STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain activities of daily living (ADLs) specifically showers for 1 (Resident #5) of 8 sampled residents, resulting in an unkempt appearance and the potential for unmet care need.Findings include:Resident #5Review of an admission Record revealed Resident #5 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: osteomyelitis of the sacral region (an infection of the bone in the sacral- low back upper buttock area of the body), a stage IV pressure wound, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 5/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #5 was cognitively intact.On 6/26/26 at 1:30 pm, Resident #5 was observed positioned on her back in bed a large brown stain was noted on the gown she was wearing and she appeared disheveled and unkept. In an observation and interview on 6/26/26 at 2:44 pm, Resident #5 was lying supine (on her back) in bed, and a large brown stain was noted on the gown she was wearing. Resident #5 reported she spilled her coffee at lunch and no one had changed her yet. When queried, Resident #5 said she was supposed to get showers twice a week on Thursday and Sunday, and she was lucky if she got one a week. Resident #5 reported she loved getting showers, they made her feel so good.In an interview on 6/26/26 at 3:06 pm, Registered Nurse (RN) W reported there was no reason Resident #5 could not get in the shower.In a telephone interview on 6/26/26 at 3:47 pm, Family Member (FM) II reported Resident #5 was not getting showers or baths at the facility and stated She (Resident #5) would love a bath or shower, she was always a ?clean fanatic'. In an interview on 6/26/26 at 4:05 pm, Certified Nurse Assistant (CNA) L reported Resident #5 preferred bed baths and did not like to get in the shower.Review of Task for Resident #5 revealed .Shower assignment Thurs & Sun AM (Thursday and Sunday morning). Documentation for the previous 30 days, 6/4/26 to 6/30/26, of 8 possible shower days, documentation indicated Resident #5 received only 4 showers during that time, and 1 bed bath. 3 additional days were undocumented.In an interview on 6/30/26 at 11:20 am, Licensed Practical Nurse (LPN) T reported Resident #5 had no reason she could not get in the shower. LPN T reported she thought Resident #5 enjoyed getting showers.In an interview on 6/30/26 at 2:37 pm, Infection Preventionist (IP) Q reported Resident #5 had a wound, but that didn't restrict her from getting in the shower.In an interview on 6/30/26 at 3:55 pm, CNA P reported Resident #5 really enjoyed her showers.In a telephone interview on 6/30/26 at 4:37 pm, LPN R reported Resident #5 should have a shower or bath twice a week and there was no reason Resident #5 could not have a shower. LPN R stated .Resident #5 loves her baths, I think it's the highlight of her stay.Request for shower documentation for Resident #5 from admission to present, additionally any refused shower documentation, and none was provided by the facility by the time of survey exit.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. This citation pertains to intakes 3056471 and 3056531.Based on interview and record review facility staff failed to notify a nurse and ensure a post-fall assessment was completed timely for 1 (Resident #6) of 3 residents reviewed for falls resulting in a delay in an assessment following a staff assisted fall and the potential for an injury and/or an increase in pain to go unaddressed. Findings include: Review of Resident #6 (R#6)'s Facility Reported Incident investigation report, dated 6/6/26, indicated R#6 had pertinent diagnoses that included dementia (decline in mental abilities) with other behavioral disturbances, genetic intellectual disability (affects brain development and impacts intelligence, learning, and life skills), and osteoporosis (disease that makes bones weak). R#6's brief interview for mental status score was noted to be .8 indicating moderate cognitive impairment. The report stated, .On June 4th (6/4/26; estimated to be approximately 11:00 AM/lunch time), an assisted event (staff intervened/assisted resident) occurred when resident (R#6)'s right leg gave out while being escorted back to her room from activities.The staff member (Certified Nurse Aide (CNA) D) lowered her safely to the floor without impact but this incident was not reported to nursing at the time.failure to report the initial assisted lowering to the floor.Action (facility's corrective action).Facility-wide education for all departments regarding.Immediate reporting of all incidents/accidents.Reinforcement of expectations regarding timely communication with nursing staff. (Note: If a resident lost his/her balance and would have fallen, if not for another person or didn't catch him/herself, this would be considered a fall). The report indicated, on 6/6/26 at approximately 6 AM, Licensed Practical Nurse (LPN) R was the first nurse to discover R#6 had fell on 6/4/26. Witness Interview statements in the report stated:- .