STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2591271. Based on interview and record review, the facility failed to notify a resident's emergency contact regarding emergency incidents including 1) A resident fall, 2) resident injury, 3) An emergency transfer to an acute care hospital for 1 resident (Resident #3) of 4 residents reviewed for falls resulting in Resident #3's emergency contact being unaware of her fall, injury and subsequent transfer to an acute care hospital for evaluation and treatment. Findings include: Resident #3 (R3)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R3 admitted to the facility on [DATE] with pertinent diagnoses including dementia (decline in cognitive abilities, memory and thinking skills that interfere with daily life), repeated falls, anxiety and depression. Brief Interview for Mental Status (BIMS) reflected a score of 7 out of 15 which indicated R3 was severely cognitively impaired (00 to 07 is severe cognitive impairment).Review of R3's fall report dated 8/5/2025 at 1:45 AM revealed Heard loud noise and resident yelling help. Walked in resident room with CNA (Certified Nursing Assistant) and observed resident lying on back behind door. Asked resident what she was trying to do prior to fall, resident stated I do not know. Assisted resident to standing position with staff assistance x 2 (2 staff member helping to get her up). Assessed resident and observed bleeding to back of head from a gash .Immediate action taken: Resident Taken to the Hospital: Y (yes). Agencies/ People Notified: Physician 8/5/2025 at 2:00 AM). The family was not notified per the fall report. Review of R3's concern form dated 8/5/2025 revealed Details of concern: Received VM (voicemail) from resident's DIL (daughter-in-law) requesting callback. Spoke with (DIL) and she was upset and asking how to get resident moved to another facility. DIL stated resident fell at 1:45 AM and was sent to ED (emergency department). They were not notified by UCRC (Upjohn Community Care Center) staff until 6:30 AM when being D/C (discharged) from hospital w/ (with) staples. Director of Nursing (DON) B completed the follow-up which revealed Action taken. was able to speak with resident's spouse and son and apologized for the breakdown in communication.staff will be reeducated on the importance of contacting family for emergency situations. Date contacted family: 8/5/2025. Another concern form was filled out on 8/5/2025 which revealed Details of concern: family requested to see someone regarding resident's care. Family was upset because they were not notified that resident had a fall at 1:45 AM. Residents spouse states he was not called until 6:30 AM. Action taken: Apologized to resident and resident's spouse. Provided direct contact information for Director of Nursing and Unit Manager for any other concerns.During an interview on 9/15/2025 at 11:55 AM, R3 stated that she didn't remember having a fall at the facility.During an interview on 9/16/2025 at 1:39 PM, FM X stated that they were not notified of R3's fall when she fell at 1:30 AM and they were called when R3 was leaving the hospital after receiving staples in her head. FM X stated that R3 always had a family member with her when she went to the hospital so she must have been scared to be by herself. FM X said that the facility can call them anytime of the day or night if anything comes up. During an interview on 9/16/2025 at 2:27 PM, Nursing Home Administrator (NHA) A and DON B' stated that they weren't sure why family wasn't notified of R3's transfer to the hospital but Registered Nurse (RN) Z was reeducated on the policy on 8/6/2025. Review of the Notification of Changes Policy with an implementation date of 3/5/2024 revealed .Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include:1. Accidents a. Resulting in injury. b. Potential to require physician intervention .4. A transfer or discharge of the resident from the facility. Additional considerations: 1. Competent individuals: a. The facility must still contact the resident's physician and notify resident's representative, if known.2. Residents incapable of making decisions: a. The representative would make any decisions that have to be made.