STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER West Woods of Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2735016. Based on interview and record review, the facility failed to protect the resident's right to be free from sexual abuse by a staff member. Findings include: Resident #114: Review of an admission Record revealed Resident #114 was a male with pertinent diagnoses which included multiple sclerosis (the body's immune system attacks the protective covering of the nerve cells in the brain and spinal cord, disrupting signal transmission), need for assistance with personal care, suprapubic catheter (thin, flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine), muscle wasting and atrophy multiple sites (loss of muscle tissue characterized by decreased size, strength, and function), depression, anxiety, and chronic pain. Review of current Care Plan for Resident #114, revised on 11/28/25, revealed the focus, .Altered functional mobility and ADL's (activities of daily living) related to: MS (muscle sclerosis), obstructive and reflux chronic pain syndrome, neurogenic bladder, debility and need for assistance with personal cares with the intervention .DRESSING: One assist with cueing and encourage to do as much for self as able.EATING: Provide physical assistance to accept nutrition by mouth.LOCOMOTION: Independent in wheelchair. Review of Interdisciplinary Documentation dated 01/26/2026 at 2:15 PM, revealed, .(Resident #114) reported an allegation of having an inappropriate non-work related relationship with a staff member. Notification made to NHA (Nursing Home Administrator), DON (Director of Nursing), NP (Nurse Practitioner) and Police. He is self-determined and doesn't wish to have family notified. Review of Facility Reported Incident dated 1/26/26, revealed, .Immediate Action: (Activities Director (AD) F) notified DON (Director of Nursing B) at 1530 (3:30 PM) 1/26/2026, NHA (Nursing Home Administrator A), at 1515 (3:15 PM) 1/26/2026 of the allegation that was made by (Resident #114). (Local County) Sherrif office was called at 1630 (4:30 PM) and (Deputy Sheriff PPP) responded to building in 1700 (5:00 PM) to interview resident, (Resident #114), and file a report. Complaint number 00063310. The alleged perpetrator was sent home immediately following the reported allegation and suspended pending investigation.Witness Interview: Alleged Victim Interview: (NHA A) and (Social Worker (SW) XX) Social Worker interviewed (Resident #114) on 1/26/2026 at 1730 (5:30 PM). (Resident #114) reports that on December 19, 2025, at 1300 (1:00 PM), he left facility on an LOA (leave of absence) per (accessible public transportation) bus to (Local Hotel) in [NAME], MI to stay overnight. He stated that he paid for the room. (Infection Preventionist QQQ) at facility met him there a few minutes after his arrival as they had planned. He brought with him a few vapes (a battery powered device that heats a liquid into an aerosol) and money. He alleges they spent the night together, having unprotected sex. The next morning, they left separately at approximately 10 AM. (Infection Preventionist QQQ) had asked him not to tell anyone about them staying together and he said he promised her he would keep it to himself. A couple days later he noticed $300 missing along with his vapes. He said he contacted her and asked about it, and she denied taking the money and said she was (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	holding his vapes for him. While on video chat with her he said he could see his vapes on her chest as she was using it while talking to him. The relationship continued over (a social media platform) between them sharing videos, and she sent him a screenshot of a picture of her buttocks wearing only a thong.Staff Interview: (CNA P) CNA was asked to give written statement regarding what (Resident #114) had reported to her by (Director of Nursing (DON) B) Director of Healthcare Services on 1/27/2026. (Resident #114) reported to me that the prostitute is what he would call the manager. When he left the facility in December, he paid for that person. We asked who he was talking about and he would not tell us the name. He bought a Nike sweater, and it went missing. I usually help him. He said the Whore took it and got lost in her garage. There was no money on his side table. The next day there was $49.00 on the nightstand, which is how much the sweater cost. He said, the whore finally paid for the sweater. He says that it has been going on with (Infection Preventionist QQQ's boyfriend), and her. I was feeding him and asked if he wanted to report it. I asked if he wanted to speak with (NHA A), NHA. He declined and wanted to speak with (Activities Director (AD) F), Life Enrichment, I reported it to (AD F), and she went to speak with him. Yesterday, he finally said he doesn't want her to take advantage of him and other people. I said, (Infection Preventionist QQQ), and he said yes. That is her. Then I left the room and he turned on the light. He pulled up the messages on the phone and showed pictures of her in her underwear. It was a phone-to-phone text message. I would see her go into his room for a while and come out with large clear trash bags. I couldn't tell what else was in the bag. I could see a sheet. I did not witness any inappropriate behavior, just what (Resident #114) reported. I have not witnessed anyone taking anything from him. Review of IDT Note dated 12/19/25 at 1:30 PM, revealed, .(Resident #114) left facility for overnight at 1300 (1:00 PM), sent with personal belongings of vape pens, knife, etc. Meds sent for the rest of today and 0800 (08:00 AM) tomorrow. Resident states he should return around 1200 tomorrow 12/20.Review of Interdisciplinary Documentation dated 12/19/2025 at 2:14 PM, .CENA (Certified Nursing Assistant) reported to this nurse that (Resident #114) stated he was taking 3,000 dollars cash with him and showed the CENA his money.Review of Interdisciplinary Documentation dated 12/20/2025 at 1:00 PM, .Resident returned from LOA (leave of absence), pleasant and denies c/o (complaints of) any discomfort and in good spirits.In an interview on 02/05/2026 12:44 PM Activities Director (AD) F reported CNA (Certified Nursing Assistant) P was one of the regular CNAs who took care of (Resident #114). AD F reported CNA P came to her to ask her to go and speak to (Resident #114) as he wanted to report someone from management. AD F reported she went to speak with Resident #114 (Resident #114). AD F reported (Resident #114) reported he had been used by (Infection Preventionist (IP) QQQ) and he proceeded to show her pictures of IP QQQ from his (a social media platform) messenger. AD F reported she was able to observe the photo and name attached to the profile and it was IP QQQs name and photo, and there were a ton of messages between them as he was scrolling his messages to show AD F the inappropriate picture IP QQQ had sent to Resident #114 of her backside wearing a thong as underwear. AD F reported Resident #114 reported when asked if it was IP QQQ, Resident #114 stated Who else it would be. AD F reported Resident #114 was scrolling fast in his phone and was unable to see any other pictures and reported he was looking for the specific photo. AD F reported Resident #114 reported the relationship started 12/4/26, as he had shown AD F several missed calls on (a social media platform)Time on that date. AD F reported Resident #114 reported it had started as IP QQQ was coming to his room and she was very friendly with him and IP