STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235262	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hickory Haven	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2709480.Based on observation, interview, and record review, the facility failed to appropriately evaluate the placement of the bed to prevent accident hazards for one (R901) of one resident reviewed for accident hazards, resulting in R901 sustaining a thermal burn to their right great toe after it made contact with the baseboard heater which was directly next to the bed. Findings include: A review of complaints submitted to the State Agency revealed an allegation that R901's foot had direct and prolonged contact with an exposed Hydronic (water) baseboard heat. Due to R901 having neuropathy (damaged nerves), they were unaware they were being burned. When staff pulled their foot away from the metal heater, it resulted in skin tearing and severe bleeding, consistent with a significant burn injury. It was noted R901 had a diagnosis of Alzheimer's Disease.On 1/20/26 at 10:38 AM, R901 was observed lying in bed. R901 was pleasant, but when asked questions, was unable to clearly answer them. R901's bed was located a floor mat's length away from a metal baseboard heat register. When touched, the metal on the top of the heater was warm to the touch. On 1/20/26 at approximately 10:40 AM, an observation of R901's right great toe was conducted with Licensed Practical Nurse (LPN) 'C'. The bottom of R901's right great toe was observed to have a round, dry, black area covering most of the bottom of the toe. A review of R901's clinical record revealed R901 was admitted into the facility on 2/21/22 and readmitted on [DATE] with diagnoses that included: cerebral atherosclerosis, type 2 diabetes mellitus with neuropathy, and peripheral vascular disease (circulatory disease). A review of R901's Minimum Data Set (MDS) assessment dated [DATE] revealed R901 had moderately impaired cognition, required substantial/maximal assistance for rolling left to right. R901 was signed onto hospice services on 6/24/25.A review of R901's progress notes revealed the following:An Alert Note dated 1/3/26 at 8:29 AM written by Licensed Practical Nurse (LPN) 'D' that read, Writer was started [sic] shift and rounds at approx. 6:45 am. Resident was observed sleeping. After a few rounds were complete by CNA (Certified Nursing Assistant). CNA was proceeding to do care when she observed his (R901) foot with injury and bleeding. Resident was accessed [sic] by writer for injury and pain .Resident appeared confused due to facial expression. Right big toe was observed bloody and newly injured. Normal saline, 4x4 and Kerlex [sic] was applied. Resident is a hospice patient. DON (Director of Nursing) was contacted as immediately as she is the abuse officer, family and hospice nurse was also notified. Awaiting hospice nurse to call back with transfer to the hospital preference .An Interdisciplinary Documentation note dated 1/3/26 at 10:23 AM written by the DON that read, In to see resident .Examined right foot. On plantar (bottom) surface of right great toe open blister 4 cm (centimeters) x (by) 3 cm with serous (thin, watery) fluid. Adjacent to blister is open area 0.5 cm x .3 (0.3) cm x 0.2 cm . (R901) does not have sensation to feet or lower legs .Hospice will be in to evaluate today .A review of a Hospice Visit Note Report dated 1/3/26 revealed the following documentation, Received patient in dining area .Writer then located facility DON .who reports that (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility aide went in to [sic] patient's room this morning to get him up and discovered that patient had hung his right leg over the bed and found his right great toe was touching the baseboard heating unit. Patient has neuropathy and does not have feeling to his feet. Aide discovered large blister to bottom of right great toe with small area where skin was open. Some bleeding also present .Wound Assessment .Patient with burn to plantar surface of right great toe .A review of a Progress Note dated 1/5/26, written by Physician 'E' revealed, Resident is seen today .to assess an injury involving residents right great toe which occurred on 1/3/2026. Resident had been noted, at that time, to have his right big toe resting on the heater in this room. There was initial bleeding to the area and subsequent blister .DIAGNOSIS AND ASSESSMENT .Blister of great toe .A review of a Health Care Practitioner Note dated 1/5/26, written by Nurse Practitioner (NP) 'F', revealed, .Nursing home staff interviewed and reported on plantar surface of right great toe the member had sustained a burn that occurred on 01/03/25 (2026) from the heater next to member's bed. A hospice nurse came out on 01/03/26 to assess the wound, she spoke with the on-call MD (Medical Doctor) per her notes who approved current treatment plan .The right great toe + (positive for) erythema (redness), + swelling, warm to touch, the plantar surface of the toe had a dry flat denuded (outer layer of skin missing) blister with scant serous drainage, underneath the blister was what appeared to be a hematoma (bruise) .Assessment .Plan .Burn Active Acute right great toe .On 1/20/26 at 12:16 PM, an interview was conducted with Maintenance Director 'G'. When queried about whether beds were typically positioned against the baseboard heater units, Maintenance Director 'G' reported he believed that was how the rooms were set up. Maintenance Director 'G' reported after the incident with R901, all beds were moved away from the heaters and fall mats, nightstands, and/or PVC pipes were used to ensure the beds did not get pushed against the heaters. A review of an incident report for R901 dated 1/3/26 at 7:30 AM, completed by LPN 'D', revealed, Resident was observed during rounds by writer sleeping. Within 15 to 30 minutes later aide was assisting resident with ADL (activities of daily living) care and stated she witnessed Resident's right foot, specifically right big toe on the heater in his room and proceeded to remove it and noticed bleeding coming from the right toe . In the Notes section it was documented on 1/19/26 that On January 3, 2026, (R901) sustained a thermal injury (burn) to the right great toe when his extremity