(CNA D).I was assisting resident (R#6) back from activities on 6/4/26 when her right leg gave out from under her.I was able to stop her before her knees hit the ground. I slowly let her down the rest of the way (onto the floor).- .(CNA L).the activity aide (CNA D) asked me to assist (R#6) back to her room. I asked what was wrong. The activity aide said her leg gave out, but she (R#6) didn't hit the floor.- .(LPN R).I came in Saturday morning at 6 AM, 6/6/2026.She (R#6) said my hip is hurt.I assessed her. - .(CNA JJ).observed (R#6) on one knee (one knee on the ground) while passing in the hall during mealtime on June 4th.stated she believed the staff member (CNA D) assisting (R#6) was reporting it to the nurse and had no further knowledge of the incident.Review of R#6's Fall During Staff Assist incident report, started on 6/6/26, stated, .Date: 6/4/2026.(R#6's) right leg gave out while she was ambulating and the Activities (sic) aide (CNA D) assisted (R#6) down to the floor on her knees.No evaluation (post-fall assessment) was performed with this incident by a nurse at this time.Notes.This incident was not reported to nursing.During an interview on 6/30/26 at 11:46 AM, CNA D reported, on 6/4/26 at approximately 11:00 AM, R#6 was walking down the hallway from the activities room to the North dining room, her right leg gave out, she slowly lowered R#6 to the floor, and R#6 came to rest in a kneeling position with her left knee and hand on the floor. CNA D confirmed after the fall she didn't notify a nurse and had not considered it a fall at the time. During a telephone interview on 6/30/26 at 2:44 PM, LPN R reported working the morning of 6/6/26 when R#6 reported right hip pain, completed an assessment, began an investigation, and discovered R#6 was lowered to the floor by staff (CNA D) on 6/4/26. LPN R reported she then immediately called the doctor and R#6 was sent to the hospital. LPN R confirmed she had worked on 6/4/26 but had not been notified that R#6 fell.Review of R#6's hospital record, dated 6/6/2026, stated, .XR (x-ray) Right Hip with Pelvis.Exam Date: 6/6/2026 at 1:34 PM.Indication: GLF (ground level fall), Pain.There is an acute right femoral neck (part of the thigh bone) fracture.Review of the facility's Accident/Incident Report Fall Management policy, revised 6/18, stated, .It is the policy of this facility to complete an accident incident report for.accidents or incidents where there is injury or the potential to result in injury; falls.When witnessing a resident fall.assessment that includes a minimum of the following will be completed by the Licensed Nurse.Full body inspection for any obvious deformity, bleeding, bruising, laceration or other signs of traumatic injury.Assessment for pain.Assessment for.Range of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Motion.Vital signs (measurements of body's basic functions).Evaluation of indication for emergency medical treatment.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included comprehensively assessing the affected resident (R#6), identified and assessed other residents who had the potential to be affected to ensure appropriate interventions/monitoring were in place, reviewed and updated residents' care plans as appropriate, facility-wide all staff education (included, but not limited to, post-fall policy and procedures, required notifications, and required follow up assessments; the education was started on 6/8/26 and completed on 6/19/26), initiated audits of all fall incidents to ensure proper post-fall procedures took place, and would review the audit findings at the facility's quality assurance meeting. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0686 Level of Harm - Actual harm 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 #3045701Based on observation, interview, and record review the facility failed to monitor and prevent the worsening of a pressure ulcer for 1 (Resident #5) and prevent the development of a pressure injury/ulcer in 1 (Resident #7) of 3 residents reviewed for pressure injuries/ulcers resulting in Resident #5 stage IV pressure wound (most severe, deep open wound that extends through the skin, underlying tissue, muscle and bone) worsening, and Resident #7 developing a stage II pressure injury (shallow, wound that affects both top layers of skin, and park of the under layer, appearing red, pink sore or blister).Findings include: Resident #5Review of an admission Record revealed Resident #5 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: osteomyelitis of the sacral region (an infection of the bone in the sacral- low back / upper buttock area of the body), a stage IV pressure wound, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 5/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #5 was cognitively intact.On 6/26/26 at 1:30 pm, Resident #5 was observed positioned on her back in bed. No additional devices were used to assist her positioning. Resident #5 was noted to have a wound vac present; a large brown stain was noted on the gown she was wearing and she was sleeping.Review of admission Assessment for Resident #5 dated 4/28/26 at 17:08 (5:08 pm) revealed .sent to hospital.for sacral wound.here for IV (intravenous) ATB (antibiotic) and wound vac (vacuum- assisted closure; a medical device that uses negative pressure to promote wound healing) to area r/t (related to) osteomyelitis.Review of Care Plan for Resident #5 revealed .Focus: potential risk for impaired skin integrity related to: history of actual impairment admitted with stage 4 to sacrum, NPWT (negative pressure wound therapy) in place.Goal: will show improvement in skin integrity as evidenced by.decreased measurements.Interventions: assess postural alignment, weight distribution.assist with repositioning with use of draw sheet as needed to prevent friction/shear.measure open areas upon admission, weekly, and prn, pressure reducing mattress, re-evaluate treatment and resident condition with no improvement to wound appearance, skin inspections with am/pm (morning and night) care and showers.Focus: skilled nursing care.intervention: bathing one assist, encourage resident to do as much for herself as able, skin care interventions, inspect skin with bathing and care, heels elevate in bed, reposition frequently, as accepted. all with an initiation date of 4/28/26 and 4/29/26.In an observation and interview on 6/26/26 at 2:44 pm, Resident #5 was lying supine (on her back) in bed, and had no additional devices used to assist her positioning or relieve pressure points. Resident #5 was noted to have a wound vac present on the foot of her bed, and an IV ball attached to the PICC (peripherally inserted central catheter; a long tube inserted into a large vein for long term antibiotic administration use) in her right arm. A large brown stain was noted on the gown she was wearing. Resident #5 reported she spilled her coffee at lunch and no one had changed her yet. When queried, Resident #5 said she was unsure if her bed was wet, but denied the coffee being hot when she spilled it. Resident #5 reported the staff didn't move her around too much in bed because of her wound vac. Resident #5 further reported she didn't know too much about the wound vac, but she knew her wound got worse when she first came to the facility and it was now starting to improve. Resident #5 reported the staff had had difficulty managing the wound vac, and at times the way the staff made it stop alarming was by turning it off. Review of Treatment Administration Record (TAR) for Resident #5 for May 2026 revealed .Sacrum: cleanse with wound cleanser, apply skin prep to peri-wound. Protect any exposed bone with contact layer with silver. Fill wound bed with black foam, cover with clear drape, cut small hole and cover with suction disk. Run machine at continuous 125 mmHg (millimeters of mercury) If seal cannot be maintained, cover with NS, moistened gauze and secure with tape daily until NPWT can be reapplied every shift Tues, Thru, Sat. with a start date of 4/30/26.Review of TAR for Resident #5 for May 2026 revealed .Sacrum: cleanse with wound cleanser, apply skin prep to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0686 Level of Harm - Actual harm Residents Affected - Few	peri-wound. Protect any exposed bone with contact layer with silver. Fill wound bed with black foam, cover with clear drape, cut small hole and cover with suction disk. Run machine at continuous 125 mmHg (millimeters of mercury) If seal cannot be maintained, cover with NS, moistened gauze and secure with tape daily until NPWT can be reapplied every shift Mon, Wed, Fri. with a start date of 5/11/26.Review of TAR for Resident #5 for May 2026 revealed 5/9/26 entry was