STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235594	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Niles	1211 State Line Rd Niles, MI 49120

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2659614 & 2661255Based on interview and record review, the facility failed to prevent significant medication errors for 1 resident (Resident #100) of 7 residents reviewed for medication errors, resulting in a change in condition, emergent transfer, and hospitalization for Resident #100. Findings include: Resident #100: Review of an admission Record revealed Resident #100 was a female with pertinent diagnoses which included dementia, dysarthria (a motor speech disorder that causes slurred or slow speech due to weak or uncoordinated speech muscles), memory deficit following a stroke, Alzheimer's disease, diabetes, metabolic encephalopathy (a brain disfunction caused by systemic metabolic problem such as liver or kidney failure, diabetes, sepsis), cognitive communication deficit (difficulty with communication caused by impairments in thinking skills like memory, attention, and problem solving). Review of Medications for Resident #100 revealed, .Resident Medications: acetaminophen (TYLENOL) 500 mg tablet Take 1 tablet by mouth every 6 hours as needed for Pain. amLODIPine (NORVASC) (calcium channel blocker for high blood pressure) 10 MG tablet Take 1 tablet by mouth every morning. aspirin 81 MG chewable tablet Chew 1 tablet daily. diclofenac sodium (VOLTAREN) (anti-inflammatory drug used to treat pain and inflammation) 1 % gel Apply 2 g (grams) to skin 4 times daily as needed for Pain. ELIQUIS (blood thinner) 5 MG tablet Take 1 tablet by mouth 2 times daily. hydroCHLOROthiazide (MICROZIDE) (used to treat high blood pressure and fluid retention, Water pill) 12.5 MG caplet Take 12.5 mg by mouth daily. Isosorbide mononitrate (used to prevent chest pain) ER(Extended Release) Take 1 tablet by mouth. Review of Incident Summary dated [DATE] at 1:10 PM, revealed, .Incident Summary: Resident was found unresponsive during morning rounds by CNA. Code blue called overhead page, nurses responded immediately, including the director of nursing (DON B). DON provided a sternal rub to arouse (Resident #100), no CPR required. VS (vitals signs) was 141/76 (blood pressure) pulse 48 o2 (oxygen saturation) 98 with a very light pulse. 911 called due to unresponsiveness. She maintained a pulse and was breathing when they arrived. Medics arrived and transported resident to hospital. At 1:30 PM the hospital notified facility that her urine drug screen came back positive for Benzodiazapam (benzodiazepine) and opioids. Per her medical record, (Resident #100) has no orders for these medications.Review of Prehospital Care Report Summary dated [DATE], Dispatched to (Facility) for a report of a 87 YOF (year old female) unconscious but breathing. Upon arrival, patient found semi-Fowlers (medical posture where a patient lies on their back with their head and upper body raised 30-45 degrees) in bed and slumped to the right, unresponsive to all stimuli, pupils fixed and constricted.Staff states that patient was at baseline yesterday evening around dinner time. She then took her meds and went to bed. Today, they are unable to wake her up. Patient is not prescribed any narcotic pain medications.06:05:32 AM, Glasgow Coma Score: 5 (Scored between 3 - 15, 3 being the worst).06:11:33 AM BP 123/61, MAP (mean arterial pressure): 82, Pulse: 49, SPO2: 86. Review of Emergency Department (ED) progress note, dated [DATE], revealed, .Diagnosis at time of disposition: 1. Unresponsive .87 y.o. female patient presenting to the ED with unresponsive state. Vital signs bradycardia (abnormally lower heart rate, defined as fewer than 60 beats per minute) and hypothermic with decreased respirations. Patient with pinpoint pupils. Narcan (medication used to reverse or (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 0760 Level of Harm - Actual harm Residents Affected - Few	reduce the effects of opioids) given without significant effect. Blood sugar okay. Withdraws to pain but moves right side more than left side. Will obtain broad laboratory workup . UA (urinalysis), UDS (urine drug screen). Patient is a do not resuscitate DNI but is currently doing okay on 2 L (liters) nasal cannula despite decreased respiratory rate.HISTORY OF PRESENT ILLNESS: 87 y.o. female presenting to the ED with unresponsive state. EMS did note constricted pupils despite no narcotic medication on her med list. No other really sedating medications on her list.Review of medical record for Resident #100 at (Local Hospital) revealed, .06:20 Medication