QQQ started to contact him on (a social media platform) Messenger. AD F reported Resident #114 reported he rented a room, stayed with her there, and they had sexual relations. Resident #114 also reported IP QQQ had stolen his vapes, other stuff and probably took his money but he had no (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	proof. AD F reported Resident #114 indicated to a nurse he might have a sexually transmitted disease (STD) after their sexual encounter, thought IP QQQ had given him an STD and IP QQQ had come to his room and asked him why he was asking for an STD test. AD F reported Resident #114 reported IP QQQ had come to his room another time and asked if he was going to tell anyone about their relationship. AD F reported after Resident #114 had reported to her, she asked Social Worker (SW) XX to go with her to check on Resident #114, but he was getting ready to leave the facility but Resident #114 did confirm he felt IP QQQ had used him and he asked if he was going to get in trouble for reporting her. AD F reported Resident #114 reported IP QQQ had contacted him at approximately 2:00 AM the night before she and SW XX went to speak to him and IP QQQ was crying and asked why he had reported their relationship, and she had been suspended because of it. In an interview on 02/05/2026 2:22 PM Certified Nursing Assistant (CNA) P reported she had been providing feeding assistance to Resident #114, and he reported when he went out in December, he was with a whore that worked here. CNA P reported that morning he reported he was tired of her (IP QQQ) stealing from him and he didn't want her to continue to take advantage and hurt anyone else at other facilities, so he told me her name, it was IPQQQ, who worked as the infection preventionist, when he went out in December to a hotel and it was also her who had been in and out of his room and Resident #114 reported he thought he had gotten syphilis from her that was why he wanted to get tested but then declined. CNA P reported Resident #114 had bought a Nike hoodie which ended up being too small for him and she was going to help him return it, when she asked Resident #114 where the hoodie was at, he reported the whore took it and got lost in her garage. CNA P asked Resident #114 who the person was he would not tell her but after that Resident #114 had found money on his nightstand and it had dawned on him the money had come from IP QQQ to replace the lost hoodie. CNA P reported she noticed IP QQQ had been going in and out of Resident #114's room more frequently, leaving with bags of linen and CNA P reported she was unsure why she was going to his room more frequently but thought it might be infection control related. CNA P asked Resident #114 who he would like to report his concern to and he indicated he would like to talk with AD K. CNA P reported she had left Resident #114's room and the call light turned back on, and Resident #114 needed his phone, and he needed her help with his phone, helped scroll to where he wanted her to stop and at the top of the screen was IP QQQ's name and picture and a picture of her butt in thong underwear. CNA P reported there were several other text messages between them. CNA P reported Resident #114 reported IP QQQ was still trying to contact him. CNA P reported Resident #114 reported the relationship between them started not long after she started at the facility. CNA P reported Resident #114 reported IP QQQ had reached out to him on (a social media platform) initially. CNA P reported Resident #114's (a social media platform) profile was not his first name it was his middle name, and she would have to know his middle name to find him. CNA P reported Resident #114 hid his (a social media platform) profile because of his child. Resident #114 reported IP QQQ had mentioned when he had spilled his Gatorade in his room, she had come to his room, he was always naked in his room, and she was pursuing him after that. In an interview on 02/05/2026 1:20 PM Social Worker (SW) XX reported she went with the NHA A when she interviewed Resident #114 and she wanted to make sure he felt safe and supported, asked if he needed anything. When the police arrived to take his statement, she reported she left the room so they could conduct their interview. In an interview on 02/05/26 at 5:51 PM, Deputy Sheriff (DS) PPP reported during her investigation it was determined IP QQQ had sought out Resident #114 for a relationship. DS PPP reported she was informed no sexual intercourse happened at the facility possibly some kissing only per Resident #114. DS PPP reported Resident #114 reported he had gone out on leave on December 19, 2025, and they had met at the hotel. Resident #114 had (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taken a ride service and IP QQQ had arrived at the hotel in her motor vehicle. Resident #114 reported they had sex, she stayed the night with him at the hotel. Resident #114 alleged he had $300.00 missing as well as some vapes which Resident #114 had observed in her possession. DS PPP reported she had interviewed IP QQQ who reported she had fallen in love with him and agreed to meet Resident #114 at the hotel. DS PPP reported IP QQQ reported there was no sexual penetration but there was sexual activity. DS PPP reported IP QQQ reported she had no financial motive to take Resident #114's money and indicated she had broken up with Resident #114. DS PPP reported she had reviewed the surveillance footage at the hotel, and both were observed in the lobby of the hotel together and it appeared to be beyond a nurse resident relationship. DS PPP indicated the report was with the prosecutor for review. This writer attempted to contact IP QQQ prior to exit. No return call was received. This writer attempted multiple times during the survey 2/4/26 - 2/10/26 to speak with Resident #114 but did not want to be interviewed. In an interview on 02/10/2026 10:49 AM NHA A reported Resident #114 reported to CNA P he was taken advantage of by a nurse, AD F went to interview him and Resident #114 reported to her, he had a relationship with IP QQQ which began on (a social media platform) Messenger with texting, sending photos and videos back of her butt and her breasts. AD F came and reported the incident to me and SW XX came with me when she went to interview Resident #114. NHA A reported Resident #114 had told her the same recount of the relationship and observed there were photos and messages. NHA A reported IP QQQ was suspended pending investigation. NHA A reported IP QQQ indicated she had been hacked, had not reported her accounts being hacked and just had deleted her accounts, and was unable to provide any documentation of reporting being hacked. NHA A reported IP QQQ reported all the messages and photos were sent by the person who hacked her accounts. NHA A reported Resident #114 reported they had stayed together at the (Local Hotel), he took $3000 with him, and she took $300 from him as well as his vapes, reported after the relationship ended Resident #114 asked for his items back and IP QQQ would not return his items. NHA A reported IP QQQ denied everything, there was no calls, texts, spending the night. NHA A reported she had attempted to contact the sheriff to obtain a copy of the final report but had not received one yet. NHA A reported she was waiting to hear from the sheriff to see if they were able to review the footage at the hotel. NHA A reported IP QQQ was terminated due to the policy of not informing the NHA of having a relationship outside of the facility.

