STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Kalamazoo	1701 S 11th St Kalamazoo, MI 49009

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation pertains to MI00143151. Based on interview and record review, the facility failed to provide an environment free from physical abuse from staff to one resident (R105) of six residents reviewed for abuse, resulting in physical abuse, and the potential for continued fear, anxiety, and psychosocial harm. Findings include: According to the Minimum Data Set (MDS) dated [DATE], R105 scored 4/15 (severely cognitively impaired) on her BIMS (Brief Interview Mental Status). Section E-Behavior indicated the resident did not have hallucinations or delusions as potential indicators of psychosis or behavioral symptoms. R105 did direct verbal behavioral symptoms towards others that significantly interfered with resident's care occurring 1 to 3 days during the last reporting period. Review of R105's Care Plan, revised 10/17/23, indicated the resident had an ADL (Activities of Daily Living) self-care performance deficit related to and including dementia, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, and depression. The goal was to meet the resident's needs using interventions that included: 1-person assist for personal hygiene (initiated 10/16/23), and 2-person assist as resident can be combative for toileting (initiated 2/12/24). Review of R105's Behavior Health Progress Note date of service 1/31/24, revealed, .has a history of depression and Alzheimer's disease prior to facility admission .PASRR/Level 2 dated 3/31/23, indicates resident has no history of intellectual disability, developmental disability, or serious mental illness . Review of R105's Progress Note dated 2/10/24 at 15:54 (3:54 PM), revealed, While receiving report this AM (morning), resident (R106) got my attention and stated, That's the one, that's her. I'll tell you later. There was a night shift CNA (Certified Nursing Assistant) standing in front of (R106). Shortly after (R106) stated, Poor (R105) she's a sweet lady. That shouldn't have happened to her, that girl is mean, real mean. At this time, I asked (R106) if we could speak in private. (R106) informed me he watched the CNA being rough pulling on (R106's) arm yanking her around hitting her. At this time, I contacted the DON. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R106's Progress Note 2/10/24 at 15:56 (3:56 PM) revealed, .Potential abuse .report resident was struck in the head . Review of R106's Progress Note 2/11/24 at 12:22 (PM) revealed, Originally identified pain type .monitoring for pain r/t (related to) allegation of abuse. Resident alert, oriented to self. Resident denies pain at this time. Resident answers No, not since the fight. When asked if she is currently experiencing pain. Review of Statement of Witness dated 2/10/24, R105 stated to Director of Nursing (DON) B, That is where I got this bruise. Review of Witness Statement dated 2/12/24, no time indicated, revealed CNA H stated, The incident occurred 2/10/24 at approximately 5:00 AM when the resident (R105) was changed in bed on this morning and she was mildly resistant to care. She started yelling and said You guys are a bunch of (swear word B******) (swear word F***) you guys. After I changed her, I got her up in her wheelchair so I could change her linens for a complete bed change. Staff exited the building at 06:30 AM. The staff (CNA H) was notified of suspension 2/10/24. Review of Witness Statement dated 2/12/24, no time indicated, revealed Registered Nurse (RN) J stated, I heard hollering from down C Hall that I recognized as (R105). I know she can get feisty during her ADL care. I started to go down to help and then quieted down, so I continued my work. Review of R105's Witness Statement dated 2/12/24, no time indicated, stated the date and time of the incident occurred on 2/3/24 at 7:00 AM. Confidential Informant (CI) L stated, I was getting ready to go to breakfast. I heard yelling, Get away from me, leave me alone coming from across the hall (room C9). I came out to the hall and saw a big black Aide (CNA) pulling on the resident's (R105) wrist, slapping her on the face and pulling her hair. I then headed to the nurse's station. As I was waiting at the nurse's station until the Aide and resident went to the dining hall and then I followed. After breakfast I went back to the nurse's station. The staff was speaking to the resident. I do not recall the staff member's name of who I told. I could recognize the Aide again if I saw her. Review of R105's Witness Statement dated 2/12/24, no time indicated, revealed CNA U stated, I didn't see or hear anything. I have no reason to feel my residents were in danger or harm's way. (CNA H) is a loud talker and maybe (CI L misinterpreted (R105's) yelling for the CNA. Review of R105's Skin Assessment, dated 2/7/24 at 16:30 (4:30 PM) indicated there were no new abnormal skin areas. Review of R105's Skin Assessment, dated, 2/10/24 at 10:17 AM, indicated there were new abnormal skin areas, purple/red discoloration to the left and right forearm and back of the right hand. These were no existing abnormal skin areas. Review of R105's Pain Evaluation, dated 2/10/24 at 10:06 AM, indicated the resident stated she had pain and hurting occasionally in the last five days. The resident points to her head to describe the location of her pain. The pain was described as aching, dull, and throbbing. The pain impacted the resident's mood. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/21/24 at 1:00 PM, Nursing Home Administrator (NHA) A stated, The police were contacted regarding the incident with (R106) and a staff member. I got a report number, but the police never came here to investigate. Review of a document received 5/21/24 at 13:34 (1:34 PM), dated 2/10/24 from NHA A revealed, On February 10, 2024, the (name of county) Sheriff's Office was contacted in regards to the alleged abuse with (R105). The officer contacted was (Deputy P). The case number assigned was 24-4745. (Deputy P) took down the incident information, generated a case number and stated no officer would come out unless our investigation warranted further involvement. On 5/21/24 at 2:21 PM, an attempt was made to contact CNA H via telephone. The number was not in service. During an interview on 5/21/24 at 4:02 PM, Licensed Practical Nurse (LPN) K stated, (R105) would scream, yell and non-sense talk. She would have different tones to yelling for different things. (R106) came to me early one morning, when an aide walked by both of use. The resident said, That is her, she is the one that hurt (R105). When the aide walked by, she turned around and looked at him in a weird way. She snapped her head back and glared at him and walked away. He got quiet then. She was a new aide. He said the aide hurt R105, and he had seen her do it. I called the DON right away to report it. According to R106's MDS dated [DATE], the resident scored 15/15 (cognitively intact) on his BIMS. On 5/22/23 at 9:08 AM, a message was left Deputy P to call surveyor with no call back by end of survey 5/23/24 at 5:30 PM. During an observation and interview on 5/22/24 at 10:00 AM, R105 was self-propelling her wheelchair around the nursing station. Surveyor complimented her manicured nails. The resident was smiling while stating she loved her nails and went over to another resident and offered the peer a drink from her Styrofoam drinking cup in a polite manner. During an interview and record review on 5/22/24 at 10:10 AM, NHA A stated, February 10 (2024) was a Saturday. I was at home and got called in to investigate the incident. I asked the CNA (R105) if anything unusual happened during her shift. She told me no. I asked if anything unusual happened with (R105), (CNA H) said the usual behaviors. I asked what she meant by that. She said (R105) was flinging her arms and said F*** you B******(swear words) while I was dressing her. She said she forgot to tell me the resident was displaying behaviors during morning ADL care. (CNA H) did not admit to hitting or pulling the resident's hair). I knew the abuse had to have happened by what (R106) told me because he had a BIMS of 15 (cognitively intact). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/22/24 at 1:42 PM, RN J stated, When I worked with (CNA H) she was a loud and boisterous person. I did not like how she talked to some of the residents. She was rough talking to them. I was at the desk one night; I walked down to her when I heard her talking loud and rough to the resident in room A bed 3. She was saying to the resident, You're not listening You're not staying in bed Stay in bed. She stopped when she saw me. I had talked to her about her verbal tone to other residents also. I told her she had to be gentler. She just shrugged her shoulders. I did not tell management at that time about how (CNA H) talked to the residents. I did not tell management until after the allegation of abuse to (R105). Management should be told when any type of abuse is suspected. I did not know (CNA H) had been rough to (R105) on February 3 (2024) until shift change. No one said anything to me. That is when (R106) told me. Then I saw (R105) had bruises on her arm. (R106) was directly across from (R105) and saw (CNA H) hit R105 on the right side of her head. (R105) told me I don't like that woman, she hit me in the head when I asked her about (CNA H). I did not go down to check on (R105) when she was yelling that night. (CNA U) and I started walking down to (R105's) room when we heard her yelling, but she was done yelling by the time we got there. At that point we had no reason to believe anything had happened because I asked (CNA H) what was going on and she didn't say anything. I did not go in and check on (R105). (R105) yells and can swear quite a bit when she is being changed if staff rushes her. It is better to have two staff when (R105) needs to be changed. That way one staff can talk to her and calm her down when the other staff is changing her. I did say to (CNA H) to ask me to help her with (R105) but that wasn't until after the incident. (R105) makes