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	06/03/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: On 06/01/2026 at 9:00 AM during a kitchen tour with dietary manager (DM) J observed the walk-in cooler gasket soiled with black build up. When queried, DM J indicated she concurred it was soiled and in need of cleaning and would ensure it was cleaned or possibly changed.According to the 2022 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.On 06/01/2026 at 9:03 AM Observed 2 in-use juice guns visibly soiled with dried red build up inside the nozzles. When queried, DM J said they should be cleaned daily and they currently needed to be thoroughly cleaned.On 06/01/2026 at 9:05 AM observed the only kitchen handwash sink was blocked by a cart. On 06/01/2026 at 9:10 AM observed interior top of microwave soiled with dried food build up. At this time DM J indicated she also saw that, and this surface should be cleaned. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. On 06/01/2026 at 9:15 AM observed the main dining room serving area with a steam table unit used for meal service and no handwash sink in this room. A hand sanitizer dispenser on the wall nearest this area was empty. DM J indicated it would be refilled before lunch service.According to the 2022 FDA Food Code section 5-204.11 Handwashing Sinks. A HANDWASHING SINK shall be located: (A) To allow convenient use by EMPLOYEES in FOOD preparation, FOOD dispensing, and WAREWASHING areas; . On 06/01/2026 at 9:40 AM observed several unused pieces of equipment stored outside the kitchen door in the exterior receiving area including: a pile of approximately 12 empty unused milk crates, large clear panels stored behind a shed, and a wheeled hot food holding unit/cabinet. DM J indicated that none of those items are used by dietary services and suggested asking maintenance about disposal of those items. On 06/01/2026 at 11:40 AM observed lunch service in the Sunshine Dining Room also with no handwash sink. CNA L touched the garbage can lid with her hands while depositing garbage then returned to the line to serve a resident dining tray and handle utensils without hand hygiene. At this time when asked about hand hygiene, CNA L indicated that resident hands were washed ahead of the meal. When it was clarified about staff hand hygiene, CNA L indicated they would use sanitizer if needed and did not use hand sanitizer at this time.On 06/01/2026 at 11:43 AM observed CNA M also touch garbage can lid then return to serve a resident dining tray without hand hygiene. When asked about hand hygiene, CNA M indicated she should use sanitizer between service to each resident and after touching garbage can lid and proceeded to complete hand hygiene.On 06/01/2026 at 11:55 AM interview with DM J about hand hygiene practices for dietary serving staff. DM J indicated she would ask for and review the facility hand hygiene policy.On 06/01/2026 at 1:20 PM observed kitchen handwash sink blocked with soiled tray cart. When queried kitchen staff N about handwash sink procedures, they said it should be kept stocked with soap, paper towel and be kept accessible. Staff N did not move the cart blocking the sink. According to the 2022 FDA Food Code section 5-205.11 (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Using a Handwashing Sink. (A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use.On 06/01/2026 at 1:25 PM observed kitchen staff P handling clean dishes in the dishwashing area and touching her face and hair then again handling clean dishes without handwashing. When asked at this time about handwashing, staff P acknowledged she should wash her hands after touching her face and hair but did not proceed to wash hands. According to the 2022 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and:(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco products, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.On 06/01/2026 at 1:45 PM observed unused equipment outside the back door of kitchen with Environmental Services Director (ESD) K. When queried, he was not sure what those items were for and suggested asking the Dietary Manager or the administrator.On 06/01/2026 at 2:15 PM interview with NHA about the unused equipment items outside the kitchen door. NHA indicated they are still working on going through things and would provide a related policy, if available. NHA later reported there is currently no related policy.According to the 2022 FDA Food Code section 6-501.114 Maintaining Premises, Unnecessary Items and Litter. The PREMISES shall be free of: (A) Items that are unnecessary to the operation or maintenance of the establishment such as EQUIPMENT that is nonfunctional or no longer used; and (B) Litter.Record review of facility policy Beverage Dispenser Nozzle Cleaning dated June 2017 indicated in part, at end of day: remove nozzles from valves or dispensing gun, rinse in warm sanitizer water for five minutes.Record review of facility policy Hand Hygiene effective December 2000, Revised September 2022 indicated:Hands may be cleaned using liquid soap and water or alcohol hand rub- after handling contaminated environmental objects.and then further included the reference to the Food Code requirements for when to wash

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an effective infection prevention and control program that included a system for identifying, water management, hand hygiene and mapping. Findings include:A review of the facility's infection prevention and control program on 6/2/26 revealed that the facility was responsible for maintaining a structured surveillance system to monitor infections, identify trends, and support infection prevention interventions. The program required that infection data be consistently collected, analyzed, and mapped by resident location, infection type, and date of onset to support outbreak identification and prevention efforts. On 6/2/26 a record review showed the facility failed to demonstrate evidence of a systematic infection surveillance process. Infection logs were incomplete and did not consistently include resident identifiers, unit assignments, infection diagnoses, or dates of onset. The facility was unable to provide documentation showing that infection data was trended over time or mapped to identify clusters or patterns of infection within specific units or the facility as a whole. April and May were both incomplete. On 6/2/26 at 11:30 a.m., an interview was conducted with the Infection Preventionist (IP). The IP stated that infections were documented when staff notified them or when they seen it in the electronic medical record; however, they acknowledged that surveillance data was not consistently tracked or analyzed due to the inconsistencies with the previous IP who was terminated