STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235374	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Senior Care & Rehab Center	22355 W Eight Mile Rd Detroit, MI 48219

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Physician/Physician Extender progress notes were entered into the clinical record in a timely manner for one resident (R35) of 19 resident's reviewed for Physician/Physician Extender progress notes. Findings include: On 6/24/25 at 8:42 AM, R35's Electronic Health Record (EHR) was reviewed for Physician/Physician Extender notes and revealed there were no Physician/Physician Extender notes found in the EHR since 12/2024. On 6/24/25 at 12:57 PM, Physician/Physician Extender practitioner notes were requested. Record review of the EHR revealed R35 was admitted to the facility on [DATE] with a diagnosis that included cerebral infarction (stroke) and attending physician listed as Medical Doctor (MD) F. On 6/24/25 at 3:25 PM, Nurse Practitioner (NP) E was interviewed and stated, I work with (MD F) and provided the care to (R35), but I did not provide notes in the medical chart. It was my mistake. The notes should be put in when the visit occurs. On 6/25/25 12:53 PM, the Director of Nursing (DON) was interviewed and said the expectation is for the Physician/Physician Extender to write a clinical note within 24 hours or performing the visit. The DON agreed there were no Physician/Physician Extender notes in the EHR for 2025 until the facility was made aware of the lack of physician notes in R35's EHR. Review of the facility's policy titled, Physician Services revised August 2006 revealed in part: Physician orders and progress notes shall be maintained in accordance with current Omnibus Budget Reconciliation Act (OBRA) regulations and facility policy.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 maintain infection control practices for two of five residents (R47 and R22) reviewed for respiratory care by not ensuring respiratory equipment was stored in a sanitary manner. This failure had the potential to expose residents to harmful microorganisms and increase the risk of infection. Findings include: On 6/23/25 at 2:00 PM, during an observation of R47's room, a nebulizer mask was noted on the bedside table uncovered and exposed to air. The mask was not stored in a protective covering. On 6/23/25 at 2:05 PM, Licensed Practical Nurse (LPN) A entered the room. When queried, about the storage of the nebulizer mask, LPN A said it should be in a plastic bag. Record review noted that R47 was admitted on [DATE] with a pertinent diagnosis of respiratory failure with hypoxia and dependence on supplemental oxygen. Record review revealed R47's Minimum Data Set assessment (MDS) dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating they were cognitively intact. On 6/23/25 at 2:30 PM, R22 was observed with a nasal canula oxygen mask attached to the back of their wheelchair, dangling and touching the floor. On 6/23/25 at 2:40, Registered Nurse (RN) B entered R22's room and observed the nasal canula mask touching the floor. RN B was interviewed and said the mask should have been in a plastic bag when not in use. Record review for R22 indicated they were admitted on [DATE] with a pertinent diagnosis of respiratory failure with hypoxia, emphysema, and malignant neoplasm of bronchus or lungs (lung cancer). Record review for R22 (MDS) dated [DATE] for (BIMS) score was 14 out of 15 indicating R22 was cognitively intact. On 6/25/25 at 10:25 AM, the Nursing Home Administrator (NHA) was interviewed and confirmed that nebulizer masks should be sanitized, and all masks should be stored appropriately when not in use. Review of facility policy titled Oxygen Administration and Safety with an effective date of 5/20/25 noted, the purpose of this policy is safe administration of oxygen therapy to the residents. Furthermore, the policy documented, .tubing will be store in a plastic bag or similar storage device when not in use.