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	08/20/2025

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision and implement interventions to prevent falls for 2 residents (Resident #1 and Resident #16) of 7 sampled residents reviewed for accidents, resulting in Resident #1 falling and sustaining a pelvic fracture, along with severe pain, and Resident #16 falling and hitting his head during an improper transfer.Findings include: Resident #1 Review of an admission Record revealed Resident #1 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Alzheimer's disease (a progressive disease that primarily affects memory, thinking and behavior). Review of a Minimum Data Set (MDS) assessment for Resident #1 with a reference date of 6/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #1 was severely cognitively impaired. Section E of the MDS revealed Resident #1 exhibited wandering behavior daily during the 14-day assessment period. Section GG revealed Resident #1 required moderate assistance (helper does less than half effort) to safely transfer self from sitting to standing, from bed to wheelchair. Review of a Care Plan for Resident #1 with a reference date of 8/22/24, revealed the focus/goal/interventions of: 1. Focus: altered functional mobility.She is alert and confused.Goal: (Resident #1) is here for convalescent care. Interventions: .Staff to anticipate needs and give physical and verbal cues for tasks.AMBULATION: Non-Ambulatory, BED MOBILITY: Assist of 1.FALL-RISK MANAGEMENT: encourage non-skid footwear, maintain personal items in reach.bed in lowest position. 2. Focus: (Resident #1) is predisposed to.impaired judgement due to diagnosis of dementia. She has a history of attempting independent surface-to-surface transfers.she has a history of repeated falls.may exercise her self determination without realizing that her movements exceed her functional capacity. Goal: (Resident #1) will be free from falls and injury through her next review. Interventions: .review and modify environmental factors as indicated.see ADL (Activities of Daily Living) plan of care for fall risk interventions. In an interview on 8/18/25 at 2:48pm, Family Member (FM) SS reported Resident #1 had suffered a pelvic fracture during a fall at the facility. FM SS reported the resident was not receiving 1:1 supervision on 2/12/25 when she fell and subsequently fractured her pelvis. Review of an Incident Report for Resident #1 with a reference date of 2/12/25 at 2:00am, revealed Resident was observed laying on her right hip. Resident stated, It's broken. Resident sent to hospital.not moved due to severe pain.Staff interview: The nurse providing care to (Resident #1) described (Resident #1) as anxious/restless and agitated.(Resident #1) refused attempts to assist (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her to bed around 8-10pm.at the Nurses station until approximately 1:30am when staff noticed that (Resident #1) was falling asleep.staff assisted her into bed at 1:40am.at approximately 2:00am.heard a bang and immediately went to investigate finding (Resident #1) in the doorway of her room on the floor crying out in pain it's broken.imagining confirmed pelvic fracture as a result of fall.spoke with CNA (Certified Nursing Assistant) who was providing care to (Resident #1).describes (Resident #1's) behavior as abnormal, stating she.was feisty and on a roll.not interested in going to sleep last night.began nodding off.at around 1:45(am) staff assisted (Resident #1) into bed and she reportedly fell shortly after.this writer met with (Resident #1) in her room.(Resident #1) has been experienced (sic) acute pain related to this fracture.treated with oxycodone 10mg (milligrams) every 2 hours as needed.(Resident #1) placed on 1:1 observations at all times as (Resident #1) is impulsive and her ability to have insight into her functional limitations is skewed by her cognitive impairment. In an interview on 8/19/25, at 1:36pm, Registered Nurse (RN) RR reported Resident #1 was restless and very busy throughout the evening of 2/11/25 and into the early morning hours of 2/12/25. RN RR reported she had concerns for Resident #1's safety and tried to supervise Resident #1 by keeping her near the nurse's station, but the resident self-propelled her wheelchair all over the building that night. RN RR reported Resident #1 had no awareness of her own physical limitations and would attempt to stand up and walk without assistance. RN RR reported Resident #1 began to fall asleep while at the nurse's station around 1:40am and staff transferred her to bed. Approximately 15 minutes later, RN RR heard a bang and responded to Resident #1's room, where she found the resident on the floor in severe pain, after a fall. RN RR described Resident #1 as experiencing severe pain as she laid on the floor of her room. When further queried, RN RR reported Resident #1 was not on 1:1 supervision on 2/12/25 and would not have fallen if she'd been on 1:1. RN RR reported providing Resident #1 with 1:1 supervision on 2/12/25 was probably an option but it had not pursued that night. RN RR reported she did not know how the facility determined if a resident needed 1:1 supervision. Review of a Diagnoses List for Resident #1 with a reference date of 2/12/25 revealed fracture of right pubis (break in the right pubic bone which typically causes pain, swelling and difficulty walking), initial encounter for closed fracture (bone break where the skin remains intact. Review of a Resident Visual Observation Assessment for Resident #1 with a reference date of 2/11-2/12/25 revealed the resident was agitated and self-propelling her wheelchair from 10pm-1:30am on this night. In an interview on 8/19/25 at 1:33pm, CNA R reported when Resident #1 was restless and agitated, staff could not turn their back on her for a second because she got up constantly and needed someone right next to her. In an interview on 8/19/25 at 1:38pm, CNA T reported sometimes Resident #1 required 1:1 supervision to remain safe during the night. CNA T reported when Resident #1 was restless, she needed staff to be at her side to keep her safe. In an interview on 8/19/25 at 3:51pm, RN TT reported the nurse responsible for caring for Resident #1 was responsible to assess the resident's needs for supervision. RN TT reported if Resident #1 was restless and agitated during the night, the nurse should call the Director of Nursing (DON) for approval to implement 1:1 supervision. RN TT reported they had called the DON a few times prior to the fall on 2/12/25 to get approval for 1:1 supervision of Resident #1 and each time it had been approved. Review of a Census Report with a reference date of 2/12/25 revealed Resident #1 resided in room (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	[ROOM NUMBER] bed 2 at the time of her fall. During an observation on 8/18/25 at 10:21am, room [ROOM NUMBER] bed 2 was noted to be approximately 40' from the nurses' station. Activity within the room was not viewable from the nurse's station. Review of a 1:1 Supervision Timeline for Resident #1, provided by Nursing Home Administrator (NHA) A revealed 10/16/24 IDT (Interdisciplinary Team) met to review high fall risk residents. (Resident #1) remains at risk for falls. Her most recent fall management assessment revealed a fall risk score of 10. (Resident #1) has a history of falls with injury at the facility. Currently (Resident #1) remains on 1:1 supervision at all times to mitigate risk of injury.11/5/24 (Resident #1) placed on 1:1 supervision last evening due to increased restlessness and exit seeking. (Resident #1) was observed by staff to attempt ambulation from her chair and her bed.she has poor insight into her functional limitations and as such.redirection is not effective in managing (Resident #1's) risk for falls.1/13/25 1:1 supervision 8am-8pm. Review of all fall incident reports for Resident #1 from 9/25/24-8/20/25, revealed the resident fell on 9/25/24 at 2:30am, on 10/2/24 at 4:06am, and on 2/12/25 at 2:00am. Each fall occurred during early morning hours, prior to 8am when Resident #1 was scheduled to have 1:1 supervision. In an interview on 8/19/25 at 2:28pm, Clinical Support Nurse (CSN) LL reported the provision of 1:1 supervision for a resident was not reflected in the physician orders but would be reflected in a resident's plan of care. CSN LL confirmed she would provide the facility's rationale and clinical process for the provision and discontinuation of 1:1 supervision for Resident #1. Documentation of the clinical process for 1:1 implementation and discontinuation was not provided by the conclusion of the survey. In an interview on 8/20/25 at 9:38am, Clinical Psychologist (CP) KK reported she used her expertise to assess resident needs for effective behavior management but was not consistently involved in the decision-making process for the provision of 1:1 supervision for Resident #1. CP KK confirmed she regularly assessed and monitored Resident #1's behavioral care needs. CP KK reported Resident #1 was very impulsive and unsafe and could not remain seated more than 90 seconds at a time when she was agitated. In an email on 8/20/25 at 10:34am, NHA A reported the facility did not provide staff with any training specifically related to the provision of 1:1 resident supervision. In an interview on 8/20/25 at 1:41pm, NHA A reported the facility did not have a policy related to the provision of 1:1 supervision for residents. When queried regarding the rationale for the use/discontinuation of 1:1 supervision for Resident #1, NHA A reported he thought the facility may have provided 1:1 supervision due to her exit-seeking behaviors, rather than her fall risk. NHA