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	04/17/2026

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to arrange room furniture in a functional manner, provide adequate power outlets for adaptive equipment and implement low-vision modifications to promote independence for one (Resident #2) of three residents reviewed for accommodation of needs, resulting in feelings of frustration, loss of independence and lack of an individualized environment.Findings include:Resident #2Review of an admission Record revealed Resident #2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: legal blindness (severe visual impairment with some usable vision, often able to see light, shapes or large print) as defined in the USA (United States of America), diabetic retinopathy (damage to the retina caused by high blood sugar levels, resulting in blurry vision, dark floaters in the visual field, poor night vision and color changes), and surgical amputation of right leg.Review of a Minimum Data Set (MDS) assessment for Resident #2 with a reference date of 2/2/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section B revealed Resident #2's vision was highly impaired- object identification in question, but eyes appear to follow objects. Section E revealed Resident #2 had no behaviors.Review of a Care Plan for Resident #2 with a reference date of 11/18/24 revealed the following focus/goal/interventions: Focus: I have impaired visual function. Goal: I will have no indications of acute eye problems through next review. Interventions: Arrange consultation with eye care practitioner as required. No other interventions were present.During an observation and interview on 4/14/26 at 11:26am, it was noted that there was a narrow space of approximately 2 feet between the end of Resident #2's bed and his chest of drawers. Resident #2's stereo sat atop the chest of drawers. Resident #2 had access to 1 electrical outlet, with 2 sockets, on his half of the room. Resident #2's laptop and a phone charger were plugged into the outlet. A talking book machine sat nearby but was not plugged in. Resident #2 reported he was frustrated by the set up of his room and reported he had to thread himself backwards between his bed and his chest of drawers, while in his powerchair, then lean his torso forward in order to see the dials on his stereo. Resident #2 reported he was also frustrated by the lack of electrical outlets within his reach in his room, because he could not charge his devices and use his talking book player at the same time. Resident #2 reported he had voiced his concerns regarding the lack of accessibility in his room to several staff members, but nothing had been done. Resident #2 stated this room feels like a cage. Resident #2 reported he wanted to do more than lay in bed like a lazy bum and felt he could do the things he wanted to do in his room if some modifications were made. Resident #2 stated I don't like to ask the staff to do things for me that I could do for myself if the room was set up better. Resident #2 reported he owned a braille writer (mechanical typewriter-like device that allows the user to emboss braille directly onto paper), enjoyed writing greeting cards with it in the past, but had not been able to use it at the facility due to the lack of outlets and workspace. Resident #2 reported he had asked for a power strip several times but was always told they were illegal. Resident #2 reported he had also asked if he could have a LED (light-emitting diode) bulb in his overhead light because it would reduce glare and allow him to adjust the light level, but no one had followed up. Resident #2 reported he felt the facility was not (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	willing to meet the needs of residents who were visually impaired.In an interview on 4/15/26 at 3:39pm, Nursing Home Administrator (NHA) A reported the facility provided power strips to residents in need of them, but he was not aware Resident #2 needed extra outlets. NHA A confirmed Unit Manager (UM) D provided weekly Caring Partners visits to Resident #2.In an interview on 4/15/26 at 3:53pm, Interim Chief Executive Officer (CEO) B reported he reviewed the Caring Partners weekly check in sheets for Resident #2 and found the resident had voiced a concern about the accessibility of his room in February 2026 but there had been no follow-up.Review of a Caring Partners form with a reference date of 2/24/26 revealed (Resident #2) wants.items in room moved around; Space is limited.In an interview on 4/16/26 at 12:04pm, UM D confirmed she provided weekly Caring Partners visits to Resident #2. UM D confirmed Resident #2 voiced concerns about the layout of his room on 2/24/26. UM D reported Resident #2 also voiced a need for a larger room due to his limited ability to access his belongings in his current room. UM D confirmed