STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235228	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Hill for Nursing and Rehabilitation	38410 Cherry Hill Road Westland, MI 48185

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure arbitration agreements were signed by the resident or appropriate responsible party, and in a manner which was explained and understood by the resident or responsible party for four residents (R23, R35, R90, and R104) of reviewed for arbitration agreements. Findings include: On 1/13/26 at 10:38 AM, an entrance conference was completed with the Nursing Home Administrator (NHA) indicating the facility offers arbitration agreements. At that time, a request for the residents who entered into an agreement was requested. A review of the list noted 77 residents who had entered into arbitration agreements. R23A review of the arbitration agreement list revealed R23 had entered into an arbitration agreement. Further review revealed a signing date of 7/25/25 by someone other than the resident. A request for guardianship documentation was requested on 1/15/26 at 10:26am however, this was not received by end of survey. A review of R23's medical record revealed the resident was their own responsible party but had a significant other listed as an emergency contact which was the person who signed R23's arbitration agreement on the date of admission. R90A review of R90's signed arbitration agreement was noted to be in English and was dated and signed by the resident on 5/10/25. Further review of the resident's medical record revealed a progress note indicating that English is not the resident's primary language: 3/12/2025 22:19 (10:19pm) admission Summary .Late Entry: Resident is non-English speaking, which presents challenges in effectively communicating needs and concerns. Alternative communication methods will be utilized as needed to ensure understanding and support . R104On 1/15/26 at 3:05 PM, R104 was asked if they had signed an arbitration agreement and explained what exactly an arbitration agreement was. The resident explained they would not have signed something like that upon admission. R104 was listed as being a resident who had entered into an arbitration agreement. R35On 1/15/26 at 3:22 PM, R35 was asked if they had signed an arbitration agreement and was explained what exactly an arbitration agreement was. The resident explained they would not have signed something like that upon admission. R35 was listed as being a resident who had entered into an arbitration agreement. On 1/15/26 at 1:35 PM, the Nursing Home Administrator (NHA) was asked about the expectation for the proper completion of arbitration agreements and acknowledged this is a new concern identified which will be worked on.On 1/15/26 at 12:14 PM, the facility's Arbitration Agreement policy was requested and not provided by end of survey.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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** Based on observation, interview, and record review, the facility failed to maintain the cleanliness of the 200-hallway shower room for one (R105) and failed to maintain linen in good repair for one (R111) of three residents reviewed for the environment. Findings include: On 01/13/2026 at 11:04 AM, R105 was interviewed in their room and reported they did not want to use the 200-hallway shower room because they felt it had mold present that was visible along the lower rear wall seam between the wall and floor. On 01/14/2026 at 1:15 PM, observation of the 200-hallway shower room revealed: 1. A black substance along the seam of the back wall and the floor where there was a gap of approximately two-three inches in the tile leaving an area that was only grout. The black substance was easily wiped onto a napkin. 2. Two areas of broken tile on wall corners leaving exposed drywall approximately four to six inches wide. 3. A clump of brown substance that appeared to be feces and a large clump of hair. On 01/15/2026 at 2:45 PM, the facility Administrator (NHA) observed the 200-hallway shower room with the surveyor and acknowledged the presence of the areas of concern within the shower room and expressed the intention to clean/repair the areas. On 01/13/26 at 9:30 AM, R111 was observed lying in bed in their room watching television. Two golf ball sized holes in the sheets were observed near their pillow, and several smaller pea sized holes were observed on the side of the sheets. R111 said the holes bothered them and were unacceptable and would not use sheets with holes if they were in their own home. On 01/14/26 at 11:00 AM, an interview was held with Unit Manager D and was asked about the holes in the bed linens. UM D stated the nursing assistants change the beds at least once a week and as needed. Any worn or torn sheets are to be sent back to laundry to be taken out of rotation. A record review revealed that R111 was admitted on [DATE] with the following medical diagnoses of Heart Failure and Chronic Respiratory Failure with Hypoxia / Hypercapnia. R111's most recent Brief Inventory for Mental Status assessment revealed a score of 15/15 indicating intact cognition. A review of the facility's policy titled Quality of Life - Homelike Environment, dated May 2017, revealed the policy statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include . clean bed and bath linens that are in good condition.