from employment two weeks prior. The IP further stated that they had just returned to the facility from a sister facility and would be there two or three days out of the week to restructure their infection control program. During an interview on 6/3/26 at 1:45 p.m., the Director of Nursing (DON)acknowledged that the facility did not have an active antibiotic stewardship committee currently and was looking to hire someone for the position. The DON stated that antibiotic use was reviewed but confirmed that they did not follow up with the previous IP before there abrupt departure. Further review revealed no evidence of an infection mapping tool or tracking system (nothing from April and May) used to visualize infection distribution across the facility. The facility could not demonstrate that infections were analyzed by location, organism type, or frequency in a manner that would allow early identification of potential outbreaks. On 6/01/2026 a record review of the Water Management Program (WMP) binder included the facility policy titled Water Management Program Policy & Procedure Effective: July 2017 Revised: October 2024 was conducted. The policy listed the key elements for a WMP, but there was minimal additional documentation that supported the policy and procedures: a water system flow diagram dated 2017 was included. Additional materials in the program binder included World Health Organization (WHO) and CDC reference materials but no listing of a water management team (WMT) members or meetings, no text description of the water system, no site-specific risk assessment, no control measures, no action steps, and no verification or validation steps for legionella prevention. Also provided by the maintenance director (MD) K were backflow preventor testing records, weekly resident room water temperature monitoring logs for scald prevention, and water sample results taken (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/23/2025 for chemical and bacteriological parameters. These water test results were not for legionella as WMP validation. On 6/01/2026 at 10:45 AM interviewed the Nursing Home Administrator (NHA) about the WMP. When asked about additional WMP documentation and more recent sample results, the NHA indicated the corporate environmental services (CEVS) staff member helps with that and she would get additional documentation from him. When asked about the WMT, she indicated that MD K provides updates during monthly Quality Assurance and Performance Improvement (QAPI) Infection Control and Safety Committee meetings and she would provide meeting minutes. QAPI Committee Minutes dated 3/10/2026 were later provided and a line item for Environmental Facility and Plant Operations notes went over the Emergency books and water management for emergency. On 6/01/2026 at 1:45 PM toured with MD K to observe the on-site water supply, storage tanks and hot water system. At this time, MD K indicated 1 of the 3 wells has been offline for over a year, but not sure which and would need to check with CEVS staff member. MD K indicated that the CEVS staff member is on site 2-3 times/month and helps with the water management and works with their contact at the Michigan Department of Environment, Great Lakes, and Energy ([NAME]). When asked about responsibilities related to the water management program, MD K indicated that he logs resident room hot water temperatures to be sure they are within a safe range; if more than 120 degrees F he will adjust in the boiler room and re-check; there are no point of use mixing valves in place. MD K indicated flushing fixtures at any vacant rooms and eyewash stations regularly but does not document this. Additional monthly water sample results were provided later in the day by NHA including the most recent 5/29/26 that was absent of total coliform. No water sample results were for legionella. Record review of an additional policy: Emergency Response Plan for the [NAME] Hickory Haven water supply system provided the name and contact of the water supply operator and basic information about the on-site water wells but does not provide information related to WMP for legionella prevention. No additional WMP documentation was provided by the end of survey. CEVS staff person was not available for interview by survey exit.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on observation, interview and record review, the facility failed to establish and maintain an effective infection prevention and control program that included a system for an ongoing antibiotic stewardship program Findings include:A review of the facility's Infection Prevention and Control Program on 6/2/26 revealed that the facility was required to maintain an ongoing infection surveillance system designed to analyze data, and implement interventions. The policy further indicated that the facility would maintain an antibiotic stewardship program that monitored antibiotic use, promoted appropriate prescribing practices, and evaluated treatment outcomes.On 6/2/26, a review of the facility's infection surveillance logs revealed incomplete documentation for two months. The logs failed to consistently identify residents with infections, track the type and location of infections, identify causative organisms, or document follow-up actions taken by the Infection Preventionist (IP). On 6/2/26 at 11:30 a.m., an interview was conducted with the IP. The IP stated that infections were documented when staff notified them or when they seen it in the electronic medical record; however, they acknowledged that surveillance data was not consistently tracked or analyzed due to the inconsistencies with the previous IP who was terminated (from employment) two weeks prior. The IP further stated that they had just returned to the facility from a sister facility and would be there two or three days out of the week to restructure their infection control program. A review of antibiotic prescribing records revealed that residents receiving antibiotics were not routinely monitored as part of an antibiotic stewardship program. Documentation failed to identify evidence of antibiotic use reviews, monitoring of antibiotic appropriateness, evaluation of culture and sensitivity reports, antibiotic duration reviews, a risk verses benefit if criteria for antibiotics was not met, or efforts to reduce unnecessary antibiotic use.During an interview on 6/3/26 at 1:45 p.m., the Director of Nursing (DON)acknowledged that the facility did not have an active antibiotic stewardship committee currently and was looking to hire someone for the position. The DON stated that antibiotic use was reviewed but confirmed that they did not follow up with the previous IP before there abrupt departure. There was no additional information provided at the exit of the survey.