

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2025
NAME OF PROVIDER OR SUPPLIER Westlake Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 10735 Bogie Lake Road Commerce, MI 48382	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2570414. Based on observation, interview and record review the facility failed to follow their policy regarding the follow up of concerns for one (R902) of four residents reviewed for quality of care. Findings include: A review of a complaint submitted to the State Agency (SA) documented multiple concerns verbalized to the facility's staff with no resolution. On 9/9/25 at 11:22 AM, R902 was observed lying on their back in bed. An interview was conducted with the resident at that time. A review of the medical record revealed R902 was re-admitted to the facility on [DATE] with diagnoses that included: acute and chronic respiratory failure, hemiplegia and hemiparesis following cerebral infarction affect left non-dominant side, dysphagia (difficulty swallowing) and required staff assistance for all activities of daily living. R902 was documented to be their own responsible party. On 9/9/25 at 11:45 AM, the facility's Administration was asked to provide all concerns/grievances filed on the behalf of R902 from January to current. A review of the grievances provided revealed the following: On 7/23/25 a family member of R902 was angry and noted Residents daughter had concerns about doctor visit schedule and other medical concerns. The resolution was entered on 7/28/25 that noted Satisfactorily- Provider saw resident and was notified of residents preferences regarding physician visit schedule and got all questions answered. On 7/24/25 a family member of R902 was upset and noted Grooming- Family Member expressed concern regarding the shower schedule and dressing for her mom. The resolution was dated 7/25/25 that noted Satisfactorily- Family and Resident preferences updated, nursing notified and provider notified. Staff educated. SW (social worker) spoke to resident about concerns. Resident pleased with care and no further concerns with showers at this time. A review of a facility policy titled Resident Concern Process review date 12/16/24, documented in part . The facility will provide an open and customer friendly atmosphere for residents and their families and representatives to voice concerns and problems with the assurance that their concerns will be heard and acted upon. All concerns should be entered electronically. The department leader will investigate and discuss the concerns with the team and will implement, or educate to prevent further concerns. the department leader will document the resolution on the concern form. and will follow up with the person reporting the concerns to explain the resolution. The facility staff failed to follow up with the family member that verbalized and reported the above concerns. On 9/10/25 at 1:18 PM, the family member to R902 (FM G) was interviewed. FM G verbalized multiple concerns reported to the facility's SW and Administration staff. FM G explained an incident they reported to the SW regarding a delay in treating an eye infection for R902. FM G also stated they reported an incident to the SW and Administration staff on how they had dressed their mother in a night gown one evening for bed. FM G' stated they returned to the facility the next afternoon for a visit and the resident had on the same night gown that was notably dirty. FM G stated the staff never followed up with them or communicated any resolutions to their concerns. On 9/10/25 at 2:11 PM, the Administrator, Director of Nursing (DON), Clinical Support (CS) and Assistant Director of Social Services (ADSS) C were all interviewed together and asked about the concerns for R902. The documented concerns were reviewed and they were asked why no one had followed up with the family member that reported the concern to discuss and/or inform them of the resolutions. ADSS C stated they followed up with R902 because . the resident is her own person. The facility policy was reviewed regarding the guidance of the follow up to be conducted with the person(s) who verbalized the concern and the Administration staff acknowledged the concern. No further explanation or documentation was provided by the end of the survey.