STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235248	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Friendship Village	1400 N Drake Rd Kalamazoo, MI 49006

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise care plans timely for 2 (Residents #47 and #23) of 12 residents reviewed for person-centered care plans resulting in an inaccurate reflection of residents' care needs and the potential for incorrect care to be provided.Findings include:Resident #47:Review of Resident #47's Care Plan Report, indicated Resident #47 was admitted on [DATE] and included anticoagulant (blood thinner medication) therapy, diuretic medication (water pill; increases passing of urine) use, and FDA (Food and Drug Administration) medication black box warning/DVT (deep vein thrombosis; blood clot forms in vein) care plans, all dated 3/6/26. The care plans stated, The resident (Resident #47) is taking a medication that is listed on the FDA's Black Box List (highlights risks of use) R/T (related to) DVT), The resident is on Anticoagulation therapy Enoxaparin (blood thinner medication), risk for bleeding, and The resident has potential for dehydration or fluid deficit. Diuretic use.During an interview on 04/02/2026 at 10:09 AM, Director of Nursing (DON) B reviewed Resident #47's current medications and confirmed Resident #47 was not receiving an anticoagulant, diuretic, or FDA black box warning medication. DON B confirmed Resident #47's anticoagulant medication (enoxaparin) was discontinued on 3/14/26, diuretic medication (furosemide) was discontinued on 3/30/26, and was no longer receiving any FDA black box warning medications. DON B confirmed the care plans had not been revised to reflect the changes.Resident #23:Review of Resident #23's Care Plan Report, indicated Resident #23 was admitted on [DATE] and included an anticoagulant therapy care plan, dated 2/25/26, that stated, The resident is on Anticoagulation therapy, is at risk for bleeding. A separate section of the care plan, dated, 2/25/26, stated, The resident (Resident #23) is on diuretic, at risk for dehydration.Review of Resident #23's physician orders, print date 4/2/26, revealed no anticoagulant or diuretic medications were ordered.Review of the facility's Resident Matrix (tool used to identify residents' care needs), dated 3/31/26, indicated Resident #23 was not receiving an anticoagulant or diuretic medication.During an interview on 04/02/2026 at 10:21 AM, DON B confirmed Resident #23's care plan indicated she received an anticoagulant medication, but Resident #23 was not prescribed any anticoagulant medication. DON B reported it was usually the unit manager who would update/revise resident care plans. DON B reported various methods staff could have used to make themselves aware of revisions that would need to be made to care plans such as review of 24-hour nurse reports, review of charts, and/or pulling order summaries. DON B confirmed updates to care plans could have been more timely. Review of the facility's Care Plans, Comprehensive Person-Centered policy, dated 3/2022, stated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 1. Implement enhanced barrier precautions related to wound care for 1 (Resident #4) of 3 residents reviewed for wound care and 2. Ensure the use of personal protective equipment during high contact care activities for a resident in enhanced barrier precautions for 1 (Resident #58) of 2 resident reviewed for the activities of daily living resulting in the potential for the spread of infection, cross contamination, and disease transmission.Findings include:Resident #4 Review of an admission Record revealed Resident #4 was a male who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Cellulitis (a bacterial infection in the skin) of the groin, pressure ulcer of the unspecified buttock Stage 2 (an injury/wound to the skin and/or underlying tissues that was a result of prolonged pressure to the skin area), and type 2 diabetes (a chronic condition that includes insulin resistance and high blood sugars). Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 3/16/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #4 was cognitively intact. In an interview and observation on 3/31/26 at 1:57 AM, Resident #4 reported he had a couple of pressure wounds on his buttock. No signage was noted outside Resident #4's room to indicate he was in enhanced barrier precautions. Review of Order Summary for Resident #4 on 4/2/26 revealed .buttocks: apply remedy silicone cream as needed for R (right) buttock Pressure injury stage II.Buttock: apply remedy silicone cream two times a day for R buttock pressure injury stage II. with a start date of 4/2/26. left buttocks: apply remedy silicone cream as needed for pressure injury stage II.Left buttocks: apply remedy silicone cream two times a day for pressure injury stage II with a start date of 3/18/26. No physician order was noted for enhanced barrier precautions (EBP). Review of Care Plan for Resident #4 on 3/31/26 revealed Focus.has potential/actual impairment to skin integrity.R buttock pressure injury stage