Given naloxone (NARCAN) syringe 2 mg - Dose: 2 mg; Route: Intravenous; Line: Peripheral IV [DATE] Left Antecubital ; Scheduled Time: 0630 AM. Review of medical record for Resident #100 at (Local Hospital) revealed, .07:37:29 Drug Screen Without Confirmation, Urine.Abnormal Result Collected: [DATE] 06:52 Last updated: [DATE] at 07:37 Status: Final result Benzodiazepine Screen, Urine: Presumptive Positive.Opiate 300 screen (detected the presence of morphine and codeine at concentration of 300 ng/mL or greater), urine: Presumptive Positive.Drugs can contribute to low body temperature and decreased respiratory drive.Temperature: 35 C (95 degrees Fahrenheit) (Device Time: 08:29:38).Pulse: 47 (Device Time: 08:29:38).Respirations: 11 (Normal respiratory rate: between 12 and 20 breaths per minute) (Device Time: 08:29:38).BP: 95/58 (Device Time: 08:30:00).MAP (mmHg): 71 (Device Time: 08:30:00).AVPU (Alert, Verbal, Pain, Unresponsive) Scale: Unresponsive.Review of Progress Notes - Social Work dated [DATE] revealed, .MSW consulted for other (please specify): Patient (Pt) from the nursing home. has benzos and opioids in system. not sure if on home med list. Pt arrived per EMS sent from (Facility), unresponsive on seen, last know normal at dinner last night. RNCM (Registered Nurse Case Manager) followed up with (Facility) to confirm if any medication was given at the facility. Per pt nurse, benzos and opioids are not on pt medication list; so that is not coming from their end. (EMS) was called to confirm if any medication was administered by EMS whilst en route to the hospital. (EMS) reports to crosscheck and get back to RNCM with details. Another drug screen has been ordered to confirm lab results. Once test results shows positive for both opioid and benzos and (EMS) reports nothing was administered to pt, a report will be made to APS for further investigations. MSW to keep following.Review of Physician Discharge Summary revealed, .Brief Summary of Hospital Stay: This is a 87 y.o. female.who presented with being found unresponsive at her care facility. She is unable to give a history so obtained from the ER and records. She lives at the SNF. She was found unresponsive on 10/31 and brought in. GCS 6. RR 9. She was noted to be hypothermic. ED workup reveals.UDS (urine drug screen) + for diazepam, no prescription.APS involved due to benzo's on UDS without prescription. discharged on [DATE]. Review of Investigation Summary revealed, .Narcotic Audit was conducted and one resident who resides on (Resident #100s) unit was identified as (Resident #101) BIMs15/15 (indicated resident was cognitively intact) who has an order for Valium (benzodiazepine: central nervous system depressant that produce sedative and hypnotic effects) 10mg two tabs at 2000 (8:00 PM). Morphine ER 60mg one tab at 2100. Tizanidine 4mg one tab at 2000 and Baclofen 10mg four tabs at 2000. All medication were signed out by (Licensed Practical Nurse (LPN) C), LPN on [DATE] at 2022 (8:22 PM) as given in the medical record.In an interview on [DATE] at 09:53 AM, CNA G reported she went into Resident #100's room to wake her up as she had not gotten up to use the bathroom all night which was unlike her. CNA G reported she said her name, Resident #100 did not respond, so she tried to move her a little and she didn't respond and then she noticed she was not breathing and then while she was watching her she took a breath but then she had stopped again. CNA G reported she called a code blue, the nurses immediately responded to the room, the DON was there, and she got her breathing. Resident #100's pulse was really low, and EMS was called. CNA G reported she stayed with Resident #100 until all the staff came in the room. CNA G reported she normally ate dinner and then would go to bed and that was what she did that night as well. CNA G reported Resident #100 was checked on every two hours throughout the night. CNA G reported the nurse on the hallway was an agency nurse.Review of Resident Interview dated [DATE], .