

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Novi Lakes Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 41795 W 12 Mile Rd Novi, MI 48377	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to implement key elements of an effective water management plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility . Findings include:On 7/7/2026 at 9:45 AM reviewed Water Management Program (WMP) documents with the Director of Plant Operations (DPO) N. Review of the document titled Legionella Water Management Plan (undated, 6 pages) identified the Water Management Team (WMT) as: Executive Director, Director of Plant Operations, Director of Health Services, and Director of Environmental Services. When asked about how the WMT functions, DPO N indicated that they do not meet regularly and have not met in the past year. The current WMP has not been reviewed/updated annually by the WMT.The WMP documents did not include a facility risk assessment to identify areas where Legionella and other opportunistic waterborne pathogens could grow and spread. The WMP did not include procedures for communication of WMP activities to the WMT, including annual legionella testing results and follow up activities.Though not indicated in the Legionella Water Management Plan (undated) document, the facility conducts annual legionella testing, and 2026 annual legionella testing results were reviewed. When asked about communication with the WMT about the testing results, DPO N indicated consulting with the corporate maintenance support person and following instructions to apply engineering controls (cleaning, disinfecting, changing faucet aerators and shower heads) when needed. DPO N indicated the WMT was not informed of the annual legionella test results, and no retesting had taken place. On 7/7/2026 at 11:25 AM interviewed the Director of Health Services (DHS). When asked about WMT involvement, she indicated the WMT doesn't meet regularly and DPO N would share concerns as needed. When asked if she was aware of annual legionella sampling results from 2025 or 2026, she was not. When asked if there had been any legionella cases in the past year, she indicated there were not.On 7/7/2026 at 11:45 AM interviewed the Executive Director (ED). When asked about WMT involvement, he indicated the WMT doesn't meet regularly. When asked if he was aware of annual legionella sampling results from 2025 or 2026 before today, he was not. He indicated that going forward the facility would include the WMP in their Quality Assessment and Performance Improvement (QAPI) program.On 7/7/2026 at 2:10 PM asked ED and DHS for any additional policies or procedures for their WMP. Corporate Clinical (CC) staff member A provided a corporate standard operating procedure (SOP) document titled Annual Legionella Testing dated 4/3/2019. This document was not currently part of the facility WMP documents. Record review of this document indicated that: Facilities Management Support will collaborate with the campus and [the vendor lab] to create the action plan for positive results. All results, retests, and steps taken must be uploaded into [electronic maintenance logs] and a copy kept in the Water Management Binder. The SOP did not include procedures for communication of testing results with the facility WMT.On 7/8/2026 at 1:45 PM An additional WMP related document (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was provided by DPO N for review, it was located within the facility Emergency Operations Plan and titled Legionella and Other Opportunistic Pathogens (undated). Record review of this document found the following: A risk assessment of water system components will be conducted to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will be completed by facility leadership and the Infection Preventionist with collaboration from other facility team members such as maintenance employees, safety officers, risk and quality management staff, and Director of Nursing. The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to determine self-administration of medications was safe and appropriate for three (R5, R46, R30) of four observed with medications at the bedside. Findings Include. R46 On 7/6/26 at 10:11AM, R46's bedside table was observed revealing two tubes of Vitamin A&D ointment (moisture barrier topical medication) and one tube of Calmoseptine (zinc and menthol topical medication). Record review of R46's Medication Administration Record (MAR) did not indicate Vitamin A&D and Calmoseptine was ordered and no prescriber's order to self-administer. On 7/7/2026 at 8:11AM, During medication administration for R11, one tube of Vitamin A&D ointment was observed on the bedside table. Record review of R11's MAR did not indicate Vitamin A&D was ordered and no prescriber's order to self-administer. On 7/7/26 at 12:21 PM, R46 was interviewed with their daughter at bedside. When inquired about having Vitamin A&D ointment and Calmoseptine, R46 could not explain the purpose of the medications and per the daughter, R46 had confusion and would not understand their use. The daughter further stated that R46 had a history of dry skin over their eye and had a history of chaffing in between their legs. Per the daughter, they assumed it may have been for those skin conditions but was not certain. R30 On 7/7/2026 at 12:20 PM, an observation of R30's room revealed a tube of Zinc Oxide (mild antiseptic skin protectant) observed at bedside. Record review of R30's MAR did not indicate Vitamin A&D was ordered and no prescriber's order to self-administer. On 7/7/26 at 4:34 PM, the Director of Nursing (DON) was interviewed and confirmed that Vitamin A&D ointment, Calmoseptine, and Zinc Oxide are medications and would have to be documented on the MAR. The DON acknowledged residents must have an order to self-administer and medications are not left at the bedside. R5 On 7/6/26 at approximately 9:25 AM, R5 was observed lying in bed. The resident was alert and able