blank, no documentation for wound vac dressing change was noted. In an interview on 6/26/26 at 2:58 pm, Infection Preventionist (IP) Q reported Resident #5's wound was deteriorating. IP Q reported Resident #5's wound vac was to be changed three times a week, and the days were changed when she first arrived at the facility. IP Q reported the order was for Tuesday, Thursday, and Saturday wound vac change and then it was changed to Monday, Wednesday, and Friday, the following week. IP Q reported an outside homecare nurse followed Resident #5 and her wound vac dressing was changed by her once a week, on Monday, and Resident #5 went to the wound clinic once a week, on Tuesday, and they changed the wound vac as well. IP Q reported the facility staff was scheduled only once a week to change Resident #5's wound vac dressing. IP Q reported the facility staff would change Resident #5's wound vac dressing on an as needed basis too.Review of Wound Treatment Clinic notes for Resident #5 dated 5/12/26 revealed .with a sacral pressure ulcer complicated by osteomyelitis status post debridement (removal of damaged tissue from a wound bed) with wound vac. is accompanied by Family Member (FM) II. she is concerned about when the wound will improve.on arrival her caregiver found the VAC unit off with no suction. Duration of disconnection is unknown. She notes fluid collecting on her back and is concerned about possible green drainage.wound bed red; necrotic; yellow/white; pink; slough (dead non-viable tissue).surrounding skin macerated (softening and breakdown of skin caused by prolonged exposure to moisture).length 7.6 cm (centimeters) x width 3.4 cm x depth 2.1 cm.wound vac not reapplied to allow skin to rest.Hold wound vac for 1 week due to skin irritation and malfunction.continue turning and reposition schedule.Review of Resident #5's record revealed no documented turning or repositioning schedule.In a telephone interview on 6/26/26 at 3:47 pm FM II reported he had attended the wound clinic appointment with on 5/12/26 with Resident #5 and reported she had a wound vac that was to be on at all times. FM II reported when Resident #5 arrived at the wound clinic appointment on 5/12/26 the wound vac was powered off, and when the wound clinic staff asked him how long the wound vac had been powered down, FM II stated .I had no answer for them I didn't know. I met Resident #5 at the appointment, and she didn't know how long it had been powered off either. FM II reported he was educated that when a wound vac was in place on a wound, but not suctioning, it could cause more harm to the wound; and it had caused damage to Resident #5's wound. FM II reported the staff at the wound clinic decided to leave the wound vac off due to the surrounding tissue being swollen and red to let the skin rest. FM II reported he attended most wound clinic appointments with Resident #5, and the wound did get worse in the beginning. FM II reported he was not sure the facility was following the orders that were being given by the wound clinic and he had been informed that the facility had run out of supplies for Resident #5's wound dressing change, and on one appointment, the facility did not send the wound vac with Resident #5 to be re-applied to the wound.Review of Resident Assistance Form (facility concern form) for Resident #5 completed via telephone for FM II revealed .5/12 wound clinic appt (appointment) he was present arrived with NPWT device on her but not function.how can we address your issue.please make sure the wound is changed daily per provider orders.Review of Wound Treatment Clinic notes for Resident #5 dated 5/19/26 revealed .wound check.wound bed slough; yellow/white; red; necrotic.surrounding skin dry; excoriated (outer layers of skin have been scraped, scratched, or picked away resulting in abrasions or open wounds).length 7.5 cm x width 5 cm x depth 1.2 cm.chronic large lower limb ulcer with persistent but improving cutaneous candidiasis peri-wound rash (a fungal infection of the skin caused by an over growth of yeast) remained incompletely resolved, so wound vac held. continue daily dressings.maintain current wound regimen.turn and reposition every 2 hours.increase protein intake at least twice daily.In an observation and interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0686 Level of Harm - Actual harm Residents Affected - Few	on 6/26/26 at 4:07 pm, Resident #5 was receiving care. Resident #5 gown was changed by Certified Nurse Assistant (CNA) M and Resident #5 was positioned supine in bed, with no assistive devices for