

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 01/09/2025
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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>47955</p> <p>Based on interview and record review the facility failed to provide a Skilled Nursing Facility-Advanced Beneficiary Notice of Non-coverage (SNF-ABN) and Notice of Medicare Non-Coverage (NOMNC) to 2 (Resident #26 and Resident #291) of 3 residents reviewed for proper notification related to Medicare A insurance coverage.</p> <p>Findings include:</p> <p>Resident #26</p> <p>Review of an Admission Record revealed Resident #26 had pertinent diagnoses which included: Chronic combined systolic (congestive) and diastolic (congestive) heart failure (increased fluid influences the heart's ability to pump), anxiety disorder, and dementia.</p> <p>Resident #291</p> <p>Review of an Admission Record revealed Resident #291 had pertinent diagnoses which included: spinal stenosis of the cervical region with surgical aftercare (surgical procedure on the neck).</p> <p>On 1/6/2025 at 10:22 AM., during entrance conference, a list of all discharged residents during the past 6 months, from Medicare A insurance coverage was requested from Nursing Home Administrator (NHA) A.</p> <p>On 1/6/2025 at 4:46 PM., NHA A provided an electronic copy of a list of discharged residents from Medicare A insurance coverage during the last 6 months.</p> <p>On 1/7/25 at 11:05 AM., this surveyor requested SNF Beneficiary Protection Notification Review document and all documented discharge information, including SNF-ABN and NOMNC forms for Resident #26 and Resident #291 from NHA A.</p> <p>On 1/7/25 at 9:49 AM., NHA A provided a completed SNF Beneficiary Protection Notification Review document for Resident #26 and Resident #291. NHA A had checked the boxes indicating a SNF-ABN and NOMNC forms were not provided to Resident #26, nor Resident #291 when they discharged from Medicare A insurance coverage.</p> <p>(continued on next page)</p>

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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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/7/25 at 1:22 PM., Financial Services (FS) L reported Resident #26 and Resident #291 both should have received a NOMNC form indicating their coverage by Medicare A was ending. FS L reported she, NHA A, Administrative Assistant (AA) N and the admission coordinator were able to provide SNF-ABN and NOMNC forms to residents who were discharging from Medicare A services. FS L reported the responsibility of providing the forms was the admission coordinator.</p> <p>The position of admission coordinator was currently unfilled.</p> <p>In an interview on 1/7/25 at 1:50 PM., Administrative Assistant (AA) N reported she was in the role of admission coordinator for a time in September and October 2024 and she was unaware that NOMNC forms were to be provided to residents who had a planned discharge. AA N reported she was not in the role when Resident #26 nor Resident #291 were discharged from Medicare A insurance coverage.</p> <p>In an interview on 1/7/25 at 2:15 PM., NHA A reported she was aware no SNF-ABN nor NOMNC forms were provided to Resident #26 and Resident #291 prior to their discharge from Medicare A services.</p> <p>No SNF-ABN or NOMNC forms for Resident #26 and Resident #291 were provided by the time of exit.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on observation, interview and record review, the facility failed to provide consistent, meaningful and person centered activities for 1 (Resident #29) of 2 reviewed for activities provided by the facility, resulting in the potential for loss of interaction, joy, self-esteem, growth, sense of wellbeing, autonomy, connectedness, identity, creativity, independence, pleasure, and comfort.</p> <p>Findings include:</p> <p>Resident #29</p> <p>Review of an Admission Record revealed Resident #29 was originally admitted to the facility on [DATE] with pertinent diagnoses which included persistent vegetative state.</p> <p>Review of Resident #29's Care Plan revealed, Per Social service interview: (Resident #29) . worked in fast food and retail. She enjoys music and church. (Resident #29) is dependent on staff for all activities and needs. Activity staff provide manicures, pedicures, music, church on TV or tablet. Date initiated: 4/9/20. Goal: In room activities of choice which include: Music, manicures, Reading books/magazines to her. Date Initiated: 4/9/20. Interventions: Assist to and from activities of choice as needed. Date Initiated: 4/9/20. Assist with reminiscing items, books and music Date Initiated: 4/9/20. Document and analyze activity preference and changes quarterly and prn (as needed) Date Initiated: 4/9/20. Engage in general conversation, state your name, position and purpose of visit prn. Date Initiated: 4/9/20. Provide assistance with outdoor patio activities weather permitting. Date Initiated: 4/9/20. Record activity attendance and analyze as needed to continue to evaluate a change in need. Date Initiated: 4/9/20.