it was important for the facility to address individual resident needs, including accessibility and low vision needs, to promote independence.In an interview on 04/16/2026 at 9:41 AM Certified Nursing Assistant (CNA) MM reported Resident #2 had complained to her about not being to see well in his room due the lighting and reported he said he wished the facility was more thoughtful about the individual needs of those with vision impairments. During an observation and interview on 4/17/26 at 10:07am, the cord for Resident #2's overhead light hung against the wall, between his nightstand and the table he used for his laptop. Both the cord and the wall were white. A piece of glow in the dark tape (approximately one inch square in size) was affixed near the end of the cord that hung toward the floor. Resident #2 reported he could not see the light cord because there was no contrast between it and the wall. Resident #2 stated I need contrast in order to be able to see things like that. Resident #2 reported until recently he had a nice bright yellow privacy curtain that he could see well, but the facility changed it without asking him and hung a dull curtain, that looked like a dingy grey color to him. The privacy curtain Resident #2 referenced was a pale light green with a faint blue floral pattern. When queried, Resident #2 reported he could not see any pattern in the curtain, and the color looked depressing.In an interview on 4/17/26 at 12:07pm, Occupational Therapist (OT) XX reported she placed glow in the dark tape on the end of Resident #2's overhead light cord so he would be able to see it at night. When queried, OT XX reported she was not aware of any concerns Resident #2 had related to accessibility/low vision modifications needed in his room.Review of an Accommodation of Needs policy with a reference date of 3/5/24 revealed .The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom and bedroom.facility staff shall make efforts to reasonably accommodate the needs.of the resident as they make use of their physical environment.based on individual needs.the facility will assist the resident in maintaining and/or achieving independent functioning, dignity and well-being.Review of A Systematic Review of Home Modifications for Aging in Place in Older Adults, https://pmc.ncbi.nlm.nih.gov/articles/PMC11988477/, revealed .The interaction between an individual's physical and cognitive abilities and the built environment significantly influences functional independence and quality of life. According to the environmental press theory, balance is maintained when the environment supports an individual's capabilities. When housing environments impose excessive demands beyond an individual's diminished functional capacity, disability and dependence increase.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2642352. Based on observation, interview, and record review, the facility failed to ensure assistance with activities of daily living (ADL) care was provided for 4 (Resident #1, #57, #16, #26) of 7 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's dependent on staff for assistance. Findings include: Resident #1: Review of Care Plan for Resident #1, revised on 3/3/26, revealed the focus, .I have an ADL (activities of daily living) deficit and need assistance with daily care r/t (related to) weakness/debility. with the intervention .ADL care to meet my needs. During an observation and interview on 04/14/2026 at 10:55 AM, Resident #1 reported she was scheduled to get her showers on Thursdays and Saturdays. Resident #1 was observed to have greasy appearing hair, her face appeared as if it needed to be washed, hair needed to be combed, and when this writer questioned if staff had offered to get a basin or washcloth for her to wash her face she indicated they had not on this day. Review of Shower Sheets revealed Resident #1 received bed baths on 4/4/26, 4/2/26, 2/28/26, and 2/22/26. Resident #1 received a shower on 3/28/26. It was noted on a shower sheet dated 3/14/26. Resident #1 was admitted on [DATE] which indicated she had 16 opportunities for staff to provide her with a shower/bed bath. Resident #1 was provided with a total of 5 shower/bed baths during this time. During an observation and interview on 04/16/2026 at 3:02 PM, Resident #1 reported she had received a bed bath earlier, but her hair appeared dirty and greasy still. When this writer queried when the last time was, she had her hair washed, Resident #1 reported it had been a couple weeks at least. Resident #57: Review of an admission Record revealed Resident #57 was a male with pertinent diagnoses which included dementia and physical debility. During an observation on 04/14/2026 at 9:52 AM, Resident #57 was observed seated in his reclining broda chair (specialized adjustable wheelchair or positioning chair designed for residents with