A reported he provided all the documentation available regarding the clinical process for the provision/discontinuation of 1:1 supervision for Resident #1. Resident #16: Review of an admission Record revealed Resident #16 was a male with pertinent diagnoses which included muscle weakness, and cognitive communication deficit (communication impairment stemming from difficulties with thinking processes like attention, memory, and reasoning, and problem (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	solving). Review of Care Plan for Resident #16 initiated on 4/17/25, revealed the focus, .Altered functional mobility and ADL's (activities of daily living) related to:. with the intervention .Dependent for ADL's.AMBULATION: Non-Ambulatory.Bed Mobility: assist of two. Review of Incident Report dated 4/19/25 at 12:00 PM, revealed, .Nursing Description: Informed by the CNA that while she was transferring the resident by herself because was not care plan available. CNA, was ready to transfer the resident into his wheelchair, the resident could not stand long enough to transfer, and CNA assisted the resident to the floor. He did bump his head on the floor, blister and bruise noted on the L (left)/side of the resident's eye.Immediate Action Taken: The resident moved upper extremities, and he is stiff on his legs, he stated to hit his head on the floor but he denies pain at this time. Transferred the resident to his wheelchair using the hoyer lift machine.Intervention: Reeducated staff to follow care plan, if one is not present, have nurse print one PRIOR to transferring.Notes: Hx (history) of osteoarthritis, cognitive communication deficit and a history of falls.(Resident #3) is non-ambulatory, requires max assistance for ADLs (activities of daily living) including bathing, transfers, and bed mobility.A quarter size bruise is noted to the left of (Resident #3's) eye.Root Cause: (Resident #3's) care plan was not followed by staff. As a result, education was provided to the staff members involved in his care. The nurse spoke with the CNA prior to this incident and asked her to wait to provide care for him until the nurse could evaluate him for his care plan needs. The CNA did not wait stating that she felt she could transfer him with one assist. (Resident #3) is care planned for a max assist 2-person transfer.Immediate Action: Staff education was completed and (Resident #3's) care plan was updated and placed in his closet by his nurse. Review of Interdisciplinary Documentation dated 4/19/2025 at 1:18 PM, revealed, .Informed by the CNA (Certified Nursing Assistant) that while she was transferring the resident by herself because was not care plan available. CNA was ready to transfer the resident into his wheelchair, the resident could not stand long enough to transfer, and CNA assisted the resident to the floor. He did bump his head on the floor, blister and bruise noted on the L (left)/side of the resident's eye.The resident is on blood thinners and NP (Nurse Practitioner) is aware, but she said not to send the resident to the hospital, just monitor for changes. In an interview on 08/19/2025 3:20 PM, Certified Nursing Assistant (CNA) M reported the nurse wanted her to get Resident #16's weight. CNA M reported she looked in the closet and there was no care plan guide there for her to refer to for his transport needs. When queried, CNA M reported there was nothing in the medical record she was able to observe for his transfer status. CNA M reported she asked Resident #16 if he was able to stand and he indicated he was able to stand. CNA M explained she had the wheelchair on the side of the bed, and he would only need to stand at the side of the bed and pivot to be seated in the wheelchair. CNA M reported Resident #16 was unable to stand and he went down onto the floor. In an interview on 08/19/2025 at 12:49 PM, Licensed Practical Nurse (LPN) D reported the care plan was usually in the closet for the CNAs to reference. Resident #16 was a new admit and his care plan was not in the closet. LPN D reported CNA M was informed not to transfer the resident if they were unsure of a resident's transfer status until she had spoken to the nurse as the incident created a safety issue for Resident #16 and he could have been hurt badly. Review of Fall Management assessment completed on 4/16/25 at 7:30 PM, revealed, .Balance: Not able to attempt without physical support .Resident presented to facility in wheelchair and told staff (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that he could not walk or stand. When staff insisted that he tried, resident and wife were stern that patient could not do it. Nurse used sit to stand to transfer patient from wheelchair to bed.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 1210578.Based on interview and record review, the facility failed to provide care and services to promote dignity and respect in 4 of 5 residents (Resident #31, #3, #17, #16) reviewed for dignity/respect, and 7 of 12 residents from the confidential group meeting, resulting in the potential for unmet care needs and feelings of diminished self-worth, sadness, and frustration.Findings include:Resident #31 Review of an “admission Record” revealed Resident #31 was a male, with pertinent diagnoses which included: need for assistance with personal care; major depressive disorder, recurrent severe without psychotic features; difficulty walking, not elsewhere classified; and muscle weakness (generalized). Review of a Minimum Data Set (MDS) assessment for Resident #31, with a reference date of 6/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #31 was cognitively intact. Further review of said MDS revealed Resident #31 was “always incontinent of bowel and bladder” and required “substantial/maximal assistance” (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.) for “toileting hygiene” (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement…) In an interview on 8/18/25 at 2:10 PM Resident #31 reported call light wait time was at least a half hour and sometimes the wait had been up to 2-3 hours. Resident #31 reported he has had to wait extended periods for staff to change his brief after having a bowel movement and “it is uncomfortable to say the least.” In an interview on 8/19/25 at 11:59 AM, “Licensed Practical Nurse” (LPN) “D” reported residents have complained to her about long call light wait times. In an interview on 8/20/25 at 9:01 AM, “Certified Nurse Aide” (CNA) “X” reported residents complained to her about long call light wait times. In an interview on 8/20/25 at 9:02 AM, CNA “FF” reported residents sometimes complained about long call light wait times. According to https://journals.lww.com/ regarding call light use, “It is one of the few means by which patients can exercise control over their care on the unit. When patients use the call light, it is usually to summon the nurse…Patients expect that when they push the call light button, a nursing staff member will answer or come to them.” Resident #3: Review of an admission Record revealed Resident #3 was a female with pertinent diagnoses which included paralysis affecting right dominant side, need for assistance with personal care, weakness, and difficulty in walking. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/18/2025 at 12:11 PM, Resident #3 reported “things haven’t changed.” Resident #3 reported over the weekend she had to wait from 6:15 PM to 8:00 PM for them to come and answer the call light. Resident #3 reported she knew the times because the long call light waits happened “quite a bit” and she wanted to make sure she had the time down on how long it took Resident #17: Review of an admission Record revealed Resident #17 was a male with pertinent diagnoses which included paraplegia (affects all or part of the trunk area, legs, and pelvic organs), and need for assistance with personal care. In an interview on 08/18/2025 at 3:59 PM, Resident #17 reported he had concerns with call lights times being usually 45 minutes to an hour. Resident #17 reported he had the most issues with his call light being answered during the evening and nighttime shifts. Resident #17 reported at night the staff were not emptying his urinal. Resident #17 reported a few nights ago the urinal was not emptied from 10:00 PM until 4:30 AM and it was full. Resident #17 reported he had [NAME] his concerns with call light wait times to the previous two nursing home administrators and he felt they tried to placate him and nothing changed. Resident #16: Review of an admission Record revealed Resident #16 was a male with pertinent diagnoses which included muscle weakness, and cognitive communication deficit (communication impairment stemming from difficulties with thinking processes like attention, memory, and reasoning, and problem solving). In an interview on 08/18/2025 at 1:45 PM, Family Member (FM) “OO” reported waiting long periods of time for call lights to be answered and when staff do respond, the staff would turn off the call light prior to completing the request. FM “OO” reported sometimes the staff would forget to come back. FM “OO” reported the call light had been turned on at 1:20 PM today, the CNA came in and turned it off and reported she would be back with someone to assist. FM “OO” reported Resident #16 had a bowel movement and had been sitting in it since then (25 minutes upon my entry to the room, no staff entered the room when this writer was present approximately 10 minutes). FM “Betty” expressed worry the staff would return as the door was closed and she wanted to ensure Resident #3 would get his brief changed. In an interview on 08/20/2025 at 1:57 PM, Certified Nursing Assistant (CNA) K reported she attempted to answer the call light as soon as possible. CNA K reported if unable to complete the requested task she would tell the resident she would return to assist them. CNA K reported she does turn off the light but does return to the resident as soon as she was able to. u In an interview on 08/20/2025 at 2:01 PM, [NAME] President of Clinical Services JJ reported the staff were educated during orientation to leave the light on until the need was met. Review of “Call Lights” received on 08/20/25 from employee orientation, revealed, “…Response to Call Lights: If you see an activated red light in the hall, you are expected to answer the call light…Assist with the need if it is within your scope or to advise the resident you will get assistance, do not turn off the call light unless you have met the resident’s need…”

