

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2025
NAME OF PROVIDER OR SUPPLIER West Hickory Haven		STREET ADDRESS, CITY, STATE, ZIP CODE 3310 W Commerce Rd Milford, MI 48380	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2581294Based on interview and record review the facility failed to notify the resident's responsible parties of an elopement for two residents (R#'s 201 and 202) of three residents reviewed for changes of condition. Findings include:A complaint received by the State Agency alleged two resident's eloped from the facility and their responsible parties were not notified.On 8/26/25 at 9:30 AM, a review of R201's progress notes revealed an Interdisciplinary Team Note entered into the record on 5/16/25 by Nurse 'B' that read, (R201) is alert to self and often ambulates throughout the facility.On 5/3/25 and 5/10/25 he did exit the facility through the front doors and staff saw him and redirected him into the facility. He was visualized by staff the entire time.A review of R201's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, adjustment disorder, mood disorder, and delirium. R201's Minimum Data Set (MDS) assessment dated [DATE] was reviewed and revealed R201 had severely impaired cognition and was independent with mobility. Documentation in the record did not indicate R201's responsible party had been notified of the elopement.On 8/26/25 at 10:25 AM, a review of R202's progress notes revealed an Interdisciplinary Team Note entered into the record on 5/16/25 by Nurse 'B' that read, (R202) is alert to self and often ambulates throughout the facility with walker.On 5/3/25 he did exit the facility through the front doors and staff saw him and redirected him into the facility.A review of R202's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: dementia, traumatic brain injury, falls, and muscle weakness. R202's MDS assessment dated [DATE] revealed R202 had severely impaired cognition and was independent with mobility with a walker. Documentation in the record did not indicate R202's responsible party had been notified of the elopement.On 8/26/25 at 12:35 PM, an interview was conducted with R201's family member/responsible party and they were asked if they had been made aware R201 had eloped through the front door of the facility and said they had not been made aware.A review of a facility provided policy titled, Wandering Resident Exit Seeking Management was conducted and read, .7. Upon return of an eloped resident:.c. The resident's family/legal representative shall be notified of the resident's status.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235262
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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practices. Deficient Practice #1 This citation pertains to intake #2581294 Based on interview and record review the facility failed to prevent an avoidable accident for one resident (R203), of three residents reviewed for accident hazards, resulting in injury requiring transfer to the emergency room. Findings include: Based on interview and record review the facility failed to prevent an avoidable accident for one resident (R203), of three residents reviewed for accident hazards, resulting in injury requiring transfer to the emergency room. Findings include: A complaint received by the State Agency alleged R203 was not properly secured during a ride in the transport van and sustained a fall from their wheelchair that resulted in injury requiring a transfer to the emergency room. On 8/26/25 at 10:41 AM, a review of R203's closed clinical record revealed they admitted to the facility on [DATE] and discharged to the emergency room on 3/17/25. R203's diagnoses included: heart disease, muscle wasting, abnormal posture, anxiety disorder and adjustment disorder. R203's Minimum Data Set assessment dated [DATE] revealed R203 had moderately impaired cognition and used a wheelchair for mobility. A review of a note entered into the record by the facility's Director of Nursing (DON) dated 3/17/25 at 12:43 PM, was reviewed and read, .Called to lobby by administrator who states resident fell out of chair during transport. Daughter at resident side and states that while stop & Mom fell forward out of wc (wheelchair). Foot pedals on & and resident fell to knees and then fell forward and hit head on seat in front .Assisted resident to bedroom and assisted to bed. Resident co (complained of) pain to left hip with ROM (range of motion), skin tears to bilateral shins dressed, during assessment O2 (oxygen level) declined to 83% and o2 & (oxygen therapy) started and O2 above 90%. Noted development of hematoma during assessment. 911 called to transport for evaluation. On 8/26/25 at 12:43 PM, a review of a facility provided incident report dated 3/17/25 was reviewed and read, Witnessed fall. Incident Location: Out of Facility/ During Transport. Nursing Description: Called to lobby by administrator who states resident fell out of chair during transport. Daughter at resident side & and states that wat & stop Mom fell forward out of wc (wheelchair). Resident Taken to Hospital? Y (yes). The report documented a bruise to the chest, a bruise to the face, a hematoma (localized area of blood outside of the blood vessels) to face, and skin tears to the right and left lower legs. Continued review of the report read, Notes. Resident expresses pain to mouth and bilateral shins. called out in pain with ROM to left hip. Abrasion across nose bridge. Blood from mouth. SPO2 (oxygen saturation) 83% (Normal levels 95%-100%) .911 called to eval and treat at ED (emergency department). Notes 3/17/25 Staff and daughter interview: (Staff Member 'A') reported that she did not have the seatbelt latched properly and when she stopped the van, (R203) fell out of wc. Daughter reports that they were on way & to schedule & doctors appt (appointment) and there was an accident. root cause: Resident was not restrained properly in van. When van stopped resident came forward and fell. Conclusion: (R203) had an accident while (Facility Name) van was transporting. (Facility Name) admitted that (R203) was not secured properly in the van and was sent to the hospital for evaluation of injuries. On 8/26/25 at 2:42 PM, an interview was conducted with the facility's Administrator. The Administrator indicated Staff 'A' admitted they secured the wheelchair to the van but while talking to R203's daughter they got distracted and forgot to place a seatbelt across R203's waist, and when they stopped R203 fell forward out of the wheelchair. On 8/26/25 at 3:12 PM, a request for a policy regarding accidents and providing a safe environment was made and the Administrator indicated the facility did not have a policy. Deficient Practice #2 This citation pertains to intake #2581294 Based on observation, interview, and record review, the facility failed to immediately intervene and thoroughly investigate the details of an elopement, by two residents (R#'s 201 and 202) resulting in the potential for resident elopements in the future. Findings include: A complaint received by the State Agency alleged R201 and R202 eloped from the facility and were found in the parking lot by a male staff member. On 8/26/25 at 9:30 AM, a review of R201's progress notes revealed an Interdisciplinary Team Note entered into the record on 5/16/25 by Nurse 'B' that read, (R201) is alert to self and often ambulates throughout the facility. On 5/3/25 and 5/10/25 he did exit the facility through the front doors and staff saw him and redirected him into the facility. He was visualized by staff the entire time. A review of R201's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, adjustment disorder, mood disorder, and delirium. R201's Minimum Data Set (MDS) assessment dated [DATE] was reviewed and revealed R201 had severely impaired cognition and was independent with mobility. It was noted there was no</p>		