</p> <p>Review of Resident #29's Recreational Pursuits (Initial Assessment) dated 4/9/20 revealed, A. Past Activity Interests: 1. List activities/interests/hobbies the resident participated in: Per Social service interview: (Resident #29) prefers to be called (name redacted). She has 1 daughter and 3 sons. (Resident #29) worked in fast food and retail. She enjoys music and church. 2. Additional comments: (Resident #29) is dependent on staff for all activities and needs. B. Spiritual 1. List any spiritual activities the resident participated in: Church in house as scheduled. 2. Does the resident wish visits by the clergy of choice while in the home? Yes. 3. List the name and contact information: No contact information listed. C. Current activity participation. 1. Does the resident wish to participate in activities while in the home? Yes. 2. Does the resident wish to participate in group activities? yes. 3. Does the resident wish to go on outings? No. 4. Does the resident wish 1:1 with staff? yes. 5. Does resident like independent activities? Unknown. D. Limitations/Special Needs. 1. Activities should be modified to accommodate cognitive deficit? yes. 2. Activities should be modified to address communication deficit? Yes. 3. Activities should be modified to accommodate hearing deficit? no. 4. Activities should be modified to address visual deficit? No. 5. Assistance should be provided to get resident to the activity? yes. 6. If any of the above answered yes, please describe the accommodation that should be made to encourage/promote activity participation: this question was not answered.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #29s Recreational Engagement reports revealed that Resident #29 had participated in 4 activities in the month of October 2024, 3 activities for the month of November 2024 and 3 activities for the month of December 2024.</p> <p>During an observation on 1/6/25 at 10:57 AM, Resident #29 was lying in bed awake. It was noted that Resident #29 did not have any music or television playing. There were no activity staff, or other facility staff in Resident #29's room interacting with Resident #29.</p> <p>During an observation 1/6/25 at 12:40 PM, Resident #29 was lying in bed awake. It was noted that Resident #29 did not have any music or television playing. There were no activity staff, or other facility staff in Resident #29's room interacting with Resident #29.</p> <p>During an observation on 1/7/25 at 1:16 PM, Resident #29 was lying in bed awake. It was noted that Resident #29 did not have any music or television playing. There were no activity staff, or other facility staff in Resident #29's room interacting with Resident #29.</p> <p>During an observation on 1/7/25 at 2:01 PM, Resident #29 was lying in bed awake. It was noted that Resident #29 did not have any music or television playing. There were no activity staff, or other facility staff in Resident #29's room interacting with Resident #29.</p> <p>During an observation on 1/8/25 at 10:24 AM, was lying in bed awake. It was noted that Resident #29 did not have any music or television playing. There were no activity staff, or other facility staff in Resident #29's room interacting with Resident #29.</p> <p>During an interview on 1/7/25 at 1:43 PM, Licensed Practical Nurse (LPN) JJ reported that Resident #29 was mostly bed bound and that facility staff only got Resident #29 up to provide her showers on her shower days. LPN JJ reported that Resident #29 enjoyed being up in her chair, but the activity department would only get her up for activities in the summer. LPN JJ reported that she would occasionally see activity staff come into Resident #29's room to paint her nails and toe nails, but she could not recall how long it had been since she had her nails done by the activity staff. LPN JJ was not able to report why the facility staff were not getting Resident #29 out of bed more often.</p> <p>During an interview on 1/9/25 at 10:09 AM, Certified Nursing Assistant (CNA) UU reported that She only ever saw Resident #29 up in her chair for activities during the summer months, or on her shower days. CNA UU reported that Resident #29 seemed to enjoy being in her geri chair, and she did not know why staff did not get her up more regularly. CNA UU reported that she hardly ever saw activity staff spending 1:1 time with Resident #29, and she mostly just laid in her bed. CNA UU reported that she had witnessed track with her eyes before, and that she felt that Resident #29 was much more coherent than some staff believed. CNA UU reported that she felt like Resident #29 would benefit from more activities.