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2591271 and #2581648. Based on observation, interview, and record review, the facility failed to ensure a resident received the necessary care and services, consistent with professional standards of practice to identify and promote the healing of a pressure ulcer in 1 resident (Resident #6) of 3 residents reviewed for pressure ulcers/skin conditions resulting in the potential for worsening and/or reoccurrence of pressure injuries due to not having the appropriate treatment in place to help with wound healing. Findings include:In an observation on 9/17/25 at 1:50 PM, observed Resident #6 in bed. DON “B” and resident rolled to right side. Observed on both left and right buttocks quarter size stage II healing pressure ulcers. Resident reported no pain with touch. Noted blanching in the surrounding area. No drainage noted. Resident #6 (R6)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R6 admitted to the facility on [DATE] with pertinent diagnoses including morbid obesity, edema (fluid retention), venous insufficiency (improper functioning of the vein valves in the legs causing swelling and skin changes) and hypothyroidism (underactive thyroid hormone which regulates metabolism, growth and other bodily functions). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R6 was cognitively intact (13 to 15 cognitively intact). During an interview on 9/15/2025 at 4:20 PM, R6 stated that she developed a pressure ulcer on her buttocks at the facility and had it for a long time. When further queried, R6 stated that she had it for many months. Review of R6's Physician orders revealed “Mepilex (absorbent foam wound dressing) to right buttock open area after NS (normal saline) cleanse. Change every 2 days and PRN (as needed).every night shift every 2 day(s). Active 2/11/2025 (start date).” Review of R6's MDS assessment dated [DATE] revealed that she was at risk for developing pressure ulcers/injuries and did not have any unhealed pressure ulcers/injuries. Review of all R6's care plans revealed a care plan for skin breakdown but nothing about risk for pressure ulcers or history of pressure ulcers. Further review of R6's chart revealed that there were no specific weekly wound notes related to her buttocks from 2/1/2025 to 9/16/2025. Review of provider {physician and nurse practitioner (NP)} notes from 2/1/2025 to 9/17/2025 revealed that there was no skin issues on her buttocks. Review of Registered Dietitian (RD) note dated 8/12/2025 revealed “…Wounds: No PI/PU (pressure injury/pressure ulcer) …” Review of RD note dated 5/13/2025 revealed “….red buttocks…” Review of RD note on 2/12/2025 revealed “…skin intact…” (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R6's skin assessments dated 8/19/2025 and 8/26/2025 revealed “…Any skin conditions requiring treatment or monitoring, including any current area receiving treatment or monitoring: Yes….Site: Right buttocks. Description: Treatment in place. Cleanse with normal saline. Apply mepilex to right buttocks open area. Change every 2 days and PRN.” Wound bed, exudate, description of area and interventions, and odor was blank. Review of R6's skin assessments dated 8/5/2025 and 8/12/2025 revealed “…Any skin conditions requiring treatment or monitoring, including any current area receiving treatment or monitoring: Yes…. Site: Other. Description: Right and left buttocks. Treatment in place. Wound bed, exudate, description of area and interventions, and odor was blank. Review of R6's skin assessments dated 7/29/2025 “…Any skin conditions requiring treatment or monitoring, including any current area receiving treatment or monitoring: Yes….Site: Coccyx. Description: Red spot on butt, placed barrier cream on.” Wound bed, exudate, description of area and interventions, and odor was blank. Review of R6's wound log revealed “Date observed: 8/12/2025. Obtained on admit: No. Site: buttocks. Wound: pressure.” Stage, measurement and exudate were blank. “Date observed: 8/19/2025. Obtained on admit: No. Site: buttocks. Wound: pressure. Measurement: scabbed. Exudate: None.” Stage was left blank. “Date observed: 8/26/2025. Obtained on admit: No. Site: buttocks. Wound: pressure. Measurement: scabbed. Exudate: None.” Stage was left blank. “Date observed: 9/3/2025. Obtained on admit: No. Site: buttocks. Wound: pressure. Measurement: scabbed. Exudate: None. ” Stage was left blank. During an interview on 9/15/2025 at 3:41 PM, NP “BB” stated that she didn't think R6 had a pressure ulcer. During an interview on 9/16/2025 at 9:15 AM, Registered Nurse (RN) “E” stated that she was aware that R6 had a pressure ulcer but didn't know how long she had it. During an interview on 9/17/2025 at 7:55 AM, Certified Nursing Assistant (CNA) “AA” stated she works with R6 a lot and she had had an area on her bottom for a while. During an interview on 9/17/2025 at 8:00 AM, Licensed Practical Nurse (LPN) “K” stated she didn't know if R6 had a pressure ulcer or not. During an interview on 9/16/2025 at 10:37 AM, Care Manager who was also the Minimum Data Set Coordinator (MDS) “R” stated that skin assessments have been a problem at the facility. When asked about R6 and whether she had a wound, MDS “R” said that she wasn't sure since there have been many changes with Unit Managers (UMs). MDS “R” stated that wound notes should be documented in the chart every week and she looked in R6's chart and couldn't find any wound notes. When discussing MDS dated [DATE], MDS “R” stated that UM “L” told her that R6 didn't have a pressure ulcer, that it was shearing (force that occurs when the skin and underlying tissues are pulled in opposite directions causing damage from the inside out) so she didn't code the MDS as a pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/16/2025 at 11:20 AM, Nursing Home Administrator (NHA) “A” was asked how it was determined that R6 had a Stage II pressure ulcer (partial thickness skin loss involving the epidermis and dermis, presenting as a shallow open wound with a red or pink moist base, or as a serum filled blister that is intact or open) which was indicated on the wound log and he stated that he googled scabbed area and saw it had to labeled as a Stage II. NHA “A” said he couldn't see the wound since he wasn't a nurse. When asked if DON “B” could look at the wound and be able to stage it, he said “probably.” During an interview on 9/16/2025 at 4:50 PM, R6 stated that the NP saw her that afternoon and noted a small brown area. NP “BB” put a new physician order on 9/16/2025 at 7 PM “Cleanse left buttocks with normal saline, pat dry, and apply circular area of xerofoam to Stage 2 area (cut to size) and cover with foam boarder dressing. Change dressing daily.” During an interview on 9/16/2025 at 2:35 PM, DON “B” was asked about when and how R6 obtained her wound at the facility and she referred this surveyor to talk to LPN “L”. She said they don't have an incident report for when it was identified. DON “B” stated that LPN “L” updates the wound log weekly and R6 doesn't have a pressure ulcer at this time. DON “B” said its MASD (Moisture Associated Skin Damage) and said former Assistant Director of Nursing (Staff) “W” put it in wrong when she filled in for LPN “L” that week. During an interview on 9/17/2025 at 8:10 AM, Unit Manager LPN “L” stated that R6 was first observed to have a pressure ulcer on 10/4/2024 and it was more a mix of shearing and excoriation (shallow scratch or abrasion on the skin causing by mechanical force resulting in partial thickness loss) so barrier cream was started and then the wound opened up to a stage II and R6 was started on mepilex. When discussing the wound log and why there was no date for when R6 acquired the pressure ulcer and why the log started on 8/12/2025, LPN “L” stated that Staff “W” did the wound log that week and put R6 as having a pressure wound to her buttocks and no measurements were put in. LPN “L” said that she saw R6's wound the following week on 8/19/2025 and it was a scabbed area and she didn't see any open areas. LPN “L” said she should have taken pressure out of the wound log at that point and it was her mistake. When asked if she followed up with Staff “W” and her observation of R6 having a pressure wound, LPN “L” said “No.” LPN “L” said R6 did not have a pressure area prior to 8/12/2025 so the log started that day. LPN “L” stated that she observed the wound every week. LPN “L” said the Interdisciplinary Team (IDT) discusses wounds in the morning meeting Monday through Fridays and whether treatments are working or not and if wounds are getting better or worse. When asked if she gives weekly wound logs to staff, LPN “L” stated she gives copies/they have access to the log. When discussing the new order put in by NP “BB” the day before on 9/16/2025 at 7PM which indicated R6 had a Stage II area to her left buttocks, LPN “L” said her assessment with DON “B” that morning was that it wasn't a pressure wound but if the NP “BB” says her buttocks is a Stage II pressure area then it must be a Stage II . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another interview with LPN “L” on 9/18/2025 at 9:40 AM, LPN “L” stated that she didn't receive any formal training with wounds/pressure ulcers. When this surveyor mentioned that the last weekly skin assessment was completed on 8/26/2025, LPN “L” said she wasn't sure what happened and it was just reinstated that morning. When discussing the last log on the wound log dated 9/3/2025, LPN “L” said she was behind and was going to update the log. Review of R6's shower sheets from February to September revealed a shower sheet on 6/6/2025 “Describe and indicate location on body outline below, report to nurse. Note any patches on residents body (location).” The left buttocks had a dot on it, was circled and Certified Nursing Assistant (CNA) “H” wrote “red, open.” During a phone interview on 9/17/2025 at 10:13 AM, CNA “H” stated that she had worked with R6 many times and the area on her buttocks opens and closes and “cracks” every so often. When discussing the shower sheet from 6/6/2025, CNA “H” said that her buttocks must have been open that day if she put it on the shower sheet. CNA “H” said the nurse Registered Nurse (RN) “CC” signed off on the shower sheet that day. During a phone interview on 9/17/2025 at 11:26 