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a low air loss mattress (LAL) was powered on for one resident (R59) of three reviewed for wound management. Findings include:On 01/13/2026 at 10:37 AM and 11:35 AM, R59 was observed to be in a LAL specialty bed. The bed had side bolsters and R59 was sunk low in the bed between the bolsters. An observation of the power unit for the bed revealed no active lights or display screen to indicate the mattress was powered on. R59 had a green wedge behind their torso and faced toward the right side of the bed. At 4:01 PM, the power unit for the mattress remained not powered on. The base of the mattress was firm and R59 reported they felt like they were laying on the frame and was adjusted their position slightly. R59 further noted they did not get out of bed often. On 01/14/2026 at 8:47 AM, R59 was observed to be in bed, sitting up and eating breakfast. The power unit for the bed had no lights or active display screen and was not powered on. At 4:23 PM, the mattress and power unit were observed with Licensed Practical Nurse (LPN) A. LPN A checked the mattress and reported they were not aware it was not working and confirmed no lights nor display were activated. On 01/15/2026 at 8:48 AM, the LAL mattress was observed with the unit manager and wound nurse LPN B. The mattress power unit had visible green lights and an active display. LPN B reported they were not aware of the mattress having been off and reported they locked the power screen to ensure it was not turned off inadvertently. LPN B reported R59 had resolved the buttocks wounds but had leg wounds which still required the LAL mattress intervention. On 01/15/26 at 1:15 PM, the Director of Nursing (DON) confirmed all beds with a LAL mattress should be checked to ensure they are powered on. A review of the record for R59 revealed R59 was admitted into the facility on [DATE]. Diagnoses included Diabetes and Mild Cognitive Impairment. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated mild to severe cognitive impairment. The MDS also documented R59 was dependent on staff to roll left and right while in bed, dressing and toileting hygiene. The active care plan documented R59 has potential for new onset pressure ulcer development r/t (related to) debility, incontinence, DMII (Diabetes-high blood sugars). Guest prefers to remain in bed almost all of the time. Date Initiated: 10/22/2024. Revision on: 08/12/2025. The care plan also documented: Resident has actual skin integrity impairment r/t: immobility, Lack of sensation, have wounds b/l (bilateral) toes I have wounds to b/l knees, b/l buttock, left side of face and chest (resolved). Date Initiated: 10/29/2024. Revision on: 03/20/2025. Interventions included, Ensure special mattress is in place (LAL) Date Initiated: 10/29/2024. Revision on: 01/14/2026. A review of the Medication and Treatment administration records for January 2026 and December 2025 revealed no monitoring of the LAL mattress was documented. A review of the facility policy titled, Care Plans, Comprehensive Person-Centered revised 03/2022 revealed, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. A review of the facility policy titled, Support Surface Guidelines revised 09/2013 revealed, Purpose: The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown . Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed . The policy did not indicate the need for monitoring a LAL mattress.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to float (positioning the heels to prevent sustained contact between the heels and the bed) a resident's heels per physician order for one (R19) of three resident's reviewed for pressure ulcer prevention. Findings include: Review of the medical record for R19 revealed they were admitted into the facility on [DATE] with diagnoses including Type-Two Diabetes Mellitus and Chronic Kidney Disease. Review of R19's Minimum Data Set (MDS) information indicated a history of facility-acquired pressure ulcers and the Brief Interview for Mental Status (BIMS) score of 8/15 indicated moderate cognitive impairment. Review of R19's current physician orders confirmed an active order stating Skin prep to bilateral heels, float heels while in bed. On 01/13/2026 at 1:47 PM, R19 was observed in bed. Their feet were laying directly on the mattress without any support to float the heels or any float boots in place. R19 was queried as to whether they knew if their heels were ever placed in a floated position or if they ever have soft boots on their feet while in bed and they indicated they could not recall. Further review of R19's facility record revealed a Braden Assessment (Assessment of pressure sore risk) dated 