</p> <p>During an interview on 1/8/25 at 10:31 AM, LPN MM reported that Resident #29 was bed bound because she was in a vegetative state. LPN MM reported that she had not witnessed activity staff come to Resident #29's room and do any 1:1 activities with Resident #29.</p> <p>During an interview on 1/9/25 at 11:49 AM, CNA U reported that she did not know why Resident #29 never got out of her bed. CNA U reported that she never witnessed activity staff complete activities with Resident #29.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/8/25 at 12:45 PM, Clinical Care Coordinator (CCC) H reported that facility staff did not get Resident #29 out of bed routinely because positioning was difficult for Resident #29. CCCH was unable to report what type of activities staff were completing with Resident #29, or how often Activity staff were completing activities with Resident #29.</p> <p>During an interview on 1/9/25 at 10:13 AM, Therapy Manager (TM) VV reported that Therapy staff had not made any kind of recommendation for Resident #29 to not be up in her geri chair. TM VV reported that having Resident #29 up in her geri chair would be the appropriate for her. TM VV confirmed that they did not note positioning issues for Resident #29 with her most recent assessment.</p> <p>During an interview on 1/9/25 at 11:34 AM, Director of Nursing (DON) B reported that she did not know why facility staff were not getting Resident #29 up in her geri chair more often. DON B was not aware how often staff were providing activities for Resident #29.</p> <p>During an interview on 1/9/25 at 11:03 AM, Activities Director (AD) C reported that some of the benefits of activities for residents with cognitive deficits included sensory stimulation, improved mood, decreased boredom, feelings of happiness and sense of touch. AD C reported that the expectation was for staff to provide 1:1 visits with residents that did not get out of bed at least once a week for at least 15-20 minutes. AD C reported that she would like to see activities completed more often, but there were times with the expectation had not been met. AD C reported that she had contacted Resident #29's family to determine what kind of activities Resident #29 would enjoy. AD C was not able to confirm what kind of religion Resident #29 practiced, what kind of television shows Resident #29 enjoyed, and what kind music Resident #29 enjoyed, and reported that staff played oldies and summer fun music for her. AD C was not able to report why Resident #29 did not get out of bed.</p> <p>During an interview on 1/9/25 at 10:51 AM, Family Member (FM) RR reported that the facility staff had never reached out to her to determine what kind of activities Resident #29 would benefit from. FM RR reported that Resident #29 enjoyed rap, pop, R and B music. FM RR reported that Resident #29 used to love cooking and watching cooking shows such as Chef [NAME]. FM RR reported that Resident #29 was a very social person, and she felt like she would definitely enjoy being up in her chair and around others. FM RR reported that Resident #29 also loved reading very much and she felt that would very much enjoy having staff read books to her.</p> <p>Despite resident's cognitive status, their activity involvement was significantly related to better scores on care relationship, positive affect, restless tense behaviour, social relations, and having something to do. [NAME] D, de [NAME] J, Willemse B, Twisk J, Pot AM. Activity involvement and quality of life of people at different stages of dementia in long term care facilities. Aging Ment Health. 2016;20(1):100-9. doi: 10.1080/13607863.2015.1049116. Epub 2015 Jun 2. PMID: 26032736.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47659</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, the facility failed to ensure that that QAA (quality assessment and assurance) meetings had the Medical Director as a mandatory attendee at least quarterly resulting in the potential for the Medical Director to not be notified of quality deficiencies occurring in the facility.</p> <p>Findings include:</p> <p>Review of the facility's Quality Assurance Performance Improvement Program policy last revised January 2015 revealed, Policy: With the support of the governing body and administration, it is the policy of this facility, to implement and maintain a Quality Assessment and Performance Improvement Program (QUAPI). QUAPI activities will involve members at all levels of the facilities organization to identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor the effectiveness of actions . 