		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		634006	B. WING _			12/7/2	023	
	/IDER OR SUPPLIE	R R REHAB CENTER LLC			STREET ADDRESS, CITY, STA 50 N PERRY ST, 1ST FLOO PONTIAC, MI 48342		DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I IIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPF DEFICIENCY)	CROSS-	(X5) COMPLETION DATE	
E0000 SS=	Preparedness S Michigan Depart Regulatory Affair Certification. At t Nursing and Rel substantial comp for participation i	2023, an Emergency urvey was conducted by the ment of Licensing and rs, Bureau of Survey and he survey Oakland Manor nabilitation was found not in bliance with the requirements in Medicare/Medicaid at 42 tergency Preparedness.	E0000					
E0039 SS= F	§418.113(d)(2), (2), §482.15(d)(2), §482.15(d)(2), §483.475(d)(2), (2), §485.542(d), §485.727(d)(2), (2), §494.62(d)(2), (2), §494.62(d)(2), (2), §494.62(d)(2), (3), §494.62(d)(2), (4), §494.62(d)(2),	direments §416.54(d)(2), §441.184(d)(2), §460.84(d) (2), §448.73(d)(2), §484.102(d)(2), §485.68(d) (2), §485.625(d)(2), §485.920(d)(2), §491.12(d) (2). *[For ASCs at §416.54, 68, REHs at §485.542, OPO, under §485.727, CMHCs at large for the folial community of the mount exercises to test the annually. The [facility] must wing: (i) Participate in a full-late is community-based (A) When a community-sand exercise every 2 (a) the facility] experiences an man-made emergency that on of the emergency plan, empt from engaging in its mmunity-based or individual, actional exercise following exercise following exercise following actual event. (ii) Conduct an se at least every 2 years, refer the full-scale or functional exergise that may include, but is cited, that may include, but is	E0039	commu exercis ill/laten Elemer All resid affected Elemer Policy e Training by Reg and det educate full sca prepare 1/15/20 Elemer Results prepare discuss concern	failed to conduct a full scale nity based emergency prepare. Residents/staff did not suffit effects. In #2 Idents/staff have the potential d. In #3 Intitled: Emergency Prepared and Testing Program was rional Maintenance Director a emed appropriate. Staff will be do nemergency preparedness exercise will be conducted. In #4 In it #4	to be dness eviewed nd LNHA ee sss and a ncy ucted by ergency wed and nd any attely.	1/15/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 12/29/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			(X3) DATE SURVEY COMPLETED	
		634006	B. WING _			_ 12/7/2	2023
NAME OF PRO	VIDER OR SUPPLIE	<u>I</u> Er			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FL PONTIAC, MI 48342	OOR	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E EFERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	scale exercise the individual, facility or (B) A mock divexercise or work facilitator and indusing a narrated emergency scenstatements, direquestions designemergency plan response to and all drills, tabletop events, and revisplan, as needed 418.113(d):] (2) provide care in thospice must comergency plan hospice must do in a full-scale exbased every 2 yecommunity based conduct an indivexercise every 2 experiences and emergency plan engaging in its mommunity-based facility-based furthe onset of the Conduct an addivers, opposite functional exerciof this section is include, but is not a second full-scale community-based functional exerciof till; or (C) A tableton in the conduct and exercity of the	e following: (A) A second full- hat is community-based or y-based functional exercise; saster drill; or (C) A tabletop shop that is led by a cludes a group discussion , clinically-relevant hation and a set of problem cted messages, or prepared hed to challenge an . (iii) Analyze the [facility's] maintain documentation of the exercises, and emergency se the [facility's] emergency .*[For Hospices at Testing for hospices that he patient's home. The hat least annually. The the following: (i) Participate ercise that is community tears; or (A) When a detercise is not accessible, idual facility based functional by ears; or (B) If the hospice atural or man-made requires activation of the , the hospital is exempt from hext required full scale detercise or individual hoctional exercise following emergency event. (ii) titional exercise every 2 the year the full-scale or se under paragraph (d)(2)(i) conducted, that may obt limited to the following: (A) ale exercise that is do or a facility based se; or (B) A mock disaster heletop exercise or workshop acilitator and includes a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 634006		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		634006	B. WING _	B. WING			12/7/2023