weird noises but usually can speak well enough to ask for water. She does not yell out unless something is bothering her. (R105) needs someone quiet and not pushy. It was not (CNA H's) first time working with (R105). I believe (R105) yelled out because (CNA H) was too rough with her and went too fast with her. Anytime abuse is suspected it should be reported to the Administrator. During an interview on 5/22/24 at 4:18 PM, R106 stated, I was standing in my doorway in my room, facing (R105's) door, she was yelling and screaming with an Aide grabbing her hands. I looked and saw the Aide grabbing her (R105) hair and jerking her around. The aide slapped her in her face. A heavy-set black girl was the aide. She saw me looking at her shaking my head. She stopped. She followed me to the nurse's desk where I was going to tell the staff what I saw. The resident was (R105). (CNA H asked me if I saw what happened. I told her What do you think. You were loud and mean. The Aide just stared at me. The only thing I got to do was tell a staff, I think a nurse. I did not like what was going on. I felt kind of sick about it. I wondered what the heck is going on and does it go on all the time. No one else was around when it happened. The Aide was by herself, and no other staff was down there to see what she was doing. That was not right. During an interview on 5/23/24 11:13 AM CNA U stated, I work at night 10:30 PM until 6:30 AM. I worked with (CNA H). She was loud; her tone was loud. It was nights and she was loud when the rest of were whispering. (R105) is very hard to approach. You must approach her in a baby/happy tone. There are times she will tell me not to touch her. I recall on 2/3/24, I heard the resident holler. She was yelling that night when (CNA H) was in her room doing cares. She was screaming and yelling louder than usual that night. She was at the end of the hall and the other staff were at the nurse's station. I thought I should go down there to see what the hollering was about and by the time I decided to go down there (R105) had stopped yelling. The CNA did not tell me what happened. (R105) would say Look, Look, she hit me right there pointing to her arm. The next time I worked with her she would repeat the story for a couple of days after it happened. Staff told (CNA H) If you need help come ask for help. It was not criteria until after the incident to take two staff when providing cares. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Psychosocial Outcomes Guide revealed that it is appropriate for the use the reasonable person concept to determine a resident's psychosocial outcome, which may not be readily determined when a resident may not be able to express their feelings, there is no discernable response, or when circumstances may not permit the direct evaluation of the resident's psychosocial outcome. Such circumstances may include, but are not limited to .cognitive impairments, or insufficient documentation by the facility; or when a resident's reaction to a deficient practice is markedly incongruent (or different) with the level of reaction a reasonable person would have to the deficient practice. Reasonable Care is the degree of care that a person of ordinary [NAME] would exercise in the same or similar circumstances. Reasonable Person standard is a legal concept that describes what a fictitious person of ordinary [NAME] would do under the circumstances. Using the Reasonable Person concept, R105 would not have wanted to be left vulnerable to experience the attack by staff in a facility she lived and relied on staff to keep her safe. Resident 105 was able to voice some evidence of harm, and it is reasonable to assume that the resident experienced fear, humiliation, and increased anxiety with behavioral outbursts due to the possibility of being confronted during future encounters of staff diminishing her level of anticipation during ADLs/ personal cares where staff may be which could increase the potential for even more increased anxiety that she could not verbalize but express in behavior(s). Resident 105 would like to have ongoing feelings of wanted socialization if she had not been cognitively impaired. Resident 105 was unable to voice the extent of psychosocial harm experienced, but it is reason to assume that R105 would experience fear, humiliation, anxiety and avoidance due to the possibility of being confronted and attacked; potentially diminishing her level of participation in ADLs which could increase her socialization cognition. Resident 105 would likely have ongoing feelings of fear and anxiety if she had not been cognitively impaired. Review of facility's 5-Day Submission, MI-FRI ID 00054861, stated, .Due to the statement of the resident who witnessed the event, the positive assessment for pain, and bruises present on forearm, the facility is substantiating that some type of physical abuse occurred . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included staff abuse education and auditing staff to resident interactions. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.