2. Governance and Leadership: a. The Quality Assurance Committee meets a minimum of monthly and is designated as the steering committee to oversee QUAPI and provide opportunity to actively engage the medical director in the process .c. The steering committee will enlist teams of caregivers across all levels and departments of the organization to identify potential concerns, and contribute to root cause analysis and performance improvement plans. And at a minimum will include i. The Administrator ii. The Director of Health Care Services. iii. A physician. iv. At least 3 other members of the facility staff .</p> <p>During an interview on 1/8/25 at 1:37 PM, Nursing Home Administrator (NHA) A reported that the facility did not have a Medical Director attend the QUAPI meetings for April, May, June and August and September 2024. NHA A reported that she was aware that the Medical Director was required to attend at least once per quarter, and that she had attempted to get the former Medical Director to attend on multiple occasions, but he still missed 5 months of attendance including one quarter.</p> <p>The facility was granted a Past Non-Compliance at the time of exit due to the new Medical Director attending QUAPI in 10/2024, 11/2024, and 12/2024, the facility re-educated pertinent staff, the QUAPI policy was reviewed and deemed appropriate, and the facility had achieved sustained compliance. Therefore, no plan of correction will be required.</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included re-educating pertinent staff, reviewing the QUAPI policy, and ensuring that the new Medical Director attends at least one meeting quarterly. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999</p> <p>Based on observation, interview, and record review the facility failed to 1) implement transmission-based precautions for 1 (Resident #35) of 18 residents reviewed for isolation precautions, 2) properly clean and sanitize resident shared equipment and 3) ensure proper use of personal protective equipment (PPE) resulting in the potential for the spread of infection, cross-contamination, and disease transmission for residents residing in the facility.</p> <p>Findings include:</p> <p>Review of CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, published 4/12/24 by the Centers for Disease Control and Prevention revealed: Adherence to infection prevention and control practices is essential to providing safe and high-quality patient care across all settings where healthcare is delivered .core practices include: clean and disinfect .frequently touched surfaces .ensure proper use of personal protective equipment .implement additional precautions (i.e., Transmission-Based Precautions) .</p> <p>1. Transmission Based Precautions</p> <p>Resident #35</p> <p>Review of an Admission Record revealed Resident #35 was originally admitted to the facility on [DATE] with pertinent diagnoses which included need for assistance with personal care.</p> <p>Review of Resident #35's Orders revealed, Enteric Precautions every day for C-DIFF (Clostridium difficle, is a highly contagious germ that can cause diarrhea and inflammation of the colon.) Start date: 12/23/24.</p> <p>During an observation on 1/6/25 at 10:22 AM, Resident #35 was sitting in her room. It was noted that Resident #35's room door did not have any signs indicating that Resident #35 was in isolation precautions. It was also noted that there was not a cart outside of Resident #35's room door with personal protective equipment (PPE) in it for staff to wear when caring for Resident #35.</p> <p>During an observation on 1/6/25 at 10:26 AM, A staff member entered Resident #35's room to take Resident #35 to an activity outside of Resident #35's room. It was noted that the staff member did not don PPE prior to entering Resident #35's room.</p> <p>During an observation on 1/6/25 at 12:06 PM, It was noted that Resident #35 had a sign on her room door that stated Resident #35 was on contact precautions. It was also noted that a cart had been placed outside of Resident #35's room door with PPE for staff.</p> <p>During an interview on 1/6/25 at 12:13 PM, Licensed Practical Nurse (LPN) MM reported that Resident #35 had been on isolation precautions since 12/23/24. LPN MM reported that she did not see that Resident #35 was missing an isolation precautions sign on her door and a cart for PPE outside of her room earlier that morning. LPN MM confirmed that staff were required to don PPE prior to entering Resident #35's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/6/25 at 12:14 PM, Clinical Care Coordinator (CCC) H reported that Resident #35 had been missing a PPE cart and sign for her door earlier that day. CCC H reported that staff had removed the PPE cart and sign in error. CCC H confirmed that staff had not been following isolation precautions for Resident #35 as her room had been missing the sign to indicate she was on isolation precautions and there was not PPE available outside of her room.