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOP PONTIAC, MI 48342	R	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	relevant emerge problem stateme prepared questic emergency plan provide inpatient must conduct ex emergency plan must do the follo annual full-scale based; or (A) Wi exercise is not a annual individua exercise; or (B) I natural or mannequires activatic the hospice is expected in the conduct an addi may include, but following: (A) A stoppidal, compared questic emergency plan response to and all drills, tabletop events and revis plan, as needed §441.184(d), Ho at §485.625(d):] Hospital, CAH] rest the emerger [PRTF, Hospital,	n using a narrated, clinically- ncy scenario, and a set of ents, directed messages, or ons designed to challenge an . (3) Testing for hospices that it care directly. The hospice ercises to test the twice per year. The hospice wing: (i) Participate in an exercise that is community- nen a community-based ccessible, conduct an I facility-based functional if the hospice experiences a nade emergency that on of the emergency plan, cempt from engaging in its I-scale community based or notional exercise following emergency event. (ii) tional annual exercise that is not limited to the second full-scale exercise cy-based or a facility based se; or (B) A mock disaster letop exercise or workshop or that includes a group a narrated, clinically- ncy scenario, and a set of ents, directed messages, or ons designed to challenge an . (iii) Analyze the hospice's maintain documentation of to exercises, and emergency e the hospice's emergency . *[For PRFTs at spitals at §482.15(d), CAHs (2) Testing. The [PRTF, nust conduct exercises to ncy plan twice per year. The CAH] must do the following: an annual full-scale exercise					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			(X3) DATE SURVEY COMPLETED	
		634006	B. WING _			_ 12/7/2	2023
NAME OF PRO	VIDER OR SUPPLIE	 ≣R			STREET ADDRESS, CITY, S	TATE, ZIP CC	DDE
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLO PONTIAC, MI 48342	OOR	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	JUDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROI DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	community-base conduct an annufunctional exercit Hospital, CAH] e or man-made er activation of the is exempt from efull-scale community-based furthe onset of the Conduct an [add and that may indefoliolity-based furth facility-based furth mock disaster door workshop that includes a group narrated, clinical scenario, and a directed message designed to cha (iii) Analyze the maintain documexercises, and ethe [facility's] em [For PACE at §4 PACE organizate to test the emergency of the manual passage in the emergency of the emergency of the manual passage in the emergency of the manual passage in the emergency of the emergency of the manual passage in the man	by-based; or (A) When a sed exercise is not accessible, all individual, facility-based ise; or (B) If the [PRTF, experiences an actual natural nergency that requires emergency plan, the [facility] engaging in its next required unity based or individual, actional exercise following emergency event. (ii) ditional] annual exercise or clude, but is not limited to the second full-scale exercise ty-based or individual, a notional exercise; or (B) A rill; or (C) A tabletop exercise to is led by a facilitator and or discussion, using a lly-relevant emergency set of problem statements, ges, or prepared questions llenge an emergency plan. [facility's] response to and entation of all drills, tabletop emergency events and revise hergency plan, as needed. * 160.84(d):] (2) Testing. The ion must conduct exercises gency plan at least annually. Initiation must do the ticipate in an annual full-nat is community-based; or inmunity-based exercise is not duct an annual individual, notional exercise; or (B) If the less an actual natural or manity that requires activation of olan, the PACE is exempt in its next required full-scale and or individual, facility-based is following the onset of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE SURVEY COMPLETED	
		634006	B. WING _			12/7/2	2023
NAME OF PRO	VIDER OR SUPPLIE	ER .			STREET ADDRESS, CITY, STA	ATE, ZIP CO	DE