to answer questions asked. During the interview two bottles of anti-fungal powder were observed on top of the resident's nightstand. R5 was asked about the powder and noted that they apply it underneath their breast because their fungus causes itchiness. A review of R5's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: encephalopathy, dementia, anxiety and psychotic disorder. (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of R5's clinical record did not note any orders for fungal powder, nor were there any orders that the R5 could self-administer medication. On 7/7/26 at approximately 10:31 AM, a second observation was made of R5. The two bottles of fungus powder were still in their room. On 7/7/26 at approximately 11:25 AM, an interview was conducted with the Director of Nursing (DON). The DON was queried as to the fungus powder and whether R5 could self-administer the medication. The DON reported that the resident did not have an order to self-administer medication.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review, the facility failed to ensure medications were stored safely, securely, and properly, in one of two medication administration carts, two of two treatment carts, and one of one medication room observed for medication storage and labeling. Findings include: On 7/7/26 at 7:56 AM, the [NAME] Trail treatment cart was observed unlocked, the top drawer revealed resident treatment medications. On 7/7/26 at 8:16 AM, the [NAME] Trail medication cart was observed for medication storage with Licensed Practical Nurse (LPN) C and revealed a bottle of lubricating eye drop medication and a nasal spray medication with no patient identifiers. LPN C acknowledged they did not know who they were prescribed to and commented they would have to find out. The second drawer revealed a round orange colored pill tablet unpackaged. The third drawer was observed with two round white colored pills unpackaged. On 7/7/26 at 8:56 AM, the Assistant Director of Nursing (ADON) E provided access to the [NAME] Lane medication room. The lower drawer of a medication cart in the medication room revealed bags of intravenous (IV) fluids. ADON E acknowledged they were current medications and available for residents who required intravenous fluid replacement. The bags were examined for expiration dates and revealed the following: two bags of D5 (dextrose) expired in October 2025, one bag of D10 (dextrose) expired in April 2025, one bag 0.45 (half normal saline) expired April 2025, and one bag of D5 with normal saline expired January 2026. ADON E acknowledged the medications were expired and was observed immediately throwing them into a garbage bag. On 7/7/26 at 4:34 PM, the Director of Nursing (DON) was interviewed and remarked Nursing staff had informed them of the medication storage concerns including unidentified medications in the medication carts and expired IV fluids. The DON was also informed of the treatment cart being unlocked and acknowledged the concerns. On 7/8/26 at 8:21 AM, the [NAME] treatment cart was observed unlocked and the top drawer revealed resident treatment medications. On 7/8/26 at 8:31 AM, ADON E was made aware of the unlocked treatment cart and acknowledged it should not be left unlocked. Record review of the policy titled Medication Storage in the Facility documented; Medications and biologicals are stored safely, securely, and properly. All expired medications will be removed from the active supply.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to provide a clean, comfortable, homelike environment for one [R69] of two residents reviewed for environment. Findings include: On 7/6/26 at 9:27 AM, R69 was observed sitting in a wheelchair in their room. R69 was asked if they had any concerns about the facility. R69 explained on Saturday [7/4/26] they were taking a shower in the bathroom when they had an accident [bowel movement]. the aide just put a towel over it. on Sunday [7/5/26] they told Licensed Practical Nurse [LPN] ?L' about the bathroom floor not being cleaned up and he sent three people in to clean it, but it still was not clean. Observation of the floor in R69's bathroom between the toilet and the shower area revealed multiple spots of brown material, some approximately the size of a quarter, some approximately the size of a dime and some dot like. An area of grout between the tiles that had the appearance of a brown colored liquid dried on the grout. When told of the observation of the bathroom floor, R69 explained they kept a very clean, tidy house and it was upsetting that the bathroom floor at the facility was not clean. Review of the clinical record revealed R69 was admitted into the facility on 7/3/26 with diagnoses that included: hydrocephalus [buildup of cerebrospinal fluid in the brain], anxiety disorder and paroxysmal atrial fibrillation. According to a Brief Interview for Mental Status [BIMS] exam dated 7/6/26, R69 was cognitively intact. On 7/7/26 at 9:03 AM, observation of R69's bathroom floor revealed the same spots of brown material and grout staining. On 7/7/26 at 2:11 PM, LPN ?L' was interviewed and asked about R69's bathroom floor. LPN ?L' explained R69 was getting a shower on Saturday when they had a bowel movement. had thought Certified Nursing Assistant [CNA] ?M' had cleaned it up, but on Sunday R69 told him the floor was still not clean. the CNA on Sunday was a different CNA and he did not think she should have to clean up the mess because CNA ?M' was working on a different hall, so he went and told CNA ?M' to clean R69's bathroom floor. CNA ?M' came with two other staff members and said they cleaned the floor. then R69 had told him the floor still was not clean that morning, so he had housekeeping go in and clean it. On 7/8/26 at 12:49 PM, CNA ?M' was interviewed by phone and asked about R69's bathroom floor. CNA ?M' explained she was giving R69 a shower on Saturday when R69 had a bowel movement. she put a towel on top of the bowel movement and continued the shower. tried cleaning it up with towels as best as she could. the next day she and a friend finished trying to clean it up. CNA ?M' was told of the observation of the spots of brown matter that were still present on Monday and Tuesday. CNA ?M' explained she had cleaned it up the best she could. On 7/8/26 at 1:43 PM, the Administrator was interviewed and asked if it was acceptable for brown matter to be present on a bathroom floor from Saturday to Tuesday. The Administrator explained that was not acceptable and it was his expectation that the floor should have been cleaned on Saturday. Review of a facility policy titled, Room Cleaning-Health Center Rooms undated read in part, .Clean floor and remove trash replacing bags. Use the room. Service Standards checklist to ensure room meets standards.