</p> <p>2. Resident Shared Equipment</p> <p>During an observation on 1/6/25 at 10:27am, 3 mechanical lift devices were stored in the hallway of the 200 hall. Each shared piece of equipment was noted to be soiled with dust and debris on the frames. 2 of the devices had foot platforms where a resident would place their feet while using the device, and the platforms were soiled with dust, debris and particles of food. The padded knee block of one device was soiled with a dried white liquid. The padded hand grip, where a resident places their hands during use, was soiled with a dried white liquid. Each machine had a cannister holder mounted to it, but no cannisters were present.</p> <p>During an observation on 1/6/25 at 10:37am, Certified Nursing Assistant (CNA) S exited a resident room [ROOM NUMBER], with a mechanical lift device, pushed the device into room [ROOM NUMBER] and closed the door. The device was not cleaned between resident use.</p> <p>During an observation on 1/6/25 at 10:42am, CNA S exited room [ROOM NUMBER] with the mechanical lift and returned it to the hallway in the area where it was previously observed. The mechanical lift remained soiled in the same manner as it was previously observed. Resident #43, who had previously been in his bed in room [ROOM NUMBER], exited the room via wheelchair, pushed by an unidentified CNA.</p> <p>In an interview on 1/6/25 at 2:10pm, CNA S reported she was not sure when shared equipment, such as mechanical lifts, should be cleaned. When further queried, CNA S reported the shared equipment used to have cannisters of sanitizing wipes on them, but they no longer did, and she was unsure if sanitizing wipes were available anywhere else. CNA S confirmed she did not sanitize the shared equipment between uses when she transferred residents on this date.</p> <p>In an interview on 1/8/25 at 1:13pm, Infection Preventionist (IP) J reported it was important to sanitize any shared equipment between resident use to reduce the likelihood of cross contamination. IP J reported shared equipment should have cannisters of sanitizing wipes attached to the device and staff should disinfect the device after each use.</p> <p>3. Personal Protective Equipment</p> <p>During an observation on 1/6/25 at 10:26am, a sign posted on the door frame of room [ROOM NUMBER] read: Under observation: face shield, N95, gown, gloves.</p> <p>During an observation on 1/6/25 at 10:32am, Licensed Practical Nurse (LPN) CC entered room [ROOM NUMBER] and wore a surgical mask for personal protective equipment (PPE). LPN CC was observed administering medication to the only resident in the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 1/6/25 at 10:37am, LPN CC reported she entered room [ROOM NUMBER] while only wearing a surgical mask for PPE and that the resident of the room was in isolation due to an exposure to a covid positive individual. When further queried about the type of PPE that was required to enter room [ROOM NUMBER], LPN C confirmed staff were required to wear an N95 mask, gown, gloves, and a face shield in effort to reduce the risk of a possible exposure to the covid 19 virus and accidental spread of the disease. LPN CC stated: You caught me. I forgot.</p> <p>During an observation on 1/6/25 at 11:04 am, Activity Aide (AA) D entered room [ROOM NUMBER] wearing a surgical mask and gloves. AA D exited the room a few minutes later and resumed preparing beverages for residents without performing hand hygiene.</p> <p>In an interview on 1/6/25 at 11:09am, AA D reported the resident in room [ROOM NUMBER] was in observation following an exposure to covid 19. When further queried about the PPE staff should wear when entering room [ROOM NUMBER], AA D reported staff should wear gown, gloves, face shield and N95 mask but stated the PPE guidelines were confusing. AA D confirmed she only wore a surgical mask for PPE when she entered room [ROOM NUMBER].