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOO PONTIAC, MI 48342	OR	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTIO RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPI DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	exercise every 2 full-scale or func paragraph (d)(2) conducted that not to the following: exercise that is condividual, a facile exercise; or (B) at tabletop exercise facilitator and incusing a narrated emergency scent statements, directly questions designed emergency plan response to and all drills, tabletop events and revisiplan, as needed §483.73(d):] (2) conduct exercise at least twice pe unannounced stemergency proc ICF/IID] must do in an annual full-community-base community-base conduct an annufunctional exercifacility experience made emergency pexempt from engosale community based functional of the emergency additional annual but is not limited second full-scale	it. (ii) Conduct an additional years opposite the year the tional exercise under (i) of this section is nay include, but is not limited (A) A second full-scale community-based or ity based functional A mock disaster drill; or (C) A e or workshop that is led by a cludes a group discussion, clinically-relevant ario, and a set of problem cted messages, or prepared ned to challenge an (iii) Analyze the PACE's maintain documentation of the exercises, and emergency et the PACE's maintain documentation of the exercises, and emergency et the PACE's exercise that is done in the community exercise is not accessible, and individual, facility-based set. (B) If the [LTC facility] es an actual natural or many that requires activation of collan, the LTC facility is paging its next required a full-rebased or individual, facility-exercise following the onset by event. (ii) Conduct an exercise that may include, to the following: (A) A exercise that is community-vidual, facility based					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		634006	B. WING _	-		12/7/2	2023
NAME OF PRO	VIDER OR SUPPLIE	ER .			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOP PONTIAC, MI 48342	र	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	drill; or (C) A tab that is led by a fa discussion, using relevant emerge problem statemes prepared question emergency plan facility] facility's documentation of exercises, and ethe [LTC facility] needed. *[For ICT to test the emergency plan that is community-base conduct an annufunctional exercisex emergency that emergency plan engaging in its not community-base functional exercise limited to the foll scale exercises thindividual, facility or (B) A mock diexercise or work facilitator and incusing a narrated emergency scen statements, directly plan response to and	se; or (B) A mock disaster letop exercise or workshop acilitator includes a group g a narrated, clinicallyncy scenario, and a set of ents, directed messages, or ons designed to challenge an (iii) Analyze the [LTC response to and maintain of all drills, tabletop mergency events, and revise facility's emergency plan, as F/IIDs at §483.475(d)]: (2) F/IID must conduct exercises gency plan at least twice per D must do the following: (i) annual full-scale exercise y-based; or (A) When a d exercise is not accessible, all individual, facility-based se; or. (B) If the ICF/IID actual natural or man-made requires activation of the the ICF/IID is exempt from ext required full-scale d or individual, facility-based se following the onset of the tit. (ii) Conduct an additional that may include, but is not owing: (A) A second full-lat is community-based or an y-based functional exercise; saster drill; or (C) A tabletop shop that is led by a cludes a group discussion, clinically-relevant ario, and a set of problem cted messages, or prepared led to challenge an (iii) Analyze the ICF/IID's maintain documentation of the exercises, and emergency					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI/IDENTIFICATION NUMBER:					DATE SURVEY IPLETED	
		634006	B. WING _	VING			2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DDE	
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST F PONTIAC, MI 48342	LOOR		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	plan, as needed. (2) Testing. The exercises to test annually. The HI Participate in a frommunity-base community-base conduct an annufunctional exercithe HHA experie man-made emer activation of the exempt from engfull-scale community-base functional exercion include, but is not a second full-scace community-base based functional disaster drill; or (workshop that is includes a group narrated, clinical scenario, and a signification of the exercises, and ethe HHA's emergoposate §486.31 must conduct exempt plan. following: (i) Contabletop exercises	se the ICF/IID's emergency *[For HHAs at §484.102] (d) HHA must conduct the emergency plan at least HA must do the following: (i) ull-scale exercise that is d; or (A) When a d exercise is not accessible, al individual, facility-based se every 2 years; or. (B) If nces an actual natural or gency that requires emergency plan, the HHA is jaging in its next required unity-based or individual, actional exercise following emergency event. (ii) tional exercise every 2 he year the full-scale or se under paragraph (d)(2)(i) conducted, that may of limited to the following: (A) ale exercise that is d or an individual, facility- exercise; or (B) A mock C) A tabletop exercise or led by a facilitator and discussion, using a ly-relevant emergency set of problem statements, es, or prepared questions lenge an emergency plan. HHA's response to and entation of all drills, tabletop mergency events, and revise gency plan, as needed. *[For 60] (d)(2) Testing. The OPO ercises to test the The OPO must do the duct a paper-based, e or workshop at least top exercise is led by a						

