STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235703	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake #3010953 Based on interview and record review, the facility failed to protect the resident's right to a safe, homelike environment by not properly inventorying and securing their valuables for one Resident (R803) of one resident reviewed. Findings include: Review of an intake received by the State Agency on 4/29/26 revealed: Resident (R803) reported to The Director of Nursing (DON)) that his golden chain with a cross and two rings were missing. (R803) stated that while he was playing (Name of card game) with the Activities Director (Staff E), she took his chain off of his neck, and stated that she had to use the bathroom, and would be right back. When she came back, (R803) stated that he requested for his chain but (Staff E) claimed that she did not have it. (R803) insisted that (Staff E) give him back his jewelry, but she maintained that she did not have it. The (Nursing Home) Administrator (NHA) received a call from The Director of Nursing (DON) reporting the incident. The administrator (NHA) initiated the investigation as it relates to this matter. Review of the report Investigation summary revealed: Resident (R803) admitted to the facility on [DATE] and lives with the following diagnosis: other seizures.cerebral infarction (stroke)., adjustment disorder with anxiety.It was reported to the administrator (NHA) that (R803) was missing some jewelry and money and that the activity supervisor (Staff E) had the items. After inquiring with the activity's supervisor (Staff E), she stated that the previous administrator had kept the items in the safe. Upon returning to work, the administrator (NHA) opened the safe and saw two envelopes with (R803's) jewelry and money. The resident was informed that his items were in the safe and he was satisfied. On 4/29/2026, the resident (R803) asked for his jewelry and it was presented to him. He, however, informed the administrator (NHA) that he needed the chain, not the rings. When asked about the chain, which was not part of the jewelry in the envelope, the resident stated that on the day it was reported, while he was playing (Name of card game) with the activity supervisor (Staff E), she had removed his chain and since then he had not seen it. There was more jewelry than just the rings and that was inconsistent with what the activities supervisor (Staff E) had stated days before. This writer contacted the activity supervisor (Staff E) for an interview regarding the chain. Activity supervisor (Staff E) when queried if she was playing (Name of card game) on 4/24/2026 (date of incident) with (R803), she declined (sic) and stated that she had not worked closely with the resident and that the resident actually did not play (Name of card game) on that day. When asked if she (Staff E) had (R803's) chain, she denied and stated that all she knew was what was held by the previous administrator. The activity supervisor (Staff E) was suspended pending investigation. The administrator (NHA) continued the investigation and retrieved footage from the video recording around the area that the resident (R803) alleged the incident occurred. Upon review, it was evident that (R803) played (Name of card game) with the activity director (Staff E). Also, the employee (Staff E) was seen taking (R803's) necklace and was not seen returning it. Facility concludes that the activity director (Staff E) took (R803's) chain and was the last one in possession of the necklace. Although (Staff E) vehemently denies possession of the necklace, this matter has been referred to the.(Name) County Sheriff's Office. The facility is determining the value of the missing necklace to replace it for (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R803). He (R803) was informed and was satisfied about replacement. The report further revealed the incident occurred on 4/24/26 at 1:58 p.m. and the police were notified on 4/29/26, and the incident was not witnessed. On 5/04/26 at 1:43 p.m., the NHA was asked via email if they had an inventory sheet for R803's belongings. No inventory sheet was received from admission or afterwards. On 5/04/26 at 3:40 p.m., R803 agreed to an interview with this Surveyor in his room via use of phone interpreter services provided by the facility Director of Nursing (DON), who was present during the interview. R803 reported during the interview their gold chain with a religious medal was taken off of them by Staff E on 4/24/26. Review of the Electronic Medical Record (EMR) showed R803 scored 15/15 on the Brief Interview for Mental Status (BIMS) assessment, dated 2/11/26, indicating they were cognitively intact. R803's profile showed they were their own responsible party.On 5/05/26 at 10:16 a.m., the NHA was asked a second time via email if they had an inventory sheet for R803's belongings. None was received from admission or afterwards. On 5/05/26 at 3:56 p.m., the NHA provided an inventory sheet for R803's belongings, dated 4/29/26, and confirmed they had no prior inventory sheet from R803's admission.Review of R803's inventory sheet titled, Resident Personal Belongings Inventory, dated 4/29/26, revealed an admission dated of 2/05/26, and the following items, Jewelry: (handwritten) 3 golden rings, 1 silver ring, 100 dollars cash. No other items were noted. Signed 4/29/26. It was noted that the gold necklace and cross pendant were not on the inventory list. On 5/04/26 at 6:05 p.m., Staff E called this Surveyor regarding the investigation. Staff E conveyed they took R803's necklace off when they were in the TV room on 4/24/26 at about 2:30 or 3:00 p.m. and put the necklace in R803's room on their bedside table. Staff E reported they were the staff that handled R803's rings upon admission and put them in the administrator's office. Staff E indicated they were terminated by the NHA, who told them R803's chain was missing. Staff E said she wished she would have documented the necklace (on an inventory sheet) and said she was on overtime and I was ready to go. Staff E confirmed they did not inventory R803's necklace when they took the necklace from them, and said, I wish there would have been a witness. Staff E said she did not know the process (for securing valuables in the facility), despite acknowledging they had handled R803's valuables (jewelry and money) upon their admission and said they had a witness at that time. On 5/05/26 at 8:15 a.m., the NHA said they spoke to Staff E on the phone on 4/24/26, who denied the incident occurred at that time and said R803's jewelry was stored in the facility safe. The NHA said when they returned to work on 4/27/26, they found four rings in the facility safe and $100 and said they were satisfied with that, after reaching out to the prior Administrator as well. The NHA reported facility nursing staff had done a room search when the incident occurred and had not found the necklace or cross pendant after R803 reported their necklace was missing. The NHA confirmed that the incident was not reported to the police or State Agency until 4/29/26, when they received and watched the video footage of the incident on 4/29/26, as R803 reported to them on 4/29/26 they were specifically missing a necklace with a cross on it. The NHA said R803 had not mentioned anything about a missing necklace until Wednesday (4/29/26) and said he wanted his jewelry. Once received, the NHA reported R803 said, My chain is not here, and the cross. The NHA confirmed they terminated Staff E after they watched the video and had concerns about Staff E who was observed taking R803's necklace, and inconsistencies during their interviews with Staff E. The NHA said R803's description of the incident had stayed consistent. On 5/05/26 at approximately 8:20 a.m., the NHA clarified Staff E should have inventoried the necklace, taken the necklace to a higher authority, and not handled the necklace themselves. The NHA shared they had concerns when Staff E denied taking R803's necklace and said they never played cards with him on 4/24/26, when video observations clearly showed they took R803's necklace and played cards with him. Review of the Policy, Resident Belongings and Personal Property, dated 6/4/25, provided by the NHA, revealed, Policy: It is the policy of this facility to protect the resident's right to possess personal belongings, such as clothing and furnishings, for their use while in the facility. Policy Explanation and Compliance Guidelines:Facility staff must support residents in the exercise of the right to have personal items of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their choice to the extent practicable.It is the policy of the facility that residents have the right to personal items and be free of interference, coercion and discrimination and reprisal from facility staff in exercise of this right.All resident possessions, regardless of their apparent value to others, will be treated with respect.The facility will support the residents' right to retain and use personal possessions to promote a homelike environment and maintain their independence.All resident personal items will be inventoried at the time of admission by the social services designee, or another designated staff member and documentation shall be retained in the medical record. Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing.9. The facility will exercise reasonable care for the protection of the resident's property from loss or theft. 14. Inventories of all items are to be reviewed and examined by Social Services or designee and the resident's representative.14. The facility will take reasonable measures to safeguard the residents' personal property. 2. Difficult to monitor items such as: cash, jewelry, family heirlooms, cellular phones, expensive clothing, collectibles, check books, credit and ATM cards and other personal identification cards (driver's licenses, Michigan issued identification and social security cards,) should not be left in the possession of the resident, but rather, be left at home or placed in the facility's designated safe keeping area.Cash, cellphones, and other valuables will not be replaced by the facility unless it is determined that a staff member's actions directly contributed to the loss.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake #3010953 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from misappropriation for one Resident (R803) of four residents reviewed for abuse. Findings include: Review of an intake received by the State Agency on 4/29/26 revealed: Resident (R803) reported to The Director of Nursing (DON)) that his golden chain with a cross and two rings were missing. (R803) stated that while he was playing (Name of card game) with the Activities Director (Staff E), she took his chain off of his neck, and stated that she had to use the bathroom, and would be right back. When she came back, (R803) stated that he requested for his chain but (Staff E) claimed that she did not have it. (R803) insisted that (Staff E) give him back his jewelry, but she maintained that she did not have it. The (Nursing Home) Administrator (NHA) received a call from The Director of Nursing (DON) reporting the incident. The administrator (NHA) initiated the investigation as it relates to this matter. Review of the report Investigation summary revealed: Resident (R803) admitted to the facility on [DATE] and lives with the following diagnosis: other seizures.cerebral infarction (stroke)., adjustment disorder with anxiety.It was reported to the administrator (NHA) that (R803) was missing some jewelry and money and that the activity supervisor (Staff E) had the items. After inquiring with the activity's supervisor (Staff E), she stated that the previous administrator had kept the items in the safe. Upon returning to work, the administrator (NHA) opened the safe and saw two envelopes with (R803's) jewelry and money. The resident was informed that his items were in the safe and he was satisfied. On 4/29/2026, the resident asked for his jewelry and it was presented to him. He, however, informed the administrator (NHA) that he needed the chain, not the rings. When asked about the chain, which was not part of the jewelry in the envelope, the resident stated that on the day it was reported, while he was playing (Name of card game) with the activity supervisor (Staff E), she had removed his chain and since then he had not seen it. There was more jewelry than just the rings and that was inconsistent with what the activities supervisor (Staff E) had stated days before. This writer contacted the activity supervisor (Staff E) for an interview regarding the chain. Activity supervisor (Staff E) when queried if she was playing (Name of card game) on 4/24/2026 (date of incident) with (R803), she declined (sic) and stated that she had not worked closely with the resident and that the resident actually did not play (Name of card game) on that day. When asked if she (Staff E) had (R803's) chain, she denied and stated that all she knew was what was held by the previous administrator. The activity supervisor (Staff E) was suspended pending investigation. The administrator (NHA) continued the investigation and retrieved footage from the video recording around the area that the resident (R803) alleged the incident occurred. Upon review, it was evident that (R803) played (Name of card game) with the activity director (Staff E). Also, the employee (Staff E) was seen taking (R803's) necklace and was not seen returning it. Facility concludes that the activity director (Staff E) took (R803's) chain and was the last one in possession of the necklace. Although (Staff E') vehemently denies possession of the necklace, this matter has been referred to the.(Name) County Sheriff's Office. The facility is determining the value of the missing necklace to replace it for (R803). He (R803) was informed and was satisfied about replacement. The report further revealed, When (date and time) did the problem occur? 04/24/2026 1:58 PM (date of incident). Are law enforcement agencies involved? Yes. Police agency/precinct contacted: (Name) Sheriff's Office. Date contacted: 04/29/2026. (Date reported to State Agency). Time contacted: 12:15 PM. Were There Any Witnesses? No. Were Other Agencies Notified? No. The report confirmed the incident occurred on 4/24/2026 and was not reported to the State Agency until 4/29/2026, five days later. On 5/04/26 at 12:20 p.m., R803 was observed dressed and well-groomed, seated in a manual upright wheelchair in the dining room at a table eating lunch, feeding himself. Review of R803's Minimum Data Set (MDS) assessment, dated 2/11/26, revealed R803 was admitted to the facility on [DATE], with diagnoses (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including stroke. R803 required set-up with eating and grooming and moderate assistance with bed mobility and transfers. The assessment showed R803 was cognitively intact and had no behaviors. Review of the Electronic Medical Record (EMR) showed R803 scored 15/15 on the Brief Interview for Mental Status (BIMS) assessment, dated 2/11/26, indicating they were cognitively intact. R803's profile showed they were their own responsible party. Review of R803's typed witness statement, received from the NHA via email on 5/04/26, revealed, I (NHA) talked to (R803) in person, and he said that his jewelry and money was missing and that (Staff E) had it. When asked what happened, (R803) mentioned that he was playing (Name of card game) with (Staff E) in the common area of the dining room lounge when she took it off of him. After taking it off, he (R803) said she (Staff E) told him that she needed to use the bathroom and would be right back. When she (Staff E) came back, he (R803) asked for it (his necklace) but she said she did not have it. Review of Staff E's typed witness statement, received via email from the NHA on 5/04/26, revealed, I (NHA) spoke to employee on phone, and this was what they said: (Staff E): I never touched his chain, and he never played (Name of card game) that day. His jewelry and money was locked in the safe by the previous administrator (NHA) at the request of (R803's) sister. Later on, through the investigation, I asked the employee what happened to (R803's) chain, as it was last seen in her possession on the (video camera) footage. This was her response: (Staff E): I don't