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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 #2715364. Based on interviews and record review, the facility failed to identify an acute change in condition for 1 (Resident #121) of a total sample of 22 residents reviewed for quality of care resulting in a delay in treatment for Resident #121 who was sent to the hospital on 1/8/26 and diagnosed with altered mental status and septic shock (life-threatening condition caused by a severe infection) from necrotic (death of cells in tissue) sacral ulcer with osteomyelitis (infection in a bone). Findings include: Resident #121Review of an admission Record revealed Resident #121 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of sacral region stage 4, and need for assistance with personal care. Review of Resident #121's Care Plan revealed, (Resident #121) has the potential for an acute condition change with cardiopulmonary, metabolic or infectious complicationsrelated to atrial fibrillation (irregular heart rhythm) and orthostatic hypotension (sudden drop in blood pressure when standing up, causing dizziness, lightheadedness, or fainting)Date Initiated: 12/19/2025. Goals: (Resident #121) will have early identification, management, treatment and resolution of an acute condition change. Interventions: Assess and document edema, breath sounds, circumoral (around the mouth) or nail bed cyanosis (bluish skin discoloration), Assess and intervene as indicated for chest pain, Assess heart rate and rhythm prn (as needed), Blood Sugars as Ordered, Check oxygen saturation levels SA02% (sic) ad capillary refill prn (as needed), initiate 02 (oxygen) as ordered, Conduct an assessment of the resident prior to initiating health care practitioner contact, Ensure effective communication of resident condition to members of the interdisciplinary staff, Evaluate pain with the pain assessment monitor on the MAR (Medication Administration Record, Obtain baseline labs as ordered by the physician review and compare lab value results prn; assess abnormal values as indicated, Report any significant change to the physician and appropriate responsible party as indicated prn, Review advanced directives and know residents wishes for treatment, Vital signs prn. Date Initiated: 12/19/2025 .Review of Resident #121's Documentation of Symptoms for Sacral wound indicated findings of increased drainage on the following dates: 12/29/25,12/30/25,12/31/25, 1/3/26,1/4/26, and 1/8/26, findings for foul order on the following dates: 12/29/25, 12/30/25, 12/31/25, 1/3/26, 1/4/26, and 1/8/26, findings for Surrounding warmth on the following dates: 12/31/25, 1/3/26, 1/4/26,1/8/26 and 1/8/26, and findings for Surrounding edema (swelling) on 12/31/25, 1/3/26, 1/4/26, and 1/8/26 . Noted that all findings were the indication of the wound infection. Review of Resident #121's Hospital Records dated 1/8/26 revealed, . ED Course: . presents by EMS (Emergency Medical Services) for altered mental status and concern of worsening sacral wound. Per EMS, the patient is typically A&O (alert and oriented) x4 and is able to ambulate. Over the last few days patient has had worsening mental status and is not ambulating. Reportedly SNF nurses were concerned that sacral wound was worsening. Reportedly SNF (Skilled Nursing Facility) nurses were concerned that sacral wound was worsening .Examination of sacral wound shows wound with VAC in place. There appears to be erythema surrounding wound with fluctuance (boggy sensation felt on palpitation, indicating a fluid filled area) present . Purulence (pus that is produced in infected tissue) noted near the tailbone . Hospital Course: . Septic shock from necrotic sacral ulcer with osteomyelitis, Bacteroides and gram positive bacilli bacteremia (presence of bacteria in the bloodstream), Pseudomonal UTI (urinary tract infection). s/p (status post) incision and drainage of sacral wound 01/09, bone biopsy shows osteomyelitis. ID (Infectious Disease) consulted . Wound Care Consult Note 1/9/26: 2. Coccyx/sacral wound 10.5 x 11 x unable to assess due to necrotic tissue with bone exposed and palpable wound connect under necrotic tissue. Undermining circumferential in varies depth to uncomfortable (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for patient to obtain measurement. Peri wound skin erythema/nonblanchable /odor noted. Right lower leg lateral 7.6 x 3.9 x tissue purplish/black. Right anterior lower leg 3.5 x 1.1 x necrotic. Left lateral ankle 8 x 4 x Deep tissue injury Assessment: . 2. Unstageable pressure ulcer coccyx/sacral. 3. Right lower leg lateral unstageable pressure injury versus Deep tissue injury 4. Right anterior lower leg unstageable pressure injury 5. Left lateral ankle appears to be deep tissue injury evolving 6. Skin tear left arm . Infectious Disease Consultation 1/14/26: . On 01/09/2026 patient had incision and drainage and debridement of the sacral wound with bone biopsy taken that is showing acute osteomyelitis . In an interview on 2/04/2026 at 1:23 PM, Family Member (FM) FFF reported Resident #121 had been admitted to the facility on [DATE] after being hospitalized due to his coccyx wound. FM FFF reported that Resident #121 had admitted to the facility to continue receiving wound care treatments. FM FFF reported Resident #121 was typically alert and oriented, and able to ambulate in his wheelchair. FM FFF reported she first noticed that something seemed to be wrong with Resident #121 during a care conference at the facility on 12/24/25 when she noted that Resident #121 seemed to be noticeably more confused. FM FFF reported she had voiced her concern that Resident #121 seemed more confused than usual and was told that staff would get back with her regarding this. FM FFF reported on 12/26/25 she found Resident #121 lying in his room and that he appeared very pale and ill. FM FFF reported the nurse caring for Resident #121 had informed her that Resident #121 had not had his sacrum dressing changed because the facility was waiting on supplies to come in. FM FFF reported she continued to voice her concerns about Resident #121 condition, but she felt that staff were not taking her concerns seriously. FM FFF reported she was called by LPN TT on 12/29/25 and told that Resident #121's wound looked worse, and that she was waiting for the wound doctor to look at it before putting the wound vac back on. FM FFF reported that she did not hear back from the facility about Resident #121's condition after she had talked with LPN TT on 12/29/25. FM FFF reported she went to visit Resident on 1/5/26 and noted that Resident #121 could hardly talk and seemed confused or sedated. FM FFF reported that she spoke with the nurse caring for Resident #121 and expressed her concerns that Resident #121 was declining, FM FFF reported that staff reported that they would look into it again. FM FFF reported that she called the facility's Social Worker (SW) on 1/6/26 to discuss her concerns that Resident #121 was declining, and that she received a call back from on 1/7/26 from SW XX that the facility had a call into the doctor at the facility to see Resident #121. FM FFF reported that the next day, 1/8/26, Resident #121 was transported to the emergency room where he was admitted to the hospital. FM FFF reported that Resident #121 was transferred to the Intensive Care Unit (ICU) and had to have surgery the following day on his sacrum wound. FM FFF reported that she had spoken with the facility's Nursing Home Administrator (NHA) A on 1/9/26 and expressed her concerns about Resident #121's health decline and the facility response. FM FFF' reported that she was told the facility was investigating her concerns. FM FFF reported that she received a follow up call from Clinical Support Nurse (CSN) AAA where she was informed that the facility had not provided care for Resident #121's up to the facility standards, and that the facility was investigating her concerns. FM FFF reported that she never heard back from the facility staff after her call with CSN AAA. During an interview on 2/05/2026 at 11:34 AM, Certified Nursing Assistant (CNA) P reported she cared for Resident #121 often. CNA P reported that when Resident #121 first came to the facility he was alert, very kind, and required assistance of 1 staff member for ADL (Activities of daily living care) and then he seemed to go downhill all of a sudden. CNA P reported that Resident #121 became combative and he became unable to feed himself. CNA P reported that it seemed like she noticed the change in Resident #121 began when the facility took his wound vac off. CNA P was not aware of the date that the facility had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed Resident #121's wound vac. During an interview on 2/05/2026 12:41 PM, CNA S reported she had cared for Resident #121 and was familiar with him. CNA S reported Resident #121 did seem to quickly decline after he was admitted to the facility. CNA S reported Resident #121 began to require more assistance, seemed more confused and was getting more combative. During an interview on 2/05/2026 at 11:40 AM, LPN TT reported that she had cared for Resident #121 multiple times since he had been admitted to the facility. LPN TT' reported Resident #121 had declined after he was admitted to the facility, and Resident #121's family member had expressed concerns related to his decline. LPN TT reported she had thought that nurses had told