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	10/09/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to notify, in writing, the reason for a discharge out of the facility to a representative of the State Long term Care Ombudsman for one (R40) of one residents reviewed for discharges. Findings include: On 10/8/24 the medical record for R40 was reviewed and revealed the following: R40 was initially admitted to the facility on [DATE] and was transferred to the hospital on 8/4/24 and did not return. A review of R40's MDS (minimum data set) with an ARD (assessment reference date) of 7/26/24 revealed R40 needed assistance from facility staff with their activities of daily living. A progress note dated 8/04/2024 at 11:19 a.m., revealed the following: Writer received resident resting in bed with eyes open. Resident is A&O x1(alert and oriented to themselves) with some confusion. Resident vital signs WNL (within normal limits), denies pain. CRCA (Certified Nursing Assistant) informed writer resident refused to let CRCA get her dressed and said she is not going anywhere, and leave her alone. While writer went in room to discharge resident she became very agitated with writer and her husband, stating 'Get my ex-husband out of here', 'I'm not going anywhere'. Resident was to be discharge <sic> home today with husband , she keep saying 'I am not going anywhere' and 'Don't touch me.' Writer contacted provider to inform of resident condition, provider order <sic> resident to be sent out EMS (Emergency Medical System) for further evaluation, due to increase <sic> confusion and agitation. Resident husband and son present at the time. Writer printed and gave CCD (Continuity of Care Document,) and Face sheet to EMS. Further review of R40's medical record revealed no documentation that notification of the transfer to to hospital was provided to the Long term care Ombudsman. On 10/8/24 at approximately 2:47 p.m., the Administrator was informed that the documentation of notification to the Ombudsman was unable to be found in the record and was requested from the facility. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/24 at approximately 2:59 p.m., Social Worker A (SW A) was queried regarding the documentation of the bed hold notification and ombudsman notification of transfer for R40. SW A. reported that the resident was supposed to discharge home with their family that day but was instead transferred to the hospital from the facility. SW A indicated that the way the information was entered into the medical record was that they were discharged and it did not trigger them to send the notices, so they were not sent. SW A indicated that after reading the notes in the record that the notices of bed hold provision and the transfer for the ombudsman for R40 should have been provided due to R40 being transferred to the hospital from the facility. On 10/9/24 a facility document titled ombudsman notification was reviewed and revealed the following: OVERVIEW-CMS (Centers for Medicare & Medicaid Services) Requirements of Participation, this SOP (standard operating procedures) will detail expectations on communication of facility initiated transfer or discharges to the State Long-Term Care Ombudsman. SOP DETAILS-Federal regulation requires that the facility sends a copy of the notice of transfer or discharge to a representative of the Office of the State Long-Term Care Ombudsman. This applies to facility-initiated discharges. The Director of Social Services, or designee, will email a copy of the notice of transfer or discharge to the Office of the State Long-Term Care Ombudsman at least 30 days before the resident is transferred or discharged . The Director of Social Services, or designee, will complete the Ombudsman Notification Observation in the electronic health record as evidence that the notice was sent to the State Long-Term Care Ombudsman. Exceptions to the 30-day requirement apply when the transfer or discharge is because- 1. The resident's welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility); or 2. The health or safety of others in the facility is endangered. In these cases, the Director of Social Services, or designee, will instead send a list of transferred and discharged residents that were exempt from the 30-day requirement on a monthly basis. The Director of Social Services, or designee, will then complete the Ombudsman Notification Observation in the electronic health record as evidence that the notice was sent to the State Long-Term Care Ombudsman. If the Director of Social Services is not present or available, the Executive Director should delegate this task to another team member to assure these notices are sent to the State Long-Term Care Ombudsman within the required time frame and the Ombudsman Notification Observation in the electronic health record is completed.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review, the facility failed to provide a written copy of the bed hold notification to the resident/resident's representative, upon acute transfer to the hospital for one (R40) of one residents reviewed for transfers/discharges. Findings include: On 10/8/24 the medical record for R40 was reviewed and revealed the following: R40 was initially admitted to the facility on [DATE] and was transferred to the hospital on 8/4/24 and did not return. A review of R40's MDS (minimum data set) with an ARD (assessment reference date) of 7/26/24 revealed R40 needed assistance from facility staff with their activities of daily living. A progress note dated 8/04/2024 at 11:19 a.m., revealed the following: Writer received resident resting in bed with eyes open. Resident is A&O x1(alert and oriented to themselves) with some confusion. Resident vital signs WNL (within normal limits), denies pain. CRCA (Certified Nursing Assistant) informed writer resident refused to let CRCA get her dressed and said she is not going anywhere, and leave her alone. While writer went in room to discharge resident she became very agitated with writer and her husband, stating 'Get my ex- husband out of