mobility challenges) in the TV room area. Resident #57 was observed to have fingernails which extended far beyond the fingertips, the nails were jagged and misshapen, with dark dried material under the nails gathered at the hyponychium (seal of skin located just beneath the free edge of the nail plate, acts as a barrier to bacteria, fungi, and debris from entering the nail bed). During an observation on 04/15/26 at 4:01 PM, Resident #57 was observed seated in the tv room area and he had dark dried material under his fingernails, his fingernails extended far beyond the fingertips and were broken and jagged. During an observation on 04/17/2026 at 11:50 AM, Resident #57 was observed seated in the tv room (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area and he had dark dried material under his fingernails, his fingernails extended far beyond the fingertips and were broken and jagged. In an interview on 04/17/2026 at 12:53 PM, UM D reported the nurses were able to cut the fingernails for a resident when asked. UM D reported the nail clippers were not kept in the nurse's cart, and the nurse would have to go to downstairs to supply to obtain them. UM D reported the CNAs were able to use the wooden nail cleaning tool to clean under a resident's fingernails during a resident's scheduled shower. Resident #16 Review of an admission Record revealed Resident #16 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: schizoid personality disorder (chronic mental health condition characterized by limited emotional expression, strong preference for isolation and lack of motivation), depression (a serious, common mental illness causing persistent sadness) and body max index (BMI) 40-44.9 (morbid obesity). Review of a Minimum Data Set (MDS) assessment for Resident #16 with a reference date of 2/6/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section D of the MDS revealed Resident #16 felt down, depressed, or hopeless during 12-14 days of the 14-day assessment period. Section GG of the MDS revealed Resident #16 was dependent (helper does all of the effort) for bathing. Review of a Care Plan for Resident #16 with a reference date of 1/27/26 revealed the following focus/goal/interventions: Focus: I have an ADL (activities of daily living) deficit and need assistance with daily care.I prefer a bed bath.Goal: I will have my needs met on a daily basis as evidenced by my neat, clean, well groomed appearance.Interventions: ADL care to meet my needs. During an observation and interview on 4/14/26 at 4:15pm, Resident #16's hair appeared tangled and disheveled, and facial hairs were noted on her chin. Resident #16 reported she preferred to have a bed bath rather than a shower but was only being assisted with getting cleaned up (bed bath or shower) about once a week and she felt that was not enough. Review of Shower Sheets for Resident #16 revealed the resident was a shower or bed bath on 4 occasions between 2/15-4/15/26. Review of a Kardex (brief overview of a resident's care needs) revealed Bathing: Bed bath 2 person assist with care at all times, on Saturday afternoon to late evening. Review of an electronic communication received on 4/15/26 at 1:02pm revealed Chief Executive Officer (CEO) B reported the facility did not have any additional shower sheets for Resident #16 for the period of 2/15-4/15/26. Resident #26 Review of an admission Record revealed Resident #26 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: congestive heart failure (progressive condition where the heart muscle is too weak to pump blood efficiently) and major depressive disorder (serious mental health condition characterized by at least 2 weeks of persistent, severe sadness, loss of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interests, fatigue). Review of a Minimum Data Set (MDS) assessment for Resident #26 with a reference date of 3/7/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 11/15, which indicated the resident was moderately cognitively impaired. Section GG of the MDS revealed Resident #26 required maximal assistance (helper does more than half) for bathing. Review of a Care Plan for Resident #26 with a reference date of 12/5/25 revealed the following focus/goal/interventions: Focus: I have an ADL deficit and need assistance with daily care.I often refuse bed baths, showers.Goal: I will maintain my current level of function through the review date. Interventions.no male caregivers, staff to assist me with ADLs.PRN (as needed) . Review of a Summary of Complaint with a reference date of 10/14/25 at 9:42am revealed Complainant stated the staff are not taking care of (Resident #26) .Complainant states that (Resident #26) has an odor. (Resident #26's) hair has been observed filthy. (Resident #26) smells of body odor. Efforts to contact the complainant were unsuccessful prior to the conclusion of the