NP MMM about Resident #121's decline, but she was not sure what NP MMM had done for Resident #121. LPN TT reported that on 12/29/25, as she changed Resident #121's wound vac, she observed bone in Resident #121's sacral wound, and that the wound was black and the tissue was necrotizing. LPN TT reported that the wound appeared to be worsening. LPN TT reported that she was instructed by Former Director of Nursing (F-DON) UU to remove Resident #121's wound vac, apply a wet to dry dressing, and contact Resident #121's wound clinic. LPN TT reported that she had tried to find what wound clinic Resident #121 had gone to, but she was unsuccessful, and she did not know if the facility was ever able to arrange a wound clinic appointment for Resident #121. LPN TT reported that when Resident #121 was sent to the hospital on 1/8/26 she had found a wound on his right leg that she did not know was even there, and she did not think that facility had treatment orders in place for Resident #121's leg wound. During an interview on 2/05/2026 at 11:57 AM, LPN PP reported that he had cared for Resident #121, and that he recalled that Resident #121 seemed to need more assistance with care after he was admitted to the facility. LPN PP reported that he had completed wound care on 1/7/26, he had noticed that Resident #121's wound did not seem to be improving, and that there were brownish slough (dead tissue) spots across the wound. LPN PP did not recall if he had notified the facility's provider that Resident #121's wound was worsening. During an interview on 2/05/2026 at 4:27 PM, LPN SS reported on 12/26/25 during Resident #121's wound care treatment she noted that the wound looked much worse than when Resident #121 was first admitted , and it was bigger in size. LPN SS reported that there were several areas where the tissue on the wound was black. LPN SS reported she had noticed that Resident #121 had seemed to have declined, and that Resident #121's family member had also voiced concerns about his decline. LPN SS reported that Resident #121 was more confused and needed more assistance than when he was first admitted . LPN SS reported that she thought she had a left a note in the provider book for NP MMM, but she could not recall when. During an interview on 2/05/2026 at 1:06 PM, Clinical Care Coordinator (CCC) CC reported Resident #121 was admitted with a wound vac on his sacral wound, and that the dressing was supposed to be changed three times a week. CCC CC reported that she did not think that the facility was aware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26. CCC CC reported that the facility submitted a referral to a wound clinic for Resident #121 on 12/31/25, and that he was scheduled for 1/14/26. CCC CC confirmed that she was aware that staff and Resident #121's family had expressed concerns that he was declining, and that she thought that NP MM was aware. During an interview on 2/5/26 at 2:13 PM, NP MMM reported that she was aware of staff and family concerns that Resident #121 was declining. NP MMM reported that she had saw Resident #121 around New Years and ordered lab work which looked good with the exception of an abnormal CRP (lab test used for assessing inflammation in the body and can aid in diagnosing and monitoring various health conditions) but since Resident #121 had a wound, she was not concerned. NP MMM reported when she saw Resident #121 on 1/8/26, he did not look good and he was not eating, so she ordered that Resident #121 be sent to the hospital. NP MMM reported that she had never been made aware that Resident #121's wound was hot to touch. During an (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 2/05/2026 at 1:54 PM, F-DON UU reported Resident #121 was admitted to the facility with a wound vac on his sacral wound. F-DON UU reported at one point the facility was questioning the wound care order and trying to figure out if Resident #121 was supposed to go to a wound clinic, but she was not aware of what the facility determined for Resident #121's wound clinic referral. F-DON UU reported that she did not notify NP MMM about the change in Resident #121's wound condition on 12/29/25, but she thought that LPN TT had. During an interview on 2/05/2026 at 2:19 PM, CSN AAA reported that she had been made aware on 1/9/26 that Resident #121's family had concerns with his care at the facility from NHA A. CSN AAA reported that she had conducted an investigation with NHA A into Resident #121's family concerns. CSN AAA confirmed that the facility had been made aware of Resident #121's family concerns about Resident #121's potential decline on 12/24/25, and that the facility had planned to follow up with Resident #121's family with an update once they had reviewed his lab work. CSN AAA confirmed that NP MMM did not see Resident #121 until 12/31/25 and labs were not ordered for Resident #121 until 12/30/26. CSN AAA was unable to report when or if nursing staff had notified NP MMM of Resident #121's decline in function, or if NP MMM had been notified about the change in Resident #121's wound condition. CSN AAA confirmed that she had found several missing treatments and documentation of Resident #121's change in condition, and that the facility had been re-educating nursing staff on this. In a follow up interview on 2/06/2026 at 8:54 AM, LPN TT confirmed that she did notify NP MMM on 12/29/25 about Resident #121's wound via text. LPN TT reviewed the text that she sent to NP MMM which indicated that she had concerns with Resident #121's wound, and that she changed his dressing to a wet to dry. NP MMM replied that she had received the text and would be in to look at Resident #121. LPN TT reported that she did not receive any follow up orders from NP MMM and she did not know when or if Resident #121 was seen by NP MMM or if his wound care orders were changed. Review of Resident #121's Progress Note dated 12/29/25 and documented by Licensed Practical Nurse (LPN) TT revealed, LPN attempted to change wound vac (negative pressure wound therapy device that uses gentle suction to promote faster and more effective wound healing) dressing. Dressing removed. LPN observed wound down to bone in right buttock wound. Left buttock wound does have some tissue left. Tissue between both wounds is necrotizing. Peri wound is red, hot to touch. (Former Director of Nursing (F-DON) UU) aware. Instructed to wet to dry (applying moist gauze to a wound, followed by dry gauze, then allowing it to dry completely and stick to dead tissue so that when it is removed the dead tissue comes with it) and call wound clinic. Wound clinic called, LPN left message on nurse line at (number redacted) for further instruction. Awaiting call back. Family aware . Review of Resident #121's Progress Note dated 12/29/25 and documented by LPN TT revealed, (wound care provider) does not see (Resident #121) for wound vac. LPN left message with (Nurse Practitioner (NP) MMM) for further instructions. Review of Resident #121's Progress Note dated 12/30/25 revealed, Resident recently declined, (NP MMM) consulted. labs to be obtained STAT .Review of Resident #121's Progress Note dated 12/31/25 revealed, .Wound vac remains on hold until further wound care evaluation completed. Wound is larger, with necrotizing tissue in the middle and bone exposure observed. Wet to dry dressing maintained at this time.Review of Resident #121's Progress Note dated 12/31/25 and documented by NP MMM revealed, Infected decubitus ulcer-Completed Augmentin and Bactrim (antibiotics) for total of 7 days. Continue wound vac, follow up with wound clinic on 1/14 .Review of Resident #121's Progress Note dated 1/6/26 revealed, . Wound care completed to buttocks, wet to dry. Wound drainage green/yellow, odor increased. Tenderness increased. Not able to participate in therapies at this time .Review of Resident #121's Progress Note dated 1/7/26 revealed, wound vac placed without much difficulties. resident tolerated procedure well. Review of Resident #121's Progress Note dated 1/8/26 revealed, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Resident #121) is being sent to the ER for further evaluation of altered mental status and ? infection (sic). Order received from (NP MMM) to send patient to the ER . Review of the facility's Change in Resident Condition policy last reviewed January 2026 revealed, Policy: It is the policy of this facility to inform the resident; consult with the residents health care practitioner, and notify the residents authorized representative according to the minimum guidelines established in this procedure and more frequently at the discretion of the licensed nurse or member of the interdisciplinary team. Purpose: To ensure provision of the necessary care and services to meet the highest practicable physical, mental and psychosocial well-being of each resident in accordance with measurable objective assessment data. Procedure: 1. The health care practitioner will be promptly notified when . b. The resident has a significant change in physical, mental, or psychosocial status i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. c. A resident assessment indicated the need to alter the treatment significantly i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new treatment . 6. Objective observations of changes in a resident's condition, including emotional changes as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be recorded in the resident's record.