		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY LETED
		634006	B. WING _	B. WING		_ 12/7/2	2023
NAME OF PRO	VIDER OR SUPPLIE	R	•	STREET ADDRESS		TATE, ZIP CC	DDE
OAKLAND MANOR NURSING & REHAB CENTER LLC					50 N PERRY ST, 1ST FL PONTIAC, MI 48342	OOR	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	using a narrated emergency scen statements, direct questions designemergency plantactual natural or requires activation the OPO is exem required testing of the emergency of the emergency even and OPO's response documentation of the emergency even and OPO's genemergency even and OPO's genemergency even and OPO's and the state of the emergency plantaction of the emergency prepared question of the emergency prepared to ensure the emergency prepared in the past twelve critical deficiencic respond to an actual response to and actual deficiencie respond to an actual response to actual	if all tabletop exercises, and its, and revise the [RNHCI's regency plan, as needed. *[.748]: (d)(2) Testing. The iduct exercises to test the The RNHCI must do the iduct a paper-based, at least annually. A is a group discussion led sing a narrated, clinicallying scenario, and a set of ents, directed messages, or ons designed to challenge an (ii) Analyze the RNHCI's maintain documentation of cises, and emergency set the RNHCI's emergency					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:		A	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
634006		634006		B. WING _			12/7/2023	
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE,	ZIP CO	DE
OAKLAND MANOR NURSING & REHAB CENTER LLC				50 N PERRY ST, 1ST FLOOR PONTIAC, MI 48342				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	F	ID PREFIX TAG	CORI	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	record review reve produce document exercise was condu- months. This could to deal with an em- preplanned for. Do- at the time of reque time of the exit con- These findings were	023 at approximately 2:00 PM, raled the facility could not ation to verify a full scale ucted in the previous 12 dleave facility staff unprepared ergency situation that can be ocumentation was unavailable est and not presented by the inference. The confirmed by interview with irector at the time of record						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLI/IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	IPLE CON IG			OATE SURVEY PLETED	
		634006	B. WING		12/7/2		023	
	VIDER OR SUPPLIE	I ER & REHAB CENTER LLC		STREET ADDRESS, CITY, 50 N PERRY ST, 1ST F PONTIAC, MI 48342				
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (EA RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE	
K0000 SS=	Life Safety Recent by the Michigan I Regulatory Affair Certification. At th Nursing & Rehab found not in subst requirements for p Medicare/Medicare	2023 and December 7, 2023, a diffication Survey was conducted Department of Licensing and s, Bureau of Survey and he survey, Oakland Manor Center, LLC - Pontiac was antial compliance with the participation in the dat 42 CFR 483.90(a), Life and the applicable provisions of the National Fire Protection 01, Life Safety Code and the FPA 99, Health Care Facilities ated on the 2nd floor of a 3 cal occupancy building of Type on, built in 1964. The 2nd floor ney is fully sprinklered and our fire barrier. The facility has detection in the corridors and corridors.	K0000					
K0321 SS= E	Areas - Enclosur protected by a fir resistance rating doors) or an autr system in accord When the appro- extinguishing sy- areas shall be sc by smoke resisti accordance with closing or autom	s - Enclosure Hazardous re Hazardous areas are re barrier having 1-hour fire (with 3/4 hour fire rated omatic fire extinguishing dance with 8.7.1 or 19.3.5.9. ved automatic fire stem option is used, the eparated from other spaces ng partitions and doors in 8.4. Doors shall be self- latic-closing and permitted to r field-applied protective	K0321	and docclosure Elemer An aud other restorage	nt room 165 is being used for stores not have a required automatic on the door. Int#2 it was conducted to ensure that no esident rooms were being used for an and it was determined that no other than the facility are being used for stime.	o o r her	1/15/2024	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		634006	B. WING _			12/7/2	12/7/2023	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE	