II.Interventions: apply moisture barrier as needed.initiated on 3/11/26.Risk for infection r/t (related to) wounds.interventions: evaluate wounds for signs / symptoms of infection.staff to follow standard precautions, including proper hand washing techniques, to minimize microorganism transmission. with an initiation date of 3/12/26. No care plan or intervention related to enhanced barrier precautions were noted. In an interview on 4/1/26 at 12:45 PM, Certified Nurse Assistant (CNA) Q reported Resident #4 was not in enhanced barrier precautions. When queried, CNA Q reported a resident who had a wound, or a catheter, or a drain wound need to be in enhanced barrier precautions, and the staff would have to wear a gown and gloves when providing care. CNA Q reported she was not aware if Resident #4 had a wound. At 12:50 PM, on 4/1/26 no signage was noted outside of Resident #4's room to indicate he had been placed into enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/1/26 at 3:38 PM, Admission/Outreach Coordinator (AOC) J reported she was responsible for entering orders for residents at admission after the orders were approved by the provider. AOC J reported she completed the resident's admission assessment and created their baseline care plan. AOC J reported an admitting resident's clinical needs were discussed at the team clinical meeting, and when queried, AOC J reported she received her directive from Infection Preventionist (IP) D if a resident needed to be in EBP when admitted . AOC J reported if a resident was admitted with a wound, they would typically require EBP and she would input the order and create the care plan if she was told to do so. In an interview on 4/1/26 at 4:27 PM, IP D reported admission Coordinator (AC) I received information regarding a resident's clinical status prior to admission. IP D reported the clinical team would discuss a resident's needs at the clinical meeting. IP D reported AC I, AOC J and Director of Nursing (DON) B, were responsible for initiating orders for EBP at admission, AC I was responsible for room readiness which included signage for precautions and a PPE cart, and she would do the audit of the orders and add any supplemental orders if needed. IP D reported EBP were used for an indwelling medical device and for chronic wounds. IP D reported Resident #4 was admitted with a pressure wound, and currently had two pressure wounds, and was not in enhanced barrier precautions. IP D confirmed there were no orders for EBP, nor a care plan related to EBP for Resident #4. At 8:12 AM on 4/2/26 no signage was noted outside or Resident #4's room to indicate he had been placed into enhanced barrier precautions. In an interview on 4/2/26 at 8:15 AM, MDS Coordinator (MDSC) C reported AC I was the one to get referral information from the hospital and she shared that information at the clinical meeting. MDSC C reported AOC J, AC I, and IP D would be the staff members who would input orders for a resident to be in enhanced barrier precautions. MDSC C reported EBP could be implement after a resident was admitted if there was found to be a need for it. AC I was not in available for interview on 4/2/26. At 10:51 AM on 4/2/26 no signage was noted outside Resident #4's room to indicate he had been placed into enhanced barrier precautions. Review of Resident #4's record on 4/2/26 revealed no noted physician order nor care plan in place for the implementation of enhanced barrier precautions. Resident #58 Review of an admission Record revealed Resident #4 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: diverticulitis (small pouches in the colon that become inflamed or infected), of the intensities part unspecified, with perforation (a hole in the wall of the intestine) and abscess (a swollen area of tissue containing pus) without bleeding, end stage renal disease (chronic condition where the kidneys no longer function), and dependent on renal dialysis (a process where the blood is filtered by a machine/artificial kidney). Review of a Minimum Data Set (MDS) assessment for Resident #58, with a reference date of 4/1/26 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #58 was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/26 at 11:14 AM, signage was noted on the door to Resident #58's room indicating she was on enhanced barrier precautions; meaning a gown and gloves needed to be worn by staff when providing high contact care. CNA L was observed providing peri care (cleaning of the genital area) to Resident #58 and was not wearing a gown while providing care. On 3/31/26 at 11:17 AM, CNA L and CNA P were observed using a gait belt and transferring Resident #58 from her bed to her wheelchair. Neither CNA L nor CNA P were wearing a gown or gloves during the observed transfer. In an observation and interview on 3/31/26 at 11:24 AM, CNA L reported Resident #58 had a fistula for dialysis, she did not have any wounds. Resident #58 was sitting in her wheelchair in her room at the foot of the bed and a JP drain (Jackson Pratt drain, closed suction surgical device that removes fluid from a wound) was noted