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	12/10/2025

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 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. (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	Based on observation, interview and record review, the facility failed to assess, monitor, document, and provide treatment per professional standards of practice for 1 (Resident #103) of 1 resident reviewed for management of skin and wounds, resulting in lack of assessment, monitoring, and the potential for a decline in overall health status.Findings include:Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included diabetes and edema. Review of Care Plan for Resident #103, revealed a focus of .(Resident #103) has the potential with acute condition change with cardiopulmonary, metabolic or infectious complications Diabetes Mellitus, Sterocoral Colitis, (serious inflammation of the colon caused by severe chronic constipation and impaction) Bilateral (both sides) hearing loss, and Hypertension (high blood pressure). with the intervention .Assess and document edema, breath sounds, circumoral (blueish tint around the mouth due to poor oxygen) or nail bed cyanosis (blueish tint on the nail bed). Review of admission Assessment completed on 11/11/25 revealed, .CARDIAC/ CIRCULATION: 2b. Edema present.2c. Location: BLE (bilateral lower extremities).2d. Pitting.2+.somewhat deeper pit/4mm, disappears in 10-15 sec. Review of Alert Note dated 11/19/2025 at 06:07 AM, revealed, . Res (Resident) has +3 pitting edema (a deep indentation (around 5-6 mm) forms when pressure is applied to swollen skin, and this pit take up to 60 seconds or more to rebound or fill back in, indicating moderate to severe fluid buildup) feet are seeping BLE (bilateral lower extremities) put in book for np (Nurse Practitioner) to f/u (follow up).Review of Skin Assessment for Resident #103 dated 11/23/25 revealed, .He has 4+ edema to bilateral ankles and feet and copious (large amount) weeping clear fluid. His BLE are covered with ABD, kerlix, and Coban, and he has been encouraged to keep them elevated . Review of Order dated 11/25/25, revealed, .Cleanse bilateral lower extremities with wound wash, pat dry, apply Optilock (super absorbent polymer core dressing which locks in drainage under compression and protect the skin from maceration (softening and breakdown of skin around a wound due to excessive moisture)) then wrap with kerlex, and then wrap with Ace bandage. Change daily and prn (as needed) every day shift for wound care. Review of Order dated 12/1/25 at 1:45 PM, revealed, .Order Summary: daily weights edema in the morning for edema. Start date 12/2/25 at 08:00 AM. Review of Weights and Vitals Summary for Resident #103 revealed no weights were taken following the order written on 12/1/25. Review of Skin Assessments for Resident #103 revealed no documented assessment was completed on 12/7/25 for weekly skin assessments. Resident #103's skin assessment day was on Sundays. During an observation on 12/8/25 at 3:12 PM, Resident #103 was seated in his wheelchair in his room, he had his feet on the foot pedals and ankles looked swollen. Resident #103 had ace bandages wrapped around his ankles, with kerlix observed underneath. During an observation and interview on 12/10/25 at 10:25 AM, Licensed Practical Nurse (LPN) I reported the wound team was coming today to look at Resident #103. Resident #103 was observed seated across from the nurse's station, legs were wrapped with ACE bandage, and he had kerlix and Optilock underneath it. In an interview and observation on 12/10/25 at 11:02 AM, Regional Nurse Consultant Q reported Resident #103 was looked at a few weeks ago due to the weeping of his legs. Regional Nurse Consultant Q reported she had come to his room to assess him as the certified nursing aide (CNA) reported he had an open area on his bottom. This writer observed Resident #103's bilateral lower legs and on his left mid-shin he had an open area approximately 2 inches long, running up and downward on his shin. The middle of the open area was wider and had white appearance on the edges. The bilateral feet were swollen, red, dry, and flaky. On his upper lower left leg by his knee, he had a dark blackish thick scab approximately the size of a quarter. Regional Nurse Consultant Q reported Resident #103 had edema on his feet still but the last time she saw him a few weeks ago, he had the edema all the way up to his knees. In an interview on 12/10/15 at 10:57 AM, LPN H reported when the provider gave an order and the documentation was to be on the treatment administration record (TAR), when entered the nurse would select the option to add to the TAR for weights done daily. LPN H reported the order would come up when the nurse was in the medical record and the nurse would document the weight completed that morning. Review of the TAR for December 25 revealed, no order for daily weights and no documented daily weights completed for Resident #103. In an interview on 12/10/25 at 11:57 AM, Director of Nursing (DON) B reported skin assessments were to be completed weekly on the assigned day, last one done for Resident #103 was on 11/30/25 and should have been completed on 12/7/25. DON B reported there was no wound assessment in the medical record which should have been implemented when the area opened on Resident #103's shin which was not documented in the medical