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2715364.Based on interview and record review, the facility failed to provide quality wound care to promote healing and prevent the deterioration of a pressure ulcer for 1 (Resident #121) of 3 residents reviewed for wound care resulting in an Immediate Jeopardy when on 1/8/26, Resident #121 was hospitalized with altered mental status and septic shock (life-threatening condition caused by a severe infection) from a necrotic (death of cells in tissue) sacral ulcer (pressure ulcer at the base of the spine) with osteomyelitis (infection in a bone) requiring surgical intervention and bone debridement. Findings include: Resident #121 The Immediate Jeopardy began on 12/26/25 when Resident #121 was unable to have his pressure ulcer cared for per orders and was not completed by nursing staff and was subsequently hospitalized with altered mental status and septic shock from necrotic (dead tissue) sacral ulcer with osteomyelitis requiring surgical intervention and bone debridement. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy verbally and via email on 2/5/26 at 4:40 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on 2/5/26, but noncompliance remains at scope of isolated and severity of actual harm due to sustained compliance that has not been verified by the State Agency. Review of an admission Record revealed Resident #121 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer of sacral region stage 4, and need for assistance with personal care. Review of Resident #121's Hospital Discharge summary dated [DATE] revealed, .Hospital Course: further examination revealed multiple deep ulcerated decubitus ulcers (pressure ulcer) and elevated CRP (lab test measures the level of C-reactive protein in your blood, indicating inflammation in the body and helping diagnose various conditions) at 8 concerning for osteomyelitis. CT (computed tomography) were reviewed . CT pelvis showed deep sacral decubitus ulcers without CT evidence of osteomyelitis . During the course of hospital stay: Patient was evaluated by surgery team, underwent debridement (medical process of removing dead, damaged, or infected tissue from a wound to promote healing and prevent infection) of the wound, clean borders achieved. Wound vac (device that uses gentle suction to promote faster and more effective wound healing), ID (Infectious Disease) recommend total of 7 days of antibiotics . He (Resident #121) is comfortable going to SNF (skilled nursing facility) with a goal for better wound care . Discharge Planning . Pressure injury, Wound clinic in 2 weeks 1/1/26 (wound care provider) in 2 weeks . Review of Resident #121's Clinical Discharge summary dated [DATE] revealed, . Follow up: Wound Clinic. When: In 2 weeks. 1/1/26 . Review of Resident #121's Documentation of Symptoms for Sacral wound indicated findings of increased drainage on the following dates: 12/29/25, 12/30/25, 12/31/25, 1/3/26, 1/4/26, and 1/8/26, findings for foul order on the following dates: 12/29/25, 12/30/25, 12/31/25, 1/3/26, 1/4/26, and 1/8/26, findings for Surrounding warmth on the following dates: 12/31/25, 1/3/26, 1/4/26, 1/8/26 and 1/8/26 and findings for Surrounding edema (swelling) on 12/31/25, 1/3/26, 1/4/26, and 1/8/26 . Review of Resident #121's Progress Note dated 1/8/26 revealed, (Resident #121) is being sent to the ER for further evaluation of altered mental status and ? infection (sic). Order received from NP MMM to send patient to the ER . Review of Resident #121's Hospital Records dated 1/8/26 revealed, . ED Course: . presents by EMS (Emergency Medical Services) for altered mental status and concern of worsening sacral wound. Per EMS, the patient is typically A&O (alert and oriented) x4 and is able to ambulate. Over the last few days patient has reportedly been more disoriented and not ambulating by himself. EMS reports that worsening facility nurses were concerned about sacral wound worsening. Reportedly SNF (Skilled Nursing Facility) nurses were concerned that sacral wound was worsening .Examination of sacral wound shows wound with VAC in place. There appears to be (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	erythema surrounding wound with fluctuance (boggy sensation felt on palpitation, indicating a fluid filled area) present . Purulence (pus that is produced in infected tissue) noted near the tailbone . Hospital Course: . Septic shock from necrotic sacral ulcer with osteomyelitis, Bacteroides and gram positive bacilli bacteremia (presence of bacteria in the bloodstream), Pseudomonal UTI (urinary tract infection). s/p (status post) incision and drainage of sacral wound 01/09, bone biopsy shows osteomyelitis. ID (Infectious Disease) consulted . Wound Care Consult Note 1/9/26: 2. Coccyx/sacral wound 10.5 x 11 (Centimeters) x unable to assess due to necrotic tissue with bone exposed and palpable wound connect under necrotic tissue. Undermining circumferential in varies depth to uncomfortable for patient to obtain measurement. Peri wound skin erythema/nonblanchable /odor noted. Right lower leg lateral 7.6 CM x 3.9 (centimeters)x tissue purplish/black. Right anterior lower leg 3.5 x 1.1 (centimeters) x necrotic. Left lateral ankle 8 x 4 (centimeters) x Deep tissue injury Assessment: . 2. Unstageable pressure ulcer coccyx/sacral. 3. Right lower leg lateral unstageable pressure injury versus Deep tissue injury 4. Right anterior lower leg unstageable pressure injury 5. Left lateral ankle appears to be deep tissue injury evolving 6. Skin tear left arm . Infectious Disease Consultation 1/14/26: . On 01/09/2026 patient had incision and drainage and debridement of the sacral wound with bone biopsy taken that is showing acute osteomyelitis . During an interview on 2/04/2026 at 1:23 PM, Family Member (FM) FFF reported Resident #121 had been admitted to the facility on [DATE] after being hospitalized due to his coccyx wound. FM FFF reported that Resident #121 had admitted to the facility to continue receiving wound care treatments. FM FFF reported Resident #121 was typically alert and oriented, and able to ambulate in his wheelchair. FM FFF reported she first noticed that something seemed to be wrong with Resident #121 during a care conference at the facility on 12/24/25 when she noted that Resident #121 seemed to be noticeably more confused. FM FFF reported she had voiced her concern that Resident #121 seemed more confused than usual and was told that staff would get back with her regarding her concern. FM FFF reported on 12/26/25 she found Resident #121 lying in his room and that he appeared very pale and ill. FM FFF reported the nurse caring for Resident #121 had informed her that Resident #121 had not had his sacrum dressing changed because the facility was waiting on supplies to come in. FM FFF reported that she continued to voice concerns about Resident #121 condition at this time, and she felt that she felt that staff were not taking her concerns seriously. FM FFF reported she was called by LPN TT on 12/29/25 and told that Resident #121's wound looked worse, and that she was waiting for the wound doctor to look at it before putting the wound vac back on. FM FFF reported that she did not hear back from the facility about Resident #121's condition after she had talked with LPN TT on 12/29/25. FM FFF reported she went to visit Resident on 1/5/26 and noted that Resident #121 could hardly talk and seemed confused or sedated. FM FFF reported that she spoke with the nurse caring for Resident #121 and expressed her concerns that Resident #121 was declining, FM FFF reported that staff reported that they would look into it again. FM FFF reported that she called the facility's Social