STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235488	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Bloomfield Health and Rehabilitation Center	6445 W Maple West Bloomfield, MI 48322

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2696425 .Based on interview and record review, the facility failed to ensure medication was available for administration per Physician's order, utilize the reserve supply of medication for administration and accurately document administration of medication in the medical record for one resident (R903) of two residents reviewed for medication administration. Findings include:On 3/9/26 a concern submitted to the State Agency was reviewed which alleged R903 was not provided their medications according to the Physician's order. On 3/9/26 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnose including Muscle weakness and Low back pain. A review of R903's MDS (minimum data set) with an ARD (assessment reference date) of 11/23/25 revealed R903 needed assistance from facility staff with most of their activities of daily living. R903's BIMS score was 15 indicating intact cognition.A review of R903's care plan revealed the following: Focus-admission #5 Alteration in Comfort / Pain Chronic Pain R/T (related to):, Acute Pain R/T: RA (arthritis), Chronic pain in his back and both shoulders on Tylenol #3 and Lidoderm patch Date Initiated: 11/17/2025 .Interventions-Administer pain medication(s) as ordered, monitor for effectiveness within 30 to 60 minutes. Date Initiated: 10/22/2025 .A Physician's order with a state date of 11/19/25 revealed the following: Acetaminophen-Codeine Oral Tablet 300-30 MG (milligram) (Acetaminophen w/ Codeine) Give 1 tablet by mouth every 4 hours for pain -Start Date- 11/19/2025.A Nursing progress note dated 11/27/25 at 11:30 revealed the following: Health Status Note-Upon arrival of shift Writer was informed in report that resident was in pain due to not receiving scheduled Tylenol #3 r/t (related to) prescription not being refilled. writer spoke with supervisor on duty to notify of situation b/c (because) resident was dissatisfied and (in) excruciating pain. NM (Nurse Manager) contacted MD (Medical Doctor) for authorization code to pull medication from backup. Writer was able to obtain medication from backup, resident consumed medication @apprx 1130. @Apprx 1400 writer went to check on resident's pain level and resident (said) that he is no longer in pain and that the pain medication was effective .An EMAR (electronic medication administration record) note dated 11/27/2025 at 05:23 revealed the following: eMar - Medication Administration Note-Acetaminophen-Codeine Oral Tablet 300-30 MG Give 1 tablet by mouth every 4 hours for pain-waiting on pharmacyA second EMAR note dated 11/27/2025 at 08:46 revealed the following:eMar - Medication Administration Note-Acetaminophen-Codeine Oral Tablet 300-30 MG Give 1 tablet by mouth every 4 hours for pain- on orderA review of R903's controlled substance log for their Acetaminophen-Codeine pain medication revealed R903's last pill from the pharmacy was administered on 11/27/25 at midnight resulting in zero medications remaining for the rest of the doses on 11/27/26. A review of the backup supply medication dispensing system's dispensing log revealed no codeine pills were removed on 11/27/25 until 7:33 a.m., indicating no medications were removed from the backup supply for the 0400 scheduled dose. A review of R903's November 2025 Medication Administration Record (MAR) revealed the 0400 dose was documented as being administered by Nurse A. Further review of the paper Acetaminophen-Codeine controlled log and the electronic backup supply dispensing log did not reveal any documentation that Nurse A had (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented removal and administered R903's 0400 dose. On 3/9/26 at approximately 2:15 p.m., the Director of Nursing (DON) was queried regarding the process for ensuring uninterrupted medication administration. The DON reported the facility Nursing staff should be reordering the medications a few days prior to running out, so that the delivery is made before the last dose is given from the previous pack. The DON indicated that if the Nursing staff run out of a medication they should contact the pharmacy and the medical provider to ensure that the medication ban be dispensed from the backup supply to ensure administration in a timely manner. The DON was queried regarding R903's acetaminophen-Codeine controlled logs that indicated no Codeine was given for the 0400 dose and it was missed. The DON indicated that Nurse A documented they gave the 8:00 AM dose, as they had documented evidence that they had pulled it from the backup supply at 733 AM to administer. The DON was queried regarding the scheduled 4:00 AM dose and they indicated that it was documented in the MAR as administered but was not removed on the controlled substance sheet or the backup supply. The DON indicated they attempted to call Nurse A but did not receive an answer. The DON indicated that since no codeine was available in the pack and nothing was dispensed from the backup supply, Nurse A probably made a documentation error on the MAR. The DON indicated that Nurse A should have pulled the medication from the backup supply and administered the codeine at the scheduled dose and time per the Physician's order. The DON indicated that Nurse A did not follow the facility procedures pertaining to the steps to take when medication is not available for administration. On 3/9/26 a facility document titled Medication Orders and Timely Administration was reviewed and revealed the following: .C. PROCEDURE: WHAT TO DO IF A MEDICATION IS NOT AVAILABLE FOR ADMINISTRATION:1. When an ordered medication is not available for administration, the nurse needs to determine why the medication is not available and then check the Electronic Backup Machine inventory list to determine if the medication is available in the Electronic Backup Machine. If so, he/she should retrieve the medication and administer as ordered. The nurse must then call the pharmacy and request the medication be sent on the next delivery.2. If the medication is not available in the backup Electronic Backup Machine, the nurse must call the pharmacy and request the medication be sent on the next delivery or ASAP (as soon as possible) as determined by the particular medication ordered.3. The nurse should ask the pharmacy to provide an expected time of delivery of the medication. If, based on the projected delivery time, the resident will miss an ordered dose of a medication, the nurse should do the following: a. Notify the physician of the expected delay in treatment; b. Document physician recommendations/comments in the interdisciplinary progress note section of the resident's medical record. Additional physician recommendations may include: 1. an order for an alternate medication that is available in the Electronic Backup Machine or available for immediate delivery from the pharmacy; 2. an order to hold the medication or change the administration time; e an order to discharge the resident to the hospital if necessary; or 3. an order for a stock med. c. The nurse should write any new or adjusted physician orders in the physician order section of the resident's medical record and proceed with processing the order. 4. At no time should there be more than one dose of the same medication not administered without the nurse responding to the situation by following this policy. The nurse should notify the Director of Nursing or designee of the situation, if appropriate. 5. If the medication is not available and was not given, the nurse must document as such. Do not document a medication was given, prior to administration of the medication to the resident .