positioning. Resident #5 reported sometimes she was put on her side, but today, she has just been on her back. During 3 observations on 6/26/26 Resident #5 was positioned on her back in bed.In an observation on 6/30/26 at 10:03 am, Resident #5 was positioned on her back in bed, no assistive devices were noted to assist with position maintenance.In an interview on 6/30/26 at 10:14 am, IP Q reported the nurse's responsibility was to change the wound vac dressing as ordered and monitor the wound vac functioning. When queried how that was documented, IP Q reported it wasn't unless the nurse documented it in a progress noted. In an interview on 6/30/26 at 10:50 am, Licensed Practical Nurse (LPN) Y reported she cared for Resident #5 a couple of times, and she did care for her when she went to the wound clinic. LPN Y reported she remembered, Resident #5's wound vac was to be left off on the day she goes to the wound clinic; LPN Y stated they put it on for the week. LPN Y reported Resident #5's wound vac dressing was removed when she had a shower, which she did that day, and the wound vac was beeping, and she had shut it off.In a telephone interview on 6/30/26 at 11:02 am Registered Nurse (RN) W reported the nurses needed to make sure Resident #5's wound vac was patent (working) and functioning and not beeping and that the wound dressing was not saturated. RN W reported there was no order to monitor Resident #5's wound vac, and there was no expected documentation of the wound vac. When queried if she was the assigned nurse when Resident #5 went to the wound clinic on 5/12/26, RN W replied that as LPN Y.In a follow-up interview on 6/30/26 at 12:16 pm, LPN Y reported she had sent Resident #5's wound vac with her to her wound clinic appointment on 5/12/26 so the wound clinic could re-apply the wound vac. LPN Y reported she that she had not done a thing with the wound vac, she did not know if it was running or not. LPN Y reported she hung the wound vac on Resident #5's wheelchair, told the transport driver it was there, and when Resident #5 returned to the facility, the wound vac was still hanging from her wheelchair in the same position. LPN Y reported she documented everything in Resident #5's record in a progress note.In an interview on 6/30/26 at 2:00 pm, Director of Nursing (DON) B and Regional Clinical Support (RCS) C reported their expectations were that Resident #5's wound vac was to be monitored at least each shift, and it should be documented in her record. RCS C confirmed there was no order in place for the monitoring of Resident #5's wound vac and there was no required documentation for monitoring her wound vac. RCS C reported an order had been created to monitor a wound vac and had been added to Resident #5's record.In an interview on 6/30/26 at 2:30 pm, IP Q reported she assisted with getting Resident #5 ready for the wound clinic appointment on 5/12/26 around lunch time and IP Q reported she did not look at Resident #5's wound vac and had no idea if it was functioning or not that day. When queried, IP Q reported Resident #5's wound vac dressing was never to be removed before going to the wound clinic.Review of interdisciplinary Documentation for Resident #5 on 5/12/26 at 5:08 am revealed .continues on wound vac for sacral wound and wound vac is in place and functioning.No further documentation was noted in Resident #5's record for 5/12/26 regarding her wound vac.Further review of Resident #5's progress notes revealed between 4/28/26 and 5/12/26 documentation regarding Resident #5's wound vac was noted 5 times, 4/28/26, 5/4/26, 5/8/26, 5/11/26 and 5/12/26.In an interview on 6/30/26 at 2:55 pm, CNA M and CNA H reported resident should be repositioned or turned every 2 hour or so, if they will allow. CNA H reported there was no place to document if a resident refused to be turned. CNA M reported that they used wedges (triangle shaped pillows) to help a resident maintain their position. On 6/30/26 at 3:00 pm a tour of Resident #5's room revealed a wedge noted on the top shelf of the closet.In a telephone interview on 6/30/26 at 4:37 pm, LPN R reported her responsibility was to monitor Resident #5's wound vac and change the dressing if ordered. When queried, LPN R reported, there was no place to documents the monitoring of her wound vac other than in a progress note.Resident #7 Review of an admission Record revealed Resident #7 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: acquired absence of the right leg above the knee, acquired absence of the left leg (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0686 Level of Harm - Actual harm Residents Affected - Few	above the knee, and progressive multiple sclerosis (a progressive autoimmune disease that affects the central nervous system that results in a range of physical and cognitive symptoms).Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 6/23/26 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #7 was cognitively intact. Section M Skin conditions: indicated Resident #7 had 1 stage II pressure injury that was not present on admission.During observations on 6/26/26 at 1:25 pm, 3:05 pm, and 4:15 pm, and 6/30/26 at 9:45 am, 11:30 am, and 2:55 pm, Resident #7 was positioned supine in bed, with no assistive devices to offload pressure or maintain positioning.Review of a Care Plan for Resident #7 revealed Focus.There is a potential for alteration in comfort: Resident #7 requires assistance with repositioning due to comorbidities. He has no skin breakdown at this time. Assist with repositioning frequently, as tolerated.initiated 6/17/26.Impaired skin integrity related to impaired mobility, dependence for repositioning and transfers, poor nutritional status.decreased ability to relieve pressure independently , as evidenced by stage 2 pressure ulcer to the sacral region developed from excoriation noted at admission.Goal: will show improvement of impaired skin integrity.Interventions: assess postural alignment, weight distribution, sitting balance, and pressure redistribution on admit and prn (as needed) assist with re-positioning with use of draw sheet as needed to prevent friction/shear, pressure recuing mattress. all initiated on 6/17/26 and revised on 6/24/26.Review of admission Assessment for Resident #7 dated 6/16/26 revealed .noted healed sacrum. and the skin section was blank.Review of Skin Assessment dated 6/16/26 revealed .noted excoriation multiple areas on buttock cream applied, some scarring noted to upper back area.Review of Skin Assessment dated 6/17/26 revealed .buttock excoriated.Review of Wound Measurement for Resident #7 dated 6/22/26 revealed .site- rt buttock (right buttock) type pressure length 12 cm x width 12 cm x depth 0 Stage II.Review of Hp skin and wound noted for Resident #7 dated 6/22/26 revealed .the resident has.Stage 2 PU (pressure ulcer) right buttock, and has bene present for less than 30 days.Assessment: location right buttock.present on admission.Review of Interdisciplinary Note for Resident #7 dated 6/24/26 revealed .buttock with MASD (moisture associated skin damage) partial thickness wound noted to right buttock, he has multiple areas of scarring to his sacrum and buttock. Cleft of buttocks with white maceration and without open areal bilateral amputation of LE (lower extremities) .Review of an Order Summary for Resident #7 revealed .Cleanser open area to right buttock with wound cleanser. Apply barrier cream to base of the wound, leave open to air. Complete every shift, every shift for stage II sacrum with a start date of 6/24/26.In an interview on 6/30/26 at 2:30 pm, IP Q reported Resident #7 looked to us at admission that he did not have a pressure injury, was seen by the wound provider a week later and she classified it as a stage II pressure ulcer. IP Q reported Resident #7 was waiting for a specialty mattress to be delivered, and he would be seen by the wound doctor weekly, barrier cream and reposition him frequently would be some interventions. IP Q reported she had not seen Resident #7 out of bed and she did not think he had gotten out of bed at all since he admitted . When queried regarding the meaning of frequently, IP Q replied no set time.In an interview on 6/30/26 at 2:55 pm, CNA M and CNA H reported resident should be repositioned or turned every 2 hour or so, if they will allow. CNA H reported there was no place to document if a resident refused to be turned. CNA M reported that they used wedges to help a resident maintain their position and CNA M entered Resident #7's room and was heard saying I think he has a couple we use. CNA M did not produce any wedges or additional devices for positioning of Resident #7.During an observation of Resident #7's room on 6/30/26 at 2:57 pm, no wedges, additional pillows, or other devices for positioning were noted. Resident #7 was observed supine, on his back, in bed with only a pillow behind his head.In a telephone interview on 6/30/26 at 4:37 pm, LPN R reported that Resident #7 had some excoriation on his bottom and that standards of care were to turn residents every 2 hours. LPN R reported Resident #7's buttock was breaking down due to him being in bed all the