</p> <p>In an interview on 1/8/25 at 1:13pm, Infection Preventionist (IP) J reported staff members should wear gown, gloves, face shield and an N95 mask any time they enter a room that has an observation sign hanging on the door frame. IP J reported the facility placed residents in observation when they had been exposed to another individual who was covid positive. IP J reported staff were instructed to wear full PPE in rooms under observation in effort to reduce their likelihood of also having exposure to the virus and to reduce the potential for spreading it others. IP J confirmed that a resident in room [ROOM NUMBER] was under observation for covid on 1/6/25. When further queried, IP J reported the facility was not moving residents if their roommate had a covid exposure. IP J reported if one resident of a semi-private room had a covid exposure, staff should wear an N95 mask, face shield, gloves, and a gown anytime they enter the room, regardless of which resident they were their to assist. IP J reported all staff should wear a surgical mask that covers their nostrils and mouth while in the hallways or common areas of the facility at this time.</p> <p>During an observation on 1/6/25 at 10:13am, an unidentified staff member was observed walking through the 200 hall with a surgical mask resting below her nostrils.</p> <p>During an observation on 1/6/25 at 2:09pm, an unidentified nurse on the 200 hall was observed wearing a surgical mask with the mask resting below her nostrils.</p> <p>During an observation on 1/9/25 at 8:43am, an unidentified staff member was observed walking through the 200 hall with a surgical mask resting below her nostrils.</p> <p>During an observation on 1/9/25 at 10:09am an unidentified staff member from the housekeeping department was observed walking in the hallway with a surgical mask resting below her nostrils.</p> <p>47659</p> <p>(continued on next page)</p>		

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 01/09/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on 1/6/25 at 12:44 PM, it was noted that a room [ROOM NUMBER] was on isolation precautions for Covid-19 observation. Outside of the room door was a PPE cart and a sign was placed on the door that indicated staff were required to wear a gown, gloves, face shield, and N-95 respirator prior to entering the room. At 12:45 PM, Certified Nursing Assistant (CNA) AA entered room [ROOM NUMBER] without donning any PPE.</p> <p>During an interview on 1/6/25 at 12:55 PM, CNA AA reported that she did not wear any PPE when entering the room. CNA AA reported that she did not know she was suppose to wear PPE prior to entering room [ROOM NUMBER]. CNA AA confirmed that she was aware that room [ROOM NUMBER] was on isolation precautions.</p> <p>During an observation on 1/6/25 at 12:57 PM, It was noted that a room [ROOM NUMBER] was on isolation precautions for Covid-19 observation. Outside of the room door was a PPE cart and a sign was placed on the door that indicated staff were required to wear a gown, gloves, face shield, and N-95 respirator prior to entering the room. At 12:57 PM, Financial Services (FS) L entered room [ROOM NUMBER] without donning PPE. At 1:00 PM, CNA AA entered room [ROOM NUMBER] without first donning PPE.</p> <p>During an observation on 1/9/25 at 9:04 AM, CNA U was noted to be walking down the 100 hall wearing her surgical mask improperly exposing her nose and mouth.</p> <p>During an observation on 1/6/25 at 2:46 PM, CNA GG was walking down the 100 hall wearing her surgical mask improperly exposing her nose and mouth. It was noted that when CNA GG saw this writer she said Oops and pulled her mask up to cover her mouth and nose.</p> <p>During an observation on 1/7/25 at 12:10 PM, CNA GG was walking down the 100 hall wearing her surgical mask improperly exposing her nose and mouth.</p>		

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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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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>46999</p> <p>Based on interview and record review, the facility failed to ensure that a qualified Infection Preventionist worked at least part-time at the facility, was provided sufficient time to perform the Infection Preventionist role, and was present to properly assess, implement, and manage the Infection Prevention and Control Program.</p> <p>Findings include:</p> <p>Review of the facility's Infection Prevention and Control Program with a reference date of 3/2020, revealed: It is the policy of this facility to implement the Infection Prevention and Control Program utilizing a systematic, coordinated and continuous approach guided by OSHA regulations, and pertinent state, federal and local regulations pertaining to infection control. The Infection Prevention Manager has the authority to institute any surveillance, prevention, or control measure indicated.</p> <p>Review of a Facility Assessment with a reference date of 10/23/24 revealed: Evaluation of Infection Prevention and Control Program: .The Infection Preventionist is a dedicated position to the role.