(Resident #101) was interviewed by (Director of Nursing (DON) B) and stated she doesn't think she (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	took her medications the night of the 30th because she doesn't remember taking them. (Resident #101) states she did not have increased pain or discomfort. (DON B) asked (Resident #101), since you are on top of your pain medication do you recall asking for the medication? She stated she didn't recall. Her pain was assessed as documented in the medical record no change in her baseline was noted during this timeframe.Resident #101's orders revealed, Resident #101 was prescribed Morphine Sulfate (powerful opioid used to treat moderate to severe pain) ER Oral Tablet Extended Release 100 MG, 3x per day at 0700, 1100, 1500 (3:00 PM). Morphine Sulfate ER Oral Tablet Extended Release 60 MG, at bedtime 2100 (09:00 PM).Diazepam Oral Tablet 10 MG at bedtime 2100 every day. Review of Staff Interview dated [DATE], revealed, (Certified Nursing Assistant (CNA) D) stated, .I worked Thursday ([DATE]), 2nd shift. She was not in my section. I did see her before dinner and at dinner. She was in her room toileting before dinner when I saw her. I am pretty sure I saw her in the dining room for dinner. She was at her baseline. The day when I came back to work, I did say to one of the nurses, the nurse that was here last night from the agency (LPN C) ([DATE]). I think she mistakenly took the wrong meds to (Resident #103). The nurse came to me and asked if she (Resident #103) was taking pills with pudding. I don't think she takes her meds with pudding, and if she said those are not hers then they are probably not as she is pretty with it. She was asking about the bed numbers, and I explained to look at the bed numbers and names and ask them because they are all pretty much with it. she said OK. It was like she didn't understand the order from the report sheet. The top rooms on the report sheet are not (First Name) and (First Name) and them. She seemed a little confused and flustered. That day I did not see (Resident #100) had any visitors that day.Review of interview conducted on [DATE] by facility revealed, .To Your Knowledge has anyone given you any medications that were not yours? Resident #103 stated, Yes at 8:00 PM last night a new nurse (LPN C) brought a cup of crushed pills for me to take. I did not take them, and I told her I don't know what they were since they are crushed. She took them away. Later she brought in my normal evening medications. In an interview on [DATE] at 2:38 PM, Resident #103 reported the nurse (LPN C) did not ask her who she was, she just said she was coming in to give me my medications, looked at the cup and the medications were crushed and she told her those were not hers, those medications were my roommates medications, she got crushed medications. Review of Resident #106's admission Record revealed she was admitted to the facility on [DATE] with pertinent diagnoses of dementia, diabetes, heart failure, bipolar disorder, and COPD. Clinical Profile revealed, .Medications: May crush together and given as few bites as able. In an interview on [DATE] at 1:44 PM, Resident #102 reported her roommate had dementia and would get up and go to the bathroom by herself. Resident #102 reported there was a new nurse (LPN C) on that night, she wanted to give Resident #102 insulin and told her she didn't take insulin. Resident #102 reported she did not sleep all night that night ([DATE]) because she believed she never got her medications and Resident #100 had received them. Resident #102 reported she thought the nurse who worked ([DATE]) gave Resident #100 the wrong medication. Resident #102 reported the nurse was an agency (LPN C). In an interview on [DATE] at 9:10 AM, CNA F reported Resident #100 wasn't her normal self and the she would transfer often, so the staff had to keep a close eye on her, but she did not get up at all that night. CNA F reported she checked on Resident #100 several times and each time she was sound asleep, but during last rounds about 5:00 AM, she was unresponsive not reactive to anything. CNA G called the code blue, nurses and other CNAs responded, Resident #100 was given sternal rubs, a cold washcloth was placed on her head by DON B and she was sent out. CNA F reported Resident #102 indicated to LPN C she did not receive insulin and LPN C came and asked me and told her to ask the other nurse, the other nurse confirmed Resident #102 did not receive insulin to LPN C. CNA F reported the agency nurse appeared really confused and she didn't know the residents. In an interview on [DATE] at 11:37 AM, Licensed Practical Nurse (LPN) C reported she had to wake up Resident #100 to give her, her medication as she had gone to bed after dinner. LPN C reported Resident #100 was not talking to her. LPN C reported nurses should ask the resident who they were to verify their identity. LPN C reported there (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	was a sheet of paper which had how each resident took their medications. LPN C reported nurses were required to follow the rights of medication administration when passing medications, which included verifying the right resident, medication, dose, time, and right