01/04/26 indicating the resident had moderate risk for pressure sores. On 01/14/2026 at 10:27 AM, R19 was observed in bed. The resident's heels were not floated and were laying directly on the mattress. On 01/15/2026 at 9:43 AM, R19 was observed in bed. Their heels were not floated and were laying directly on the mattress. On 01/15/2026 at 12:41 PM, Certified Nursing Assistant (CNA) F was interviewed and reported when a resident has orders for their heels to be floated, they float the heels either by using heel float boots or by placing a pillow under the lower legs to elevate the heels off the bed surface. On 01/15/2026 at 12:46 PM, Registered Nurse (RN) G, Unit Manager of R19's living area, was interviewed and asked their expectation when a resident has orders for their heels to be floated and said the heels should be floated either by use of heel float boots or use a pillow under the lower legs to elevate the heels. RN G indicated that use of the heel boots is usually specified in the order. On 01/15/2026 at 1:15 PM, the facility Director of Nursing (DON) was interviewed and asked their expectation when a resident has orders for their heels to be floated in bed. The DON reported their heels should be floated either by placing a pillow under the lower legs or via use of heel float boots. Review of the facility policy Prevention of Pressure Injuries, dated April 2020, revealed the intervention Select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview, and record review, the facility failed to address the behavioral health needs of one resident (R23) of one reviewed for behavioral health resulting in an assault of another resident. Findings include: On 1/13/26 at 11:44 AM, R23 was observed lying in bed and asked about a recent incident involving their previous roommate and stated, [they] thought I was [their] whipping boy and I hit [them] with a weight. R23 did not provide any additional information regarding the incident.A review of R23's medical record revealed they were admitted into the facility on 7/23/25 with diagnoses which included Post-Traumatic Stress Disorder, Hemiplegia and Hemiparesis, and Hypertension. Further review revealed the resident was cognitively intact and required one-person assist with activities of daily living (ADL's).A review of the following progress notes revealed the following: 10/8/2025 08:30 (8:30am) Behavior Note: Patient has been observed being confused and aggressive. Patient was redirected several times because [they were] trying to climb out of bed and walk without assistance. Patient is A + O x 2 (alert and oriented to person and place) and has left side weakness in arm and leg. While trying to put patient's legs back into the bed and the bed in the lowest position, the patient was seen and observed by staff striking the nurse with [their] fist. The patient was redirected and the Administrator and DON (Director of Nursing) have been notified of this behavior. The patient will continue to be monitored for safety. 11/9/2025 06:37 (6:37am) Behavior Note: Resident was having a behavior issue causing and throwing things on the floor writer told [them] to be calm and behavior ceased and sleeping. 1/10/2026 20:44pm (8:44pm) Nursing Note: At 6:20pm writer observed resident throwing roommate's items at [them]. Roommate stated [R23] hit [them] with a hand weight on [their] left forehead and underneath left eyelid. Writer separated them. Propelled [R23] out to hallway. No signs of injury to patient . 1/12/2026 08:57am (8:57am) Nursing Note: Writer went to resident's room and asked resident to discuss the events that transpired between [themselves] and [their] former roommate. Resident stated that [they] struck the roommate and stated [they] would do so again. Writer redirected resident and informed [them] that physical assault of another resident is not acceptable. Resident became dismissive and stated [they] would do what [they] wants and instructed writer to leave the room. Writer acknowledged and exited the room . Further review of R23's medical record revealed the following care plan, Focus: Problematic manner in which resident acts characterized by ineffective coping; Agitation related to: Anxiety, Frustration, No apparent reason, and physically aggressive. Date Initiated: 10/08/2025 .Interventions: Be careful of not invading residents' personal space. Date Initiated: 10/08/2025. Initiate Behavior Management consult. Date Initiated: 10/08/2025. Keep schedules routine & predictable. Date Initiated: 10/08/2025. Praise/ reward resident for demonstrating consistent desired/acceptable behavior. Date Initiated: 10/08/2025. Remove resident from public area when behavior is disruptive/ unacceptable. Talk with resident in a low pitch, calm voice to decrease/eliminate undesired behavior and provide diversional activity. Date Initiated: 10/08/2025. Resident on 15 min (minute) check for 72 hours to be followed by 30 mi (minute) checks for 72 hour and 1-hour checks for last 72 hours. Date Initiated: 01/10/2026 . Further review of R23's medical record did not reveal