here', 'I'm not going anywhere'. Resident was to be discharge home today with husband , she keep saying 'I am not going anywhere' and 'Don't touch me'. Writer contacted provider to inform of resident condition, provider order resident to be sent out EMS (Emergency Medical System) for further evaluation, due to increase confusion and agitation. Resident husband and son present at the time. Writer printed and gave CCD (Continuity of Care Document,) and Face sheet to EMS. Further review of R40's medical record revealed no documentation that a copy of the bed hold notification was provided to the resident or residents representative when transferred to the hospital. On 10/8/24 at approximately 2:47 p.m., the Administrator was informed that the documentation of notification that the bed hold provision to R40 was unable to be found in the record and was requested from the facility. On 10/08/24 at approximately 2:59 p.m., Social Worker A (SW A) was queried regarding the documentation of the bed hold notification and the ombudsman notification of transfer for R40. SW A reported that the resident was supposed to discharge home with their family that day but was instead transferred to the hospital from the facility. SW A indicated that the way the information was entered into the medical record was that they were discharged and it did not trigger them to send either of the notices so they were not sent. SW A indicated that after reading the progress notes in the record, that the notices of bed hold provision and transfer to the to the ombudsman for R40 should have been provided due to R40 being transferred to the hospital from the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 a facility document titled Bed hold notification was reviewed and revealed the following: OVERVIEW -Residents and Responsible Parties have a right to be notified verbally and in writing on reserve bed payment policy per the state plan when someone goes out to the hospital or on a therapeutic leave. Before a nursing facility transfers a resident to a hospital or the resident goes on a therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration of the state bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; the reserve bed payment policy in the state plan if any; the nursing facility's policies regarding bed-hold periods permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed hold policy SOP (standard operating procedures)-Before transferring a resident to a hospital or allowing a resident to go on a therapeutic leave, the Nursing designee or other designated staff member should provide written information to the resident and a family member or legal representative of the bed hold and admission policies .In cases of emergency transfers, the notice of bed hold policy under the state plan and facility's bed hold policy should be provided to the resident or resident's representative by nursing designee within 24 hours of the transfer. This may be sent with other papers accompanying the resident to the hospital .During the daily census reconciliation when transfer/discharge information is identified, the BOM will place a phone call to the Responsible Party notifying them of the bed hold policy and the room reserve rate allowing them to direct facility to hold the bed or not .Medicare A and Managed Care Primary - Payers do not cover bed holds when Resident is on a hospital or therapeutic leave over 24 hours. BOM will place a phone call to the Responsible Party. If the Resident/Responsible Party elects not to hold the bed, a discharge census event will be entered. Follow census event guide for instructions. Medicaid primary - If the hospital leave or therapeutic leave extends longer than the state allowed Medicaid bed hold days, BOM will contact the Responsible Party to see if they would like to pay to continue to hold the bed at the Medicaid per diem rate. If they elect not to hold the bed, they will be subject to the next available bed and Responsible Party should make arrangements to remove belongings from the room. IN Only: There will be a 10-day courtesy bed hold per hospital and therapeutic leave. When updating census in MatrixCare, make sure to choose non-billable for both hospital and therapeutic leaves with a status code of 30 still patient to ensure Level of Care is not terminated Once phone call is placed, BOM will make note of conversation and outcome in the Progress Notes section in MatrixCare and complete Resident Bed Hold Authorization Form. Progress Note should be detailed and include person spoken with and notification of whether or not they elected to hold the bed. Resident Bed Hold Authorization form should be completed and Resident/Responsible Party signature obtained by fax, e-mail scan or mailed and returned. Bed Hold Policy should be sent with authorization form .When Resident Bed Hold authorization form is signed it should be scanned in to Resident documents in MatrixCare and filed in the resident AR file. Follow census event guide to enter the correct census event in MatrixCare .

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on observation, interview and record review, the facility failed to ensure coordination of behavioral health services for five (R4, R17, R35, R32 and R145) of five residents reviewed for behavioral health care, resulting in delayed and/or unmet mental and psychosocial care needs and staff unaware of individualized approaches and targeted behaviors. Findings include: R145 On 10/07/24 at approximately 10:01 a.m., R145 was observed in the hallway/common area sleeping on the couch and was difficult to arouse. On 10/08/24 at approximately 9:25 a.m., R145 was observed in their room, laying in their bed with a nasal cannula that was infusing oxygen at two liters per minutes. R145 appeared to be confused when asking questions regarding the staffing levels in the facility was and providing nonsensical responses. On 10/7/24 the medical record for R145 was reviewed and revealed the following: R145 was initially admitted to the facility on [DATE] with diagnoses that included