure whether CPR was performed. She is not medical, but she was blue on the lips and her face. Maybe they performed CPR. I really don't know.According to an interview with the Director of Nursing (DON) on [DATE] at 10:30 AM, the DON stated that the resident had syncope and was sent to the hospital on (DATE). It did not deem an investigation necessary because the event is a medical condition. The surveyor asked who diagnosed that the resident had a syncopal episode? Is the syncopal episode concluded from an investigation of what happened? The DON remained quiet and did not answer. The surveyor asked, How did R77 bump her head, and what caused the cyanosis of the lips and face? Was any staff member present during the syncopal episode? Did a provider or a physician give this diagnosis? where (continued on next page)

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	235660	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Woodfield	5370 East Baldwin Road Grand Blanc, MI 48439

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there staff statements obtained in this particular event? Did she fall? Was she on the floor? Why was she transferred to the chair? Was she on the floor, then to the chair, then to the bed? The DON stated. There was no soft file or investigation because it did not warrant one.Regional Staff on [DATE] at 12:15 PM insisted that the incident was a medical change in condition and did not need any investigation.Executive Director was interviewed on [DATE] at approximately 3:45 PM along with the Administrator. The Executive Director stated that she was not aware of this incident and, when checked, was off at the time. When asked if this incident was deemed an investigation, she agreed, yes. She would. The Administrator revealed that she received a report stating that R77 had a change in condition and was sent to the hospital. She did not know the details about the shower done by the family where she passed out and called emergency 911. She agreed that it would be deemed an incident report and a call to the Executive Director.A call was made to the Nurse-in-charge of R77 (during the [DATE] incident) on [DATE] at 3:31 PM. The surveyor left a voicemail, but there was no reply. The surveyor learned from the facility Executive Director that the Nurse-in-charge was terminated and is no longer employed by the facility.Physical Therapy notes dated [DATE] to [DATE] were reviewed. Upon review of the Rehab notes, no notes were found, nor was there any indication that the family received ADL care training, specifically bathing/showering, in the rehab record or in R77's progress notes. on 3/26,26 Rehab notes revealed discontinued service on [DATE]: Not assessed prior to sudden hospitalization. Occupational Therapy (OT) notes dated [DATE] to [DATE] were reviewed. No notes were found, nor was any indication written that the family received ADL care training, specifically bathing/showering, in the rehab record or in R77's progress notes. on 3/26,26 Rehab notes revealed discontinued service on [DATE]: Not assessed prior to sudden hospitalization. The OT progress notes dated [DATE] , R77 Functional Skills Assessment revealed: Bathing- Shower/bath self: Partial/moderate assistance. Functional Skills Assessment-Functional Mobility: Tub/Shower Transfer=Supervision or touching assistance. The OT Progress Notes continued . Assessment and Summary of Skilled Services: Skilled Interventions Provided Skilled Treatment interventions included instructing and training the patient in compensatory strategies, energy conservation techniques, safety precautions, safe transfer techniques, and the use of assistive device(s) to decrease fall risk and maximize ADL independence. Discharge (D/C) Destination: Acute Care Hospital. D/C Reason: Discharge to Hospital.An interview with Rehab by the surveyor on [DATE] at 2:30 PM confirmed that the family did not receive any training to perform R77's Activities of Daily Living (ADLs).On [DATE] at 10:30 AM, the Activities of Daily Living (ADL) Policy was requested, and the Executive Director stated that the facility did not have an ADL policy.Fall Management Program Guidelines, undated, were reviewed on [DATE] at 4:00 PM.Purpose Statement: The purpose of this policy is for (Name of the Company) to strive to maintain a hazard-free environment, mitigate fall risk factors, and implement preventative measures. (Name of the Corporation mentioned) recognizes even the most vigilant efforts may not prevent all falls and injuries .Policy for Abuse was reviewed on [DATE] at 4:05 PM.Purpose StatementThe purpose of this policy is to: (Name of Company mentioned), has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.Policy: Abuse, Neglect, and Exploitation Procedural GuidelinesProcedure:1. (Name of Company mentioned), has implemented processes in an effort to provide a comfortable and safe environment.2. The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures3. Definitions: ABUSE is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.f) Investigationi. The Executive Director is accountable for investigating and reporting.ii. Exercising caution in handling evidence that could be used in a criminal investigation. (e.g., not tampering or destroying evidence)iii. Investigating different types of alleged violationsiv. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.v. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause.vi. Providing complete & thorough documentation of the investigation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive care plan for 1 resident (Resident #85) of 19 residents reviewed, resulting in Resident #85 lacking Care Plan interventions for a neck brace, which could lead to the resident lacking necessary care and services. Findings Include: Resident #85: Care Plans A record review of the Face sheet and electronic medical record indicated Resident #85 was admitted to the facility on [DATE] with diagnoses: history of falls with facial fracture, sixth cervical vertebral fracture, fracture of first thoracic vertebra, wedge compression fracture of second thoracic vertebra, fracture nasal bones, maxillary fracture, dementia, hypothyroidism, anxiety, and hypertension. On 6/08/2026 at 10:19 AM, Resident #85 was observed sitting in a Broda chair in the dayroom on the 100 Hall. The resident was observed to have large purple bruising on both sides of her face, and she was wearing a neck brace. The neck brace had a large round dark red stain approximately 2 cm x 2cm on the lower left front of the neck brace. She was resting with her eyes closed. On 6/8/2026 at 10:20 AM Nurse N was interviewed about Resident #85, and she said the resident had been at the facility for a Couple days. The nurse was asked about the resident's neck brace, and she said she thought it was dried blood on the front of the brace, but she would have to look into it. On 6/8/2026 at 2:00 PM, Nurse N was interviewed and said a new neck brace was ordered for Resident #85. A review of the physician orders for Resident #85 identified, Cervical collar, may remove for skin checks Twice a day, start date 6/3/2026. A review of the Care Plans for Resident #85 provided the following: Resident has impairment in functional status related to C6 and facial fractures, hypertension, dementia, start date 6/3/2026. Skin integrity: At risk for skin breakdown related to impaired mobility, start date 6/3/2026. There was no mention of checking the skin under the neck brace. There was no mention of the neck brace. Falls: Resident is at risk for falling related to impaired mobility, start date 6/3/2026. There was no mention of wearing a neck brace due to the prior falls and fractures. Pain: At risk for pain related to facial and C6 fractures, start date 6/3/2026. There was no mention of wearing a neck brace. The resident's Care Plans did not mention the neck brace. On 6/10/2026 at 1:34 PM the resident was observed in her room lying in bed awake; a new soft neck brace was in place. Nurse N was interviewed and she said the new neck brace was provided the day before (6/9/2026).

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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** Based on observation, interview, and record review, the facility failed to ensure that appropriate skin care was provided for one resident (Resident #40) and that appropriate Activities of Daily Living (ADL) care for one resident (Resident #77) was provided by trained nursing staff during showers for 6 residents reviewed for skin and ADL care. Findings include: Resident #40 (R40):According to the facility Face Sheet, R40 was admitted to the facility on [DATE] with a diagnosis of Hypertensive Heart Disease with CHF, Pneumonia, Difficulty Walking, and Mild Cognitive Impairment in addition to other diagnoses.On [DATE] at 3:05 PM, R40 was observed to be alert and oriented, with a Brief Interview of Mental Status (BIMS) Score of 13/15 per CMS-generated data submitted by the facility. A score of 13-15 means that the individual's cognitive function is intact. A review of R40 's Care Plan for skin care dated [DATE], indicated:1. Moisture-Associated Skin DamageInterventions:Keep skin clean and dry.Observe for pain/itching/ discomfort and treat as ordered.Observe MASD for decline or s/sx of infection,Notifying the physician as needed.Treatment as needed.2. At risk for skin breakdown related to morbid obesity and impaired mobility Treatments as ordered.On [DATE] at 3:05 PM, R40 was observed in her room sitting