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to employ an Activity Director with the required qualifications resulting in the potential for unmet met psychosocial needs, feelings of boredom and a lack of person-centered activities. This citation has the potential to impact the residents who choose to participate in structured activities and/or are dependent for their leisure needs.Findings include:Review of certification standards of the National Certification Council for Activity Professionals revealed ADC (Activity Director Certified) Certification ensures an individual has the knowledge and skills to lead and direct an activities and life enrichment department. ADC Certification validates the competencies necessary to be an Activity Director including leadership, management, advocacy, care planning and documentation.Review of Leisure engagement in older adults is related to objective and subjective experiences in aging, [NAME] K. Bone, Feifei Bu, [NAME] K. Sonke, [NAME] Fancourt (2024), revealed Leisure engagement has potential to slow health and functional decline in older age.there is extensive evidence linking leisure engagement to physical and mental health across the life course.Older adults should be supported and encouraged to incorporate physical and creative activities into their everyday lives.In an interview on 08/18/2025 at 11:43am, NHA A stated The Activities Director is working on her certification. She is about 30-40% completed (with the required training). I do not know how much experience she has.In an interview on 8/20/25 at 2:22pm, Activity Director (AD) P reported she was enrolled but had not completed an Activities Director training course and did not have 2 years' experience in social or recreational programming. AD P reported she had worked at the facility for a little over a year and had completed about 30% of an activity professional certification course. AD P reported she struggled to provide activities that would meet the needs of residents with severe cognitive impairments and often found those residents could not focus on the group activities that were being provided. When further queried, AD P reported she was not supervised by a qualified Activities Director at this time and felt she needed support and guidance to ensure the residents were provided with activities that met their needs.Review of the facility's Activity Calendars with reference dates of 6/2025, 7/2025 and 8/2025, revealed no activity opportunities in the evenings, no structured opportunities to participate in physical activity 2-3 times per week, and no specialized programs for residents with severe cognitive impairments.Review of the facility's Activities Director Job Description, with no reference date, revealed Qualifications.Those who don't currently have a certification, must, at a minimum, begin an Activity Professional Certification Course within 90 days of employment and be certified within 12 months of employment.primary functions and responsibilities of this position are as follows: 1. Plan, schedule and implement a program of individual and group activities based on residents' schedule, needs and desires.5. Identify and document in the resident's care plan, the activity interests and needs.11. Plan and implement evening functions.29. Review the activity plan.for residents with little or no activity.determine if there is a problem or concern that can be resolved, improved or addressed.to improve the resident's Quality of Life.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate infection control practices that included 1.) proper hand hygiene during medication administration for 4 (R27, R6, R52, and R3) residents observed during medication administration, 2.) resident-shared equipment not being cleaned prior to use for 1 (R6) of 18 residents and, 3.) adequate Enhanced Barrier Precautions (EBP) for 2 (R3, R5) of 2 residents observed for infection control practices, resulting in the potential of cross-contamination and the harborage of pathogens leading to infection among a vulnerable population.Findings include: R27 According to R27's Minimum Date Set (MDS) dated [DATE], diagnoses included coronary artery disease, hypertension, Alzheimer's disease, dementia, anxiety disorder, and depression. During an observation, interview, and record review on 8/20/2025 at 7:05 AM with Registered Nurse (RN) L at the South Medication cart, a small clear plastic cup held multiple pills, tablets, and capsules was in the cart's top drawer. RN L poured the medications out of the cup onto a piece of paper that had numbers written on it. RN L, using her bare hands counted 15 various types of medications and put them back into the cup then went to R27's room to administer them. R6 According to R6's Diagnoses, the resident had methicillin susceptible staphylococcus aureus infection, intraspinal abscess and granuloma, and other bacterial agents as the cause of diseases classified elsewhere. During an observation and interview on 8/20/25 at 7:18 AM, RN L was removing R6's medications from their packages with her bare hands and placing them into a medication cup. After all medications were prepared, RN L administered them to R6. R6 stated, I found out recently I am receiving an antibiotic to keep me clean, so I don't catch anything. RN L reported the resident had been ill with some type of respiratory infection. R52 According to R52's MDS dated [DATE], R52 diagnoses included cancer, heart failure, diabetes mellitus, hyperlipidemia, thyroid disorder, arthritis, anxiety disorder, depression, and chronic lung disease. During an observation on 8/20/2025 at 7:32 AM, RN L was removing R52's medications from their packages with her bare hands and placing them into a medication cup. After all the medications were prepared, RN L administered them to R52. R3 According to R3's MDS dated [DATE], diagnoses included coronary artery disease, heart failure, hypertension, diabetes mellitus, stroke, hemiplegia, and depression. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/20/2025 at 8:02 AM, RN L was removing R3's medications from their packages with her bare hands and placing them into a medication cup. After all the medications were prepared, RN L administered the medications to R3. RN L stated, I used hand sanitizer before I touched each pill so I should be able to use my bare hands. Resident-Shared Equipment During an observation on 8/20/2025 at 7:05 AM Registered Nurse (RN) L took R27's blood pressure using a blood pressure cuff and checked level of oxygen using a pulse oximeter then placed both into a resident-shared equipment basket for storage. Neither piece of resident-shared equipment was cleaned after use. One other blood pressure cuff was in the basket and the cuff used on R27 was placed on top of it after use. No disinfecting wipes were seen on the cart. During an interview on 8/20/2025 at 10:50 AM Corporate Infection Control (IC) JJ stated, For infection control prevention, resident-shared equipment should be cleaned between each resident. (Name of disinfectant) wipes are kept on each piece of equipment or cart that is used regularly on rotation with residents. Bare hands should not be used to take pills out of their package for infection control purposes either. Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or o Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 . Resident #3: Review of an admission Record revealed Resident #3 was a female with pertinent diagnoses which included diabetes, paralysis affecting right dominant side, difficulty in walking, weakness, joint inflammation, and need for assistance with personal care. During an observation and interview on 08/18/2025 at 12:11 PM, Resident #3 was observed lying in her bed, she was dressed, she had on non-slip socks. Resident #3 reported the provider came in on Monday last week (8/11/25) and Resident #3 reported she informed them of the wound on her right heel. Resident #3 reported the wound provider came on Friday (8/15/25) and she had debrided the wound. Resident #3 reported she had asked the nurse multiple times on Saturday (8/16/25) about changing her dressing but she never got it changed until 4:00 PM and then it was not done again. Resident #3 reported she had only one dressing change on Saturday, it was freshly debrided wound (removed damaged tissue) and Resident #3 reported how important it was for her to get her dressing changes. Resident #3 reported she had only one dressing change on Sunday as well. Resident #3 reported she had asked about a dressing change around 10:00 AM on Sunday and it was not done until 6:00 PM. Resident #3 reported she had asked the nurse today prior to her shower at 09:30 AM and the dressing still had not been changed. Review of HCP Visit dated 8/11/25 at 11:56 AM, revealed, .Report of new wound to her R (right) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ankle.R