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOF PONTIAC, MI 48342	3		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	bottom of the do zone locations o deficient in REM Area Automatic Boiler and Fuel-Laundries (large Repair, Maintena Soiled Linen Roo e. Trash Collecti gallons) f. Comb Rooms/Spaces (Laboratories (if csee K322) This REQUIREM evidenced by: Based on observat failed to provide If fire barrier having (with 3/4 hour fire fire extinguishing shall be separated resisting partitions 8.4. Doors shall be closing and permi applied protective inches from the be practice could affe fire. Findings Include: On December 6, 2 observation reveal been converted to large fire load of cand patient ventilations of the converted to large fire load of cand patient ventilations.	ot exceed 48 inches from the or. Describe the floor and f hazardous areas that are ARKS. 19.3.2.1, 19.3.5.9 Sprinkler Separation N/A a. Fired Heater Rooms b. r than 100 square feet) c. ance, and Paint Shops d. oms (exceeding 64 gallons) on Rooms (exceeding 64 gallons) on Rooms (exceeding 64 ustible Storage (over 50 square feet) g. classified as Severe Hazard - MENT is not met as Ition and interview, the facility Hazardous areas protected by a 1-hour fire resistance rating a rated doors) or an automatic system in accordance with When the approved automatic system option is used, the areas from other spaces by smoke and doors in accordance with the self-closing or automaticated to have nonrated or field-plates that do not exceed 48 bottom of the door. This deficient ext 10 occupants in the event of the Room 165 has a storage room and contains combustible cardboard boxes atton units. The room is not elf closing door. This will		storage closure and up forms to of door Elemer The Ad all roon random address inspect commit	nt#4 Iministrator/designee will inspectors monthly for three months and the sed immediately. Results of the ion/audits will be brought to the tee for review and recommend strator is responsible for sustain	tic door Il review round rections ct/audit d then I be e QAPI ations.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		634006	B. WING			12/7/2	023	
	OVIDER OR SUPPLIE	I FR & Rehab Center LLC		STREET ADDRESS, CITY, STATE 50 N PERRY ST, 1ST FLOOR				
				PONTIAC, MI 48342				
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	the space and ente These findings we	moke, heat and fire to escape r the adjacent areas. re confirmed through interview nce director at the time of						
K0353 SS= F	Sprinkler System Automatic sprink are inspected, te accordance with Inspection, Testi Water-based Fire Records of system inspection and te secure location a sprinkler system system supply so REMARKS informon-required or psystem. 9.7.5, 9. This REQUIREM evidenced by: Based on observate failed to ensure the inspected, tested a with NFPA 25, and as required by 9.7. practice could affed a fire. Findings Include:	b) Who provided c) Water	K0353	shower Missing missing Sprinkle outside debris. Plastic room 1 biohaza Elemer The mis shower The mis replace Dust ar over the 153 we Plastic located sprinkle utility roall reside affected effects, Elemer Facility sprinkle heads to stuck to 1/15/24	g sprinkler head escutched room g sprinkler head escutched in room 165. er head over the nurses stor froom 153 covered with material stuck to sprinkler 10/custodial closet and out ard/soiled utility room. Int#2 saing sprinkler head escut froom was replaced on 12/sing sprinkler heads in rood on 12/19/23. Ind debris covering the spring enurses station and outsing eleaned 12/8/23. Indicate the sprinkler in the room 110/custodia er head outside the biohaz on was removed on 12/6 dents/staff have the potent, there is no evidence of concerns noted.	cheon in 2/19/23. som 165 were inkler heads I closet and trained to be any ill/latent of all the sprinkler ris, plastic eon plates by	1/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		634006	B. WING _			12/7/2	2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, 2	ZIP COI	DE	
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOR PONTIAC, MI 48342			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (EA RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE	