up on her bed. When asked how she was, R40 was concerned and complained of redness, itching, and discomfort in her abdominal skinfold areas, under her breast, and sometimes in her privates. R40 stated she has been complaining of her issue to the nurses and has not been seen by a doctor for it. R40 expressed that sometimes it becomes unbearable that she could not sleep. She would ask the Nursing Assistant (CNA) assigned to her to apply it to her folds and under her breast, and it gives her so much relief that she reports that she is able to sleep. She was previously treated for her fungal infection in the areas mentioned when she was home, and she wanted to take precautions to prevent it from happening again.A review of R40's medication list was conducted on [DATE] at 11:30 AM. R40's Medication and treatment record dated [DATE] has no prescribed medications, no skin treatments, and no preventative skin care orders. No vaginal cream treatments were noted.On [DATE], at 9:45 am, while waiting for the Certified Nurse Aide to provide skin care, R40 showed the surveyor two tubes of cream kept in her bedside table drawer. R40 revealed that the aides apply them on her abdominal folds and under her breast when she's having discomfort. She further described her discomfort as burning, painful, and itchy. R40 stated she needed them last night and slept better last night after the nurse applied it on her foldsAt 10:15 AM on [DATE], the CNA came to perform her skin check with the surveyor; the abdominal fold area was intact but red. There was a raised reddened area that she had pointed ([NAME] -size) under her right breast and the adjacent abdomen touching the breast that was red. The raised area was red, and it was apparently of a similar shape because the skin was rubbing against each other. R40 commented, That area burns! The CNA confirmed they were applying the cream per the R40's request and commented further that she must have brought them from home.The nurse confirmed at 10:30 AM that R40 had no skin or topical cream ordered for her. The nurse on duty explained that she is just initiating an assessment for R40 self-medication. The nurse confirmed that she did not have the order to keep her own and apply the cream without the doctor's go-ahead. R40 must have brought the vaginal cream and the skin cream from home because no skin care was ordered for her. While in R40's room, the nurse pointed out that the Desitin cream is available over the counter, but the vaginal cream is a prescription treatment. None were listed in her physician's orders.According to the Director of Nursing (DON), on [DATE] at 10:00 AM, there was no skin care or vaginal cream ordered for R40. An assessment and an order allowing her to self-medicate are needed to have R40 keep them at bedside.According to the DON and the Executive Director, on [DATE] at 2:30 PM, the company did not have a policy for ADL (Activities of Daily Living) Care.Resident #77 (R77):A review of R77's progress notes, dated [DATE] at 1:27 PM, described: Resident R77 was receiving a shower by daughter when she became unresponsive. The resident hit her head on the grab bar. The resident was breathing with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a faint pulse. Resident's face and lips cyanotic. The resident was transferred from a wheelchair to bed. When the resident was transferred to bed, she returned to consciousness but continued to close her eyes while the staff was talking to her. Resident's BP was 75/54. The resident's pulse continued to be faint and irregular. The resident was placed in the Trendelenburg position. EMS was contacted. Family at the bedside is visibly upset. ADHS was present at the time, and the resident was taken to the nearby hospital (hospital name mentioned).According to the facility face sheet, R77 was [AGE] years old, admitted on [DATE], and was discharged on [DATE].R77 had a list of diagnoses and received treatment for Type 2 Diabetes Mellitus with hyperglycemia, essential hypertension, gastro-esophageal reflux disease without esophagitis, adjustment disorder, and anxiety disorder, in addition to other diagnoses. R77's Brief Interview for Mental Status (BIMS) Score, assessed on [DATE], was 14/15. A score of 14 means that the person is cognitively intact. The Minimum Data Set (MDS), GG section, assessed on [DATE], coincided with the Care Plan for ADLs created on [DATE] at 11:11 AM and indicated that Resident (77) requires staff assistance to complete self-care and mobility functional tasks safely and completely. GOAL: Resident's functional needs will be met safely by staff. R77 did not have a care plan specifying that the family can provide R77's ADLs, particularly showers.An attempt to call the family member via phone