

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2025
NAME OF PROVIDER OR SUPPLIER  Medilodge of Kalamazoo		STREET ADDRESS, CITY, STATE, ZIP CODE  1701 S 11th St Kalamazoo, MI 49009	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</b></p> <p>This citation pertains in intake MI00152648</p> <p>Based on observation, interview, and record review, the facility failed to provide assistance with toileting for 1 (Resident #103) of 5 residents reviewed for activities of daily living (ADL) care resulting in the potential for avoidable negative physical outcomes for resident's who are dependent on staff for assistance.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included difficulty in walking and pain in left foot.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 3/26/25 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #103 was moderately cognitively impaired.</p> <p>Review of Resident #103's Kardex (Care area report for staff to reference to determine what kind of care residents need) revealed, ADL'S: TOILETING: 2 person assist. TRANSFERS: 2 person assist with sit-to-stand .</p> <p>Review of facility's Incident report dated 4/22/25, revealed, Incident Summary: Staff (Certified Nursing Assistant (CNA) D) allegedly told (Resident #103) to use the bathroom in her pants. That she was not going to transfer her to rest room. Investigation Summary: (CNA D) was suspended pending investigation. (CNA D) was terminated after the allegation was verified All resident with a BIMS of 10 or higher were interviewed and no concerns were raised. Those that could not be interviewed had skin and pain assessment completed. No concerns were found during the audit. All staff are being educated on neglect/abuse and care plans prior to working the next shift .</p> <p>In an observation and interview on 5/13/25 at 3:33 PM, Resident #103 was sitting in her room. Resident #103 reported that she no longer had any concerns with staff at the facility. Resident #103 was unable to recall the details of the incident between her and CNA D.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/13/25 at 3:54 PM, Licensed Practical Nurse (LPN) M reported that she was caring for Resident #103 on 4/22/25. LPN M reported that she had gone into Resident #103's room to administer medications to her. LPN M reported that Resident #103 had asked to use the restroom before LPN M started her intravenous (IV) medication. LPN M reported that she had asked CNA D to assist Resident #103 to the bathroom, and CNA D had reported that she did not know how to transfer Resident #103, so LPN M instructed her to check Resident #103's Kardex and let her know if she needed assistance. LPN M reported that around ten minutes later, CNA D approached her and let her know that Resident #103 was all set. LPN M reported that when she went into Resident #103's room, Resident #103 asked her for help and told her that CNA D told her to just go to the bathroom in her brief. LPN M reported that she further queried Resident #103 and that Resident #103 had confirmed that CNA D had told her that she couldn't take her to the bathroom, and she should pee in her brief and then she would come back to clean her up. LPN M reported that she asked CNA D if she had told Resident #103 to go to the bathroom in her brief, and that CNA D confirmed that she did tell Resident #103 to go to the bathroom in her brief. LPN M reported that she notified Nursing Home Administrator (NHA) A immediately after CNA D confirmed that she had told Resident #103 to go to the bathroom in her brief.</p> <p>In an interview on 5/14/25 at 8:23 AM, LPN L reported that she had worked with CNA D frequently and was familiar with her. LPN L reported that CNA D was a new CNA, and inexperienced. LPN L reported that she did not have concerns with CNA D and how she interacted with residents, but that CNA D seemed to be afraid to ask staff for help and seemed to get offended easily when staff tried to coach and redirect her. LPN L reported that CNA D was aware of how to review a resident's kardex and knew how to transfer residents, but seemed to hesitate to provide certain care.</p> <p>In an interview on 5/13/25 at 4:17 PM, CNA D reported that she was a new CNA, and had started working at the facility in February 2025. CNA D reported that she had always checked and changed Resident #103, and that she never took her to the restroom. CNA D reported that she had observed staff use a hooyer (machine used to transfer residents with limited mobility) before and she did not trust using it because it looked dangerous. CNA D confirmed that Resident #103's care plan noted that she would use a sit to stand (a device used to assist residents with limited mobility with transfer) but that she was also not comfortable with using the sit to stand on Resident #103, because Resident #103 did not like the sit to stand. CNA D reported that she had explained to Resident #103 that she did not want to assist her to the restroom because she was afraid she would fall, so she asked her to go in her brief. CNA D confirmed that Resident #103 did not want to urinate in her brief, and wanted to transfer to the toilet. CNA D reported that she had always planned to clean Resident #103 up after she soiled herself in her brief. CNA D reported that she should have offered to let Resident #103 use a bed pan since I was not going to transfer her. CNA D confirmed that she did not ask any staff members to help her transfer Resident #103.</p> <p>In an interview on 5/13/25 at 3:06 PM, Nursing Home Administrator (NHA) A reported that she was notified on 4/22/25 by LPN M that CNA D had told Resident #103 to go to the bathroom in her brief instead of taking her to the restroom. NHA A reported that she immediately suspended CNA D and began an investigation into the allegation. NHA A interviewed Resident #103 who confirmed that CNA D asked her to go to the bathroom in her brief. NHA A reported that CNA D did admit to telling Resident #103 to go to the bathroom in her brief, and had said that she did not know Resident #103's transfer status, so she did not know how to transfer her. NHA A reported that she re-educated all staff on 4/22/25 or before they started their next shift on abuse and neglect, and how to find a resident's kardex, which shows the resident transfer status. NHA A confirmed that CNA D had signed off on education in her orientation stating she knew how to transfer residents and review their kardex information.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included educating all staff members in the facility on the abuse policy, kardex information, honoring resident wishes and following the kardex for ADL care, and when to contact the abuse coordinator. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		