</p> <p>In an interview on 1/8/25 at 1:13pm, Infection Preventionist (IP) J reported she was behind on several of her responsibilities including offering covid 19 vaccinations to residents, tracking the use antibiotics for residents, and completing staff fit testing to ensure staff members were using the correct size particulate respirators when they entered isolation rooms. IP J reported approximately 10 residents were eligible and consented to receive the vaccination for a few weeks but she had not had time to complete the necessary steps to provide the vaccinations. IP J confirmed receiving the covid vaccination was very important at this time as the facility was currently experiencing a covid outbreak. IP J reported she had not completed any antibiotic stewardship indicators for the month of January 2025. IP J reported to be effective, monitoring of antibiotic use should be done daily.</p> <p>In an interview on 1/9/25 at 9:17am, IP J reported when she was hired for the role, she was told her time would be solely dedicated to the responsibilities of that role, but more recently was told she would have other duties based on the facility's census. IP J reported she had worked as a floor nurse 9 times in the recent weeks, been on-call 1-3 times per week, and had various other duties that interfered with her ability to maintain the responsibilities of her role as Infection Preventionist.</p> <p>In an interview on 1/9/25 at 11:57am, Nursing Home Administrator (NHA) A confirmed that IP J had worked as a floor nurse several times in recent weeks, that some requirements of the Infection Control program were not in compliance, and the IP J reported she was not able to complete all her responsibilities as the Infection Preventionist.</p> <p>Review of a list of residents waiting for the covid 19 vaccination, provided by the facility, revealed 10 residents were awaiting the covid 19 vaccination.</p>		

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 01/09/2025
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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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>46999</p> <p>Based on interview and record review, the facility failed to ensure COVID-19 immunizations were offered to 10 residents reviewed for COVID-19 immunizations, resulting in an increased risk for infection, and the potential spread of COVID-19 infection to other residents, staff, and visitors.</p> <p>Findings include:</p> <p>Review of the facility's Covid-19 Vaccine Administration policy, with a reference date of May 2023 revealed: It is the policy of this facility to facilitate through partnership with the local health department, consulted pharmacy, and contracted pharmacy to provide the COVID-19 Vaccine according to standards set forth by the Center for Disease Control and Prevention.</p> <p>In an interview on 1/8/25 at 1:13pm, Infection Preventionist (IP) J reported she was behind on several of her responsibilities including offering covid 19 vaccinations to some residents. IP J reported the facility offered a round of covid vaccinations in October 2024, but there had not been follow up for residents who could not receive the vaccination at that time due to the lack of a consent form, or who were admitted after that time. IP J reported approximately 10 residents were eligible and had consented to receive the vaccination, but she had not had time to complete the necessary steps to provide the vaccinations. IP J confirmed receiving the covid vaccination was very important at this time as the facility was currently experiencing a covid outbreak. When further queried about the length of time that had passed since the residents had consented to the vaccination, IP J reported it had been at least a few weeks. IP J reported she had been delayed in ordering the vaccination because she was told she had to order at least 10 doses at a time.</p> <p>In an interview on 1/8/25 at 2:33pm, Pharmacy Representative (PR) TT reported any facility it serviced, including this facility, should stock covid vaccinations onsite. PR TT reported there was no minimum amount of vaccinations the facility could order at one time.</p> <p>In an interview on 1/9/25 at 9:17am, IP J confirmed the facility had not provided the covid 19 vaccination to several residents who had consented to having the vaccination. IP J reported the facility had not provided residents with a covid vaccination in a few months. IP J reported the facility did not have any covid vaccinations available onsite.</p> <p>Review of a list of residents waiting for the covid 19 vaccination, provided by IP J, revealed 10 residents were awaiting the covid 19 vaccination.</p>		