was made on [DATE] at 3:30 PM. Family returned the call on [DATE] at 3:39 PM and stated that they were present during the incident. When asked who they were? Family #1 stated, My sister and I were giving mom a shower, and, according to Family #1, they did not receive any training or an in-service from the facility on how to provide showers. Staff asked them if they could give it, so they did. They were not aware of any training requirement. They were alone with their mother when it happened, and no staff was available when their mother started to pass out. There were no other staff present during the shower when she slumped over and hit her head on the shower bar. Family #1 further described that they activated the call light immediately but could not leave to yell for help, and it took a very long time for staff to respond. Family #1 said, It was the maintenance man who came first on the scene, and no nurse or aide responded to the call. When staff finally responded, they laid her flat on the floor, and an ambulance was called. We held her in the shower chair, so she did not fall, but she was moved to the ground by staff to assess her breathing and pulse. She was on the floor when the ambulance came. Family #1 was unsure whether CPR was performed. She is not medical, but she was blue on the lips and her face. Maybe they performed CPR. I really don't know.According to an interview with the Director of Nursing (DON) on [DATE] at 10:30 AM, the DON stated that the resident had syncope and was sent to the hospital on (DATE). It did not deem an investigation necessary because the event is a medical condition. The surveyor asked who diagnosed that the resident had a syncopal episode? Is the syncopal episode concluded from an investigation of what happened? The DON remained quiet and did not answer. The surveyor asked, How did R77 bump her head, and what caused the cyanosis of the lips and face? Was any staff member present during the syncopal episode? Did a provider or a physician give this diagnosis? where there staff statements obtained in this particular event? Did she fall? Was she on the floor? Why was she transferred to the chair? Was she on the floor, then to the chair, then to the bed? The DON stated. There was no soft file or investigation because it did not warrant one.Executive Director was interviewed on [DATE] at approximately 3:45 PM along with the Administrator. The Executive Director stated that she was not aware of this incident and, when checked, was off at the time. When asked if this incident was deemed an investigation, she agreed, yes. She would. The Administrator revealed that she received a report stating that R77 had a change in condition and was sent to the hospital. She did not know the details about the shower done by the family where she passed out and called emergency 911. She agreed that it would be deemed an incident report and a call to the Executive Director.Physical Therapy notes dated [DATE] to [DATE] were reviewed. Upon review of the Rehab notes, no notes were found, nor was there any indication that the family received ADL care training, specifically bathing/showering, in the rehab record or in R77's progress notes. on 3/26,26 Rehab notes revealed discontinued service on [DATE]: Not (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed prior to sudden hospitalization. Occupational Therapy (OT) notes dated [DATE] to [DATE] were reviewed. No notes were found, nor was any indication written that the family received ADL care training, specifically bathing/showering, in the rehab record or in R77's progress notes. on 3/26,26 Rehab notes revealed discontinued service on [DATE]: Not assessed prior to sudden hospitalization. The OT progress notes dated [DATE] , R77 Functional Skills Assessment revealed: Bathing- Shower/bath self: Partial/moderate assistance. Functional Skills Assessment-Functional Mobility: Tub/Shower Transfer=Supervision or touching assistance. The OT Progress Notes continued . Assessment and Summary of Skilled Services: Skilled Interventions Provided. Skilled Treatment interventions included instructing and training the patient in compensatory strategies, energy conservation techniques, safety precautions, safe transfer techniques, and the use of assistive device(s) to decrease fall risk and maximize ADL independence. Discharge (D/C) Destination: Acute Care Hospital. D/C Reason: Discharge to Hospital.An interview with Rehab by the surveyor on [DATE] at 3:30 PM confirmed that the family did not receive any training to perform R77's Activities of Daily Living (ADLs).On [DATE] at approximately 2:30 AM, the Activities of Daily Living (ADL) Policy was requested, and the Executive Director stated that the facility did not have an ADL policy.