know, (NHA name). I don't know what happened to the chain after that. The employee was made aware that the police were involved and she (Staff E) said, It's okay. On 5/04/26 at 12:38 p.m., Certified Nurse Aide (CNA) D was asked about the incident between R803 and Staff E on 4/24/26. CNA D confirmed the incident occurred on 4/24/26, when R803 came to the nurse's station on Friday, 4/24/26, and said, My necklace, my necklace.It's gone. CNA D said R803 spoke very clearly, despite English being their second language. CNA D described R803 always wore the gold chain, and described it had his wife's ring on it, and a cross. R803 reportedly explained to CNA D that Staff E took off his necklace and pointed to his ring on (his hand) and said, I just didn't get back the necklace and cross. CNA D reported they saw R803 did not have their gold necklace on or after the incident. CNA D said that afternoon they saw Staff E enter R803's room prior to R803 saying anything about their necklace, and knocked their urinal over, and rushed out frantically afterwards, which they found unusual. CNA D said they believed the Director of Nursing (DON) witnessed this also. CNA D said they noticed Staff E clings to (R803) and is always with him (prior to being terminated). Surveyor asked CNA D if they had reported this to anyone in management and said they had not. CNA D said R803 had never removed their necklace. CNA D said they understood misappropriation was a form of abuse and reported the incident to the DON, who was at the nurse's station with them on 4/24/26. Review of CNA D's typed witness statement, dated 4/30/26 at 9:51 a.m., revealed, On Friday, April 24, 2026, (R803- initials) approached the nurse's station while the UM (Unit Manager, LPN H), DON, and I (CNA D) were all there. (R803) asked about his necklace. He stated that (Staff E) had taken it off of him to put a ring on it. (The ring that is/was on his left hand). He (R803) said that after she (Staff E) took if off he never got it back. And the ring was never put on the necklace; it was still on his finger. (R803) was very upset and sad about the situation. Making comments like, I thought (Staff E) was my friend, referring to (Staff E). As we all know there is a language barrier between (R803) and most; he can be very hard to understand. However, he was very clear about the statements he made and gave great details on how the situation went. And (R803) was sure that (Staff E) was the one who had taken it. They had sat together for majority of the time that day. (Staff E and R803). Also, I might add that I (CNA D) was the CENA that got (R803) dressed and up in his chair that day and I believe he had his necklace on that morning. On 5/04/26 at 3:40 p.m., R803 agreed to an interview with this Surveyor in his room via use of phone interpreter services provided by the facility Director of Nursing (DON), who was present during the interview. R803 was asked what happened on Friday, April 24th (2026). R803 said he was playing (Name brand) cards with my friend (in English). R803 described, .She (Staff E) took the chain off of me and (the) little (religious) medal and she (Staff E) put in on the table and came back; I didn't saw (see) it anymore. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She (Staff E) took the chain and she went to the bathroom. R803 was asked if they knew her name, and R803 responded, (Staff E), and said, .Only me and her were there. R803 also reported Staff E kept coming in their room (prior to the incident). Then R803 became emotional, appeared upset, and began crying. It did not appear they could answer more questions, so they were not interviewed further about the incident. R803 was asked if they felt safe at the facility and said he was Ok. On 5/04/26 at approximately 4:15 p.m., the DON was asked about R803 becoming tearful during the interview. The DON explained that the necklace had sentimental value to him and said it was difficult for him to discuss. The DON confirmed R803 was their own responsible party. The DON said they did not know until this interview Staff E had been coming to their room, as he nor staff had reported this to them. On 5/04/26 at 4:55 p.m., video footage of the incident was reviewed with the Nursing Home Administrator (NHA) and the Human Resources representative, Staff F. It was noted there was no audio of the footage. The NHA reported they had no written timeline of the incident, as the video (times) stood for itself. It was observed on 4/24/26, with a video timestamp beginning at 1:55 p.m., R803 was dressed and seated in their manual upright wheelchair in the dining room lounge, with Staff E seated on an orange couch on their right side, with a table in front of both of them. There was a resident in the lounge with them seated in a tall wheelchair, with his back to them. Staff E leaned over and reached forward for R803's necklace and then walked behind R803 and unfastened it. Staff F sat back down on the orange couch and appeared to place the necklace on the table where they were playing cards and continued playing cards with R803. Staff E appeared to pick the necklace up and left shortly afterwards and walked out of the camera view at 1:59 p.m. Review of a second video at 1:59 p.m. showed Staff E entered R803's room from the hallway and then quickly exited. The room was unable to be visualized. Review of a third video at 2:00 p.m. showed Staff E had returned to where R803 was seated in the lounge area again with R803 and continued playing cards with them. Staff E was observed to be looking over their shoulders during the video, appearing unsettled or distracted shortly after the incident. Surveyor requested Staff E's employee file in its entirety after reviewing the videos. Review of Staff E s employee file, with the NHA and Human Resources representative, Staff F, revealed Staff F cleared a complete background check and had abuse training upon hire, on 2/04/26, and had no written disciplinary action in the file since their date of hire, which the NHA confirmed. The file showed Staff E was certified as an Activity Director. Both confirmed Staff E's last date of working was on 4/27/26, and she was suspended and terminated on 4/29/26. A letter of termination was provided. On 5/04/26 at 6:05 p.m., Staff E called this Surveyor regarding the investigation. Staff E stated at about 2:30 or 3:00 p.m. on 4/24/26 they were sitting with R803 in the TV room and R803 asked her to take the necklace off and put on the ring that was on his finger so she took the necklace off and handed it to him and he took the rings off and handed it to her and then he asked her to put the necklace in his room. Staff E described at that time she set the necklace onto the table (in the lobby) and said afterwards they finished playing the game. Staff E said left to do something and when she returned, she picked up the necklace and put it in on the table in R803's room, on the side of his bed. Staff E said when she came back out, R803 told her he told he had to go to the bathroom and she took him to his room and she asked if he wanted her to put the necklace on him and he said, No. Staff E said then R803 kept talking about his rings and Staff E told R803 they were locked up in the administrators office. Staff E said she was the one who took the rings from him (upon admission) and put them back in the office. Staff E said they wheeled R803 back out to the TV room. On 5/24/26 at approximately 6:10 p.m., Staff E said shortly afterwards one of the nurses came up to the nurse's station and said nobody knew where R803's necklace was. Staff E said the necklace was in his room on the side of his bed and it had been placed there before. Staff E clarified when R803 asked for anything to come off (prior to 4/24/26) they put it on the bedside table and (in) the drawers. Staff E said when you put it on, it only had one ring on it and he put one ring on the necklace and then one ring on his finger. Staff E continued, There were two rings off and he put the wedding band on his finger on the necklace, and he wanted it back in his room and said, Just put it in my room (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for now. Staff E reported they were