any additional behavioral interventions or monitoring of their triggers and behaviors following any of R23's behaviors. On 01/15/2026 at 11:55 AM, an interview was completed with Social Worker E regarding R23's behavioral health. SW E explained the resident declined to receive behavioral health services. She was also asked about the resident's care plan and completion of their OBRA assessment (Omnibus Budget Reconciliation Act of 1987, mental health and intellectual disability screening) related to services needed and acknowledged she is new to the position and isn't familiar with the resident. She advised she would look into it and get back with the surveyor; however, no additional information was provided prior to the end of survey. Further review of R23's medical record did not reveal any refusals for behavioral health services. On 01/15/2026 at 1:35 PM, (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview was conducted with the Nursing Home Administrator (NHA) and asked about R23 assaulting another resident and explained he had no prior knowledge of behaviors that may have predicted the incident between the two residents.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to follow pharmacy recommendations for one resident (R77) of five reviewed for Medication Regimen Reviews (MRRs). Findings include: A review of R77's monthly MRR's noted the following dates the resident had irregularities reported by the pharmacist: 5/19/25, 6/24/25, and 7/21/25. A review of the irregularities report for 5/19/25 indicated the following, Please ensure lab results for the following labs are completed and scanned into [electronic medical record] as ordered 4/14/25, as results could not be located in this resident's chart at the time of review, CMP and CBC (comprehensive metabolic panel and complete blood count), Fasting lipid panel (measures the amount of certain fat molecules in the blood), HgbA1c level (measures the amount of glucose in the blood). A review of the irregularities report dated for 6/24/25 indicated the following, Please ensure lab results for the following labs are completed and scanned into [electronic medical record] as ordered 4/21/25, as results could not be located in this resident's chart at the time of review, CMP and CBC, Fasting lipid panel, HgbA1c level. A review of the irregularities report dated 7/21/25 indicated the following, Please ensure lab results for the following labs are completed and ***scanned into [electronic medical record] *** as ordered 4/21/25, as results could not be located in this resident's chart at the time of review, CMP and CBC, Fasting lipid panel, and HgbA1c level. The irregularities reports did not reveal the attending physician reviewed the identified irregularity, the action, if any, taken, or a rationale for the action not being taken. On 1/15/26 at 2:42 PM, a request for R77's labs were requested from the facility for April 2025 to present however, the Director of Nursing (DON) indicated the resident has declined having their labs drawn, therefore they had not been completed. A request for the refusals was made and was provided with one progress note dated 7/30/25 indicating the resident declined labs on that date. The DON acknowledged the lack of documentation. A review of R77's medical record revealed the resident was admitted into the facility on 9/30/22 with diagnoses which included Diabetes, Heart Disease, Hypertension and Chronic Kidney Disease. Further review revealed the resident was cognitively intact and required limited assist with activities of daily living. Further review did not note previous refusals of lab draws.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to store medication not at the bedside for one resident (R50) of one resident reviewed for storage of drugs and biologicals.Findings include: On 1/13/26 at 9:30 AM, R50 was observed laying in their bed watching television. Their bed was cluttered with papers other items. A bag of cough drops, an over-the-counter inhaler, and two prescription inhalers were observed at the bedside. When asked about the medications at bedside R50 stated the nurse gave them to them.On 1/14/26 at 10:30 AM, R50 was observed sitting up on the side of their bed going through the clutter. Three inhalers were observed at the bedside.Record review on 1/15/26 revealed R50 was admitted into the facility on 2/25/23 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD); anxiety disorder and acute cough. R50's most recent Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15 indicating intact cognition. Further review identified no active physician orders for R50 to self-medicate.01/15/2026 at 1:46 PM, an interview was conducted with the facility's Director of Nursing (DON) and were asked about self-medication of residents. The DON revealed residents are assessed for self-administration. A request was made for R50 self-administration assessments prior to 1/14/26 and there were none.A facility policy on self-administration of medications was requested but not received by end of the survey.