time.Review of facility policy Skin at Risk Assessment, Documentation, Staging & Treatment with a revision date of 1/2020 revealed .to assess resident risk factors for the development of impaired skin integrity and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0686 Level of Harm - Actual harm Residents Affected - Few	intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools.to limit the development of avoidable pressure ulcers.the following guidelines are reviewed and implemented as indicated for each individual risk factor: daily skin inspections with am and pm care.limitation of skin injury due to friction or shearing through proper positioning.use of pressure relieving devices.shower twice weekly as accepted and desired and prn including skin inspections.change the residetns positions every 2 hours and more frequently if redness or irritation of the skin develops.assessment of individualized need for pressure redistribution support surfaces.individualize the resident goals and interventions as documented on the plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3045701Based on interview and record review the facility failed to ensure complete and accurate medical records of 3 (Resident #5, Resident #7, and Resident #6) of 8 sampled residents resulting in incomplete and inaccurate documentation and the potential for a diminished medical outcome.Findings include: Resident #5 Review of an admission Record revealed Resident #5 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: osteomyelitis of the sacral region (an infection of the bone in the sacral- low back upper buttock area of the body), a stage IV pressure wound, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 5/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #5 was cognitively intact. Review of Resident #5's medical record revealed no noted order for monitoring her wound vac. Review of Treatment Administration Record (TAR) for Resident #5 for April 2026 revealed .Daily weight x 3 days post admission every day shift for 3 days. Documentation for 4/29/26 and 4/30/26 were blank. Review of TAR for Resident #5 for April 2026 revealed .Lidocaine External Gel 2% Apply to sacrum topically every day shift every Tue, Thu, Sat (Tuesday, Thursday, Saturday) for wound care. 4/30/26 was blank. Review of TAR for Resident #5 for April 2026 revealed .Sacrum: cleanse with wound cleanser, apply skin prep to peri-wound. Protect any exposed bone with contact layer with silver. Fill wound bed with black foam, cover with clear drape, cut small hole and cover with suction disk. Run machine at continuous 125 mmHg (millimeters of mercury) If seal cannot be maintained, cover with NS, moistened gauze and secure with tape daily until NPWT can be reapplied every shift Tues, Thru, Sat. with a start date of 4/30/26.4/30/26 was blank. Review of TAR for Resident #5 for May 2026 revealed .Lidocaine External Gel 2% Apply to sacrum topically every day shift every Tue, Thu, Sat (Tuesday, Thursday, Saturday) for wound care. 5/9/26, 5/22/26, 5/25/26, and 5/27/26 were all blank. Review of TAR for Resident #5 for May 2026 revealed .PICC (peripherally inserted central catheter; a long tube inserted into a large vein for long term antibiotic administration use) Line transparent dressing and needleless connectors changes of every seven days and as needed.5/4/26, 5/11/26, and 5/25/26 were all blank. Review of TAR for Resident #5 for May 2026 revealed .Sacrum: cleanse with wound cleanser, apply hydrofera blue and cover with dry dressing every other day. 5/18/26 was left blank. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of TAR for Resident #5 for May 2026 revealed .Sacrum: cleanse with wound cleanser, apply remedy clinical antifungal ointment (Miconazole 2.0%) and triad (a cream wound dressing designed to adhere to damaged skin) to peri wound (area around wound) apply vashe gel then calcium alginate to wound bed, cover with ABD/bordered foam dressing every day shift. 