AM, RN “CC” stated that R6 had an open area/pressure ulcer on 6/6/2025 and she did not notify anyone about the open area and continued with the normal treatment of mepilex. RN ‘CC” said she saw the wound on 9/16/2025 in the evening and it wasn't open and didn't look like a pressure ulcer. Review of R6's chart on and around 6/6/2025 revealed that there was no weekly skin assessment that day, no progress note indicating she had a pressure ulcer and nothing noted by the provider on 6/13/2025. During an interview on 9/16/2025 at 2:10 PM, Registered Dietitian (RD) “V” and Director of Health and Wellness (DHW) “U” stated that they haven't seen a wound log. DHW “U” said she was the contract RD before RD “V” started and she didn't see a wound log since she started there. They were both unaware of R6's wound. During another interview on 9/17/2025 at 2:11 PM, DON “B” stated that she wasn't sure why NP “BB” was not aware of R6 having a wound until conversation with this surveyor and why the mepilex order was started in February. DON “B” stated she didn't agree with NP “BB's” assessment of the wound because it didn't look like a Stage II since the areas are blanchable (redness or altered skin area that turns white or pale when pressure is applied and then returns to its original color promptly). DON “B” said she will talk to NP “BB” and see what the best treatment would be. Review of the Skin Assessment Policy dated 3/7/2024 revealed “…Policy Explanation and Compliance Guidelines: …7. Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate.” (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Wound Management Policy dated 3/7/2024 revealed “…Policy Explanation and Compliance Guidelines: …c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. d. Assessments of pressure injuries will be performed by a licensed nurse and documented on the Push Tool 3.0. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS… 4. Interventions for Prevention and to Promote Healing: a. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions….5. Monitoring: a. The Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. b. The attending physician will be notified of: i. The presence of a new pressure injury upon identification. ii. The progression towards healing, or lack of healing, of any pressure injuries weekly. iii. Any complications (such as infection, development of a sinus tract, etc.) as needed. c. A Focused Incident Review will be performed on each pressure injury that develops in the facility. Findings will be reported in the monthly QAA Committee Meeting. d. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule, and as needed when actual or potential problems are identified.”

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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** This citation pertains to intake #2591271.Based on interview and record review, the facility failed to maintain accurate documentation in resident medical records in 1 resident (Resident #1) of 4 residents reviewed for ADLs (activities of daily living) resulting in not knowing whether the resident received or refused a shower.Findings include:Resident #1 (R1)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] with pertinent diagnoses including type 2 diabetes, bipolar disorder, anxiety and depression. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R1 was cognitively intact (13 to 15 cognitively intact). Resident discharged from the facility on 3/17/2025.During an interview on 9/17/2025 at 11:22 AM, R3's Family Member (FM) Y stated that she had several concerns when R3 was at the facility and had a meeting with management. One of her concerns was whether R3 was receiving showers/bed baths to check her skin for yeast/rashes. Review of R1's shower sheets revealed that there was documentation that R1 received 4 showers/bed baths and refused 2 showers/bed baths during her stay. Only 6 showers/bed baths out of 12 possible showers during her stay had documentation on shower sheets. During an interview on 9/17/2025 at 12:05 PM, Nursing Home Administrator (NHA) A provided a late entry progress note written by the nurse dated 3/3/2025 after a family meeting on 3/2/2025 which revealed Late Entry: Spoke with resident daughter per request. Resident received a bed bath on 2/26/25 with no skin issues reported. Resident also declined a bed bath and shower on 2/28/25 when approached X3. When NHA was asked where the Unit Manager got her information from since there were no shower sheets or other documentation to support the bed bath on 2/26/2025 and the refusals of the bed bath/shower on 2/28/2025, he said he didn't know.Review of the Documentation in Medical Record Policy with an implementation date of 3/13/2024 revealed Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: .2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.