STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235642	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westlake Health Campus	10735 Bogie Lake Road Commerce, MI 48382

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 1/5/26 at approximately 9:40 a.m., during the initial tour of the kitchen, the following concerns were observed with cook F. Multiple single portioned condiments with an expired use by date (UBD) of 12/25/25 were observed in the reach in refrigerator. Two bags of refrigerated boiled eggs were observed without a UBD. A single serving portioned container of barbeque sauce was observed without any received or used by dates. an uncovered/cooked turkey breast was observed in a pan without any labeling on it indicating a used by date or a cooked date. An opened to air bag of frozen fried chick was observed in the freezer without a UBD or a received date. Two pans of pureed broccoli and green beans were observed without any labeling. A bag of frozen chicken breast was observed in the freezer, open to air and unsealed. Four portable containers of carbon dioxide were observed to be freestanding and unchained/unsecured. A pile of single and stale marshmallows was observed unsealed in an open container that had no dating. Dried grease spillage was observed on the racks and in the bottom flooring in the mealtime express warmer. On 1/5/26 at approximately 10:06 a.m., the concerns were reviewed with cook F and they indicated they would have to throw away the items that were past the UBD and the unlabeled food items. [NAME] F indicated they would have to get the racks and flooring of the warmer cleaned and would throw away the marshmallows. On 1/7/26 at approximately 10:17 a.m., the concerns noted in the Kitchen on 1/5/26 were reviewed with the Food Service Director B (FSD B). FSD B reported that they had gone over all the items of concern with cook F and they were starting to provide in-servicing/education to the kitchen staff on the identified concerns. A review of the 2022 Food and Drug Administration (FDA) Food Code revealed the following: refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practices. Deficient practice #1 Based on observation, interview and record review the facility failed to ensure a Physician's order was obtained for a wound dressing for one resident (R75) of one resident reviewed for non-pressure wounds. Findings include:R75 On 1/05/2026 at approximately 10:36 a.m., R75 was observed in their room, laying in their bed. R75 was observed to have multiple foam dressings on their left forearm that were undated and had dried blood showing through. R75 was asked how they got the wound and they reported they had fragile skin and ripped their skin getting out of bed the day before. On 1/6/26 at approximately 11:42 a.m., R75 was observed in their room, up in their bed. R75 was observed to have to multiple foam bandages on their left forearm. The bandages were both dated 1/5/26. R75 was queried regarding the bandages and reported they had been changed by the Nurse the previous night (1/5/26). On 1/7/27 at approximately 8:50 a.m., R75 was observed in their room, up in their wheelchair. R75's left forearm was observed to have a foam dressing on it with a date of 1/6/26. On 1/5/26 the medical record for R75 was reviewed and revealed the following: R75 was initially admitted to the facility on [DATE]. A review of R75's Physician orders revealed no orders for the dressings on R75's left forearm. A review of R75's progress notes and observations did not reveal any documentation of R75 sustaining a skin tear to their left forearm including no Physician notification or assessment of the skin tear. On 1/7/26 at approximately 8:58 a.m., Nurse D was interviewed regarding the dressing on R75's left forearm and was asked what the dressing order was. Nuse D was observed reviewing R75's medical record and reported that there was no Physician's order for the dressing, but they had applied new dressing the previous night due to the dressing being soiled. Nuse D indicated they would contact the Physician and get an order for R75's left forearm wound. On 1/7/26 at approximately 9:02 a.m., during a discussion with the Director of Health services (DHS), the DHS was asked about R75's skin tear and why there was not any documentation regarding it and why there were no Physician orders for the wound, and they reported there should have an order for the dressing and they would look into the concern. On 1/7/26 at approximately 11:10 a.m., during a follow up conversation with the DHS, the DHS was asked about R75's left forearm wound and they reported there was no documentation done at that time and no order for the dressing. The DHS reported they had to provide in-service education to R75's Nurse regarding obtaining a Physician's order and documenting new skin impairments in the medical record. ON 1/7/26 a facility document titled Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines was reviewed and revealed the following: Purpose Statement-The purpose of this policy is to: Utilized to describe and monitor bruises, rashes, lesions, skin tears, and lacerations .Procedure: Skin Tear laceration-1. If skin alteration is noted upon admission, admitting nurse should complete the template/assessment progress note. IDT should review this timely and wound nurse or designee complete an assessment in wound management or Wound Zoom. 2. If skin alteration occurs post admission, follow the below steps: a. Complete Skin Tear/Laceration