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F 0689 Level of Harm - Minimal harm or potential for 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 pertains to Intake Number 3011265.Based on interview and record review, the facility failed to ensure that neurological assessments (neuro checks) were completed per Standards of Practice after unwitnessed resident falls and/or witnessed falls with a head injury for 1 resident (Resident # 80) of 3 resiudents reviewed for falls, resulting in the potential for head injury without necessary Neuro assessments. Findings Include: Accidents Resident #80: A record review of the Face sheet electronic medical record (EMR) indicated that Resident #80 was originally admitted to the facility on [DATE] and with several readmissions and diagnoses: Dementia, anxiety, depression, epilepsy, heart disease, Chronic pain syndrome, COPD, GERD, history of falls. The resident died on [DATE]. A record review of an Event Report dated [DATE] indicated Resident #80 fell at the facility on [DATE] at 9:20 AM: At 9:20 AM after transfer to the wheelchair with aide assistance, the resident leaned forward and fell, landing on knees and striking the right eye on the tray table. Redness noted to the right eye. At approx. 1:40 PM Resident verbalizes pain during range of motion in right lower extremity. X-ray order for right hip pain. x ray shows fracture Evaluation Notes: Patient w/BIMS 0 (with Brief Interview for Mental Status/BIMS score of 0/15 = severe cognitive loss). Further review of the medical record indicated there were no documented Neurological assessments after the resident hit her face on the tray table. On [DATE] at 3:37 PM, the Director of Nursing/DON was interviewed about Resident #80's fall she said she recalled the resident fell in the hallway near the 200 hall in the common area. She said Resident #80 leaned forward and fell, fractured hip and hit her face. On [DATE] at 9:30 AM, the DON provided a copy of a paper document titled, Neurological Checks the entry Date/Time of Fall was dated [DATE] for Resident #80. The entry Baseline at Initial Assessment was not dated or timed. There was no assessment for the left eye and the right eye identified Redness above right eye. There was no mention of a Neurological assessment for the resident's eyes, to identify if they were reacting to light and accommodation; the size of the pupils; or if the resident's mentation was changed, or if she could follow commands. The remainder of the Neurological Checks document included vital signs only: blood pressure, heart rate, temperature, respirations and oxygen saturation. In addition, there was a column titled, Any changes from Baseline? all lines were blank with no reference to a specific dated/timed Neuro assessment. The DON said usually the Neuro assessments would be completed in the computer, but they were not. Reviewed with the DON that the Neurological Checks document for Resident #80 was lacking assessment information used to monitor the residents neurological status. She said that was all there was documented. A review of the Care Plans for Resident #80 revealed the following: ADL's (Activities of daily living): Resident requires staff assistance to complete self-care and mobility functional tasks completely and safely, start date [DATE]. Falls: Resident at risk for falling r/t (related to): (altered) balance, weakness, diagnosis of dementia, history of falls, start date [DATE]. There was no mention of ensuring a Neurological assessment after falling and hitting the resident's face or head.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, and record review the facility failed to ensure that staff records for Covid-19 vaccination education, and acceptance or declination of the vaccination were documented and maintained for 2 staff members Certified Nursing Assistant (CNA) L and Nurse M of 3 staff members reviewed for Covid-19 vaccinations. Findings Include: Infection Control: On 6/10/2026 at 10:09 AM, during an interview with Infection Control Practitioner O she said she said she had worked as the ICP at the facility for 2 years and was responsible for the Immunization program for residents and staff. She said staff were assessed on hire for vaccination status and she said the MCIR Michigan Care Improvement Registry was reviewed to determination staff vaccination status. The ICP O said staff were offered Covid-19 vaccinations through a pharmacy or at their providers office. During the interview with ICP O on 6/10/2026 at 10:30 AM, a request was made to review 3 staff L, M, and N for Covid-19 vaccination screening, proof of offering the vaccination, education for the vaccination and acceptance or declination of the vaccination. On 6/10/2026 at 11:55 AM, during an interview with the Administrator, she said she sent an email to the facility pharmacy requesting copies of the Covid-19 vaccination forms for Staff L and M as she said the facility did not keep a copy of the forms for the two staff. A copy of Covid-19 vaccination record and Declination of Covid-19 Vaccination signed 2/10/26 was received for Staff N. The Administrator said education for the Covid-19 vaccination was hanging on the wall in the staff breakroom for their review. A Vaccination Information Statement/VIS document was not noted as being provided to Staff N. On 6/10/2026 at 12:14 PM, the Administrator provided a copy of the email to the facility pharmacy requesting Covid-19 vaccination information for Residents L and M. Prior to exit of the survey on 6/10/2026 at 4:30 PM, there was no additional employee vaccination information received from the facility. A review of the Facility Assessment dated 2/2/2026 identified a section titled Facility Resources Needed to Provide competent Support and Care for our Resident Population Every Day and During Emergencies; there was no mention of an Infection Control Practitioner or Infection Preventionist. Further review of the document revealed it did not mention staff or resident vaccinations. There was one entry titled, Infection Prevention and Control: Identification and containment of infections, prevention of infections. There was no additional information. A review of the facility policy titled, Infection Prevention and Control Program (IPCP), dated reviewed 11/19/25 provided, Purpose Statement: the purpose of this policy is to: To establish and maintain and infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Is based on the facility assessment. There was no mention of staff vaccinations.