vascular dementia, unspecified severity, without behavioral disturbance; psychotic disturbance; mood disturbance; and anxiety. A review of R145's MDS (minimum data set) with an ARD (assessment reference date) of 9/18/24 revealed R145 needed assistance from staff with most of their activities of daily living. R145's BIMS score (brief interview for mental status) was eight, indicating moderately impaired cognition. A review of R145's active Psychotropic medications revealed the following: Rexulti (brexpiprazole) (antipsychotic medication) ICD-9 Diagnosis: N/A with a start date of 9/12/24 and Lexapro(escitalopramoxalate) tablet; 5 mg (milligram); amt (amount): 1tab (tablet); oral Special Instructions: Anxiety with a start date of 9/29/24. A review of R145's social service assessment dated [DATE] revealed the following: Psychiatric/Mood/Other Diagnosis: [None of the above] (checked) .Resident's mood is addressed in the plan of care: [No] (checked) . Potential Indicators of Psychosis-Check all that apply-[None of the above] (checked) . A progress note dated 9/29/24 revealed the following: Resident wife informed provider resident was taken Lexapro 5mg Daily at home for anxiety. Writed <sic> contacted [Physician] and okay with resident (taking) medication while at facility. Provider request resident to be seen by Psych. Writer placed new order into EMAR (electronic medication administration record). A review of R145's comprehensive care plan failed to identify the specific resident centered behaviors and symptoms of their individualized behavioral health disease process that would warrant the prescribed antipsychotic and antidepressant medications as well as resident specific monitoring of their identified behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/24 at approximately 10:15 a.m., during an interview with Social Worker A (SW A), SW A was Informed of the medical record review for R145 that did not include any documentation of focuses on R145's potential mood or psychosis symptoms as well as no individualized targeted behaviors or resident specific interventions that were not present in record that warranted administering antipsychotic and antidepressant medications. SW A was also queried why R145 did not have a diagnosis for their antipsychotic medication. SW A responded by indicating that they did not have a diagnosis for the medication due to R145 declining facility psychiatric services. SW A then reported that when a resident declined psychiatric services, the attending Physician had to do the evaluation and put in the appropriate diagnoses. SW A was queried who was responsible for talking with the family and the resident to identify the resident's specific behaviors and interventions to appropriately address their behavioral health needs while at the facility and they indicated it was the interdisciplinary team that did them together. At that time, SW A was queried for any further documentation that R145 had resident specific interventions and targeted behaviors for their psychotropic medications and behavioral health needs. No additional information was received before the end of the survey. 48680 R32 On 10/7/24 at 10:20 AM, R32 was observed in the hall way in a wheel chair. R32 went to their room so they could be asked about their stay at the facility the R32 stated their were no issues with the facility and that they enjoyed it here. A record review revealed that R32 was admitted to the facility on [DATE] with the diagnosis of muscle weakness, dysphagia and personal history of behaviors and mental disorders. With a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Further review revealed that R32 was prescribed Clonazepam (an antianxiety medication) 0.5mg and sertraline (an antidepressant medication) 100mg. A medication regimen review was completed on 9/26/24 with the recommendation to conduct a gradual dose evaluation for sertraline and clonazepam. The care plan was reviewed and there was no targeted behaviors specific to the resident as to what staff should look for and there were no non-pharmacological interventions in place for the resident. On 10/8/24 at 10:17AM an interview was held with SW A. She was asked when R32 was last evaluated by psychiatric services since the MRR (Medication Regimen Review) stated they (the facility) would obtain an evaluation. SW A said that R32 had refused psychiatric services and the attending physician was supposed to cover and review the medication recommendations. SW A was then asked how would the frontline staff (nurses/certified nursing assistants) know the targeted behaviors were and what are the non pharmalogical interventions in place for R32 to determine whether they need to be medicated. SW A explained that there were no patient specific behaviors documented in the medical record or care plan that would alert the frontline staff of targeted behaviors. 41415 R17 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/7/24 at 9:22 AM, R17 was observed in the community room sitting in their wheelchair with their eyes closed. R17 did not respond to verbal stimuli. A review of the medical record revealed R17 was admitted to the facility on [DATE] with diagnoses that included: dementia, restlessness, agitation, and adjustment disorder with anxiety. A Minimum Data Set (MDS) assessment dated [DATE] documented a BIMS score of 3 which indicated severely impaired cognition. Review of the physician orders included the following medications: Buspirone 15 mg (milligram) three times a day for anxiety Lorazepam 0.5 mg every 4 hours as needed for anxiety Seroquel 25 mg for increased behaviors and delusions Trazodone 50 mg once a day and 100 mg at bed time for increased behaviors A review of the care plans failed to identify the resident's behaviors, resident specific monitoring of their identified behaviors and resident centered interventions to address the behavioral needs of the resident. R4 On 10/7/24 at 9:36 AM, R4 was observed lying in bed on their back. A review of the medical record revealed R4 was admitted to the facility on [DATE] with diagnoses