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2599423. Based on interviews and record reviews the facility failed to ensure a physician order was followed for one (R903) of two residents reviewed for catheter care. Findings include: A review of a complaint submitted to the State Agency (SA) noted that R903 was admitted to on 8/15/25 with a foley catheter due to urinary retention. On the morning of 8/21/25 the resident was . eating in the dining room, and he did not feel good. (R903) looked pale, dizzy, and he did not seem like himself. The complainant stated they requested the nurse to check for a UTI (urinary tract infection). The complainant stated the nurse talked to the doctor who stated . (R903) would have to get blood drawn first, and that it would take two days for the results to come back. The complainant then requested to speak to the doctor and was told the doctor was gone for the day. The complainant stated . felt that they had no choice but to take (R903 name) to the hospital at that point. The resident was admitted to the hospital on intravenous antibiotics. A review of the medical record revealed that R903 was admitted to the facility on [DATE], with diagnoses that included : dementia and benign prostatic hyperplasia with lower urinary tract symptoms, urine retention and a foley catheter. A review of a progress note dated 8/21/25 at 10:34 AM, documented . The resident stated being cold and have chills, VSs (vital signs) are WNL (within normal limits), afebrile, denied pain at this time. Family is present in the room. (Doctor name) informed order for CBC (complete blood count), CMP (comprehensive metabolic panel) Stat (immediate) received, Blood collected, lab called for pick up, samples is waiting for pick up. The writer coming back to the floor, informed by (nurse name) that family took resident to the hospital for evaluation. This note was documented by Registered Nurse (RN) E .A review of a nursing note dated 8/21/25 at 3:22 PM, documented . The writer was informed by resident's daughter, that resident was admitted to (hospital name) with UTI diagnosis. This note was also documented by RN E. A review of R903's physician orders revealed the following order:8/15/25 - May dip urine is &lt;sic> s/s (signs/symptoms) of UTI, then may send urine for C&S (culture and sensitivity) if positive for leukocytes. The review of the record revealed no documentation of a dip stick to have been completed or urine obtained for testing. On 9/10/25 at 12:48 PM, RN E was interviewed and asked about the incident of R903 to have been transferred to the hospital by their family. RN E explained the family had approached them and informed them that R903 didn't feel good. RN E stated they went to do vitals on R903 and it was okay and the resident stated he was chilly. RN E explained they contacted the doctor (Physician F) who informed them to do STAT labs. When asked why they had not completed the dip stick order for analysis of the resident's UA to rule out a UTI as the physician order directed, RN E stated they planned to complete the dip stick order when they had returned from their break. RN E went on to explain that when they returned from their break the family had already left to take the resident to the hospital. On 9/10/25 at 2:52 PM, a telephone interview was conducted with Physician F. Physician F was asked during that interview if they were aware of the family to have observed the resident to have been .pale, dizzy, and he did not seem like himself. on the morning of 8/21/25 when the nurse contacted them. Physician F stated it was their understanding that the resident had chills. During the interview Physician F stated if they felt like the resident was going septic and had a change of condition they would have definitely treated the resident. On 9/10/25 at 10:53 AM the interim Director of Nursing (DON) and Clinical Support (CS) B were both interviewed. When asked about the dip urine orders reviewed for R903, the DON explained the facility had a urine order set for all residents. The DON stated if signs/symptoms are observed the nurses are to complete the urine dip stick as ordered. If the dip stick is positive for leukocytes the urinalysis is sent out for testing and to have a culture and sensitivity completed. The DON was asked why RN E had not carried out the order as implemented by the Physician for R903 and the DON stated they could not say why RN E did not complete the order, however their expectation would have been for the nurse to follow the physician orders and the physician directive. No further explanation or documentation was provided by the end of the survey.</p>		