medial (middle) ankle wound discussed with nursing staff.wound specialist to be seen this week. Recommend Medi-honey application daily until evaluation. Review of the order for the dressing change dated 8/15/25 revealed the dressing was to be changed during the day (6 AM to 2 PM) and evening shifts (2 PM to 10PM). During an observation on 08/19/2025 at 2:03 PM, Resident #3 did not have an enhanced barrier precautions (EBP) sign on the wall or door to her room to indicate she had a diagnosis which required the staff to utilize personal protective equipment (PPE) during high contact resident care, such as showering, transferring, wound dressing changes, etc. Resident #5: Review of an admission Record revealed Resident #5 was a male with pertinent diagnoses which included dementia, paralysis left side and right side, stroke, and tube feeding. During an observation on 08/18/2025 11:14 AM Resident #5 was observed in his room seated in his wheelchair, he had a gown on still, enhanced barrier precautions (EBP) sign on the door to his room. During an observation and interview on 08/18/2025 at 2:03 PM, Resident #5's Family Member (FM) UU reported his water flush was leaking over his brief and down the front of him. CNAs BB and U entered the room donned with gloves and no gowns to assist in preparing Resident #5 to be transferred to his bed for a brief change and clothing change. Resident #5 was coughing up his phlegm and the wife suctioned him . CNA R entered the room and she did not don a gown only gloves. LPN E ensured the resident's flush and tube feeding tubes were capped off at the juncture. LPN E was observed to not have gloves or a gown on as well as had approximately 2 inches long painted fake fingernails. LPN E removed the bags of tube feeding and the fluid and disposed of them. Resident #5's left leg was up and straight out, supported on his foot pedals, which had padding on each side of his lower leg and foot area. LPN E lowered his wheelchair left leg footrest. CNA BB and CNA R hooked him up to the back side of the hoyer and CNA U hooked him up to the front side, slowly raised him up to lower him to the bed, he cried out and resident replied he was a little stiff. CNA U removed his call light and oxygen prior to transferring him to his bed. Resident #5 was slowly lowered to the bed, his body was unparallel to the bed and had to be adjusted as he was slowly lowered to the mattress. CNA U assisted his head and neck to the pillow, CNA R supported his legs. In an interview 08/20/2025 at 2:13 PM, CNA R reported the EBP sign on the door indicated the staff would wear a gown and mask when hands on care were provided to the resident. In an interview on 08/20/2025 at 2:16 PM, CNA G reported EBP were used when providing hands on care to a resident. CNA G reported if I went into the room to give him his lunch or bring him water, PPE was not required. CNA G reported if he were to raise him up in the bed or transfer him he would have to don PPE. In an interview on 08/20/2025 at 9:43 AM, Corporate Infection Preventionist (CIFP) JJ reported if a resident had a chronic wound the resident would be placed on EBP but if it was a small shearing or superficial the resident would not be placed on EBP. CIFP JJ reported typically a resident was placed on EBP when a pressure ulcer or ulcer wound was discovered. CIFP JJ reported Resident #3 should have been placed on EBP on 8/11/25 when the ulcer was discovered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/2025 at 9:53 AM, CIFP JJ reported when direct contact care was to take place, a gown and gloves would be donned prior to providing care. CIFP JJ reported the last time staff was educated on EBP was in July 2025.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living.Findings Include:On 8/18/25 at 10:59 AM, observation of the kitchen hand sink, near the dish machine area, found that the soap and the paper towel dispenser for the hand sink are on the opposite wall as the hand sink. Further observation found the paper towel dispenser over an area used for drying clean pots, pans, and utensils.On 8/18/25 at 1:25 PM, An interview with Maintenance Director (MD) I found that the facility is in good repair, however there are a few roof leaks that pop up when the rain gets heavy. MD I has been bidding out the repairs to get them complete, but they have not been finalized and no timeline for the complete repairs have been set. On 8/18/25 at 1:47 PM, Observation of the Clean Utility storage found clean and sanitary items stored on the floor. When asked how items get on the floor. The MD I stated that staff get in a hurry and end up dropping items as they grab what they need. On 8/18/25 at 1:50 PM, Observation of the South Hall spa room found an accumulation of debris under the mat of the shower bed. Further review found what looked like flakes of skin, with paper and plastic debris. An interview with MD I found that staff do not use the shower bed often.On 8/18/25 at 2:15 PM, Observation the East Hall Clean linen room found items stored on the floor, MD I stated the room would get cleaned nightly. On 8/18/25 at 2:35 PM, Observation of the Mechanical Room door, in the boiler room, found a gap underneath the door that would allow for pest entry. On 8/19/25 at 9:45 AM, A revisit to both Spa rooms on the South Hall found clean and sanitary linens and briefs stored on the short shower wall that separates the shower and the sink area, leaving them open and exposed to contamination. On 8/19/25 at 9:47 AM, observation of the hall near resident room [ROOM NUMBER], found a large trash container in the middle of the hall catching dripping water from the ceiling. Further observation found multiple tiles wet with a few tiles that had started falling apart due to excess moisture. On 8/19/25 at 10:55 AM, observation of the love seat near the courtyard entrance found an increased accumulation of debris and trash under the cushions. A dirty folded up dollar bill, a used band-aid, and a dirty wadded up Kleenex was among the dirt debris. On 8/19/25 at 11:00 AM, observation of the Spa room on the North Hall found clean and sanitary linens stored on the half shower wall, leaving them open and exposed for contamination. On 8/19/25 at 11:05 AM, Observation of the double doors used for deliveries and a employee entrance, found a visible gap and space where the doors meet at the bottom middle, allowing pests to freely enter the building.On 8/19/25 at 11:31 AM, An interview with MD I found that with all the heavy rain last night he has been attending to the roof leaks that have been occurring and trying his best to stay on top of them while waiting for needed repairs. MD I stated he was able to get the leak to stop near resident room [ROOM NUMBER], but it will still need a solid repair to last.On 8/19/25 at 1:55 PM, Observation of the therapy room found that the parallel bars were loose in the brackets that bring the bars closer together or further apart. The surveyor was able to move them back and forth with no way to steadily hold them in place. An interview with Therapy Program Manager NN found that staff and residents generally just use the outside of the bar, but that the screws holding the bars width from each other are stripped and do not tighten well. Further review of therapy equipment found that the right pedal of the arm bike slowly comes off as residents use it and staff must keep trying to retighten the pedal so that residents can use it properly over the course of the day.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASARR) Level II Exemption Form 3878 (Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification Level II Screening) was completed timely for 1 resident (Resident #2) of 3 residents reviewed for PASARR, resulting in the lack of the local Community Mental Health Services Program (CMHSP) to have a complete picture of the resident status.Findings include:Resident #2Review of an admission Record revealed Resident #2 was a female, with pertinent diagnoses which included: unspecified dementia (a group of symptoms that affect memory, thinking, and problem solving that interfere with daily life), unspecified severity, with other behavioral disturbance; major depressive disorder, recurrent, unspecified; delusional disorders; and generalized anxiety disorder.Review of Resident #2's Preadmission Screening (PAS)/Annual Resident Review (ARR) Level I Screening form dated 1/31/25 revealed, .Section II Screening Criteria.1. X Yes The person has a current diagnoses of X Mental Illness or X Dementia 2. X Yes The person has received treatment for X Mental Illness or X Dementia 3. X Yes The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.DISTRIBUTION: If any answer to items 1 - 6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested.A review of Resident #2's medical record on 8/19/25 at 10:13 AM revealed no form DCH-3878 exemption was found.In an interview on 8/20/25 at 8:41 AM, [NAME] President of Clinical Services (VPCS) JJ was requested to provide evidence that a Level II Exemption Form 3878 was completed for Resident #2.In an interview on 8/20/25 at 1:36 PM, VPCS JJ reported the Level II Exemption Form 3878 was not completed by the physician when it was due because the form hadn't pulled over in the computer for him to sign it at that time. VPCS JJ reported it was the responsibility of the Social Worker to make sure the correct forms were in place. VPCS JJ reported she did not know what happened with Resident #2's form. VPCS JJ reported Resident #2's Level II Exemption Form 3878 was completed on 8/20/25.The Social Worker was not available for interview during the survey period of 8/18/25 - 8/20/25.

