

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 10/07/2025
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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

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 10/07/2025
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)		
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2623642Based on interview and record review, the facility failed to conduct accurate assessments, complete wound treatments per Physician orders, implement interventions in a timely manner and have new wounds regularly assessed by medical providers for one resident (R901) of two residents reviewed for pressure ulcers, resulting in R901 developing two unstageable pressure ulcers on the left and right buttock that worsened into an infection which required an acute care transfer. Findings include:On 10/7/25 a concern submitted to the State Agency was reviewed that alleged R901 developed multiple pressure ulcers that became infected while at the facility. On 10/7/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] with diagnoses including Displaced intertrochanteric fracture of left femur, Osteomyelitis (bone infection) unspecified and was discharged to the hospital on 7/14/25. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 6/24/25 revealed R901was dependent on facility staff with most of their activities of daily living. R901's BIMS score (brief interview for mental status) was 14 indicating intact cognition. Section M (skin condition) documented R901 was at risk for developing pressure ulcers and had no unhealed pressure ulcers/injuries. A review of R901's admission careplans revealed the following: Problem Start Date: 06/19/2025 Category: Skin Integrity At risk for skin breakdown r/t (related to) decline in functional mobility, bladder incontinence .Approach- Approach Start Date: 06/19/2025. Keep resident as clean and dry as possible. Minimize skin exposure to moisture. A Nursing admission assessment dated [DATE] revealed R901 had a braden scale score (a tool used to predict risk of skin breakdown) of 17 which indicated they were at risk of developing pressure ulcers. Further review of the assessment did not document any pressure ulcers present on R901's body. A progress note dated 6/26/25 revealed the following: MASD (moisture associated skin damage) noted to both but <sic> cheeks, skin open, bruise to right buttock, family & NP (Nurse Practitioner) & wound care, [Nurse B] made aware, Triad paste per order, applied, continue to monitor. A progress note dated 6/26/25 revealed the following: Resident observed with a bruise measuring approx. (approximately) 7x1cm (centimeters) on the R (right) buttock. Bruise is dark purple/red in color and is linear. Resident uses the bed pan frequently and bruise is due to sitting on the bed pan. Resident receives anticoagulant therapy and is at risk for easy bruising. Resident also noted with widespread MASD in the gluteal cleft area. Area was cleansed and Triad cream applied. Surrounding skin with blanchable redness. Intervention for bruising is to encourage resident to use the toilet as opposed to the bedpan. A progress note dated 7/2/25 revealed the following: .Two pressure ulcers noted on the coccyx present from admission, see wound management for measurements. New orders placed to cleanse with WC/NS (wound cleanser/normal saline), apply medihoney, apply foam dressing daily.A Nursing Wound Details assessment dated [DATE] completed by Nurse B revealed the following: Wound Type-Pressure Ulcer.Wound Location-Left buttock.Length-4 centimeters (cm). Width-2 cm. Can depth be measured? [No]. Exudate Amount Light Exudate color and consistency-Serosanguineous (pale red to pink, thin and watery) Stage-Stage II .Tissue Type-Epithelial Tissue. Skin surrounding wound: Assess within 4cm of wound edge. Erythema (redness)/blanchable. Present on Admission/Re-entry: Yes.A second Nursing Wound Details assessment dated [DATE] completed by Nurse B revealed the following: Wound Type-Pressure Ulcer.Wound Location-Right buttock.Length-4 centimeters (cm). Width-7.5 cm. Can depth be measured? [No]. Exudate Amount: Light Exudate color and consistency Serosanguineous. Wound odor present? No. Stage-Unstageable - Slough and/or Eschar. Tissue Type-Necrotic Tissue Present on Admission/Re-entry: Yes.A Nursing Wound Details assessment dated [DATE] revealed the following: Wound Type-Pressure Ulcer.Wound Location-Left buttock.Length-6 centimeters (cm). Width-2 cm. Can depth be measured? [No]. Exudate Amount-Light. Exudate color and consistency-Seropurulent (yellow or tan, cloudy and thick) Stage-Unstageable - Slough and/or Eschar. Tissue Type-Slough. Present on Admission/Re-entry: Yes. A second Nursing Wound Details assessment dated [DATE] revealed the following: Wound Type-Pressure Ulcer.Wound Location-Right buttock.Length-4 centimeters (cm). Width-7.5 cm. Exudate Amount-Light. Exudate color and consistency-Seropurulent. Stage-Unstageable - Slough and/or Eschar. Tissue Type-Slough. Present on Admission/Re-entry: Yes. A review of R901's Physician ordered enhanced barrier precautions (EBP) (precautions used to prevent infection) revealed no EBP orders were implemented to protect R901's wounds from infection until 7/10/25.A progress note dated 7/12/25 revealed the following: Foul odor noted in coccyx wound, recent lab results</p>		