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI002570414. Based on observation, interview and record reviews the facility failed to consistently maintain an ongoing Infection Control Surveillance system and ensure to consistently follow the facility's policy for the Infection Prevention and Control Program. This deficient practice had the potential to affect multiple residents residing in the facility, (including R's 902 and 905) two of three residents reviewed for Infection Control Surveillance. Findings include:R902A review of a complaint submitted to the State Agency (SA) documented concerns of the facility's timeliness to treat R902's bilateral conjunctivitis. The complaint also noted multiple concerns with the facility's Infection Control Surveillance. On 9/9/25 at 11:22 AM, R902 was observed lying on their back in bed. An interview was conducted with the resident at that time. A review of the medical record revealed R902 was re-admitted to the facility on [DATE] with diagnoses that included: acute and chronic respiratory failure, hemiplegia and hemiparesis following cerebral infarction affect left non-dominant side, dysphagia (difficulty swallowing) and required staff assistance for all activities of daily living. R902 was their own responsible party. A review of the progress notes revealed the following: A Nurse Practitioner (NP) note dated 6/17/25 at 12:16 AM, documented in part . DATE OF SERVICE: Jun, 16, 2025. Left eye discharge, Right eye discharge. Left exudate, Left eyelid swelling, Right exudate, Right eyelid swelling.A nursing note dated 6/17/25 at 11:29 AM, documented new order for bilat (bilateral) eye conjunctivitis ordered, pharmacy was called, awaiting to deliver it.A nursing note dated 6/17/25 at 11:52 PM, documented Changed order start and stop dates for eyes drops to coordinate with pharmacy delivery. Should come in between 2-3am, to start at 4am.An Infection Event note dated 6/19/25 at 10:19 AM, documented IDT Review: Infection-Resident with bilateral eye conjunctivitis. S/sx (signs/symptoms) of infection include: bilateral eye redness, itchiness, yellow discharge. Resident meets Mcgreer's criteria for infection. Order is for Polymyxin eye drop. for treatment of infection. Contact precautions initiated due to diagnosis. Nursing to monitor for effectiveness of antibiotic and for adverse effects r/t (related to) abt (antibiotic) therapy.A nursing note dated 7/23/25 at 12:36 PM, documented in part . Patient's daughter expressed concern to provider regarding a possible double eye infection, noting redness in both eyes. Following the assessment, the on call provider prescribed new order for Polymyxin ophthalmic drops. The patient and her daughter were informed about the treatment plan, including the correct administration of the eye drops and the importance of adhering to the medication regimen. (This order was documented as a late entry and created on 7/30/25 at 11:46 AM.)A nursing note dated 7/24/25 at 7:58 AM, documented in part . IDT (interdisciplinary team) Review: Resident assessed with bilateral eye purulent drainage, redness on the surrounding skin and sclera and c/o (complaint of) itching to bilateral eyes. Resident meet Mcgreer's criteria for eye infection. Discussed with NP and resident started on Polymyxin 7/23-8/2 for treatment of bilateral conjunctivitis. Resident placed on contact precautions. Nursing to monitor for effectiveness of abt and for adverse effects r/t abt therapy. Goal is for the infection to clear without complication.A NP note dated 7/24/25 at 11:56 AM, documented in part . was evaluated today for bilateral eyes conjunctivitis. Bilateral eyes redness, yellow crusty discharge, watery, and itchiness. Resident states she has been complaining of itcy &it; eyes couple days ago. Resident has a history of eye conjunctivitis couple weeks ago and she finished the course of antibiotic. Will order polymyxinB-sulfa trimethoprim antibiotic eyes drop q (every) 4 hours needed 8/2. Encourage resident to clean her eyes with room temp clean clothes, and maintain proper hygiene.A review of the June 2025 Medication and Treatment Administration Record (MAR/TAR) revealed the following: Polymyxin B sulf-trimethoprim drops; 10,000 unit- 1mg (milligram)/mL (milliliter); Apply 1 drop in each eye for conjunctivitis. Start date 6/17/25 and End date 6/17/25. Multiple nursing notes documented waiting to arrive. This indicated the pharmacy had not delivered the medication which caused a delay in treatment. A second order for the above eye drops was implemented and started at 4:00 AM on 6/18/25. Two days after the assessment and identification by the NP of the bilateral conjunctivitis for R902 on 6/16/25. The medication was noted to have been completed on 6/27/25. A review of the progress notes revealed no re-evaluation of the effectiveness of the antibiotic eye drops, nor a reassessment of R902's eyes after the completion of the antibiotic eye drop treatment on 6/27/25. A review of the Infection Control Surveillance documentation for June 2025, noted the identification of R902's eye infection, however contained no documentation on whether the infection had resolved or the re-evaluation of the contact precautions for R902. Review of the complaint submitted to the SA documented in part . resident has been waiting with</p>		