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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. Based on observation, interview, and record review the facility failed to provide ADL (activities of daily living) care, to include nail care, to a dependent resident in 1 (Resident #36) of 4 residents reviewed for ADL care, resulting in the potential for Resident #36 to experience feelings of embarrassment and diminished self-esteem.Findings include:Resident #36Review of an admission Record revealed Resident #36 was a male, with pertinent diagnoses which included: spastic quadriplegic cerebral palsy (a severe form of cerebral palsy, a movement disorder, that affects movement in all limbs) and unspecified intellectual disabilities.Review of a Minimum Data Set (MDS) assessment for Resident #36, with a reference date of 6/10/25 revealed a Staff Assessment for Mental Status indicating Resident #36 had a problem with both short-term and long-term memory. Further review of said MDS revealed Resident #36 was dependent on staff for Shower/Bathe self (The ability to bathe self, including washing, rinsing, and drying self.), and Personal hygiene (The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands.)Review of Resident #36's Care Plan revealed a focus of (Resident #36) has altered functional mobility and ADL's related to: he (sic) diagnosis of Spastic Cerebral Palsy.He can be combative with care and has episodes of restlessness and agitation and has hx (history) of placing hands in brief when incontinent. with care planned interventions which included ADL's: Dependent for ADL's with a date initiated of 2/17/22.During an observation on 8/18/25 at 11:26 AM, noted Resident #36 was seated in his room in his specialized wheelchair. Resident #36's fingernails, specifically the thumb and index finger on the right hand, were caked with a black substance underneath the nails.During an observation on 8/19/25 at 8:26 AM, Resident #36 was seated in his specialized wheelchair across from the nurses' station. Resident #36's fingernails, specifically the thumb and index finger on the right hand, remained caked with a black substance underneath the nails.During an observation and interview on 8/19/25 at 3:00 PM, Licensed Practical Nurse (LPN) D observed Resident #36's fingernails with this surveyor. LPN D confirmed that Resident #36's fingernails, specifically the thumb and index finger on the right hand, were caked with a black substance underneath the nails.During an observation and interview on 8/20/25 at 8:58 AM, LPN D observed Resident #36's fingernails with this surveyor. LPN D confirmed that Resident #36's fingernails, specifically the thumb and index finger on the right hand, were caked with a black substance underneath the nails. LPN D reported it was embarrassing to her that Resident #36's nails were still dirty.Review of Resident #36's Shower Assignment Task report revealed Resident #36 received a shower on 8/20/25 documented at 3:06 AM.In an interview on 8/19/25 at 8:42 AM, Family Member (FM) GG reported Resident #36 did not refuse cares (referring to ADL cares).In an interview on 8/19/25 at 10:42 AM, Certified Nurse Aide (CNA) M reported it was important to clean Resident #36's nails because he would dig in his brief with his hands. CNA M reported cleaning of fingernails was part of giving a resident a shower.In an interview on 8/19/25 at 12:47 PM, CNA AA reported nail cleaning and clipping, if needed, was part of what was done when a resident received a shower. CNA AA reported nails should also be cleaned in between shower time if they are dirty. In an interview on 8/19/25 at 3:16 PM, Registered Nurse (RN) EE reported Resident #36 did not refuse ADL cares.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide individualized activities designed to support the psychosocial well-being of 1 of 18 Residents (Resident #1) reviewed for activities, resulting in a potential for feelings of social isolation, loneliness, anxiety and boredom.Findings include: Review of Revolutionizing the Experience of Home by Bringing Well-Being to Life: The [NAME] Alternative Domains of Well-Being, Copyright 2012, Rev. 2020, revealed The [NAME] Alternative defined one domain of wellness as Connectedness- the state of being connected; alive .engaged, involved . without meaningful interactions the individual can become disconnected .develop loneliness, helplessness, and boredom.Resident #1Review of an admission Record revealed Resident #1 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: Alzheimer's disease (a progressive disease that primarily affects memory, thinking and behavior), major depressive disorder (persistent sad mood that impacts daily life) and adjustment disorder (mental disorder defined by maladaptive response to psychosocial stressor).Review of a Minimum Data Set (MDS) assessment for Resident #1 with a reference date of 6/11/25, revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #1 was severely cognitively impaired. The MDS reflected Resident #1 experienced wandering daily during the 14-day assessment period and her family member expressed it was somewhat important to the resident that she do things in groups of people, pursued her favorite activities, listen to music, participated in religious activities, go outdoors, and spent time around pets. Further review of this assessment revealed Resident #1was easily distractible and experienced disorganized thoughts.Review of a Care Plan for Resident # 1 with a reference date of 9/9/24, revealed a focuses/goals/interventions of: 1. Focus: At Risk for decreased Activity pursuits related to: anticipated dementia worsening. (Resident #1) enjoys listening to music and being outside. She will participate in some activities with coaxing but loses interest quickly and leaves. Goal: Will participate in activities of their choice which include: (sic) relaxing outside and listening to music, some social activities like bingo and birthday parties. Interventions: .Assist to and from activities of choice.Assist with reminiscing items, books and music.Provide assistance with outdoor patio activities weather permitting.record activity attendance and analyze as needed to continue to evaluate a change in need. 2. Focus: Resident has the potential for psychosocial distress.Goal: Adjustment to nursing home placement as evidenced by participation in daily routine and socialization with peers.Interventions.with presentation of behavioral and psychological symptoms of dementia, attempt to use social interventions such as tactile stimulation, sorting objects, appropriate touch, music and sounds to increase stimulation of the senses and to decrease negative behaviors. Review of Recreational Engagement records for Resident #1 with a reference date of 5/1/25-8/19/25 revealed Resident #1 was recorded as participating in 1 outdoor activity and 6 religious activities during the 15-week period. No pet visits or involvement in music activities were documented for Resident #1. The record also contained no documentation of Resident #1 participating in tactile stimulation or sorting activities. Conflicting information was noted in Resident #1's Recreation Engagement records, including documentation of refusal and simultaneous documentation of participation in the same activity (same date/time), duplicate entries of participation in the same activity at the same time, and participation in group activities that were not offered on those days per the Activity Calendar.In an interview on 8/19/25 at 1:38pm, Certified Nursing Assistant (CNA) T reported Resident #1 wandered through the halls of the building throughout the entire day. CNA T stated she's on the move from the moment she gets up. CNA T reported she assisted Resident #1 to group activities, but she usually could not focus her attention on the activity.In an interview on 8/20/25 at 9:38am, Clinical Psychologist (CN) KK reported Resident #1 was very impulsive and could not focus her attention on tasks of interest for more than 90 seconds, as a result, Resident #1 needed personalized interventions to optimize her ability to engage in (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities.During serial observations on 8/19/25, Resident #1 self-propelled her wheelchair through the halls of the facility at 9:23am, 10:13am, 11:36am, 1:57pm, 2:41pm and 4:16pm. It was noted that Resident #1 did not have dementia sensory items as she attempted to engage in her surroundings.During serial observations on 8/20/25, Resident #1 self-propelled her wheelchair through the halls of the facility at 9:52am, 1:46pm, 2:21pm, 2:59pm, and 4:02pm. It was noted that Resident #1 did not have access to tactile sensory items or music of her choosing as she attempted to engage in her surroundings.No social interactions between Resident #1 and staff, residents or visitors were observed as she propelled her wheelchair around the building on 8/18, 8/19, and 8/20/25.In an interview on 8/20/25 at 2:22pm, Activity Director (AD) P reported Resident #1 was not able to consistently maintain her attention on most group activities and was not scheduled to receive 1:1 activity visits on a regular basis. AD P confirmed that if Resident #1 was present in a group activity for any length of time, it was recorded in her Recreational Engagement Record, but she usually only stayed a minute or two. AD P reported she had not received training related to activity programming for residents with severe cognitive impairments and it was difficult to ensure their activity needs were met. AD P stated we offer her group activities but who knows if she likes them. AD P reported she provided Resident #1 a baby once, thinking she could carry it with her as she wandered around the facility. When queried about Resident #1's response to the baby, AD P stated she held it for a minute but then gave it back, so I guess she didn't like it. AD P reported Resident #1 spent most of her time just self-propelling her wheelchair around the facility, making her rounds. AD P reported she had not completed the training to become a certified activity professional, was new to the profession, and needed support as she learned how to meet the needs of residents with dementia.