Worker (SW) on 1/6/26 to discuss her concerns that Resident #121 was declining, and that she received a call back from on 1/7/26 from SW XX that the facility had a call into the doctor at the facility to see Resident #121. FM FFF reported that the next day, 1/8/26, Resident #121 was transported to the emergency room where he was admitted to the hospital. FM FFF reported that Resident #121 was transferred to the Intensive Care Unit (ICU) and had to have surgery the following day on his sacrum wound. FM FFF reported that she had spoken with the facility's Nursing Home Administrator (NHA) A on 1/9/26 and expressed her concerns about Resident #121's health decline and the facility response. FM FFF' reported that she was told the facility was investigating her concerns. FM FFF reported that she received a follow up call from Clinical Support Nurse (CSN) AAA (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	where she was informed that the facility had not provided care for Resident #121's that was up to the facility standards, and that the facility was investigating her concerns. FM FFF reported that she never heard back from the facility staff after her call with CSN AAA. During an interview on 2/05/2026 at 11:34 AM, Certified Nursing Assistant (CNA) P reported she cared for Resident #121 often. CNA P reported that when Resident #121 first came to the facility he was alert, very kind, and required assistance of 1 staff member for ADL (Activities of daily living care) and then he seemed to go downhill all of a sudden. CNA P reported that Resident #121 became combative and he became unable to feed himself. CNA P reported that it seemed like she noticed the change in Resident #121 began when the facility took his wound vac off. CNA P was not aware of the date that the facility had removed Resident #121's wound vac. During an interview on 2/05/2026 12:41 PM, CNA S reported she had cared for Resident #121 and was familiar with him. CNA S reported Resident #121 did seem to quickly decline after he was admitted to the facility. CNA S reported Resident #121 began to require more assistance, seemed more confused and was getting more combative. During an interview on 2/05/2026 at 11:40 AM, LPN TT reported that she had cared for Resident #121 multiple times since he had been admitted to the facility. LPN TT' reported Resident #121 had declined after he was admitted to the facility, and Resident #121's family member had expressed concerns related to his decline. LPN TT reported she thought that the nurses had told NP MMM about Resident #121's decline, but she was not sure what NP MMM did for Resident #121. LPN TT reported on 12/26/25 she was unable to complete Resident #121's dressing change to his sacral wound because the facility did not have the wound vac supplies. LPN TT reported she passed along to the oncoming nurse that the nurses would need to complete a wet to dry dressing change and remove Resident #121's wound vac that night if the supplies did not arrive. LPN TT reported that when she returned to the facility on [DATE], Resident #121's wound vac was still on, and the facility did not have supplies, so she was not able to confirm if the facility had changed Resident #121's dressing since 12/26/25. LPN TT reported that on 12/29/25, as she changed Resident #121's wound vac, she observed bone in Resident #121's sacral wound, and that the wound was black and the tissue was necrotizing. LPN TT reported that the wound appeared to be worsening LPN TT reported that she asked for Former Director of Nursing (F-DON) UU and LPN NN to assist her to provide treatment to Resident #121's wound. LPN TT reported that she was instructed F-DON UU to remove Resident #121's wound vac, apply a wet to dry dressing, and contact Resident #121's wound clinic. LPN TT reported that she tried to find what wound clinic Resident #121 had gone to, but she was unsuccessful. LPN TT reported that when Resident #121 was sent to the hospital on 1/8/26 she had found a wound on his right leg that she did not know was even there, and she did not think that facility had treatment orders in place for Resident #121's leg wound. During an interview on 2/05/2026 at 11:57 AM, LPN PP reported that he had cared for Resident #121, and that he recalled that Resident #121 seemed to need more assistance with care after he was admitted to the facility. LPN PP reported that he had completed wound care on 1/7/26, he had noticed that Resident #121's wound did not seem to be improving, and that there were brownish slough (dead tissue) spots across the wound. LPN PP reported that he thought that there was some issue with Resident #121's wound vac, so the facility had removed the wound vac and completed wet to dry dressings for a while, but he was not able to confirm the date that Resident #121's wound vac was removed or placed back on. When this writer queried LPN PP about Resident #121's TAR documentation on 12/21/25, where LPN PP had documented a . under the note for if Resident #121's wound care treatment had been complete, LPN PP reported that he did not know why he did not document whether the treatment was completed or not, and that he should have documented more than a period. LPN PP confirmed that his documentation did not indicate whether he had completed Resident (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#121's wound care treatment, and that he could not recall if he had missed any of Resident #121's wound care treatments. LPN PP reported that he could not recall if had notified the facility's provider that Resident #121's wound was worsening. During an interview on 2/05/2026 at 4:12 PM, LPN NNN reported she had cared for Resident #121 and recalled that Resident #121's wound care treatments were scheduled to completed on first shift. This writer queried about LPN NNN's documentation for Resident #121 on 12/31/25 which stated, No wound care this shift. LPN NNN reported she had documented that to remove the task from her list, and to confirm that she did not complete Resident #121's wound care treatment on that shift. LPN NNN confirmed that she had passed that information along to the oncoming nurse, but there was no way to verify if Resident #121's wound care treatment had been completed. LPN NNN reported it was common for her to skip treatments when she worked at the facility because she was struggling to manage the workload. During an interview on 2/05/2026 at 4:27 PM, LPN SS reported she was the nurse that had admitted Resident #121. LPN SS reported that Resident #121 was not admitted with his wound vac on, and she was not sure when the facility had gotten his wound vac. LPN SS reported she recalled documenting Resident #121's wounds but could not recall if she measured them or what any of his wounds looked like. LPN SS reported the admitting nurse places orders based on the hospital discharge paperwork, which is where she found the order for Resident #121's wound vac treatment. LPN SS did not recall if Resident #121 had an appointment scheduled with a wound clinic. LPN SS confirmed that she had been told by LPN TT on 12/26/25 that if the supplies did not come in for Resident #121's wound vac treatment, she would need to complete a wet to dry dressing change. LPN SS reported that on 12/26/25 during Resident #121's wound care treatment she noted that the wound looked much worse than when Resident #121 was first admitted , and it was bigger in size. LPN SS reported that there were several areas where the tissue on the wound was black. LPN SS reported she had noticed that Resident #121 had seemed to have declined, and that Resident #121's family member had also voiced concerns about his decline. LPN SS reported