terminated by the NHA who told them R803's chain was missing. Staff E then asked, Did they say anything about missing money in the safe? I don't know what is going on. Staff E then said they never had access to the safe with his ring. Staff E said she wished she would have documented the necklace (on an inventory sheet) and said she was on overtime and I was ready to go. Staff E said with the rings (upon admission) I did the progress note and his sister came to the building and insisted on them being taken off. Staff E said at that time she put them in the office and said, I guess there was a witness (prior). I wish there would have been a witness (in this situation). Staff E said she did not know the process (for securing valuables in the facility) and had nothing further. On 5/05/26 at 8:15 a.m., the NHA acknowledged R803 spoke to Licensed Practical Nurse (LPN) G when the incident occurred (on 4/24/26) and confirmed the DON was in the facility. The NHA said they spoke to Staff E on the phone on 4/24/26, who denied the incident occurred at that time and said R803's jewelry was stored in the facility safe. The NHA said when they returned to work on 4/27/26, they found four rings in the facility safe and (cash amount) and said they were satisfied with that, after reaching out to the prior Administrator as well. The NHA reported LPN G and CNA D had done a room search when the incident occurred and had not found the necklace or cross pendant after R803 reported their necklace was missing. The NHA confirmed that the incident was not reported to the police or State Agency until 4/29/26, when they received and watched the video footage of the incident on 4/29/26, as R803 reported to them on 4/29/26 they were specifically missing a necklace with a cross on it. The NHA said R803 had not mentioned anything about a missing necklace until Wednesday (4/29/26) and said he wanted his jewelry. Once received, the NHA reported R803 said, My chain is not here, and the cross. The NHA confirmed they terminated Staff E after they watched the video and had concerns about Staff E who was observed taking R803's necklace, and inconsistencies during their interviews with Staff E. The NHA said R803's description of the incident had stayed consistent and there were no witnesses. On 5/05/26 at approximately 8:20 a.m , the NHA explained they became concerned as Staff E said she never played (Name of card game) on that day (4/24/26) during their phone interview on 4/24/26. The NHA said to Staff E on Monday (4/27/26), when she worked, (R803) said you took his necklace. The NHA said they had to suspend Staff E at that time and requested the footage from corporate and by Wednesday (4/29/26) they reviewed it and confirmed Staff E took R803's necklace from them and it had not been found since. The NHA continued after reviewing the video they called Staff E and said, I talked to you earlier and you said he never played (Name of card game), and Staff E said, I never touched his necklace and the only thing I ever know was about (is) his money. The NHA described they said You (Staff E) played (Name of card game) with him in the lounge on Friday, the 24th, and from what I see in the video, you placed it (the necklace) on the table and before you stood up, you picked it up and you left with the necklace in your hands and according to R803 you told him you had to use the bathroom and he hasn't changed his story. You said you never used the bathroom, and you used his bathroom, and it makes me think you had a motive going to his room and to the bathroom. The NHA said per camera footage after the incident, Staff E was observed looking over their shoulders nervously. The NHA clarified Staff E should have inventoried the necklace and taken the necklace to a higher authority and not handled themselves. The NHA shared they had concerns when Staff E denied taking R803's necklace, saying they never played cards with him, and said they never used the bathroom, which they told R803 they were doing. The NHA said the police came to the facility Wednesday (4/29/26) at noon the same day they confirmed the necklace was taken, and Staff Es reporting of the incident was not what they observed on video. On 5/05/2026 at 9:35 a.m., LPN G said they recalled the incident between R803 and Staff E on 4/24/26 when they were working. LPN G said they saw the necklace earlier that day around R803's neck, midway through the day, and R803 said he couldn't find his gold necklace, around 3:30 p.m . LPN G described R803 wore the necklace regularly around his neck with his wife's wedding rings and reported R803 said to LPN G, The lady who I played (Name of card game) took if off. and said R803 was upset and crying. LPN G explained they and the (continued on next page)

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	235703	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing staff searched R803's room and could not find his necklace and said they reported his concerns to all the necessary parties (management) at that time, including the Unit Manager, LPN H, who was there at the nurse's station when the incident was reported. LPN G said there were no witnesses reported. LPN G said R803 was a reliable reporter as he was always alert and fully oriented and had no psych or behavioral issues nor had any accusations prior. Review of LPN G witness statement, dated 4/29/26 at 3:14 p.m., received from the NHA on 5/05/26, revealed: On 4/24/26, a resident's (R803's) necklace was reported missing. The resident (R803) notified staff that the necklace could not be located. A thorough search was conducted by me, the CNA, and the Unit Manger in the resident's room, including the bed area, closet, dresser, and all personal belongings and clothing. The dining areas were also searched. The necklace was not found during the search. The resident stated that the one he plays (Name of card game) with took it off him. On 5/05/26 at 11:38 a.m., Unit Manager, LPN H, reported they were at the nurse's station on 4/24/26 with the DON, LPN G, and CNA D when the incident occurred. LPN H described R803 came up to them and said, My necklace is missing.She took my necklace off for my ring and I did not get it back. LPN H said they asked R803 who and he said, (Staff E) from activities, and explained, I asked her to take my necklace off to put my ring on (it) and it is missing; I did not get it back. R803 said this happened when they were playing cards with Staff E, and kept saying, I thought she was my friend. LPN H said they texted Staff E at 3:04 p.m. and showed Surveyor a text message from their cell phone and said they asked Staff E what happened. LPN H reported Staff E said they never played cards with R803 and LPN H said to Staff E they saw them playing cards with R803, and Staff E never responded back after. LPN H said they found this concerning since they had directly witnessed Staff E playing cards with R803 that afternoon. LPN H said they and CNA D searched for the necklace including in R803's room, tray table, and dresser and never found the necklace. LPN H said R803's description stayed consistent. LPN H said Staff E was in the facility the following Monday (4/27/26) working and again denied the incident occurred as described by R803. When asked if this was a concern to them, LPN H said it was a form of abuse and said the DON was aware and they understood the NHA was made aware on 4/24/26, per a phone call made to the NHA after the incident.During the interview on 5/05/26 at approximately 11:45 a.m., LPN H said they sent Staff E a text message to see what occurred, right after R803 reported the concerns. Staff E showed Surveyor their phone and a copy of the text message. Review of LPN H's text message to Staff H, dated 4/24/26 at 3:04 p.m., read as follows: LPN H asked (blue font), Hey, (Staff E), this is (LPN H), do you have (R803) necklace? Staff E responded (black font), No, he said it was taken off to put his ring on. He's got rings in the safe but I haven't seen his necklace. He kept saying something about praying. LPN H said (blue font), Okay. He is saying you have it. That you took if off to put his ring on but did not give it back. Staff E responded, No, he already has