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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. Based on observation, interview, and record review, the facility failed to ensure adequate care and appropriate treatment for 2 residents (Resident #3 and Resident #16) of 18 sampled residents reviewed for quality of care, resulting in the potential for development of new wounds and infection. Findings include: Resident #3: Review of an admission Record revealed Resident #3 was a female with pertinent diagnoses which included diabetes, paralysis affecting right dominant side, difficulty in walking, weakness, joint inflammation, and need for assistance with personal care. Review of current Care Plan for Resident #3, revised on 3/26/24, revealed the focus, .Impaired skin integrity related to: She had a diagnosis that delay wound healing: Stage 3 kidney disease (kidney damage where the kidneys are not functioning optimally); congested heart failure; coronary artery disease; irregular heart rate; high blood pressure, and diabetes.admitted with a diabetic ulcer to her right heel that has closed and remains at risk to resurface - tx (treatment) order in place for protection only. with the intervention .Skin inspections with am/pm care and showering report abnormal to the charge nurse.SKIN: Heels elevated in bed as tolerated; Inspect heels with care and report to charge nurse as indicated; Sage boots on when in bed.During an observation and interview on 08/18/2025 at 12:11 PM, Resident #3 was observed lying in her bed, she was dressed, she had on non-slip socks. Resident #3 reported the provider came in on Monday last week (8/11/25) and Resident #3 reported she informed them of the wound on her right heel. Resident #3 reported the wound provider came on Friday (8/15/25) and she had debrided the wound. Resident #3 reported she had asked the nurse multiple times on Saturday (8/16/25) about changing her dressing but she never got it changed until 4:00 PM and then it was not done again. Resident #3 reported she had only one dressing change on Saturday, it was freshly debrided wound (removed damaged tissue) and Resident #3 reported how important it was for her to get her dressing changes. Resident #3 reported she had only one dressing change on Sunday as well. Resident #3 reported she had asked about a dressing change around 10:00 AM on Sunday and it was not done until 6:00 PM. Resident #3 reported she had asked the nurse today prior to her shower at 09:30 AM and the dressing still had not been changed. Note: no sage boots noted out in the room or on Resident #3. Review of the order for the dressing change dated 8/15/25 revealed the dressing was to be changed during the day (6 AM to 2 PM) and evening shifts (2 PM to 10PM). Review of Treatment Administration Record (TAR) dated August 2025, revealed, .Rt (Right) Heel: Cleanse with NS (normal saline) apply honey and calcium alginate (high absorbency wound dressing) cover every day and evening shift for Diabetic ulcer on heel. Review of documentation of treatment revealed the first treatment documented on 8/16/25 Day and documented twice a day each day on Saturday 8/16, Sunday 8/17, Monday 8/18. Note: No dressing change was noted as completed on the administration record prior to 8/15/25. Review of HCP Visit dated 8/11/25 at 11:56 AM, revealed, .Report of new wound to her R (right) ankle.R medial (middle) ankle wound discussed with nursing staff.wound specialist to be seen this week. Recommend Medi-honey application daily until evaluation. During an observation and record review on 08/19/2025 at 1:23 PM, Resident #3 had one sage boot on the seat of her wheeled walker over by the entry door and one on top of her bed. During an observation and interview on 08/19/2025 at 1:50 PM, Registered Nurse (RN) L reported she had a wound about half dollar size on her inner heel. When Resident #3 was queried, she reported the nursing staff had not put any sage boots on her feet since she discovered the wound on 8/11/25 during her shower. Resident #3 reported she had seen the podiatrist today and he had informed her she should have something in place to keep her heel off the bed. Resident #3 was looking in her closet and remembered she had a pair of sage boots in her closet, and she took them out and put the one on her right heel today. Resident #3 reported she doesn't have any pain with the wound due to her neuropathy but when it was debrided on Friday it did hurt. Resident #3 reported she received her dressing change last night at approximately 1:00 AM. Resident #3 reported she was not happy to be woken up at that time but was happy the dressing was changed. This writer observed the cleaning (continued on next page)

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	235625	A. Building B. Wing	08/20/2025

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and dressing application performed by RN L. The wound was cleaned, treated with Medi honey (medical grade manuka honey product that promotes healing by drawing fluid from the surrounding tissue, helps to liquefy and remove non-viable tissue and helps to control bacteria and reduce inflammation), and calcium alginate pad, and covered with a foam dressing dated and initialed as 8/19/25. Resident #3 reported she asked the nurse on Sunday how many times it was ordered to be changed because she knew it was to be changed twice a day, and she was informed there was no order and she didn't change it until 6:00 PM. Resident #3 reported the provider came in on Monday 8/11/25 and looked at the wound on her right heel but there was no order for treatment until after the wound provider came in on Friday (8/15/25) as she had no treatment and/or dressings applied from 8/11/25 until 8/16/25. In an interview on 08/19/2025 at 1:50 PM, RN L reported the nurse documented a yes, no or refused when they go in to document for the treatment. RN L reported the nurse had to put an answer in there in order to move on. RN L reported the CNAs (certified nursing assistants) did not complete shower sheets for resident skin observations when assisted the resident with a shower. RN L reported if something was discovered, the CNAs verbally informed the nurses of any issues. RN L reviewed the order for the wound treatment and indicated the wound dressing change was to be completed during the Day-- 6 AM to 2 PM, and Night - 2 PM to 10 PM.Review of Kardex for Resident #3 reviewed on 08/20/2025 at 10:33 AM, there was no intervention for sage boots on the Kardex. In an interview on 08/20/2025 at 10:38 AM, RN L reported skin assessments were to be done every week, changes with the care plan can be done by the nurse such as adding new interventions and focus for the resident. RN L reported there was a binder at the nurse's station which had guides on what to do if had a certain thing like a new skin wound. RN L reported the guide helped the nurse completed the required tasks for the new concern like modifying the care plan, assessments, etc. Review of Skin Assessments revealed Resident #3 had her last one completed on 8/5/2025. Note no skin assessment was completed on 8/11/2025 when Resident #3 reported she discovered the wound on her right heel. No Skin Assessment was completed on 8/18/25. Resident #16: Review of an admission Record revealed Resident #16 was a male with pertinent diagnoses which included muscle weakness, and cognitive communication deficit (communication impairment stemming from difficulties with thinking processes like attention, memory, and reasoning, and problem solving). Review of Care Plan for Resident #16 initiated on 4/17/25, revealed the focus, .Altered functional mobility and ADL's (activities of daily living) . with the intervention .Dependent for ADL's.AMBULATION: Non-Ambulatory.Bed Mobility: assist of two.Review of Interdisciplinary Documentation dated 7/23/25 at 3:32 PM, revealed, .A review of MDS based skin risk assessment scales, reveal the following risk factors are present for the development of skin impairment: GG-(Resident #16) has bilat impairment of legs and 1side of upper extremities.Dependent for toileting and transfers via mechanical lift. He is non ambulatory and is not able to propel self in wheelchair. H-Always incontinent of bowel and bladder, wears briefs for dignity and containment.M- Has thin and fragile skin that can bruise and tear easily. Currently has MASD (moisture associated skin damage) to buttock and groin. Interventions in place to mitigate risk of skin impairment include Pressure relieving mattress, pressure relieving wheelchair pad, skin inspections with bathing and daily cares, skin barrier cream with incontinence care. During an observation and interview on 8/20/25 at 9:05 AM, Resident #16 was in bed awake. Resident agreed to have brief change and observation for abnormal skin issue(s). Certified Nursing Assistant (CNA) K donned appropriate PPE provided care necessary for a brief change. Observation of Resident #16's penis and foreskin did not reveal any outward visible signs of infection as evb (evidence by) no discharge, odor, redness, raw or open skin. The foreskin was pulled back and cleaned by CNA K appropriately. Resident #16 was rolled onto his right side for observation of his buttocks, coccyx, and sacrum. CNA K spread the resident's buttock cheeks apart to clean the area and exposed an open area approximately the size of a quarter between the cheeks. The open area was red within the opening and covered in a sticky white cream-like substance. CNA K stated, That looks like a sore. You have to spread his buttock cheeks apart to find it.In an interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 08/20/2025 at 2:12 PM, Corporate Infection Preventionist JJ reported Resident #16 had an abrasion on his upper left butt cheek /split. Corporate Infection Preventionist JJ reported a skin assessment was not completed, a progress note was not entered for it from a nurse. Corporate Infection Preventionist JJ reported the CNA would verbally tell the nurse and the facility did not have the CNAs complete shower skin sheets for residents. Corporate Infection Preventionist JJ confirmed the last skin assessment was completed on 8/5/25.In an interview on 08/20/2025 at 2:15 PM, RN L reported she received report the nurse this morning noticed the open area on his bottom when she observed care for Resident #16. In an interview on 08/18/2025 at 1:45 PM, Family Member (FM) OO reported Resident #16 had messy pants and had been waiting for staff to come change him since 1:20 PM, FM OO reported the staff member had told her they had to get another staff member to transfer him from his wheelchair to the bed. FM OO reported he had loose stools earlier when he was changed to get up out of bed. FM OO reported when the CNAs come into his room and check him, they check the front of his brief and it would be dry because when he was lying down it runs to the back and the back would be soaked on him, like it was earlier, but they don't check the back of the brief when they check him. FM OO reported a few days ago, green pus was observed coming out of Resident #16's penis. FM OO reported he had a urinary trach infection recently and got antibiotics for it, but FM OO wondered if it was back or never left.