that Resident #121 was more confused and needed more assistance than when he was first admitted . LPN SS reported that she thought she had a left a note in the provider book for NP MMM, but she could not recall when. During an interview on 2/05/2026 at 1:06 PM, Clinical Care Coordinator (CCC) CC reported Resident #121 was admitted with a wound vac on his sacral wound, and that the dressing was supposed to be changed three times a week. CCC CC reported that she did not think that the facility was aware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26. CCC CC reported that the facility submitted a referral to a wound clinic for Resident #121 on 12/31/25, and that he was scheduled for 1/14/26. CCC CC confirmed that she was aware that staff and Resident #121's family had expressed concerns that he was declining, and that she thought that NP MM was aware. CCC CC reported that she was on vacation from 12/27/25- 1/5/26, and when she returned from vacation, she discovered that two of the facility nurses had put in an order for Resident #121's sacral wound care order to be changed to a wet to dry dressing. CCC CC reported that she did not know who had given the order for the nurses to change Resident #121's wound care orders, so she instructed LPN PP to place the wound vac back on Resident #121. CCC CC reported that she did not know why the facility nurses were documenting that the facility was out of wound care supplies, because the facility was never out of supplies, and that they were in the storage room. CCC CC reviewed Resident #121's TAR with this writer and confirmed that Resident #121 had several missing and inaccurate documentation for wound care treatments. CCC CC reported that if a nurse marks a treatment as hold- see note, the nurse should document the reason the treatment was missed. CCC CC reported Medical Records (MR) ZZ would have been responsible for arranging appointments for Resident #121. During an interview on 2/05/2026 at 1:27, MR ZZ reported that she was responsible (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for reviewing the hospital discharge orders for residents to arrange transportation/scheduling for residents. MR ZZ reviewed Resident #121's hospital records with this writer and confirmed that she was not aware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26, and that she had missed this, therefore Resident #121 had not gone to the wound clinic during his admission at the facility. During an interview on 2/05/2026 at 1:39 PM, NP MMM reported she had been made aware that nursing staff at the facility were concerned about the presence of bone on Resident #121's sacral area, and that she had told the facility staff that they were able to use an adaptic (non-adherent wound dressing) dressing to cover the wound and continue to use the wound vac as ordered. NP MMM reported that she did not recommend a change to Resident #121's wound care orders. NP MMM reported that she was alerted verbally by a nurse in the facility that Resident #121 did not have his wound vac on but she could not recall who the nurse was or what date this was. NP MMM reported that she was under the impression that Resident #121's wound vac was placed back on when she told staff it needed to be on, but she did know when staff put Resident #121's wound vac back on. In a follow up interview on 2/5/26 at 2:13 PM, NP MMM reported that she was aware of staff and family concerns that Resident #121 was declining. NP MMM reported that she had saw Resident #121 around New Years and ordered lab work which looked good with the exception of an abnormal CRP (lab test for assessing inflammation in the body and can aid in diagnosing and monitoring various health conditions) but since Resident #121 had a wound, she was not concerned. NP MMM reported when she saw Resident #121 on 1/8/26, he did not look good and he was not eating, so she ordered that Resident #121 be sent to the hospital. NP MMM reported that she had never been made aware that Resident #121's wound was hot to touch. During an interview on 2/05/2026 at 1:54 PM, F-DON UU reported Resident #121 was admitted to the facility with a wound vac on his sacral wound. F-DON UU reported at one point the facility was questioning the wound care order and trying to figure out if Resident #121 was supposed to go to a wound clinic, but she was not aware of what the facility determined for Resident #121's wound clinic referral. F-DON UU reported that she was aware that nursing staff were reporting that they did not have the supplies to treat Resident #121's wound, but that the facility did have supplies because she had found them, but she was unable to report what date she found the supplies. F-DON UU reported that she had instructed LPN TT to remove Resident #121's wound vac on 12/29/25, because the facility would typically complete a wet to dry dressing until orders were verified by a provider. F-DON UU reported that she did not notify NP MMM about the change in Resident #121's wound condition on 12/29/25, but she thought that LPN TT had. During an interview on 2/05/2026 at 2:19 PM, CSN AAA reported that she had been made aware on 1/9/26 that Resident #121's family had concerns with his care at the facility from NHA A. CSN AAA reported that she had conducted an investigation with NHA A into Resident #121's family concerns. CSN AA reported Resident #121 had been admitted to the facility and she thought that Resident #121 was not admitted with the wound vac on his sacral wound, but that Resident #121 did get a wound vac and was supposed to have the wound vac on. CSN AAA reported a nurse removed the wound vac and notified F- DON UU, who she assumed told the nurse to initiate a wet to dry dressing for Resident #121. CSN AAA confirmed that NP MMM had ordered that Resident #121's wound vac should be placed back on, and she did not want staff completing wet to dry dressing treatments. CSN AAA confirmed that nurses were supposed to notify the provider anytime that they determine a new treatment may be needed, as the wound care treatment order must come from the facility provider. CSN AA confirmed that the facility's nursing documentation did not indicate when or if a provider was notified about the change in Resident #121's wound and how long the wound vac was off for. CSN AA confirmed that there were several missing documented treatments for Resident #121's wounds, and that there was not an order (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for Resident #121's leg wound. CNS AA reported she was unaware that Resident #121 was supposed to follow up with a wound clinic on 1/1/26. During an interview on 2/06/2026 at 8:34 AM, LPN NN reported that she had assessed Resident #121's sacral wound with LPN TT on 12/29/25. LPN NN reported that she recalled LPN TT notifying F-DON UU and NP MMM and being instructed to complete a wet to dry dressing on Resident #121's sacral wound. LPN NN reported Resident #121's wound looked very gray, and there was a very strong odor. LPN NN reported that LPN TT was waiting for new orders from NP MMM for Resident #121's wound, and so she did not replace Resident #121's wound vac. During a follow up interview on 2/06/2026 at 8:54 AM, LPN TT confirmed that she did notify NP MMM on 12/29/25 about Resident #121's wound via text. LPN TT reviewed the text that she sent to NP MMM which indicated that she had concerns with Resident #121's wound, and that she changed his dressing to a wet to dry. NP MMM replied that she had received the text and would be in to look at Resident #121. LPN TT reported that she did not receive any follow up orders from NP MMM and she did not know when or if Resident #121 was seen by NP MMM or if