5/22/26 and 5/27/26 were blank. Review of TAR for Resident #5 for May 2026 revealed .Sacrum: cleanse with wound cleanser, apply skin prep to peri-wound. Protect any exposed bone with contact layer with silver. Fill wound bed with black foam, cover with clear drape, cut small hole and cover with suction disk. Run machine at continuous 125 mmHg (millimeters of mercury) If seal cannot be maintained, cover with NS, moistened gauze and secure with tape daily until NPWT can be reapplied every shift Mon, Wed, Fri. 5/13/26 was blank. In a telephone interview on 6/30/26 at 11:02 am Registered Nurse (RN) W reported blank documentation indicated something wasn't done. RN W reported there was no order to monitor Resident #5's wound vac, and there was no expected documentation of the wound vac. In an interview on 6/30/26 at 2:00 pm, Director of Nursing (DON) B and Regional Clinical Support (RCS) C reported their expectations were that Resident #5's wound vac was to be monitored at least each shift, and it should be documented in her record. RCS C reported documentation should be completed each shift. RCS C confirmed there was no order in place for the monitoring of Resident #5's wound vac and there was no required documentation for monitoring her wound vac. Further review of Resident #5's progress notes revealed between 4/28/26 and 5/12/26 documentation regarding Resident #5's wound vac was noted 5 times, 4/28/26, 5/4/26, 5/8/26, 5/11/26 and 5/12/26. In a telephone interview on 6/30/26 at 4:37 pm, Licensed Practical Nurse (LPN) R reported her responsibility was to monitor Resident #5's wound vac and change the dressing if ordered. When queried, LPN R reported, there was no place to document the monitoring of her wound vac other than in a progress note. Resident #7 Review of an admission Record revealed Resident #7 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: acquired absence of the right leg above the knee, acquired absence of the left leg above the knee, and progressive multiple sclerosis (a progressive autoimmune disease that affects the central nervous system that results in a range of physical and cognitive symptoms). Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 6/23/26 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #7 was cognitively intact. Section M Skin conditions: indicated Resident #7 had 1 stage II pressure injury that was not present on admission. Review of TAR for Resident #7 for June 2026 revealed .Daily weight x 3 days post admission every day shift for 3 days. Documentation for 6/18/26 and 6/19/26 were blank. Review of TAR for Resident #7 for June 2026 revealed .Cleanse open area to right buttock with wound (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235625	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Woods of Bridgman	9935 Red Arrow Hwy Bridgman, MI 49106

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cleanser, apply barrier cream to base of the wound, leave open to air complete every shift. 6/25/26, 6/26/26, and 6/27/26 all had blank documentation. Review of TAR for Resident #7 for June 2026 revealed . Suprapubic cath care, (a catheter inserted directly into the bladder through the skin) every shift, empty foley catheter drainage bag Q (every shift) . Documentation was missing from 6/16/26, 6/17/26, 6/18/26, 6/19/26, 6/24/26, 6/25/26, 6/26/26, and twice on 6/27/26. In an interview on 6/30/26 at 2:00 pm, RCS C reported her expectations were that nurses documented in the resident's medical record to reflect the care given to residents. In a telephone interview on 6/30/26 at 4:37 pm, LPN R reported her responsibility was to document what she completed in the resident's medical records. LPN R reported .if it wasn't documented, it wasn't done. Resident #6 (R#6):Review of R#6's pain care plan, dated 8/26/25, stated, .Focus.(R#6) has a potential for alteration in comfort: swelling with arthritic joints (inflammation or swelling of one or more joints), dementia (decline in mental abilities), cognitive communication deficit (impaired ability to communicate).Interventions.Evaluate the effectiveness of the medication provided.Provide medication as ordered. During an interview on 6/30/26 at 3:20 PM, Licensed Practical Nurse (LPN) Y reported on 6/5/26 at an unknown time, R#6 was walking the halls independently as she normally had done, showed no signs or symptoms of pain, but R#6 informed her she had some pain. LPN Y reported upon further questioning, R#6 was unable to describe the pain or location at that time. LPN Y confirmed she gave R#6 a PRN dose of acetaminophen but forgot to document it in the medication administration record (MAR). Review of R#6's MAR, dated 6/1-6/30/26, stated, .Acetaminophen (medication used to relieve mild to moderate pain) Oral Tablet 500 MG (milligrams) Give 1 tablet by mouth every 4 hours as needed for Pain. The administration record for acetaminophen on 6/5/26 was blank (empty). The sections, Pain Level (numerical pain value; 0 (no pain) - 10 (highest pain level)) and PRN (as needed), were empty which reflected no documentation for pain level, which nurse gave the medication, time of medication administration, or effectiveness.