	escutcheon plate is head in the main's potentially lead to functioning as des fire. 2. On December 6 PM, observation on the corridor outsid the air diffuser and station is loaded at debris. This will p the automatic wet needed during a fi from discharging a 3. On December 6 PM, observation or resident room 165 escutcheon plate filead to the sprinkle designed when needed to the sprinkler heads custodial closet and the biohazard soile potentially lead to functioning as des fire. These findings we	sevealed the sprinkler head somissing from the sprinkler hower room. This may the sprinkler head not igned when needed during a severaled the sprinkler head in the of resident room 153 next to a the sprinkler over the nurse and covered with dust and otentially delay activation of fire sprinkler system when the sprinkler system when the designed temperature. 1, 2023 at approximately 1:15 evealed the sprinkler heads in the designed temperature. 2023 at approximately 1:15 evealed the sprinkler heads in the are both missing the sittings. This may potentially the head not functioning as eded during a fire. 1, 2023 at approximately 1:20 evealed plastic material stuck to solocated in the Room 110 do the sprinkler head outside of edutility room. This will the sprinkler heads not igned when needed during a tree confirmed through interview ance director at the time of		of sprir then mo concerr Results the QAI recomn	will conduct a visual inspection of nkler heads weekly for four weeks onthly for three months. Any ident as will be scheduled for cleaning/rest of the inspections will be brough PI committee for review and nendations.	and tified repair. t to		
K0363 SS= E	protecting corridorequired enclosurexits, or hazardo	Corridor - Doors Doors or openings in other than ares of vertical openings, ous areas resist the passage of made of 1 3/4 inch solid-	K0363	closed.	nt room 153 door does not latch v nt rook 155 door does not latch w	-	1/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		634006	B. WING _			023		
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE	
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOF PONTIAC, MI 48342	?		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IIIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	of resisting fire for in fully sprinklered only required to a containing flamm materials have problem and the following sprinklered on the following sprinklered on the following sprinklered on the following sprinklered on the sprinklered of	od or other material capable or at least 20 minutes. Doors at seast 20 minutes. Doors at seast 20 minutes. Doors at seast 20 minutes are resist the passage of smoke. In doors to rooms hable or combustible ositive latching hardware. The prohibited by CMS are requirements do not apply sea that do not contain mbustible material. The promote of the prom		closed. Cross of unit to the door Cross of resident between Elemer All resident effects. Elemer Facility room 1: closed. Facility room 1: closed. Facility room the closed. Facility room to closed. Facility room to close of Facility room to close of Facility room to complete the closed. Facility room to close of Facility room to complete the close of Facility door the close of th	corridor double doors from the label obby space have a gap being exceeding 1/8 inch. corridor south double doors from the interior to the dining corridor haven the doors exceeding 1/8 incheated, there is no evidence of ill/lated, there is no evidence of ill/lat	resident tween in the ear a gap in the e		

		(X1) PROVIDER/SUPPLIER/CLI/IDENTIFICATION NUMBER:	A (X2) MULT A. BUILDIN	IPLE CON	ISTRUCTION		ATE SURVEY LETED
		634006	B. WING	WING 12		12/7/2	023
NAME OF PROVIDER OR SUPPLIER OAKLAND MANOR NURSING & REHAB CENTER LLC			'		STREET ADDRESS, CITY, ST 50 N PERRY ST, 1ST FLO		DE
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENT FULL REGULATION FULL REGULATION STATE OF THE PROPERTY OF THE PROPE	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION) ded core wood or capable of ge of smoke. There is no closing of doors. Clearance foor and floor covering is not Roller latches are prohibited by on corridor doors and rooms able or combustible materials. Inplying with 7.2.1.9 are open devices that release when or pulled are permitted. The plates of unlimited height are shoors meeting 19.3.6.3.6 are be labeled and made of steel or compliance with 8.3, unless the int is sprinklered. Fixed fire is are allowed per 8.3. In rtments there are no restrictions trance of glass or frames in s. This deficient practice could is in the event of fire. 1, 2023 at approximately 1:05 vealed resident room 164 door on closed. This will potentially and fire to pass through the oor and into the occupied 1, 2023 at approximately 1:30 vealed resident room 153 door on closed. This will potentially and fire to pass through the oor and into the occupied	ID PREFIX TAG	three m address inspect for revi	PONTIAC, MI 48342 I/IDER'S PLAN OF CORRECTION SHOULD BEFERENCED TO THE APPROFIDERICIENCY) Interpretation of the concessed immediately. The result ions will be brought to QAP ew and recommendations.	ON (EACH E CROSS- PRIATE rns will be s of the I committee	(X5) COMPLETION DATE