his wound care orders were changed. Review of Resident #121's Care Plan revealed, (Resident #121) potential risk for impaired skin integrity related to: History of fragile skin, current sacral pressure ulcer (localized injuries to the skin and underlying tissue that occur over the sacral (tailbone) area due to prolonged pressure, Poor nutritional intake, impaired functional mobility . Date Initiated: 12/19/2025. Goal: (Resident #121) will show improvement of impaired skin integrity as evidence by no S/S (signs/symptoms) of infection and decreased measurements and/or prevention of avoidable impaired skin integrity will be achieved. Date Initiated: 12/19/2025. Interventions: Admit, quarterly, and prn (as needed) re-evaluation utilizing MDS (Minimum Data Set) based scales, Assess footwear as indicated, Assess postural alignment, weight distribution, sitting balance, & pressure redistribution on admit and prn (as needed), Assist with re-positioning with use of draw sheet as needed to prevent friction/shear, Measure open areas upon admission, weekly, prn, Pressure reducing cushion to wheelchair, Pressure reducing mattress, Re-evaluate treatment and resident condition prn with no improvement to wound appearance and/or measurements. Date Initiated: 12/19/2025. Review of Resident #121's admission assessment dated [DATE] indicated that Resident #121 was admitted with wounds on his right iliac crest (bony ridge at top of your hip bone), left inner ankle, right outer ankle, and sacrum. Noted that the assessment did not include measurements or description of the type of wound for each area. Review of Resident #121's HCP (health care provider) Visit dated 12/22/25 and documented by Nurse Practitioner (NP) MMM revealed, . Assessment and Plan: Infected decubitus ulcer-Continue Augmentin and Bactrim for total of 7 days. Wound vac, follow up with wound clinic .Review of Resident #121's Wound Measurements dated 12/24/25 revealed, .Observations: Right Anterior Leg: Length: 0.5 CM (centimeters). Width: 0.5 CM. Depth: 0.2 CM. Site: Right flank (area between the lower rib cage and top of the hip bone) Length: 0.5 CM. Width: 0.5 CM. Depth: 0.2 CM. Site: Right lateral leg: Length: 0.5 CM. Width: 1 CM. Depth: 1 CM .Site: Right buttock: Length: 6 CM. Width: 3.6 CM. Depth: 1.6 CM. Stage: IV. Site: Sacrum. Length: 8 CM. Width: 4 CM. Depth: 4 CM. Stage: IV . The documentation indicated the wound on Resident #121's Right buttock had Granulation (is reddish connective tissue that forms on the surface of a wound when the wound is healing- firm/red, moist, pebbled healthy tissue and Slough (dead tissue)- dry/or wet, loose or firmly attached, yellow to brown dead tissue present with moderate amounts of Serous- (thin, yellowish fluid) and Sanguineous (bloody fluid). The wound had a presence of odor, and the wound edges were presented as rolled (curled under). Tunneling (a narrow passageway or tunnel extending from the wound, usually in one direction) or undermining (damage that extends beneath the wound edges in multiple directions, creating pockets or shelves beneath the skin) was also noted. Review of Resident #121's Treatment Administration Record (continued on next page)

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(TAR) revealed, Wound Care; Sacrum: Cleanse area with NS (normal saline), Frame wound withtegaderm (type of wound dressing), loosely fill area with black foam, Cover with drape/tegaderm to secure seal. Cut quarter size hole into middle of drape and connect suction pad . Negative Pressure Wound Therapy (NPWT) to: 125mmhg Set vacuum at 125 mmHg Intermittent. Inspect settings and visualize dressing is intact every shift. every day shift. every Mon (Monday), Wed (Wednesday), Fri (Friday). Hold date 12/29/25-12/31/25. Noted that the treatment had not been documented to indicate if the treatment was completed or missed on 12/22/25 and 1/2/26. On 12/26/25 and 12/31/25 the TAR treatment was documented as See progress note. Review of Resident #121's TAR revealed, Wound Care: R (right) buttock with sacrum- cleanse with NS and apply wet to dry Dakins solution (wound cleanser) dressing. Change every day and PRN if dressing becomes soiled or disrupted. Everyday shift for wound management. Discontinue date: 1/10/26. It was noted that the treatment was not documented as completed or missed on 1/2/26. The treatment was documented as completed on 1/1/26, 1/3/26, 1/4/26, 1/5/26 and 1/7/26. Review of Resident #121's TAR revealed, Sodium Hypochlorite External Solution 0.25 % (wound cleanser solution). Apply to affected area topically every day and evening shift for wound. Discontinued: 1/7/26. Noted that this order did not identify which wound this treatment was indicated for.Review of Resident #121's TAR revealed, Wound location: left hip ulcer; cleanse with NS, pat dry with gauze, apply boarder foam dressing every day shift. Discontinued date 12/27/25. Noted that the treatment had not been documented to indicate if the treatment was completed or missed on 12/22/25. On 12/21/25 and 12/25/25 the TAR treatment was documented as See progress note. Review of Resident #121's TAR revealed, Wound location: Right posterior ribs, Open area x2 cleanse with NS, pat dry with gauze, apply boarder form every shift. Noted that it the treatment was not documented as completed or missed on 12/30/25 and see progress note on 12/31/25. Noted that there were no treatments orders for the right ankle or left ankle or right leg in Resident #121's TAR. Review of Resident #121's Progress notes dated 12/21/25 and 12/25/25 revealed Orders: administration note: . Noted that the nurse only documented a . (period) in the progress note and did not indicate why the treatment was missed/held. Review of Resident #121's Progress note dated 12/26/25 revealed, Orders administration record: Awaiting wound vac supplies.Review of Resident #121's Progress Note dated 12/29/25 revealed, This author attempted to change wound vac dressing today. Supplies have not arrived . Review of Resident #121's Progress Note dated 12/29/25 and documented by Licensed Practical Nurse (LPN) TT revealed, LPN attempted to change wound vac dressing. Dressing removed. LPN observed wound down to bone in right buttock wound. Left buttock wound does have some tissue left. Tissue between both wounds is necrotizing. Peri wound is red, hot to touch. DON (Former Director of Nursing) UU aware. Instructed to wet to dry (applying moist gauze to a wound, followed by dry gauze, then allowing it to dry completely and stick to dead tissue so that when it is removed the dead tissue comes with it) and call wound clinic. Wound clinic called, LPN left message on nurse line at (number redacted) for further instruction. Awaiting call back. Family aware . Review of Resident #121's Progress Note dated 12/29/25 and documented by LPN TT revealed, (wound care provider) does not see (Resident #121) for wound vac. LPN left message with Nurse Practitioner (NP) MMM for further instructions. Review of Resident #121's Progress Note dated 12/30/25 revealed, Resident recently declined, NP MMM consulted. labs to be obtained STAT .Review of Resident #121's Progress Note dated 12/30/25 revealed, Treatment completed and resident with little resistance. some drainage noted to old dressing with some odor to it .Review of Resident #121's Wound Measurements dated 12/31/25 revealed, .Observations: Site: Right buttock: Length: 6 CM. Width: 3.6 CM. Depth: 1.3 CM. Stage: IV. Site: Sacrum. Length: 8.3 CM. Width: 3.9 CM. Depth: 2 CM. Stage: IV . The documentation indicated the wound on Resident #121's Right buttock had Granulation (is reddish (continued on next page)

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