came into contact with a wall heating register. The incident occurred while the resident was positioned in bed, which had been placed adjacent to the heating unit .The root cause of the incident was the placement of the resident's bed in close proximity to a wall-mounted heating register, creating an environmental hazard. The bed placement was intended to mitigate fall risk and facilitate transfers, however, it inadvertently introduced a unforeseeable burn risk .On 1/20/26 at 2:53 PM, an interview was conducted with LPN 'D' via the telephone. LPN 'D' explained when she did rounds on 1/3/26, she did not notice R901's foot on the heater, but did ensure she called his name and he responded with no signs of distress. About 10 to 20 minutes later, a CNA yelled out for her and when LPN 'D' went to R901's room, the CNA told her R901's foot had to be pulled off of the heater which was next to the bed. At the time LPN 'D' entered the room, the CNA had already moved R901's foot and it was bleeding. LPN 'D' reported she had to apply pressure to stop the bleeding. LPN 'D reported when she did rounds R901 was positioned on his side with his right foot lying over the left foot. On 1/20/26 at 3:36 PM, an interview was attempted with CNA 'H' via the telephone. There was no option to leave a message. CNA 'H' was not available prior to the end of the survey. A review of an investigation conducted by the facility revealed the following:A written statement from CNA 'H' that noted, On January 3, 2026, I (CNA 'H') was passing hall trays, when I got to (R901) room I noticed blood on the wall, the lady passing waters stated that his legs bleed. So I went over to observe. I didn't (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	see anything on his legs that's when I lifted the bottom of his foot and noticed the injury. I then notified the nurse.A written statement from LPN 'D' that noted, .Upon rounding I observed patient position on his side breathing and without pain or discomfort. I called his named [sic] and he responded with no sounds of distress. That was approximately 6:45 AM. I was rounding on other patient, counting and getting report from nurse on previous shift. After tending to another patient with blood sugar matter, CNA called out for a nurse. I responded and she told me 'Resident foot was removed from heat register and was bleeding.' I went into his room inspect the right big toe to observed the bleeding .On 1/20/26 at 3:15 PM, an interview was conducted with the DON. When queried about what happened with R901, the DON reported the nurse did not observe R901's foot on the heater during rounds and about a half hour later a CNA notified her that R901's foot was on the heat register and when she moved it, it was bleeding. The DON assessed the wound, as well as the hospice nurse sent a picture to the hospice physician to determine appropriate treatment. The DON reported it was determined the wound was a burn, but did not know the degree of the burn. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the following: On 1/3/26, R901's bed was moved away from the heat register, first aid was provided, the wound was assessed, the care plan was updated, and R901 was observed for 72 hours for safety and positioning. On 1/5/26, R901's wound was assessed by facility medical provider and additional treatment orders and antibiotics were started. A facility-wide assessment identified other residents potentially affected and environmental barriers were placed (fall mats, nightstands, and the use of PVC pipes), and bed positioning was corrected. Staff education was initiated regarding minimum clearance requirements between beds and heating units. Daily environmental rounds were conducted to ensure compliance and prevent recurrence, and findings were reviewed by Quality Assurance Committee to ensure continued compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2615411Based on record review and interview, the facility failed to secure medication storage in an unlocked medication cart (Sapphire Cart) allowing one resident (R904) to gain access to another resident's medications resulting in one medication, Namenda (medication to treat moderate to severe dementia) never recovered.Findings Included:A Facility Reported Incident (FRI) received by the State Agency revealed on 9/1/25 at 9:30 AM, R904 was observed with three pill packets and several loose pills in their left pant pocket. All medications were reconciled apart from the Namenda.Clinical record review revealed R904 was admitted to the facility on [DATE] for long term care and had a medical history of diabetes, urinary retention, and falls related to muscle weakness. R904 was independent in a wheelchair for short distances, alert and orientated to person and place and was their own responsible party. R904 had a documented Brief Interview mental Status (BIMS) score of 8/15 indicating moderate cognitive impairment.A telephone interview on 1/20/26 at 2:33 PM, with Registered Nurse (RN) B acknowledged and took full responsibility for leaving the Sapphire Medication Cart unlocked. On 9/1/25 RN B recalled they were very busy that morning and when they went to assist another resident with their breakfast, they must had walked away from the medication cart and did not lock it. RN B said they were informed by one of the Certified Nurse Assistants (CNA) they saw R904 had pill packets hanging out from their pant pocket and when confronted, R904 blamed another resident had the medications, took them from them, and was going to tell the staff. RN B said they immediately notified the Director of Nursing (DON), which a cart audit was conducted, and all medications were accounted for except one (Namenda).On 1/20/26 at 4:05 PM, the DON and Nursing Home Administrator (NHA) confirmed no nursing staff could start their shift without one-to-one education with the DON on the Medication Storage Policy. Observation audits were conducted for the entire month of September 2025 daily and at each eight-hour shift verifying medication cart were locked.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included education of the medication storage policy and documented observation audits verifying medication carts were locked. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.