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, staff interview, and record review, the facility failed to provide services to prevent the development of and promote healing of pressure ulcers/injuries for 1 (Resident #8) of 3 residents, resulting in the development of pressure ulcers. Findings include: Resident #8: Review of an admission Record revealed Resident #8 was a male with pertinent diagnoses which included need for assistance with personal care, muscle weakness, stroke, tracheostomy, diabetes, and respiratory failure. Review of current Care Plan for Resident #8, revised on 4/30/25, revealed the focus, . Altered functional mobility and ADL's (activities of daily living) related to: (Resident #8) admitted from skilled rehab to our facility for skilled rehab. Does flinch or wince when moved in bed. with the intervention .SKIN: Heels elevated in bed as tolerated; Inspect heels with care and report to charge nurse as indicated.APM (alternation pressure mattress) to bed, Setting: Static *pressure relieving pad to wheelchair *sage boots (help reduce the risk of bedsores by keeping the heel floated, relieving pressure). Revision on: 06/06/2025. Review of current Care Plan for Resident #8, revised on 4/30/25, revealed the focus, . Potential risk for impaired skin integrity.Bridge heels in bed if indicated (DC if contraindicated) to protect heels. Date Initiated: 05/01/2025.Measure open areas upon admission, weekly, prn (as needed) Date Initiated: 05/01/2025.Pressure reducing cushion to wheel chair. Date Initiated: 05/01/2025.Pressure reducing mattress Date Initiated: 05/01/2025.Re-evaluate treatment and resident condition prn with no improvement to wound appearance and/or measurements.During an observation on 08/18/2025 at 2:41 PM, Resident #8 was observed in his room, lying supine in bed, no sage boots or bridging of his feet were observed. Resident #8 was not observed to have a bandage on either foot. During an observation on 08/20/2025 9:36 AM Resident #8 was observed lying in his bed had a pillow under his calves but it was deflated and his heels were directly on the bed, there was no bandage noted and he did not have his sage boots on. The wedge was on top of the blankets on the right side of his upper thigh area. In an interview 08/20/2025 at 10:18 AM, Licensed Practical Nurse (LPN) O reported Resident #8's boots were in the closet, she reported the CNAs took them off as they were getting him up but he should have them on when he was in the bed. Review of Order dated 08/07/2025, revealed, .R(right)/heel: cleanse with NS (normal saline), dry, apply silicone dressing and cover. every night shift every Tue, Thu, Sun for wound on R/heel. Review of Order dated 08/07/2025, revealed, .Inferior to the R/lower leg: cleanse with NS, dry, apply silicone dressing and cover. Three times a week and as needed. every night shift every Tue, Thu, Sun for wound on R/lower leg.Review of Interdisciplinary Documentation dated 8/7/2025 at 8:35 PM, revealed, .Resident has open area on right heel and open area on RLE (right lower extremity) dressing applied and pressure reducing boots turned on side to offload pressure.Review of Wound Measurement dated 8/19/25 at 11:17 AM, revealed, .Right heel.Pressure.length: 1.7 CM.Width: 1.9 CM.Depth: 0.1.Stage II (Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister).Right Lateral (outer) heel.(Resident #8) was observed to have a small open area to the lateral side of his right heel. The area is open, wound bed is beefy red in the center of the wound. NP (Nurse Practitioner) assessed wound today and stated that it is a stage II pressure area to the heel. Wound measured and dressing orders for Xeroform (gauze impregnated with a heavy metal compound with antimicrobial properties to help prevent infection) applied to wound bed and then cover with a dry dressing. Sage boots to be worn to bilateral feet when up and offload with pillows when in bed.Family/POA/Responsible party will be notified of new wound. Review of HCP Note dated 8/19/25 at 09:08 AM, revealed, .Staff reported new observed wound to R heel.Does have right sided hemiplegia (paralysis).New right heel ulcer-recommend wound specialist to evaluate and treat. Start Xeroform cover with dry dressing until then every other day.R hemiplegia-supportive care, use of offloading pillows and wedges. Review of policy, Skin at Risk Assessment Documentation, Staging & Treatment revised 1/2020, revealed, .6. The following guidelines are reviewed and implemented as indicated for each individual risk factors: f. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Use of pressure relieving devices, i.e., chair cushions, pressure reduction mattresses, low air loss mattresses.l. Use of pillows or devices to bridge heels as indicated.m. Assessment of individualized need for pressure redistribution support surfaces.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, the facility failed to provide tracheostomy emergency care equipment (Ambu bag, trach device and obturator (Key component used during the insertion or change of a tracheostomy tube (trach; inserted into the stoma (opening in the trachea to maintain an open airway and facilitate breathing) at the bedside for 1 (Resident #8) of 1 resident reviewed for respiratory care, resulting in the potential of serious negative outcome if Resident #8 were to need emergent tracheostomy replacement. Findings include: According to Emergency and Basic Equipment for Individuals with Tracheostomy: All clinical staff should be aware of the location of equipment for individuals with tracheostomy. Equipment should be kept at bedside in an easily accessible location for both routine and emergency use. When transferring an individual to a different location within a unit or to an outside unit, emergency equipment should also be available.Clinicians should be prepared in case of emergency as the medical condition of a patient with tracheostomy and/or mechanical ventilation may change quickly. Emergency equipment is necessary at the bedside as well as during transportation. https://tracheostomyeducation.com/emergency-equipment/Resident #8: Review of an admission Record revealed Resident #8 was a male with pertinent diagnoses which included acute respiratory failure with hypoxia (life threatening condition where the lungs cannot maintain sufficient blood oxygen levels to support organ function), and tracheostomy (surgical procedure that creates an opening in the trachea (windpipe) through the neck to allow for breathing). Review of current Care Plan for Resident #8, revised on 4/30/25, revealed the focus, . Altered functional mobility and ADL's (activities of daily living) related to: (Resident #8) admitted from skilled rehab to our facility for skilled rehab. Does flinch or wince when moved in bed, improving verbally with speaker valve in place but will look at you when you talk to him. He has a Shiley Flex uncuffed size 6 trach placed on 3/5/25 due to respiratory failure, inability to protect airway. Requires frequent suction. with the intervention .RESPIRATORY EQUIPMENT: Trach Shiley flex size 6 uncuffed, humidifier, trach mask. Nebulizer Date Initiated: 05/01/2025.Flex uncuffed size 6 trach placed on 3/5/25 due to respiratory failure, inability to protect airway. Requires frequent suction, humidifier in place . During an observation on 08/18/2025 at 11:39 AM, observed no Ambu bag, tracheostomy tube, and obturator in Resident #8's room and drawers. During an observation on 08/18/2025 at 11:39 AM, observed no Ambu bag, tracheostomy tube, and obturator. Resident #8's suction tubing was placed directly on the nightstand with no barrier. During an observation on 08/20/2025 9:36 AM Resident #8 was observed lying in his bed and there was no Ambu bag, tracheostomy tube, and obturator in his room. During an observation on 08/18/2025 at 2:41 PM, Resident #8 was observed in his room, lying supine in bed. No Ambu bag, tracheostomy tube, and obturator were observed in his room. In an interview on 08/20/2025 at 10:04 AM, [NAME] President of Clinical Services JJ reported Resident #8 should have an Ambu bag, tracheostomy tube, and an obturator at the bedside if an emergent situation arose for Resident #8. [NAME] President of Clinical Services JJ reported this was the policy for the facility. In an interview 08/20/2025 at 10:18 AM, Licensed Practical Nurse (LPN) O reported Resident #8 used to have an Ambu bag on the wall and the tracheostomy tube as well. LPN O looked in his closet, drawers and there was no Ambu bag, trach and obturator in the room. During an observation and interview on 08/20/2025 at 10:20 AM, [NAME] President of Clinical Services JJ came to Resident #8's room and looked on his tables, in his nightstand, closet and the wall in his room and reported she was unable to find an Ambu bag, tracheostomy tube, and obturator in the room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record, the facility failed to ensure proper labeling of medications in 1 of 1 medication cart (South medication cart) reviewed for medication storage, resulting in the potential for residents to receive medications with altered potency and decreased efficacy.Findings include:During an observations and interview on 8/19/25 at 2:05 PM and 8/20/25 at 7:05 AM, Registered Nurse (RN) was at working out of the South Medication Cart. RN L reported she did not know everything that was in the drawer. She continued reporting she kept a few of her personal things in the drawer and used the code alert to test wander guard bracelets. Observed the top left drawer on both dates to contain:-cooking timers- glucometers-code alert tester for wander guard bracelets-key ring with multiple keys attached, RN L stated, I have no idea what those keys are for. I've never used them.-2-vape pens that were labeled with a resident's name. RN L stated, Those vaping pens were confiscated from a resident that used to be in room [ROOM NUMBER] and is now in a room in front of the building. -Swiss Army knife-glucometer test strips-cuticle cutters-blue roll of tape-thermometers-a candy sucker-scissors-multiple wander guard bracelets-pill crusher-empty syringe-probe covers for thermometers-packages of wound dressings-packages of thickening agents-tube of manuka honeyDuring an interview on 8/20/2025 at 10:50 AM Corporate Infection Control (IC) JJ stated, Only resident medications and treatment items should be kept in the medication cart. Anything else could compromise the medications and/or treatments. The night shift nurses should be going through the medication carts to make sure none of the items found in the medication cart (referring South Medication cart) were in there and the carts are clean and organized.Review of facility policy Medication Storage & Stability revised April 2021, revealed, Policy: Medications and biologicals are stored safely, securely, and properly.Medications storage areas are kept clean, well-lit, and free of clutter.Medications storage conditions are monitored monthly.