that included mood disorders. Review of the physician orders revealed the medication of Trazodone 150 mg. There was no indication for use noted. Review of a Social Services note dated 8/25/24 at 12:06 PM, documented in part . DX (diagnosis): delusional disorders, insomnia, mood disorder . Target behavior are in place for depression . Review of the care plans failed to identify the resident's behaviors, resident specific monitoring of their identified behaviors and resident centered interventions to address the behavioral needs of the resident. R35 On 10/7/24 at 9:01 AM, R35 was observed seated on a couch in their room with the lights off. R35 was watching an electronic device on their table. A review of the medical record revealed R35 was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease, Dementia, Anxiety disorder, and Depression. Review of the physician orders revealed the following medications: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Buspirone 10 mg for anxiety three times a day Escitalopram oxalate 20 mg once a day for depression Risperdal 0.5 mg twice a day for behaviors Wellbutrin XL 450 mg once a day for depression Review of the care plans failed to identify the resident's behaviors, resident specific monitoring of their identified behaviors and resident centered interventions to address the behavioral needs of the resident. On 10/8/24 at 10:13 AM, the Social Worker (SW) A was interviewed and asked what resident specific behaviors were being monitored for R's 17, 4, & 35 and what resident centered interventions were implemented for the behaviors. SW A stated they would review the medical record and follow back up. At 10:27 AM, SW A returned and acknowledged they were unable to provide additional information or documentation. SW A confirmed the facility utilized a generic physician order to monitor residents on psychotropic medications, however the orders were not resident specific. No further information or documentation was provided by the end of the survey.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 22960 Based on observation and interview, the facility failed to maintain the exterior dumpster area in a sanitary manner. This deficient practice had the potential to affect all residents in the facility. Findings include: On 10/7/24 at 9:05 AM, 8-10 trash bags were observed on the ground next to the dumpster. There was a brown liquid leaking out onto the ground from one of the bags. Dietary Manager (DM) D stated that the dumpster was probably full, so staff put the bags on the ground. DM D further stated that the dumpster was emptied this morning, but the bags had not yet been transferred into the dumpster.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 41415 Based on interview and record reviews the facility failed to implement an effective antibiotic stewardship program for three (R302, 192, & 193) of five residents reviewed for infections. Findings include: Review of the Center for Disease Control's (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 2015: .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority.Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use . Antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics when followed over a year . studies have shown that40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile, increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic- resistant organisms .Infection prevention coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections .Identify clinical situations which may be driving inappropriate courses of antibiotics such as asymptomatic bacteriuria or urinary tract infection prophylaxis and implement specific interventions to improve use . Review of the April, May, & June 2024 infection surveillance logs revealed the following: April - R302 was documented to have a Urinary Tract Infection (UTI) that did not meet McGeer's criteria (a tool utilized to determine if antibiotics are being utilized appropriately). Macrobid (an antibiotic) was prescribed to the resident from 4/4/24 until 4/9/24. May - R192 was documented to have a UTI that did not meet McGeer's criteria. Bactrim DS (an antibiotic) was prescribed to the resident from 5/7/24 until 5/11/24. June- R193 was documented to have a UTI that did not meet McGeer's criteria. Cephalexin (an antibiotic) was prescribed to the resident from 6/25/24 until 7/1/24. Review of the medical records for R's 302, 192 & 193 revealed no documentation that either antibiotic was reviewed for appropriateness. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/24 at 1:50 PM, a meeting was held with the facility's interim Infection Control Nurse (ICN) B (who also served as the facility's Infection Preventionist). ICN B stated they had recently obtained the duties as the ICN for the last few weeks as an interim. ICN B confirmed when asked that the facility followed the McGeer's criteria for all infections. ICN B was asked the facility's protocol for residents who are admitted with an antibiotic or recently prescribed an antibiotic for an infection that did not meet criteria. ICN B stated they probably should be notifying the providers, however they stated they have not notified the providers of the residents who did not meet criteria. ICN B stated moving forward they would ensure the providers are notified of the residents that did not meet criteria and ensure documentation is kept in the medical records. ICN B was asked about R's 302, 192 & 193 and asked how they ensured the appropriateness of each antibiotic prescribed to the residents if they did not meet criteria of an infection and ICN B stated they would review the records and follow back up. At 2:52 PM, ICN B returned and stated they were unable to provide any additional information or documentation. Review of a facility policy titled Antibiotic Stewardship Guideline reviewed 12/31/23, documented in part . PURPOSE - Optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic . New orders for antibiotic usage will be reviewed . including antibiotics on new admissions from the community .