to be pinned to her shirt on the left side of her body. CNA L was observed removing the linen from Resident #58's bed, he was not wearing a gown or gloves during the linen removal. Review of Order Summary for Resident #58 on 4/2/26 revealed .Coccyx/sacral pressure injury stage II: cleanse with soap and water. Pat dry. Apply purocol (collagen based wound dressing) to wound bed and cover with mepilex (a soft silicone wound dressing) every Tuesday and Thursday with a start date of 3/26/26 and a revision on 3/31/26.EBP-Enhanced barrier precautions due to JP drain with a start date of 3/26/26. Review of Care Plan for Resident #58 on 3/31/26 revealed Focus.Potential for the spread of multi-drug resistant organisms (MDROs) to other residents or staff during high contact related to: JP drain. Place enhanced barrier precautions signage outside of resident room to include all types of PPE to be utilized. Interventions: Place PPE personal protective equipment) near the resident's room for use. Provide education to resident and or resident representative on Enhanced barrier precautions per CDC (Centers for Disease Control and Prevention) guidelines. Provide education to staff on Enhanced Barrier Precautions. Enhanced Barrier Precautions PPE_ Apply gloves and gowns before performing the HIGH CONTACT (examples are dressing, bathing, hygiene, changing brief/assisting with toileting, transferring, providing bed mobility, changing linens, device care or use, wound care) resident care activity. Initiated on 3/26/26 with a revision on 3/30/26. In an interview on 3/31/26 at 2:21 PM, CNA P reported the signage posted on Resident #58's room door indicated she was in enhanced barrier precautions and that the staff should wear a gown and gloves when providing care to her. When queried, CNA P confirmed neither she nor CNA L were wearing gown and gloves when they transferred Resident #58 into her wheelchair, and they should have been wearing it. CNA P stated CNA L and I talked about how were weren't wearing it as soon as we all exited the room earlier. In an interview on 04/01/2026 at 11:35 AM, Infection Preventionist (IP) D reported that the facility's current practice for implementing Enhanced Barrier Precautions (EBP) included residents with indwelling medical devices and wounds that have been present for greater than 3 months. IP D reported that if a resident had a surgical wound they would not implement EBP unless it had been present greater than 3 months. IP D further explained that only chronic wounds required EBP and their understanding of chronic was if it had been present for greater than 3 months. IP D reported that the facility used CDC (Centers for Disease Control and Prevention) guidelines to develop their infection control policies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Enhanced Barrier Precautions dated 12/2024 revealed, .1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. 2. Enhanced barrier precautions apply when: a. A resident is infected or colonized with a CDC-targeted MDRO, but does not have a wound or indwelling medical device . b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained . 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray.8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting; e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care); i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and j. wound care (any skin opening requiring a dressing) . References included CDC guidelines and APIC (Association for Professionals in Infection Control and Epidemiology) document Implementing the Use of Enhanced Barrier Precautions in Skilled Long-Term Care Nursing Facilities. Review of CDC guidance at www.cdc.gov/long-term-care-facilities, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes revealed, .13. If a resident does not have a history of a MDRO but does have an indwelling medical device or wound, should they still be placed on Enhanced Barrier Precautions? Yes. Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. 14. Why did CDC expand Enhanced Barrier Precautions to include all residents with wounds or indwelling medical devices, regardless of MDRO status? Indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized .23. The guidance describes that all residents with wounds would meet the criteria for Enhanced Barrier Precautions. What is the definition of a wound in relation to this guidance? In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers. Ostomies, such as colostomies or ileostomies, are not defined as a wound for Enhanced Barrier Precautions Reviewed of Implementing the Use of Enhanced Barrier Precautions in Skilled Long-Term Care Nursing Facilities by APIC dated 2024 revealed, .What is considered a chronic wound? The longer a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound is present, the more concern we have for those wounds becoming colonized with an MDRO. Chronic wounds are often poorly healing wounds or areas of the skin in residents with underlying medical conditions, resulting in pressure areas, diabetic ulcers, and venous or arterial stasis wounds .