survey. Review of a Task Description for Resident #26 revealed ADL-Bathing Mondays and Thursday AM; I often refuse to take a shower/bath in the shower room; I would rather have a bed bath most of the time on my shower days. During an observation and interview on 4/14/26 at 4:22pm, Resident #26 was in bed, was wearing a hospital gown and appeared disheveled. Resident #26 reported she does not get cleaned up as often as she would like and isn't offered the opportunity twice a week. Review of Shower Sheets provided by the facility for Resident #26 revealed the resident was offered or received bathing during 10 of 17 opportunities between 2/15-4/25/26. Review of an electronic communication received on 4/15/26 at 1:02pm revealed Chief Executive Officer (CEO) B reported the facility did not have any additional shower sheets for Resident #26 for the period of 2/15-4/15/26. In an interview on 4/16/26 at 8:49am, Certified Nursing Assistant (CNA) MM reported when staffing numbers fall below what was scheduled, staff were not able to offer residents shower/bathing assistance at times. In an interview on 4/16/26 at 2:49pm Unit Manager (UM) D reported CNAs were expected to complete a shower sheet each time they offered residents assistance with bathing. UM D reported after the CNA completed a shower sheet; the nurse was expected to sign it and then turn it in for the UM to review it. UM D reported each resident was scheduled to receive at least 2 opportunities for bathing each week and could request additional opportunities per their preference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 pertains to intake #2616992Based on observation, interview and record review, the facility failed to ensure residents achieved their highest practicable physical well-being and follow professional standards of practice by: 1. ensure staff assess and monitor non-pressure wounds, 2.) recognize and assess symptoms of infection, 3.) follow physician's orders for use of medication, and 4.) recognize episodes of hypoglycemia(low blood sugar level)/hyperglycemia(elevated blood sugar level) requiring physician's notification in 5 (Resident #29, #45, #3, #18 and #10) of 18 residents reviewed for quality of care, resulting in Resident #29 not being assessed or treated for potential eye infection, the potential for infection of a wound for Resident #45, Resident #3's elevated blood sugar levels going unreported to the physician, Resident #18's low blood sugar level not being reported to the physician, and Resident #10 receiving medications outside ordered parameters. Findings include:Resident #29: Review of an admission Record revealed Resident #29 was a male with pertinent diagnoses which included diabetes, mild cognitive impairment (noticeable memory or thinking changes), acquired absence of left eye, strep group B (bacteria can cause sepsis) in left knee, and arthritis due to bacteria in left knee. Review of current Care Plan for Resident #29, revised on 3/11/26, revealed the focus, .I am at risk for skin breakdown. with the intervention .Notify resident/representative of any new areas of skin alteration. During an observation and interview on 04/14/2026 at 1:13 PM, Resident #29 was dressed and observed seated in his wheelchair. This writer observed Resident #29's left eye which had thick dried green eye discharge matted on his top and bottom eyelashes. Resident #29 had moist, stringy green material which stretched from the top to bottom lashes. His bottom and top left eye lids appeared irritated and swollen. Resident #29 reported he believed the issue with his eye was a blocked tear duct and reported he does not have an ointment placed in his eye, and the nurse sometimes put drops in his eye. Review of Medication Administration Record (MAR) for Resident #29 revealed, he was prescribed on 3/11/26, Refresh Tears Ophthalmic Solution.Instill 3 drops in both eyes three times a day for dry eyes. Review of the MAR for March 2026 and April 2026, revealed it was documented Resident #29 had received drops in his eyes three times per day at 0900, 1400 (2:00 PM), 2100 (9:00 PM). In an interview on 04/17/2026 at 11:14 AM, Director of Nursing (DON) C reported the nurse should clean the resident's face and eyes, complete an assessment and notify the provider to do a follow up. Review of Resident #29's medical record revealed there was no physician communication note for the physician to follow up with the resident on his left eye discharge. In an interview on 04/16/2026 at 9:42 AM, Infection Preventionist (IFP) E reviewed the infection tracking report and reported she did not have Resident #29 on the tracking. IFP E reported due to the lack of documentation by the floor nurses quite frequently a resident would be started on an antibiotic or require precautions and they would not complete the necessary documentation, and she would not (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be notified and therefore she would not be tracking the resident. IFP E reviewed Resident #29's medical record and reported there was nothing there which indicated a concern for infection with his left eye. This writer explained the observation had of Resident #29's eye and IFP E reported the resident should have been assessed and the provider contacted to assess further. IFP E reported she had provided education to the nurses on 2/12/26 using the assessment and documenting findings in progress notes. Review of Resident #29's provider progress notes revealed no assessment or documentation of a concern for potential infection in Resident #29's left eye. In an interview on 04/17/2026 at 12:12 PM, Interim Chief Executive Officer (CEO) B reported Nurse Practitioner (NP) N stated she was not aware Resident #29 had unusual drainage from the removal of his left eye. In an interview and review of Resident #29's medical record on 04/17/2026 at 11:15 AM, Director of Nursing (DON) C reported she was unable to locate a progress note, and/or an assessment for possible infection in the medical record. DON C reported there was not a physician communication note for the concern with Resident #29's eye. Resident #45 Review of an admission Record revealed Resident #45 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #45, with a reference date of 3/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #45 was cognitively impaired. Review of the Functional Abilities revealed that Resident #45 required partial to moderate assistance for hygiene. Review of Resident #45's Skin Care Plan revealed, I am at risk for skin breakdown.Date initiated: 4/19/21. Interventions: .Report any changes in skin to physician. Date initiated: 5/10/23. There was no mention of a wound on Resident #45's chin. During an observation on 04/14/2026 at 11:27 AM Resident #45 was lying in his bed, his gown was soiled with flakes of dried blood and there was a large deep open wound on his left chin/neck. There was no signage indicating that Resident #45 had Enhanced Barrier Precautions (EBP) in place for the open wound that was not covered. Review of Resident #45's Weekly Skin Check dated 4/6/26 revealed, Skin warm & dry, skin color WNL and turgor is normal. No new skin issues identified . # 3 Skin issue has NOT been evaluated. Location: chin, left.open wound that resident picks at non-stop.Wound is greater than 3 months . Resident #45's Weekly Skin Checks dated 3/27/26 and 3/20/26 are exactly the same as 4/6/25. In an interview on 04/15/2026 at 1:40 PM, LPN KK reported that the wound on Resident #45's chin/neck was a skin cancer that he elected not to get treatment for years ago. LPN KK reported that there were no orders for wound care and/or a dressing. Review of Resident #45's Dermatology (skin specialist) Visit Note dated 7/19/23 revealed, .Basal Cell Carcinoma (skin cancer), nodular type on the left inferior medial buccal cheek (lower cheek/chin). We (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.report to MD (Doctor of Medicine) s/sx of hypoglycemia.repot to MD PRN (as needed) s/sx of hyperglycemia. Review of a complaint filed on 9/15/25 at 10:02am revealed Complainant states the nurse broke the rules by not calling the doctor due to a reading (blood sugar over 500) . Review of a Blood Sugar Graph for Resident #3 with a date range of 9/1/25-4/17/26 revealed the resident's blood sugar level registered at over 500mg/dL (milligrams per deciliter of blood) 3 times during that time period. Review of a Blood Sugar Summary for Resident #3 revealed the resident's blood sugar registered at 523mg/dL on 12/11/25, 547mg/dL on 12/29/25 and 541mg/dL on 3/12/26. Review of Progress Notes revealed no documentation of physician notification related to Resident #3's episodes of critical blood sugar levels on 12/11/25, 12/29/25 and 3/12/26. In an interview on 4/16/26 at 2:46pm, Unit Manager (UM) D reported it was the expectation that the responsible nurse would contact the physician if a resident's blood sugar registered less than 70mg/dL or greater than 350 mg/dL. UM D reviewed the documentation for Resident #3, confirmed his blood sugar registered greater than 500mg/dL on 3 occasions and there was no documentation that the physician was notified or that further action was taken. Resident #18 Review of an admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnosis which included: type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #18 with a reference date of 2/20/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 1/15, which indicated the resident was severely cognitively impaired. Section N of the MDS revealed Resident #3 received daily injections of insulin. Review of a Care Plan for Resident #18 with a reference date of 10/9/25 revealed the following focus/goal/interventions: Focus: I have a nutritional problem r/t (related to) .DM (diabetes) with insulin.Goal: I will be free from hunger.Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Review of a Blood Sugar Summary for Resident #18 with a reference date of 4/1-4/17/26 revealed the resident experienced hypoglycemia (blood sugar below 70mg/dL) on 4/1, 4/6, 4/9, and 4/14/26. Review of Progress Notes for Resident #18 on 4/1, 4/6, 4/9 and 4/14/26 revealed no documentation of physician notification of the resident's low blood sugar. In an interview on 4/16/26 at 9:44am, Licensed Practical Nurse (LPN) FF reported the nurse should contact the physician if a resident's blood sugar level was less than 70mg/dL or greater than 250mg/dL. LPN FF reported blood sugar levels outside these parameters required physician guidance. LPN FF reported the nurse should also document in a progress note that the physician was contacted and any new orders given/guidance given. (continued on next page)

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	04/17/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/16/26 at 9:47am, Registered Nurse (RN) I reported the nurse should contact the physician immediately if a resident's blood sugar level registered below 70mg/dL or above 350mg/dL unless there was already further guidance for the nurse to follow in the physician's orders for the resident. RN I reported the nurse should also document contacting the physician and the guidance they provided in a progress note. In an interview on 4/17/26 at 10:43am, Nurse Practitioner (NP) N confirmed it was an expectation that a provider would be contacted by the nurse if a resident's blood sugar was higher than 350 mg/dL or lower than 70 mg/dL because it may be necessary to further medical direction in order to maintain the well-being of the resident. Resident #10 Review of an admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks) and hypotension (low blood pressure). Review of Resident #10's Orders revealed, Midodrine (medication used to treat low blood pressure) 10 mg (milligrams). Give 1 tablet by mouth before meals for hypotension. Hold if systolic (the top (first) number in a blood pressure reading, measuring the maximum pressure in your arteries when the heart muscle contracts and pumps blood) blood pressure above 130. Review of Resident #10's Medication Administration Record (MAR) revealed that Resident #10 had received the midodrine medication when her blood pressure was out of order parameters on the following dates: 2/7/26, 2/12/26, 3/1/26, 3/7/26, 3/20/26, two administrations on 3/21/26, 3/23/26, 3/24/26, 3/25/26, 4/4/26 and 4/8/26. It was also noted that on 3/27/26 the midodrine order was documented as given without vital signs documented to indicate if Resident #10's vital signs were in parameters to administer the medication.

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	04/17/2026

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

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the cleanliness of resident shared equipment, resulting in the potential for cross contamination, infections, and bacterial harborage. Findings include: During an observation on 04/14/2026 at 9:57 AM, outside of room [ROOM NUMBER] there was a hoyer (mechanical device used to transfer limited mobility residents) in the hallway along the wall. The hoyer dried white material on the footrest base area, there as dried brownish/tannish material spots splattered on the base. During an observation on 04/14/2026 10:31 AM sit to stand outside of room [ROOM NUMBER] had dirt and debris on the based and foot board area. The knee pads had white dried smeared material on the curve of the knee pad on the inside of the pad, a gait belt on it as well as slung over the top, plastic bag with no wipes in it. There was a hoyer next to it, which had white dried material on the base of the machine on both sides, like someone had white powder on their feet and had stepped on it. There was a plastic bag with no wipes in it.During an observation on 04/15/2026 at 2:22 PM, the sit to stand outside of room [ROOM NUMBER] and room [ROOM NUMBER] was soiled as it was yesterday. There were purple wipes in the plastic bag. There was white dried material on the knee pads, and the footrests had dirt and debris on them. During an observation on 04/15/2026 at 2:24 PM, the hoyer (mechanical lift) between room [ROOM NUMBER] and room [ROOM NUMBER] had dried white material on the footrest base area, there was dried brownish/tannish material spots splattered on the base. In an interview on 04/16/2026 at 09:18 AM, Infection Preventionist (IFP) E reported the staff had recently had Customer service training on 12/23/25 and 3/27/26 which also included re-education and reminders to perform sanitization of resident shared equipment after each use to prevent the spread of potential infection.