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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 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. Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in 1 of 18 residents (Resident #3) reviewed for accuracy of medical records, resulting in inaccurate treatment records and the potential for providers to not have an accurate picture of resident status and condition.Findings include: Resident #3: Review of an admission Record revealed Resident #3 was a female with pertinent diagnoses which included diabetes, paralysis affecting right dominant side, difficulty in walking, weakness, joint inflammation, and need for assistance with personal care. Review of current Care Plan for Resident #10, revised on 3/26/24, revealed the focus, .Impaired skin integrity related to: She had a diagnosis that delay wound healing: Stage 3 kidney disease (kidney damage where the kidneys are not functioning optimally); congested heart failure; coronary artery disease; irregular heart rate; high blood pressure, and diabetes.admitted with a diabetic ulcer to her right heel that has closed and remains at risk to resurface - tx (treatment) order in place for protection only. with the intervention .Skin inspections with am/pm care and showering report abnormal to the charge nurse.SKIN: Heels elevated in bed as tolerated; Inspect heels with care and report to charge nurse as indicated; Sage boots on when in bed.During an observation and interview on 08/18/2025 at 12:11 PM, Resident #3 was observed lying in her bed, she was dressed, she had on non-slip socks. Resident #3 reported the provider came in on Monday last week (8/11/25) and Resident #3 reported she informed them of the wound on her right heel. Resident #3 reported the wound provider came on Friday (8/15/25) and she had debrided the wound. Resident #3 reported she had asked the nurse multiple times on Saturday (8/16/25) about changing her dressing but she never got it changed until 4:00 PM and then it was not done again. Resident #3 reported she had only one dressing change on Saturday, it was freshly debrided wound (removed damaged tissue) and Resident #3 reported how important it was for her to get her dressing changes. Resident #3 reported she had only one dressing change on Sunday as well. Resident #3 reported she had asked about a dressing change around 10:00 AM on Sunday and it was not done until 6:00 PM. Resident #3 reported she had asked the nurse today prior to her shower at 09:30 AM and the dressing still had not been changed. Note: no sage boots noted out in the room or on Resident #3. Review of HCP Visit dated 8/11/25 at 11:56 AM, revealed, .Report of new wound to her R (right) ankle.R medial (middle) ankle wound discussed with nursing staff.wound specialist to be seen this week. Recommend Medi-honey application daily until evaluation. Review of the order for the dressing change dated 8/15/25 revealed the dressing was to be changed during the day (6 AM to 2 PM) and evening shifts (2 PM to 10PM). Review of Treatment Administration Record (TAR) dated August 2025, revealed, .Rt (Right) Heel: Cleanse with NS (normal saline) apply honey and calcium alginate (high absorbency wound dressing) cover every day and evening shift for Diabetic ulcer on heel. Review of documentation of treatment revealed the first treatment was documented on 8/16/25 Day and documented twice a day each day on Saturday 8/16, Sunday 8/17, and Monday 8/18. Note: No dressing change was noted as completed on the administration record prior to 8/15/25. During an observation and interview on 08/19/2025 at 1:50 PM, Registered Nurse (RN) L reported she had a wound about half dollar size on her inner heel. When Resident #3 was queried, she reported the nursing staff had not put any sage boots on her feet since she discovered the wound on 8/11/25 during her shower. Resident #3 reported she had seen the podiatrist today and he had informed her she should have something in place to keep her heel off the bed. Resident #3 was looking in her closet and remembered she had a pair of sage boots in her closet, and she took them out and put the one on her right heel today. Resident #3 reported she doesn't have any pain with the wound due to her neuropathy but when it was debrided on Friday it did hurt. Resident #3 reported she received her dressing change last night at approximately 1:00 AM. Resident #3 reported she was not happy to be woken up at that time but was happy the dressing was changed. This writer observed the cleaning (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and dressing application performed by RN L. The wound was cleaned, treated with Medi honey (medical grade manuka honey product that promotes healing by drawing fluid from the surrounding tissue, helps to liquefy and remove non-viable tissue and helps to control bacteria and reduce inflammation), and calcium alginate pad, and covered with a foam dressing dated and initialed as 8/19/25. Resident #3 reported she asked the nurse on Sunday how many times it was ordered to be changed because she knew it was to be changed twice a day, and she was informed there was no order and she didn't change it until 6:00 PM. Resident #3 reported the provider came in on Monday 8/11/25 and looked at the wound on her right heel but there was no order for treatment until after the wound provider came in on Friday (8/15/25) as she had no treatment and/or dressings applied from 8/11/25 until 8/16/25. In an interview on 08/19/2025 at 1:50 PM, RN L reported the nurse documented a yes, no or refused when they go in to document for the treatment. RN L reported the nurse had to put an answer in there in order to move on. RN L reported the CNAs (certified nursing assistants) did not complete shower sheets for resident skin observations when assisted the resident with a shower. RN L reported if something was discovered, the CNAs verbally informed the nurses of any issues. RN L reviewed the order for the wound treatment and indicated the wound dressing change was to be completed during the Day-- 6 AM to 2 PM, and Night - 2 PM to 10 PM. In an interview 08/20/2025 at 9:58 AM, Corporate Clinic Support Nurse (CCSN) LL reported in the medication administration or treatment administration record, the nurse would check and initial what was completed, if a resident refused the nurse would indicate that. CCSN LL reported the nurse could enter a progress note indicating a resident refused by charting by exception so the refusals could be tracked.

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	08/20/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care (LTC) Ombudsman of residents who transferred from the facility, with the reason for a transfer. Findings include:Review of email dated 8/13/25 at 12:08 PM from Ombudsman PP stating they had only received one transfer report this year (2025) in May and had brought this to the facility's attention a few times. Review of email dated 8/20/25 at 10:08 AM from Nursing Home Administrator A stating the Administrator was responsible for supplying the transfer report and was looking for them.Review of email dated 8/20/25 at 11:16 AM from NHA A stating to confirm. I do not have a record of these being sent to the Ombudsman.