Incident in EHR (electronic health record) by an RN/LPN along with the template/assessment progress note. IDT should review this timely and wound nurse or designee complete an assessment in wound management or Wound Zoom . b. Continue to monitor weekly in wound management. c. Must review for at least 1 week in wound management. Once the wound nurse/designee determines that the wound is healing as expected, resolved or becomes a chronic skin condition this wound nurse/designee may heal the wound in wound management or Wound Zoom. Deficient Practice #2 Based on observation, interview and record review, the facility failed to ensure appropriate transportation arrangements were provided for one resident (R79) of one resident reviewed for transportation/appointments. Findings include: R79 On 1/05/26 at approximately 11:07 a.m., R79 was observed in their room, lying in bed with visitor H at the bedside. R79 was queried if they had any concerns regarding their care and visitor H reported that R79 was not provided any transportation to their Orthopedic doctor appointment that day and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their appointment was at 10:45 (AM) and as a result, they had missed the appointment. On 1/5/26 the medical record for R79 was reviewed and revealed the following: R79 was initially admitted to the facility on [DATE]. A Physician's order with a start date of 1/5/26 revealed the following: Follow up appointment w/orthopedic surgeon [Name of Surgeon] D/D (Discontinue) ONCE COMPLETE Once A Day 06:30 AM - 10:00AM A hospital Transition of Care Form dated 12/26/25 revealed the following follow-up appointments: Specialists in Orthopedic Surgery on 1/5/26 at 10:45 AM. On 1/7/26 at approximately 9:02 a.m., during a conversation with the DHS, the DHS was queried regarding R79's missed Doctor's appointment and why the facility had not assisted R79 in arranging transportation for them. The DHS reported they would look into the concern. On 1/7/26 at approximately 11:10 a.m., during a follow up conversation with the DHS, the DHS indicated there was a miscommunication between Nursing and R79's family regarding the needs for transportation to their appointment. The DHS reported the Nurse who was aware of the appointment never clarified with R79's family who was going to provide transportation to the appointment, so the appointment was missed. The DHS indicated the family member did not ask about transportation and that they just informed the facility about the appointment date and time and the Nurse who received the information and implemented the order never clarified with the family regarding who would be providing transportation. On 1/7/26 the facility policy titled transportation that pertained to how transportation was scheduled and arranged was reviewed and revealed the following: OVERVIEW-Transportation is provided from the hospital to a campus, to medical appointments by bus or car, for campus outings and various trips. We are committed ta doing aur best to accommodate transportation wherever the residents wish to go, such as shopping, restaurants, museums, parks etc, A successful transportation program has defined expectations and guidelines regarding scheduling, pricing and team responsibilities Suggested 'Steps for Communication': 1. Nursing should fill out all necessary sections of the transportation request form and submit to the TA (transportation associate) and or LED (Life Enrichment Director) at least 48-72 hours in advance of an appointment Noted changes to appointments, whether by campus or family, should be communicated, by Nursing, to the family, and to the TA DHS (Director of Health Services) Role-1. Educate the Nursing team on the process for requesting and scheduling transportation. Educate on notifying the responsible party of the medical appointment and asking them to transport their loved one first, before using in-house services .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure nutritional supplements were provided as ordered, failed to ensure timely assistance was provided for meals and failed to modify the plan of care to the resident current needs for one (R8) of three residents reviewed for Nutrition. Findings include:On 1/5/26 at 9:30 AM, R8 was observed lying on their back in bed and did not wake with verbal stimuli. Observed against the wall was R8's breakfast tray with a bowl of dry rice cereal, a sliced banana, yogurt and coffee unopened. Utensils wrapped in a navy color cloth napkin was observed to be unopened. There was no staff present in the room.Review of the meal ticket on the breakfast tray noted the following in part, . Magic cup. Peach Oatmeal. Diced Peaches. Resident Notes: [NAME] Krispies, Diced Banana, Yogurt. decaf coffee. The magic cup was not observed on the resident's tray.On 1/7/26 at 9:04 AM, R8 was observed laying on their back in bed waving their arm with their eyes unopened. Observed against the wall was R8's breakfast tray- a fruit cup, peach yogurt, a bowl of dried rice Krispies, coffee and two white Styrofoam cups- all untouched. Utensils wrapped in a navy color cloth napkin was observed untouched on the tray. There was no staff present in the room.Review of the meal ticket on the breakfast tray noted the following in part, . Magic cup. Yogurt. [NAME] Krispies. Cranberry Juice. Decaf Coffee. The magic cup was not observed on the resident's tray.On 1/7/26 at 9:20 AM, Certified Nursing Assistant (CNA) E (the aide assigned to R8 on 1/7/26-dayshift) was