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review the facility failed to ensure tube feeding automatic water flush was administered per the physician order for one [R70] of one resident reviewed for tube feeding. Findings include: On 7/6/26 at 9:45 AM, R70 was observed lying in bed. A tube feeding pole was observed next to R70's bed. Two bags were hanging from the top of the pole, one contained the tube feeding formula and one contained water. The tube feeding pump indicated it was delivering the formula. The bag containing the water for automatic flush appeared to be full, it was at the 1000 milliliters [ml] mark at the top of the bag. Upon further observation, the pump was not set for automatic water flush, the settings were blank. R70 was asked if they were able to eat or drink food or water in addition to their tube feeding. R70 explained they only received tube feedings, they did not eat or drink any food or water. Review of the clinical record revealed R70 was admitted into the facility on 7/3/26 with diagnoses that included: stroke, dysphagia [difficulty swallowing] and lung cancer. According to a Brief Interview for Mental Status [BIMS] exam dated 7/3/26, R70 was cognitively intact. Review of R70's tube feeding care plan initiated 7/6/26 revealed interventions that included, .Administer enteral feeding per doctor's order. Assess for dehydration. Review of physician orders for R70 revealed an order with a start date of 7/5/26 for automatic water flushes with a rate of 40 ml/hr [milliliters per hour]. On 7/6/26 at 2:59 PM and 7/7/26 at 9:00 AM, observation of R70's tube feeding revealed a full bag of water, 1000 ml, and the pump not set to deliver automatic flushes. On 7/7/26 at 10:04 AM, R70's automatic flush settings was observed with the Director of Nursing [DON]. The DON verified the flush bag was full, and that the pump was not set to deliver automatic flushes. On 7/7/26 at 11:16 AM, the DON explained R70 should have been getting automatic flushes at 40 ml/hr, and she had contacted the doctor and told the dietician that R70 had not been receiving flushes. Review of a facility policy titled, Tube Feedings undated read in part, .Pumps allow rates to be set for feeding product and water flushes.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident's medical record was accurate and complete for one (R73) of one resident reviewed for accurate resident records. Findings include: On 7/6/26 at approximately 10:39 AM, R73 was observed lying in bed. The resident was alert but had difficulty answering questions asked due to a language barrier. The resident's family member was present and noted that the resident was admitted to the facility on [DATE] following a fall at home. A review of R73's electronic medical record was conducted utilizing the Quick Guide for Surveyor form. The form noted that to obtain resident's diagnoses the Surveyor should review the residents face sheet by scrolling to current IDC-10 (international classification of diseases). An attempt was made to obtain R73's diagnoses via their face sheet, but no diagnoses were noted. Continued review of R73's clinical record revealed, in part the following: 7/7/26 (9:24 AM): Resident admitted with dx (diagnosis) of depression & insomnia and will remain on trazadone (an antidepressant used to regulate mood and also acts as a sedative). Authored by Social Service Director (SSD) B. On 7/7/26 at approximately 12:22 PM, an interview was conducted with SSD B. SSD B was asked as to how they obtained the diagnoses of depression and insomnia for R73 as nothing had been noted on the resident's face sheet. SSD B reported that when no diagnoses are noted on a face sheet, they are instructed to view the resident's hospital records provided upon entry. SSD B noted that it is often difficult to find the diagnoses via hospital records. When asked how they determined the resident had a diagnosis of depression and insomnia, SSD B pulled up R73's hospital record, scrolled through several pages and pointed out an area on the documentation that noted the resident had a H/o (history of) Insomnia. SSD B could not locate a diagnosis of depression and noted that they would revise their note as Depression was not noted. On 7/8/26 at approximately 9:35 AM, the Administrator was queried as to why R73 did not have accurate diagnoses in their medical record face sheet. The Administrator reported that they were aware that newly admitted residents' diagnoses are not placed in the residents' records by facility staff and suggested speaking with Corporate Clinical Registered Nurse (CCRN) A. On 7/8/26 at approximately 9:41 AM, an interview was conducted with CCRN A. CCRN A was asked about the delay in putting in residents diagnoses on their face sheets and the issue that occurred with R73. CCRN A noted that they were aware of the delay with residents' diagnoses being entered into their medical records and confirmed that putting in incorrect diagnoses is a concern. On 7/8/26 at approximately 8:44 AM, a request for the facility policy pertaining to accurate medical records was made. No policy was provided before the end of the survey.		