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure proper infection control protocols and practices for 2 (Resident #103 & #105) of 3 residents reviewed for infection control, resulting in the increased potential for the spread of infection, bacterial harborage, cross contamination, and disease transmission for residents residing in the facility. Findings include: Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning (putting on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi drug resistant organisms) to staff hands and clothing .EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions (infection control measures used for infections spread by touch) do not otherwise apply; or o Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 .Review of Centers for Disease Control (CDC) poster for Enhanced Barrier Precautions, revealed, .Enhanced Barrier Precautions: Everyone Must .Clean Their Hands, including before entering and when leaving a room .Providers and Staff Must Also .Wear Gown and Gloves for the following High Contact Resident Care Activities .Dressing .Bathing/Showering .Transferring .Changing linens .Providing hygiene . Changing briefs or assisting with toileting .Device care or use: central line, urinary catheter, feeding tube, tracheostomy .Wound Care: any skin opening requiring a dressing .Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included diabetes and edema. Review of Resident #103's medical record revealed an order dated 12/5/25 for .Enhanced barrier precautions during high contact resident activities every shift for weeping edema to BLE (Bilateral lower extremities). Review of Care Plan for Resident #103, revealed no focus for enhanced barrier precautions (EBP) in place for him. During an observation on 12/8/25 at 3:12 PM, Resident #103 was seated in his wheelchair in his room, he had his feet on the foot pedals and ankles looked swollen. This writer observed no EBP signage or personal protective equipment (PPE) holder on the door for use. Resident #103 did appear to have ace bandages wrapped around his ankles and feet. Review of Alert Note dated 11/19/2025 at 06:07 AM, revealed, .Res (Resident) has +3 pitting edema (a deep indentation (around 5-6 mm) forms when pressure is applied to swollen skin, and this pit take up to 60 seconds or more to rebound or fill back in, indicating moderate to severe fluid buildup) feet are seeping BLE (bilateral lower extremities) put in book for np (Nurse Practitioner) to f/u (follow up). Note: EBP should have been implemented during this time due to Resident 103's legs weeping fluid.Review of Interdisciplinary Documentation dated 11/22/2025 at 1:35 PM, revealed, .(Resident #103).diagnosis of DM (diabetes) and recent sepsis (life threatening medical emergency caused by the body's overwhelming response to an infection).He has 4+ edema (the most severe form of pitting edema, characterized by a deep pit (8mm or deeper) that takes 2-3 minutes or longer to rebound after pressure is applied to the swollen area) to his BLE with weeping and legs are wrapped with ABD (a thick highly absorbent wound dressing used for heavy-draining wounds), kerlix (bulky, crinkle-weave gauze bandage used to cushion protect, and absorb fluids from wounds) and Coban (self-adherent elastic wrap). Review of Order dated 11/25/25, revealed, .Cleanse bilateral lower extremities with wound wash, pat dry, apply Optilock (super absorbent polymer core dressing which locks in drainage under compression and protect the skin from maceration (softening and breakdown of skin around a wound due to excessive moisture)) then wrap with kerlex, and then wrap with Ace bandage. Change daily and prn (as needed) everyday shift for wound care. Review of Skin Assessment dated 11/30/25, revealed, .Res (Resident) has dressing to BLE (bilateral lower extremities) and are covered with ABD, kerlix and Coban, and he has been encouraged have them elevated. Res has +3 pitting edema and is weeping clear fluid. Resident #105: Review of an admission Record revealed Resident #105 was a male with pertinent diagnoses which included a foley catheter (flexible tube inserted into the bladder through the urethra to drain urine) and wounds on his left lower extremity. Review of Care Plan for Resident #105, revealed a focus, .(Resident #105) has altered functional mobility and ADL's (activities of daily living) related to: r/t (related to) right sided hemiparesis (paralysis), muscle weakness, contracture (permanent tightening/shortening of muscles, tendons, skin, and tissues around a joint) of muscle in the right upper arm, dependence on renal dialysis, need for assistance