that ring on in (sic) ever (sic) took his necklace off at all. LPN H said (blue font). He said this morning you took it off while playing (Name of card game). Staff E did not respond to this last message. The text thread ended there. Review of LPN H's witness statement, dated 4/29/26 at 3:07 p.m., revealed, A resident came to the nursing station asking about his necklace and stated that (Staff E) had it. (R803) states she took it off so he could place his ring on it but she never gave it back and that she took it while they were playing (Name of card game). I called (Staff E) and she stated she did not have the necklace and never took it off of him. Perhaps his family, who stopped by to bring him clothes, took it off him. I asked (R803) if his family came to see him today and he stated, ?yes', but they were not here long. They stopped by to bring him clean clothes. Then he goes back to staying, (Staff E), my friend in activities has it. She took it off when we were playing (Name of card game). On 5/05/26 at 12:45 p.m., the DON was asked about R803 reporting their necklace was missing. The DON confirmed they were working on 4/24/26 in the 3:00 (p.m.) hour when the incident was reported to them by R803. The DON said they were at the nurse's station with LPN H, LPN G, and CNA D when R803 came up to them in their wheelchair and told them (Staff E) took his necklace off while they were playing (name of card game) and said, Where's my necklace? The DON further (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	described R803 pointed at their own cross they were wearing, and they said to R803, What happened?. The DON reported R803 described they were playing (Name of card game) with (Staff E) (which they mispronounced) and said (Staff E) took my necklace off, and said in Spanish, Mi amiga, mi amiga (my friend, my friend).She was my friend. The DON said they and staff searched in the facility, and in the area where R803 and Staff E played cards, and in R803's room, and never found the necklace. The DON confirmed they called the NHA who was the abuse coordinator after R803 reported the incident to them and told the NHA R803 reported Staff E had taken off their necklace when they were playing (Name card game). The DON said the incident would be considered misappropriation. When asked about R803's cognition, The DON said R803's BIMS score was 15 (of 15), and they were alert and oriented times four (to person, place, time, and situation). During the interview, the DON was shown a copy of their typed witness statement, received via email from the NHA, and acknowledged this was their statement and signature. Review of the DON's witness statement, provided on 5/05/26 by the NHA, typed and dated 4/24/26 1500 (3:00 p.m.), revealed, .The resident (R803) came to the nursing station and asked where his necklace was. This writer (DON) told the resident that she did not know where his necklace was at the time but recalled that he (R803) does usually wear one with a cross around his neck but that the necklace was not evident at that time. This writer asked the resident when was the last time he recalled having the necklace around his neck. He (R803) stated that earlier, he and Staff E were playing (Name of card game) and that she had taken it from around his neck after pulling on it. He (R803) stated that he had told her not to pull on it and that when he asked her for the necklace again, she said that she did not have it. This writer asked the CENA (CNA D) to go into the resident's room and look for the resident's necklace. She (CNA D) could not find it. Writer went to check the dining room where the activities usually occur and could not find the necklace. At this time the writer called the NHA to report what the resident had reported to her and that is sounded like a possible allegation of misappropriation. The resident (R803) stayed near the nursing station and continued to ask that staff help him find the necklace. He (R803) stated that he was surprised that Staff E had his necklace and had not returned it as he believed her to be a friend of his. Having not found the necklace, this writer and the other nursing staff (LPN G, CNA D, LPN H) stated to the resident that we would continue to look for his necklace and report it to the Administrator (NHA). The Administrator (NHA) phoned this writer and asked that the phone be taken to the bedside of the resident for an interview. Review of Staff E's Time Card, received via email from the NHA on 5/04/26, revealed from 4/23/26 through 5/07/26, Staff E worked on Thursday, 4/23/26 from 7:15 a.m., to 3:45 p.m., on Friday, 4/24/26, from 6:23 a.m., to 3:00 p.m, and on Monday, 4/27/26, from 5:30 a.m. to 3:18 p.m., confirming Staff E worked after the allegation of misappropriation was made by R803 to four nursing staff and the NHA on 4/24/26. Review of a letter, on facility letterhead, received via email from the NHA on 5/04/26, dated 4/29/26, revealed, Dear (Staff E). Per our conversation, we have reached a conclusion on your suspension pending investigation due to the allegation made against you for the missing jewelry from one of our residents at (the facility). Your employment at (the facility) is terminated, effective immediately. Signed by Staff F . Review of the policy, Abuse, Neglect, and Exploitation, dated 1/14/26, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions:. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent.IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse - (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse 2. Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body 3. Physical injury of a resident, of unknown source 4. Resident reports of theft of property, or missing property.V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation. F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 2. Assuring that reporters are free from retaliation or reprisal; 3. Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint. 4. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 3010953. Based on interview and record review, the facility failed to report an allegation of misappropriation timely for one Resident (R803) of four residents reviewed for abuse. Findings include:Review of an intake received by the State Agency on 4/29/26 revealed: Resident (R803) reported to The Director of Nursing (DON)) that his golden chain with a cross and two rings were missing. (R803) stated that while he was playing (Name of card game) with the Activities Director (Staff E), she took his chain off of his neck, and stated that she had to use the bathroom, and would be right back. When she came back, (R803) stated that he requested for his chain but (Staff E) claimed that she did not have it. (R803) insisted that (Staff E) give him back his jewelry, but she maintained that she did not have it. The (Nursing Home) Administrator (NHA) received a call from The Director of Nursing (DON) reporting the incident. The administrator (NHA) initiated the investigation as it relates to this matter.Review of the report Investigation summary revealed: Resident (R803) admitted to the facility on [DATE] and lives with the following diagnosis: other seizures.cerebral infarction (stroke)., adjustment disorder with anxiety.It was reported to the administrator that (R803) was missing some jewelry and money and that the activity supervisor (Staff E) had the items. After inquiring with the activities supervisor (Staff E), she stated that the previous administrator had kept the items in the safe. Upon returning to work, the administrator opened the safe and saw two envelopes with Mr. Hernandez's jewelry and money. The resident was informed that his items were in the safe and he was satisfied. On 4/29/2026, the resident asked for his jewelry and it was presented to him. He, however, informed the administrator that he needed the chain not the rings. When asked about the chain, which was not part of the jewelry in the envelope, the resident stated that on the day it was reported while he was playing (Name of card game) with the activity supervisor (Staff E), she had removed his chain and since then he had not seen it. There was more jewelry than just the rings and that was inconsistent