	PM observation re	, 2023 at approximately 1:30 wealed resident room 155 door n closed. This will potentially					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY MPLETED	
		634006	B. WING	WING			12/7/2023	
NAME OF PROVIDER OR SUPPLIER OAKLAND MANOR NURSING & REHAB CENTER LLC					DE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	COR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	resident corridor of space. 4. On December 6 PM observation redouble doors from space have a gap 1 inch. This will all through the doors 5. On December 6 PM observation redouble doors from corridor have a gal 1/8 inch. This will through the doors These findings we	and fire to pass through the door and into the occupied 5, 2023 at approximately 1:15 Everaled the cross corridor In the resident unit to the Lobby Dow the passage of smoke Into the adjacent space. 5, 2023 at approximately 1:15 Everaled the cross corridor south In the resident unit to the dining In between the doors exceeding In allow the passage of smoke Into the adjacent space. Everaled the cross corridor south In the resident unit to the dining In the passage of smoke Into the adjacent space. Everaled through interview Ince Director at the time of						
K0712 SS= F	transmission of a simulation of em drills are held at times under vary quarterly on eac with procedures part of establish conducted between coded announce of audible alarm This REQUIREN evidenced by: Based on record refailed to ensure fin of a fire alarm signer.	rills Fire drills include the a fire alarm signal and ergency fire conditions. Fire expected and unexpected ring conditions, at least h shift. The staff is familiar and is aware that drills are ed routine. Where drills are een 9:00 PM and 6:00 AM, a rement may be used instead s. 19.7.1.4 through 19.7.1.7 MENT is not met as	K0712	Septem signatus simulati Elemer No evid deficier Elemer Facility alarm pfacilities Facility 12/28/2 Facility drills by Facility	cility fire drill records for August 2 aber 2023 only contained employ ires and documentation of fire ire. Int#2 dence ill/latent effects noted due not practice. Int#3 will obtain quarterly dialer report oanel activity from McLaren Oakles manager by 1/15/24. Conducted 3rd shift fire drill on	to t of fire and ft fire	1/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		634006	B. WING			12/7/2	023	
NAME OF PRO	VIDER OR SUPPLIE	I. R	<u> </u>		STREET ADDRESS, CITY, STATE	, ZIP COI	DE	
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOR PONTIAC, MI 48342			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
	least quarterly on planning and cond competent persons leadership as requiparterly. This defi occupants in the effindings Include: On December 6, 2 record review revectord review revectord review revectord fire drills of September 2023, cemployees participarticly Drills cannot be worth are occurring these findings we	023 at approximately 2:15 PM ealed the facility is not ills as required by 19.7.1.4. The records for August 2023 to only contain signatures of pating in the drills. The Fire erify signals are sent to the enry, or simulation of actual fire		subsequent fire drills for review. Element#4 Facility will create and implement a calendar to schedule subsequent fire drills for the next 12 months. Staff will be educated at least quarterly on fire safety. Administrator is responsible for sustained compliance.		e next on fire		
K0914 SS= F	Testing Electrica and Testing Hos patient bed locat sedation or gene administered, an installation, replay Additional testing defined by docur Receptacles not these locations a exceeding 12 mg (LIM), if installed less than or equational testing the LIM test swith activates both visual testing the LIM test swith activates both visual testing the LIM test swith activates with testing the LIM test swith activates both visual testing the LIM test swith activates with testing the swith testing the	ns - Maintenance and all Systems - Maintenance pital-grade receptacles at ions and where deep gral anesthesia is the tested after initial accement or servicing. It is performed at intervals mented performance data. It is the das hospital-grade at are tested at intervals not onths. Line isolation monitors at intervals of all to 1 month by actuating the per 6.3.2.6.3.6, which is all and audible alarm. For automated self-testing, this performed at intervals less	K0914	Elemen Facility testing 1/15/24 Facility docume inspect complia Elemen Facility mainter subseq	failed to record the annual testing ident room receptacles. Int#2 will conduct and record the annual testing of the resident room receptacles. Will conduct and a review of life tentation to identify any other ions or documentation that is out ance by 1/15/24.	ual s by safety t of	1/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		634006	B. WING			12/7/2	023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP COI	DE	