interviewed and asked if R8 was able to feed themselves and CNA E stated . No, she requires to be fed by staff. When asked whose responsibility it was to feed R8 their breakfast, CNA E replied the aides or the nurses.A review of the medical record revealed R8 was admitted to the facility on [DATE], with diagnoses that included: dementia, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, psychotic disorder with hallucinations, gastro esophageal reflux, cognitive communication deficit, protein calorie malnutrition, contracture to the left hand and gastrostomy status. R8 was noted to have severely impaired cognition and was dependent on staff assistance for all Activities of Daily Living (ADLs).A review of a physician order noted the following, . Fortified Foods, Pre-cut meats. Special Instructions: Magic cup with breakfast and lunch. Further review of the physician orders revealed no directive on the assistance level needed by staff for R8 meals.A review of a physician order discontinued on 7/8/25, documented the following in part . Fortified. Meats cut-up, 1:1 (one on one) assistance with meals, Magic cup with breakfast and lunch.A review of the Resident Profile documented in part . Diet: Feeding tube. Fortified foods. Regular, Regular Texture, Thin Liquids. Meats cut up. Sit upright (90 degrees) when eating and drinking and for 30 minutes after eating. Styrofoam cup for all liquids due to hand tremors. The profile gave no directive on the assistance level needed for meals.A review of the care plans revealed the staff's failure to modify the care plan to reflect the current needs of R8's assistance levels needed for meals and the failure to provide supplements as ordered.On 1/7/26 at 11:10 AM, an interview was conducted with the Director of Nursing (DON). A review of the electronic medical record was conducted with the DON. The Physician order for R8's diet and the resident profile was reviewed with the DON. The DON was asked what level of assistance is needed for R8's meals and the DON was unable to verify what assistance level was needed. The DON was then asked whose responsibility it was to ensure all supplements (magic cup) was provided to the resident at breakfast and lunch and the DON stated it was the responsibility of the kitchen staff. The DON stated they would follow up on the concerns. At 11:48 AM, the DON returned and stated they were following up on updating R8's plan of care.No further explanation or documentation was provided by the end of the survey.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Physician orders and a comprehensive plan of care was in place for one resident (R77) on oxygen therapy of one resident reviewed for respiratory care. Findings include: On 1/05/2026 at approximately 10:52 a.m., R77 was observed in their room, up in their wheelchair. R77 was observed to have oxygen infusing at 2 LPM (liters per minute). R77 was asked if they know how much oxygen they should be receiving and they reported they did now know. On 1/6/26 at approximately 2:05 p.m., R77 was observed in the common area, up in their wheelchair. R77 was observed to have a portable E-tank of oxygen infusing via nasal canula at 2.5 LPM. On 1/6/26 at approximately 2:30 p.m., R77 was observed in their room, laying in their bed. R77 was observed to have oxygen infusing at 2 LPM. On 1/6/26 the medical record for R77 was reviewed and revealed the following: R77 was initially admitted to the facility on [DATE] and had diagnosis including Chronic obstructive pulmonary disease, and Anxiety disorder. A review of R77's Physician orders was conducted and did not reveal any orders from the Physician that indicated how many liters per minute of oxygen therapy R77 was supposed to be provided. A review of R77's care plan was reviewed and revealed the following: No baseline care plan or comprehensive care plan was present in the record addressing R77's use of oxygen therapy. On 1/6/26 at approximately 2:32 p.m., Nurse D was queried regarding how many liters per minute R77 should be provided and they indicated it should be 1-2 liters per minute. Nurse D was then observed reviewing R77's medical record and indicated R77 did not have a current order for oxygen and that they would have to put one in. Nurse D was queried if R77 had been on oxygen therapy for a long time and they reported they had and thought that there used to be an order for them. Nurse D was observed reviewing old Physician orders and they indicated that R77 had a previous oxygen order, but it had been discontinued, and nobody had placed a new order in the record. On 1/6/26 at approximately 2:40 p.m., MDS (minimum data set) Coordinator G was queried regarding the location of baseline care plans for R77 who was a newly admitted residents on oxygen therapy. MDS Coordinator G reviewed R77's medical record and indicated that R77 did not have a plan of care for oxygen therapy and that they would have to ensure one was placed in the record. On 1/7/26 at approximately 9:02 a.m., during a conversation with the Director of Health Services (DHS), the DHS was queried regarding the clinical process for residents on oxygen therapy and they reported that the resident needs a Physician's order and a plan of care to be provided oxygen. A facility document titled Oxygen Administration was reviewed and revealed the following: OVERVIEW Guidelines to properly Administering Oxygen and any Respiratory procedure. SOP (standard operating procedure) 1. Verify physician's order for the procedure .