with what the activities supervisor (Staff E) had stated days before. This writer contacted the activity supervisor (Staff E) for an interview regarding the chain. Activity supervisor (Staff E) when queried if she was playing (Name of card game) on 4/24/2026 (date of incident) with (R803), she declined (sic) and stated that she had not worked closely with the resident and that the resident actually did not play (Name of card game) on that day. When asked if she had (R803's) chain, she denied and stated that all she knew was what was held by the previous administrator. The activity supervisor (Staff E) was suspended pending investigation. The administrator continued the investigation and retrieved footage from the video recording around the area that the resident (R803) alleged the incident occurred. Upon review, it was evident that (R803) played (Name of card game) with the activity director (Staff E). Also, the employee (Staff E) was seen taking (R803's) necklace and was not seen returning it. Facility concludes that the activity director (Staff E) took (R803's) chain and was the last one in possession of the necklace. Although (Staff E') vehemently denies possession of the necklace, this matter has been referred to the.(Name) County Sheriff's Office. The facility is determining the value of the missing necklace to replace it for (R803). He (R803) was informed and was satisfied about replacement. The report further revealed, When (date and time) did the problem occur? 04/24/2026 1:58 PM. (date of incident). Are law enforcement agencies involved? Yes. Police agency/precinct contacted: (Name) Sheriff's Office. Date contacted: 04/29/2026. (Date reported to State Agency). Time contacted: 12:15 PM. Were There Any Witnesses? No. Were Other Agencies Notified? No. The report confirmed the incident occurred on 4/24/2026 and was not reported to the State Agency until 4/29/2026, five days later. On 5/04/26 at 12:38 p.m., Certified Nurse Aide (CNA) D was asked about the incident between R803 and Staff E on 4/24/26. CNA D confirmed the incident occurred on 4/24/26, when R803 came to the nurse's station on Friday, 4/24/26, and said, My necklace, my necklace.It's gone. CNA D said R803 spoke very (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clearly, despite English being their second language. CNA D described R803 always wore the gold chain, and it had his wife's ring on it, with a cross as well, and said always wore them. R803 reportedly explained to CNA D that Staff E took off his necklace and pointed to his ring on (his hand) and said, I just didn't get back the necklace and cross. CNA D reported they saw R803 did not have their gold necklace on. CNA D said they understood misappropriation was a form of abuse and reported the incident to the Director of Nursing (DON), who was at the nurse's station when R803 reported their necklace was taken on 4/24/26. CNA D said they found R803 understandable. Review of the Electronic Medical Record (EMR) showed R803 scored 15/15 on the Brief Interview for Mental Status (BIMS) assessment, dated 2/11/26, which showed they were cognitively intact. On 5/04/26 at 3:40 p.m., R803 agreed to an interview with this Surveyor via use of phone interpreter services provided by the facility Director of Nursing (DON), who was present during the interview. R803 was asked what happened on Friday, April 24th (2026). R803 said he was playing (Name) cards with my friend (in English). R803 described, .She (Staff E) took the chain off of me and (the) little Christ (religious) medal and she (Staff E) put in on the table and came back; I didn't saw (see) it anymore. She (Staff E) took the chain and she went to the bathroom. R803 was asked if they knew her name, and R803 responded, (Staff E), and said, .Only me and her were there. R803 also reported Staff E kept coming in their room. Then R803 became emotional, appeared upset, and began crying. It did not appear they could answer more questions, so they were not interviewed further about the incident. R803 was asked if they felt safe at the facility and said he was Ok, in English. On 5/04/26 at 4:55 p.m., video footage of the incident was reviewed with the Nursing Home Administrator (NHA) and the Human Resources representative, Staff F. It was noted there was no audio of the footage. It was observed on 4/24/26, with a video timestamp, beginning at 1:55 p.m., R803 was dressed and seated in their manual upright wheelchair in the dining room lounge, with Staff E seated on an orange couch on their right side, with a table in front of both them. Staff E leaned over and reached for R803's necklace and then walked behind R803 and unfastened it. Staff F sat back down on the orange couch and appeared to place the necklace on the table where they were playing cards and continued playing cards with R803. Then Staff E picked the necklace up and left shortly afterwards and walked out of the camera view in the area. On 5/04/26 at 8:15 a.m., the NHA acknowledged R803 spoke to Licensed Practical Nurse (LPN) G when the incident occurred (on 4/24/26) and confirmed the DON was in the facility. The NHA said they spoke to Staff E on the phone and they denied the incident occurred at that time and said R803's jewelry was stored in the facility safe. The NHA said when they returned to work on 4/27/26 they found four rings in the facility safe and (cash amount) and said they were satisfied with that. The NHA reported LPN G and CNA D had done a room search when the incident occurred and had not found the necklace or cross pendant after R803 reported their necklace was missing. The NHA confirmed that the incident was not reported to the police or State Agency until 4/29/26, when they watched the video footage of the incident on 4/29/26, and R803 reported to them that on 4/29/26 they were missing a necklace with a cross on it. The NHA confirmed they terminated Staff E after they watched the video and had concerns about Staff E taking R803's necklace, from their observations from the video, and some inconsistencies during their interviews about the incident with Staff E. The NHA explained they immediately reported the incident to the police and State Agency on 4/29/26 when they confirmed the incident had occurred from video footage received on 4/29/26 and said there were no witnesses to the incident. The NHA said R803's description of the incident on 4/24/26 had stayed consistent from their reporting. On 5/05/2026 at 9:35 a.m., LPN G said they recalled the incident between R803 and Staff E on 4/24/26 when they were working. LPN G said they saw the necklace earlier that day around R803's neck, midway through the day, and R803 said he couldn't find his gold necklace, around 3:30 p.m . LPN G described R803 wore the necklace regularly around his neck with his wife's wedding rings and reported R803 said to LPN G, The lady who I played (Name of card game) took if off. and said R803 was upset and crying. LPN G explained they and the nursing staff searched R803's room and could not find his necklace and said they (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported his concerns to all the necessary parties (management) at that time, including the Unit Manager, LPN H, who was there at the nurse's station when the incident occurred. LPN G said there were no witnesses reported. LPN G said R803 was a reliable reporter as he was always alert and fully oriented and had no psych or behavioral issues nor had any accusations prior. On 5/05/26 at 11:38 a.m., Unit Manager, LPN H, reported they were at the nurse's station on 4/24/26 with the DON, LPN G, and CNA D when the incident occurred. LPN H described R803 came up to them and said, My necklace is missing.She took my necklace off for my ring and I did not get it back. LPN H said they asked R803 who and he said, (Staff E) from activities, and explained, I asked her to take my necklace off to put my ring on (it) and it is missing; I did not get it back. R803 said this happened when they were playing cards with Staff E, and kept saying, I thought she was my friend. LPN H said they texted Staff E at 3:04 p.m. and showed Surveyor a text message from their cell phone and said they asked Staff E what happened. LPN H