OAKLAND M	ANOR NURSING	& REHAB CENTER LLC			50 N PERRY ST, 1ST FLOOR PONTIAC, MI 48342			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (E. RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIATI DEFICIENCY)	SS-	(X5) COMPLETION DATE	
	than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure electrical receptacles are maintained and tested as required by 6.3.4 of 2012 NFPA 99. This deficient practice could affect all occupants in the event of electrical outlet failure. Findings Include: On December 7, 2023 at approximately 11:15 AM record review revealed the facility cannot provide documentation to verify outlets in resident/patient care areas are tested at intervals not exceeding 12 months. This could potentially allow outlets in the patient/resident care area to fail when in use. These findings were confirmed with the Manger of Facilities through interview at the time of record review.			Facility will maintain documentation of subsequent inspections for review. Element#4 Administrator will be responsible for sustained compliance		sible		
K0917 SS= E	Electrical Systen System Recepta cover plates sup critical branches marking. 6.4.2.2. (NFPA 99)	ns - Essential Electric Syste ns - Essential Electric cles Electrical receptacles or plied from the life safety and have a distinctive color or 6, 6.5.2.2.4.2, 6.6.2.2.3.2	K0917	The red 158 and RP-EP: an auto staff or	d Manor Skilled Nursing and Rehting a temporary waiver for K917. If emergency outlets in rooms 156d 159 are fed from emergency page. Panel RP-EP2 is not wired thromatic transfer switch. The reside facility have not suffered any ill/la or health/safety concerns related	5, 157, inel ough nts, atent	6/7/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION	TION (X3) DAT COMPLE		
		634006	B. WING _	G		12/7/2	12/7/2023	
NAME OF PROVIDER OR SUPPLIER OAKLAND MANOR NURSING & REHAB CENTER LLC					STREET ADDRESS, CITY, STAT 50 N PERRY ST, 1ST FLOOI PONTIAC, MI 48342	,	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	failed to ensure eleplates supplied frobranches have a direquired by 6.4.2.2 of NFPA 99. This occupants in the efficiency of NFPA 100 occupants in the efficiency occupants in the efficiency occupants with State of NFPA 100 occupants with State on the efficiency occupants with the efficiency occupants with the process of NFPA 100 occupants with the occupants of NFPA 100 occupants occupant	re confirmed through interview of Facilities, Maintenance inistrator at the time of		No resistant process accider situation covers accider situation covers accider situation contract two bree by two evaluat that fee salon. Temperature accider situation of the contract two bree by two evaluat that fee salon. Temperature accider situation of the contract two bree by two evaluat that fee salon. Temperature accident situation of the contract two bree by two evaluations of the contract two evaluations of the contract two bree by two evaluations of the contract two bree by two evaluations of the contract two evaluations of the contract two evaluations of the contract two evalu	dents will be admitted to rooms 8 or 159 that would require en ent. Signage is posted at the r to remind staff that the red out 156, 157, 158, and 159 will not n case of a power outage. The notice in the emergency prepare that have identified the rooms to e emergency power. All staff we did n regard to this notemergency/red outlet. The resents' rooms 156, 157, 158, and corarily removed and will have installed by 1/30/24. Doing so notal use of the outlets in an emin. In conjunction with McLaren did Hospital maintenance directed and, facility will contact and elector to move the wiring being feakers in the RP-EP 2 panel to breakers in the RP-E panel, the did the lights in the shower room 7 hese breakers can be utilized and plugs in rooms 156, 157, 15 are wiring that feeds the lighting froom and salon can be redirected and use of emergency powed rooms during orientation. All n-serviced monthly in regards and compliance by 6/7/24 strator will be responsible for con and compliance.	nergency ourses' lets in have re is edness hat do vill be doutlets will be reakers and for the 58 and in the cted to doutlets doublets dou		