route. LPN C reported nurses should verify the resident's identity by checking the name on the door, room number, asking he resident and using photos in the chart. LPN C reported she had 29 residents at dinner time and then approximately 40 after midnight and she was busy all night long and it was hard as she did not know the residents. LPN C reported she would pull medications for both residents in each room and then take the medications into the room. LPN C reported she rounded all night on all her patients and Resident #100 was breathing. LPN C reported the CNA was finishing her last round and heard a code blue was called and then realized it was a resident on the hallway she had been assigned to. LPN C reported she ran out of the hallway and when into the room. The DON was performing a sternal rub trying to get her to be responsive, she was breathing, light and light pulses, called 911, went to get vitals, pulse and put O2 on her, tried to stabilize her. LPN C reported when she was talking to the NHA she indicated she had made a med error. LPN C reported she made a mistake and this situation had never happened to her before, it was just a lot, she reported she had too many residents. LPN C stated, almost killed a lady over a mistake. LPN C reported when she spoke to the DON B she indicated she must have mixed up the medications, indicated she had charted under the wrong chart. LPN C stated, It was an accident, I didn't mean for it to happen.It was a really big mistake. In an interview on [DATE] at 2:29 PM, DON B reported she was on another hallway and heard the code blue, told the aide to get the crash cart, got there to assess the situation, on the way had another aide grab the red book for code status. DON B reported when she got there Resident #100 had a pulse, she had respirations which were irregular, two or three regular and apneic (stopped breathing) episode for approximately 30 seconds maybe and then a big breath, very irregular. DON B reported the staff reviewed the code status, verified with other nurses around, someone felt for her pulse add respirations, start on oxygen, didn't have the O2 level as the pulse oximeter was not reading it, made sure she had oxygen especially with irregular breaths, another nurse got the blood sugar, and the staff had checked all the things and they were working on sending her out, the aide stayed in there with her until EMS arrived. In an interview on [DATE] at 2:14 PM, LPN I reported pharmacy delivers the medication packets every day for the next day. LPN I reported the narcotic medication were kept in a separate drawer in the medication cart. LPN I reported there was a separate key for the narcotic medication drawer. This writer observed the narcotic medications blister packages in the drawer. LPN I reported medications were checked for resident name, room number, medication, dosage, time administered against the order/MAR in the electronic medical record against the blister package for the narcotic medication. LPN I reported for the regularly scheduled medications they come in packets with the resident's name, room, and time noted at the top and the medication and dosage on the front of the package, open the package and compare the individual packets against the order/MAR and then dispense into the medication cup. LPN I reported nurses should always address the resident or ask then to tell her their name if able to respond, compare to photo in electronic medical record prior to administering the medication. In an interview on [DATE] at 12:32 PM, Clinical Care Coordinator (CCC) H reported she had worked the first 4 hours of second shift on Resident #100's hallway. CCC H reported the off going nurse would give verbal report to the oncoming nurse. CCC H reported she and LPN C completed the count of narcotic medications prior to her leaving for the day. CCC H reported she and LPN C counted all the narcotics after she checked all the other in the fridge as well and the number was correct. CCC H reported each hallway had a sheet which tells the nurse how each resident takes their medications, and the floor nurses were responsible for updating those sheets. In an interview on [DATE] at 2:43 PM, Resident #104 stated .A few days ago the nurse had brought in my meds and left them to sit on the table as she was crocheting at the time, so when she finished, she went to take them but didn't have water so she paused and looked and there were three of the same looking pills and she reported mine are different, so she told the staff. Resident #104 asked her (continued on next page)

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