reported Staff E said they never played cards with R803 and LPN H said to Staff E they saw them playing cards with R803, and Staff E never responded back after. LPN H said they found this concerning since they had directly witnessed Staff E playing cards with R803 that afternoon. LPN H said they and CNA D searched for the necklace including in R803's room, tray table, and dresser and never found the necklace. LPN H said R803's description stayed consistent. LPN H said Staff E was in the facility the following Monday (4/27/26) working and again denied the incident occurred as described by R803. When asked if this was a concern to them, LPN H said it was a form of abuse and said the DON was aware and they understood the NHA was made aware on 4/24/26, per a phone call made to the NHA after the incident. On 5/05/26 at 12:45 p.m., the DON was asked about R803 reporting their necklace was missing. The DON confirmed they were working on 4/24/26 when the incident occurred. The DON said they were at the nurse's station with LPN H, LPN G, and CNA D when R803 came up to them in their wheelchair and told them (Staff E) took his necklace off while they were playing (name of card game) and said, Where's my necklace? The DON further described R803 pointed at their own cross they were wearing, and they said to R803, What happened?. The DON reported R803 described they were playing (Name of card game) with (Staff E, which they mispronounced) and said (Staff E) took my necklace off, and said in Spanish, Mi amiga, mi amiga (my friend, my friend).She was my friend. The DON said they and staff searched in the facility, and in the area where R803 and Staff E played cards, and in R803's room, and never found the necklace. The DON said R803 reported the incident to them on 4/24/26 in the 3:00 (p.m.) hour. The DON confirmed they called the NHA after R803 reported the incident to them and told the NHA R803 reported Staff E had taken off their necklace when they were playing (Name card game) and said the incident would be considered misappropriation. When asked about R803's cognition, The DON said R803's BIMS score was 15 (of 15), and they were alert and oriented times four (to person, place, time, and situation). The DON said they reported the incident to the NHA on 4/24/26, after R803 alleged Staff E had taken their necklace off of them and it was missing. Review of LPN G witness statement, dated 4/29/26 at 3:14 p.m., received from the NHA on 5/05/26, revealed R803 reported to them on 4/24/26 their necklace was missing, and said the resident (R803) notified staff the necklace could not be located. Their statement described a thorough search was conducted by them, LPN H, and CNA D, and R803's necklace was not found. The statement further revealed R803 stated, The one he plays (Name of card game) with took it off him. Review of the policy, Compliance with Reporting Allegations of Abuse, Neglect, Exploitation, implemented 11/01/2022, revealed, It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property are reported immediately ot the Administrator (NHA) of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235703	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 2731788. Based on interview and record review, the facility failed to ensure appropriate documentation for skin and wound treatment for one Resident (R802) of two residents reviewed for skin and wounds. Findings include: A complaint received by the State Agency on 2/02/26 revealed: Complainant states the resident (R802) has developed deep bedsores on her buttocks that staff have to pack. The complainant states he hasn't seen the sores, but his wife said they were deep. The complainant states on an unknown date, an unknown female nurse applied menthol to the resident's buttocks which made her cry in pain. Complainant states the resident is left in a urine-soaked brief for up to 8 hours before being changed. Review of R802's census revealed they were admitted to the facility on [DATE] and were discharged [DATE].Review of R802's profile revealed they were their own responsible party. Review of R802's Minimum Data Set (MDS) assessment revealed they were admitted with diagnoses including lung disease, pneumonia, heart failure, and morbid obesity. The assessment revealed they were dependent for toileting, bed mobility, and transfers. The Brief Interview of Mental Status (BIMS) assessment showed they were cognitively intact. Review of the skin assessment showed R802 was admitted with no pressure ulcers and Moisture Associated Skin Damage (MASD - a condition where prolonged exposure to moisture leads to inflammation and erosion of the skin, often red or raw in appearance). Review of R802's Electronic Medical Record (EMR) showed they were sent to the emergency room on 2/13/26 for a urinary tract infection. The EMR including census confirmed R802 was not admitted to the hospital at that time or during their stay. Review of R802's physical orders revealed two orders for wound care after discharge as follows: Clean sacrum with NS (normal saline). Pat dry, apply zinc oxide ointment (a topical skin protectant), apply ABD (dressing), Every Monday, Wednesday, Friday. Date started 2/02/26 at 7:00 a.m. and discontinued 2/17/26. Left gluteal (buttocks area); cleanse with ns (normal saline) or wound cleanser; dry and apply triad (wound paste used for a variety of wound types) bid (twice daily) and prn (as needed). Dated 2/01/26 to 2/18/26. It was noted neither order included a wound description, or reason for the treatment. Review of R802's Treatment Administration Record (TAR), dated February 2026, revealed sacral wound treatments were missed (blank entries) on 2/04, 2/06, and 2/16. Review of R802's TAR, dated February 2026, revealed R802's buttocks wound treatments were missed (blank entries) on 2/01 (p.m.), 2/04 (a.m. and p.m.), 2/06 (a.m.), 2/08 (a.m.), 2/14 (a.m.), 2/15 (p.m.), and 2/18 (a.m.). Review of the EMR including R802's progress notes showed no documented reasons for the omissions, and no descriptions of the wounds or clear reasons for treatments. Review of R802's physician Discharge summary, dated [DATE] at 22:19 (10:19 p.m.), revealed no notation or mention of any skin concerns, wound descriptions, reasons for skin treatments, or any documentation of skin related issues. Review of R802's physician medicine and rehabilitation progress notes, dated 2/17/26, and 2/12/26, showed no skin concerns, or documentation of reasons for skin or wound treatments.Review of R802's advanced (nursing) skilled evaluations, dated 2/16/26, 2/15/26, 2/13/26, 2/12/26, 2/11/26, and 2/08/26, all revealed, .Skin: No skin issues identified. This was despite wound care treatments being in place on these dates. Review of R802's advanced skill evaluation, dated 2/09/26 at 14:50 (2:50 p.m.), revealed, .Skin note: Barrier cream applied to buttocks. This was a notation that showed no diagnoses and had no notation regarding the sacral treatment or wound. Review of R802's advanced skill evaluation, dated 2/07/26, revealed, .No skin issues identified. Skin note: Barrier cream applied. There was no notation regarding the sacral treatment. Review of R802's nurse noted, dated 2/09/26 at 13:38 (2:38 p.m.), revealed, .She has an open area to left gluteal which is receiving treatment. This was the first notation found regarding a skin concern, and showed an open area, which was not clearly described. Review of R802's transfer form to the hospital, dated 2/13/26, revealed, Pain Location: Site: Groin: Red and Moist. Left buttock: Open area. Right buttock: Open area.Skin/Wound Care: Pressure Ulcers/ Injuries (continued on next page)

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	235703	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing and Rehabilitation Center LL	50 N Perry St, 1st Floor Pontiac, MI 48342

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(stage, location, appearance, treatments): Open areas of concern. Other wounds / bruises: (blank). Review of R802's hospital hand off form to facility, dated 1/21/26, revealed, Friction and shear (R buttock) and non-stageable (left buttock). Triad (wound paste) over wound base and foam. This appeared to show R802 was admitted with open areas, which may have been pressure ulcers or open wounds. There was no other description found. Review of R802's assessments with the Director of Nursing (DON) confirmed there were no wound assessments, descriptions, or skin assessments found. Review of R802's February TAR was reviewed with the DON, and the missing wound treatments, with blank entries. On 5/05/26 at approximately 1:15 p.m, the DON reported they understood the concern, and their expectation would be the skin and wound assessments as well as wound description would be found in the EMR, per standards of wound care practice. The DON had no explanation for the missing wound treatments, after they reviewed R802's progress notes with Surveyor. The DON concurred there was no explanation for the missing TAR entries, with no explanation found in R802's progress notes and understood the concern. Review of R802's Care Plan with the DON showed R802 had an abrasion. There was no mention of MASD, open areas, pressure ulcers, or other skin concerns. On 5/05/26 at 3:06 p.m., the DON returned and reported the facility had switched EMR's and they found one wound description document for R802's left gluteal wound, which showed an abrasion. The DON said the documents may have been missing between EMR's but provided no additional documents which described R802's sacral wound by exit. So, it remained unclear why R802 had a sacral wound treatment, and if it was an open area. The ICD 9 code on the document showed an abrasion to their left lower leg per the DON. The DON reported it remained unclear why the Triad wound treatment cream was being used, although they reported it was a wound treatment or a barrier cream. The DON clarified their documentation expectations for wounds would be weekly measurements, wound descriptions, skin assessments, and wound staging (for severity) if there was a pressure injury. The DON said they understood the concern related to incomplete skin and wound documentation. The DON concurred there was no way to tell if R802's wound treatments were provided on the dates of wound treatment log omissions for February 2026 and said they understood the concern. Review of a wound care provider document provided by the DON, dated 1/30/26, was an untitled document by a wound care provider. The documents revealed R802 was referred by R802's primary care provider. The assessment revealed R802 had a skin concern on their left glut (buttocks) with no drainage, 7 days old. The wound showed an abrasion on R802's left lower leg (not MASD). Showed not resolved, ICD: S80.812D. Reported on 1/23/26, with an area of .8 (centimeters). [NAME]. Size 0.9 x 0.8 x 0.1. Area square centimeters: 0.72 (centimeters) with healing tissues and no infection. This was called wound 1. This showed the wound was likely acquired after R802's admission on [DATE], as the wound was documented initially on 1/23/26. Review of a second wound care provider note, dated 2/13/26, revealed R802's wound 1 was resolved 2/13/26 on their left glute and area was 0 with healed tissue. The treatment Triad remained in place per provider orders, and the document showed abrasion handwritten on the bottom. On 5/05/26 at 4:20 p.m., the complainant reported in a phone interview that R802 had an open sized wound on her bottom, and alleged they weren't treating it the way was supposed to be done when sometimes they (nursing staff) did the treatments and sometimes they did not, as people were calling off work. R802 said they had a picture of one of the wounds and said the nurse's were discussing packing the wound. The complainant reported they had filed at least one grievance during R802's stay. Review of a photo received from the complainant showed two smaller adjacent open areas on the back of the left thigh, flat in appearance, with pink granulation tissue primarily seen in the wound bed. No photo was received of a sacral wound. Concerns were shared with the Nursing Home Administrator (NHA), who asked surveyor to speak with the former NHA/DON prior to exit related to no nursing wound care assessments, descriptions, skin assessments, and limited documentation found in the EMR, and the missing February (2026) TAR entries. The NHA reported they had no additional documentation to provide. The NHA denied having any concern forms for R802. On 5/05/26 at approximately 5:55 p.m., the former NHA/DON reported (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R802 had MASD, and not an abrasion, despite the Care Plan and the wound care description note of an abrasion, which was shared. The former DON reported Zinc Oxide did not always have menthol, and acknowledged they were aware it had irritated R802, and said they had discontinued the treatment and changed it out for Triad paste. Surveyor shared the Zinc Oxide order remained on the TAR for one of the two wounds, near R802's discharge, on 2/17/26. The former DON had no explanation. The former DON denied R802 had any pressure ulcers and said their wound may have been from friction and shear and the rest of the treatments were prophylactic. The former DON said there may have been concerns when they switched EMR's related to the missing wound care documents. The DON said R802's gluteal wound was MASD and their sacral treatment was prophylactic only (preventative, with no wound). The omissions on the R802's February TAR were reviewed with the former DON and they had no explanation. The former DON reported they understood the concerns with the missing skin assessments and said they would have benefitted from a wound care coordinator at that time. The former NHA/ DON denied having any concern forms for R802. The NHA /facility was given an opportunity to provide any additional documents prior to exit and none were provided. Surveyor conveyed concerns remained related to missing nursing and physician wound documentation, no skin assessments, no clear wound descriptions (other than wound care provider notes not in EMR), and the missing February (2026) TAR entries. No additional comment was provided or documents by exit. Review of the policy, Wound Treatment Management, dated 1/1/2022, revealed, Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.Policy Explanation and Compliance Guidelines:1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse.3. Dressing changes may be provided outside the frequency parameters in certain situations:a. Feces has seeped underneath the dressing.b. The dressing has dislodged.c. The dressing is soiled otherwise or is wet.4. Dressings will be applied in accordance with manufacturer recommendations.5. Treatment decisions will be based on:a. Etiology of the wound:i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial,venous, diabetic, moisture or incontinence related skin damage.ii. Surgical.iii. Incidental (i.e. skin tear, medical adhesive related skin injury).iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis).b. Characteristics of the wound:i. Pressure injury stage (or level of tissue destruction if not a pressure injury).ii. Size - including shape, depth, and presence of tunneling and/or undermining.iii. Volume and characteristics of exudate.iv. Presence of pain.v. Presence of infection or need to address bacterial bioburden.vi. Condition of the tissue in the wound bed.vii. Condition of peri-wound skin.c. Location of the wound.d. Goals and preferences of the resident/representative.6. Guidelines for dressing selection may be utilized in obtaining physician orders (see attached).a. The guidelines are to be used to assist in treatment decision making.b. Due to unique needs and situations of individuals, the guidelines may not be appropriate foruse in all circumstances.c. The facility will follow specific physician orders for providing wound care.7. Treatments will be documented on the Treatment Administration Record.8. The effectiveness of treatments will be monitored through ongoing assessment of the wound.Considerations for needed modifications include:a. Lack of progression towards healing.b. Changes in the characteristics of the wound (see above).c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance withhis/her rights. Reference: European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance.