STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235311	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing Home Inc	8290 W C Ave 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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100146395 and M100146349. Based on interview and record review, the facility failed to ensure an effective process for receiving and addressing grievances in 1 (Resident #2) of 1 resident reviewed for grievances, resulting in unresolved concerns. Findings include: In an interview on 8/28/24, Family Member (FM) M reported R2 was sent to the facility for care of her pressure ulcers. There was a malfunction with the wound vac (vacuum-assisted closure) for at least 3 days and R2 did not receive any other wound care when it was not working. She is now in the hospital because of it. FM M reported he filled out a grievance form on behalf of R2 who dictated to him what to write down because she was not feeling well and could not write herself. R2 was having concerns with pain and needed assistance with care and a nurse was mouthy, [NAME], and ignored her. A Certified Nursing Assistant (CNA) overheard what the staff member said and advised them to put it in writing. The CNA told him she took the grievance form to the Administrator. In an interview on 8/27/24 at 3:00 PM CNA O was questioned about R2 and FM M having a grievance about her care at the facility. CNA O reported she did work the day she overheard the nurse being rude to R2. R2 complained of not getting her medications or pressure ulcer treatments. CNA O reported she gave the grievance form to the Director of Nursing (DON). In an interview on 8/28/24 at 11:18 AM, the Nursing Home Administrator (NHA), the DON, and the Assistant Director of Nursing (ADON) reported they did not receive any grievances forms from R2 and is not aware of R2 having concerns about her care or complaints of a staff member caring for her. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled Resident Rights- Grievances last updated on 5/2/19 revealed: 4. Any resident or representative or member of the resident's family of the resident council may present a grievance to the Administrator orally or in writing giving the rise to the grievance. 5. The Administrator or designee in the absence of the administrator, shall confer with persons involved in the incident and other relevant persons and within three to seven days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal representative, if any. 8. All written grievance decisions will include the date the grievance was received, a summary statement of the residents grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken to be taken by the facility as a result of the grievance, and the date the written decision was issued.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI0014459 and MI00146322. Based on interview and record review, the facility failed to follow physician orders for 1 of 8 residents (R4) reviewed, resulting in R4 not receiving medications per the physician's order, and the physician not being notified of R4's high blood sugar readings per the physician's order. Findings include: A review of R4's Admission Record, dated 8/26/24, revealed R4 was a [AGE] year-old resident admitted to the facility on [DATE] with multiple diagnoses that included diabetes. A review of R4's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 5/13/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R4 had short-term and long-term memory problems with inattention and disorganized thinking. In addition, R4's MDS revealed he had severely impaired cognitive decision-making skills. During an interview on 8/26/24 at 10:25 AM, Certified Nursing Assistant (CNA) E stated there are nurses not administering medications to the residents. She stated she heard from residents that they were not receiving their prescribed medications. However, she did not know the names of any of the nurses who were allegedly not administering medications to residents. A review of R4's May 2024 Medication Administration Record (MAR), revealed the following: - Licensed Practical Nurse (LPN) B had documented NA in the boxes marked for blood sugar level in the Novolog insulin per sliding scale times on 5/13/24 at 1630 (4:30 PM) and 5/13/24 at 2000 (8:00 PM). - LPN C had documented NA in the boxes marked for blood sugar level in the Novolog insulin per sliding scale times on 5/14/24 at 1130 (11:30 AM). In addition, LPN C had marked in the box with her initials a code of 9 (Other/See Progress Notes). A review of R4's progress notes, dated 5/7/24 to 5/14/24, revealed the following: - Default PN (Pharmacy Note) Type for eMAR (electronic medical record) progress note, dated 5/13/24 at 1630, revealed, BS = HI (blood sugar reading was HI (a value above the maximum range of the machine to read)- 12 units [Novolog insulin] given and physician called. - Default PN Type for eMAR progress note, dated 5/13/24 at 2000, revealed, BS= HI- 12 units given. - Default PN Type for eMAR progress note, dated 5/14/24 at 1130, revealed, BS= HI- 1 unit given and logged for physician whom is in house (at the facility) at the time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R4's physician order, dated 5/8/24, revealed R4 was to receive Novolog Insulin before meals and at bedtime. The order also revealed if R4's blood sugar was greater than 349, then R4 should receive 12 units of insulin and the physician should be called. During an interview on 8/27/24 at 3:45 PM, the Director of Nursing (DON) was notified that it appeared on 5/13/24 at 8:00 PM R4's blood sugar reading was HI and the nurse gave 12 units of Novolog insulin. However, it did not appear that they had called (notified) the physician per the physician's order. The DON was also notified that the nurse documented she gave 1 unit of Novolog insulin for a HI blood sugar reading on 5/14/24 at 11:30 AM and logged for physician (wrote/sent a message to the physician) the HI reading instead of giving 12 units of Novolog insulin and calling the physician per the physician's order. The DON stated she thinks the 1 unit might have been a typo, but she agreed that it appears that the nurse only gave 1 unit and there is no way she can see if it was a typo or not because the nurse no longer works for the facility. The DON was also notified that the surveyor could not find any documentation that the physician addressed R4's HI blood sugar reading on 5/13/24 at 4:30 PM and/or was even aware that R4 had HI blood sugar readings on 5/13/24 at 8:00 PM and 5/14/24 at 11:30 AM. The DON stated she would check and see if there were any notes that the physician was actually notified of the HI blood sugar readings on 5/13/24 at 8:00 PM and 5/14/24 at 11:30 AM. She stated she would also check and see if she can find a note or any documentation that the physician had addressed R4's HI blood sugar reading on 5/13/24 at 4:30 PM. Copies were requested from the DON of any documentation that the physician was notified and/or made aware of R4's HI blood sugar readings on 5/13/24 at 4:30 PM, 5/13/24 at 8:00 PM, and 5/14/24 at 11:30 AM, if found. As of the completion of the survey and exit from the facility, the facility failed to provide any additional documentation. During an interview on 8/28/24 at 9:45 AM, Licensed Practical Nurse (LPN) A stated that when a nurse documents logged for physician in the MAR (Default PN Type for eMAR progress note) it means that the nurse wrote a note to the physician on the log sheet in the physician's book at the nurse's station. She stated the physician will then review the physician's book when they are in the facility and should see the note. She further stated that logging the note in the physician's book was not the same as calling them.

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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 - 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** 37573 This citation pertains to intakes M100146395 and M100146349. Based on interview and record review, the facility failed to follow their policy and appropriately provide pressure ulcer care as ordered for 1 (Resident #2) of 4 residents reviewed for pressure ulcers, resulting in hospitalization . Findings include: A Wound Vacuum-Assisted Closure (or wound VAC) is a method used to decrease air pressure around a wound to assist the healing. It is also referred to as negative pressure wound therapy. During a VAC procedure, a healthcare professional applies a foam bandage over an open wound, and a vacuum pump creates negative pressure around the wound. This means the pressure over the wound is lower than the pressure in the atmosphere. The pressure pulls the edges of the wound together while removing fluids and infections from the wound. https://www.webmd.com/a-to-z-guides/what-is-vacuum-assisted-wound-closure Review of a Face Sheet for R2 revealed she admitted to the facility on [DATE] with pertinent diagnoses of osteomyelitis of vertebral, sacral and sacrococcygeal region and pressure ulcers of right hip and sacral region. In an interview on 8/28/24, Family Member (FM) M reported R2 was sent to the facility for care of her pressure ulcers. There was a malfunction with the wound vac for at least 3 days and R2 did not receive any wound care when it was not working. She is now in the hospital because of it. FM M reported he and R2 did express concerns to staff that wound care was not being done. In an interview on 8/27/24 at 4:00 PM, Confidential Informant (CI) N reported R2 did not have wound care services as ordered. The wound vac was not working because the nursing staff did not know how to use it. One time the wound vac was not working and R2 had a wet to dry dressing in place that was in place for several days. When it was finally changed, the dressing was dry and hard to get out of the wound. Review of Hospital Records dated 8/5/24 for R2 revealed she was sent to the emergency department with a chief complaint of increased confusion. Had wound vac in place for known decubitus ulcer but was removed on 8/1 because the facility 'had no more canisters. Pt (patient) now febrile (fever) and tachycardic (increased heart rate) . Apparently, they ran out of the canisters was for osteomyelitis (bone infection) of the sacral (base of spine in pelvic area) and coccygeal (tailbone) region and they therefore took off the wound VAC. Assessment: 1. MRSA (methicillin-resistant Staphylococcus aureus) Septicemia (blood poisoning) in setting of stage IV decubitus ulcer, 2. Subacute/chronic osteomyelitis with a contiguous focus of infection. CT Abdomen and Pelvis with Contrast: Final Result- 1. Worsened sacral decubitus ulcer with worsened associated osteomyelitis and myositis (muscle inflammation). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 8/27/24 at 9:15 AM, Wound Care Nurse Practitioner (NP) P reported if the staff had a problem with the wound vac for R2, they are to do a wet to dry dressing in its place. If staff were not able to troubleshoot the wound vac, they are to call the Director of Nursing (DON), the Unit Manager, or their direct supervisor. NP P was aware the facility had a problem with the wound vac for R2. Review of a Nursing Progress note dated 7/9/24 for R2 revealed Wound vac removed due to machine malfunction. Wet to dry dressing placed on open areas. Wound vac reordered, awaiting arrival. Review of the Practitioner Progress note dated 7/9/24 for R2 revealed: The patient has a large sacral wound with wound VAC. The margins of which are increasing, and she has some slight purulent material with discharge on the lateral aspect of the wound. Review of the Practitioner Wound Care Progress Notes dated 7/10/24 for R2 revealed: -Wound 1: Pressure wound sacral stage IV- Plan: Clean with normal saline and wound VAC to be applied and changed on Tuesday, Thursday, and Saturday. Measurement: 10.1 x 9.7 x 1.4. Post debridement: 10.1 x 9.7 x 1.5 cm. -Wound 2: Right trochanter, unstageable pressure-induced tissue damage. Plan: Cleanse with normal saline and apply Santyl and then wound VAC to be applied and changed on Tuesday, Thursday, and Saturday. Measurement: 4.3 x 4.4 cm x undetermined. Post debridement measurements: 4.4 x 4.6 cm x undetermined. -Wound 3: Left heel, stage III pressure wound. Plan: Cleanse with normal saline and apply A&D ointment daily. Measurement: 0.3 x 0.5 cm x scab. Review of the Practitioner Wound Care Progress Notes dated 7/23/24 for R2 revealed: -Wound 1: Pressure wound sacral stage IV- Plan: Cleanse with Dakin's and apply wound Vac to be changed Tuesday, Thursday, and Saturday. -Wound 2: Right trochanter, unstageable pressure-induced tissue damage, which is now reclassified to stage IV pressure wound. - Plan: Cleanse with normal saline and apply Santyl and bridge wound VAC to be changed on Tuesday, Thursday, and Saturday. -Wound 3: Left heel, stage III pressure wound. - Plan: Cleanse with normal saline and apply A&D ointment daily. Review of Wound Care Progress Notes dated 7/30/24 for R2 revealed: -Wound 1: Pressure wound sacral stage IV- Plan: Cleanse with Dakin's and apply wound Vac to be changed Tuesday, Thursday, and Saturday and apply barrier cream to surrounding tissue. Apply Flagyl (antifungal) powder. Measurement: 11.6 x 12.8 x 1.4 cm. No undermining or tunneling was noted. Post-debridement Measurement 11.8 x 12.8 x 1.5 cm. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound 2: Right trochanter, unstageable pressure-induced tissue damage, which is now reclassified to stage IV pressure wound. - Plan: Cleanse with normal saline and apply Flagyl powder and then apply wet-to-dry dressing daily and apply barrier cream to surrounding to tissue. Measurement: 3.7 x 3.9 x 1.2 cm with undermining of 1.7 at 5 o'clock. Post-debridement Measurement: 3.8 x 4.0 x 1.4, with undermining of 1.9 cm at 5 o'clock. -Wound 3: Left heel, stage III pressure wound. - Plan: Apply A&D ointment daily. Review of a Physician Progress note dated 8/1/24 for R2 revealed: Have asked the nursing staff to apply Dakins wet to dry for the wound infection of the right hip. Review of the Order Summary and the Treatment Administration Record (TAR) for R2 revealed the following orders: 6/25/24- Apply Triple antibiotic ointment to left heel. Present as small, scabbed area on outer aspect. Monitor for any changes, every day and night shift. Not documented as done on the day shift on 7/23, 7/25, or 7/30. 6/26/24 - Negative pressure wound therapy to Sacrum and right hip @ 125 mmHg continuous: Cleanse areas with NS, pat dry, skin prep wound edges, Apply black sponge, cut to fit wound cavity, cover with plastic drape- bridge areas together and secure vac (Ensure Black foam is not touching any intact skin) every day shift, every Tue, Thu, Sat. use Dakins to cleanse coccyx wound. (sic) -Not documented as done on 7/23/24, 7/27/24, 7/30/24 or 8/1. (The resident received one wound vac dressing change from 7/20 to 8/3 (7/25/24 and 8/3/24 only). 6/26/24 - Santyl Ointment 250 UNIT/GM (Collagenase) Apply to right hip wound topically every day shift every Tue, Thu, Sat for wound care. -Santyl Ointment to the right hip was documented as a see nursing notes (code 9) on 7/9 and 7/11, not documented as done on 7/27, documented as a refusal (code2) on 8/1, and not documented as done on 8/3. 7/19/24-Wound Care for Stage 4 on Sacrum and Stage 3 on right hip: Cleanse with Normal saline; Apply wet to dry dressing. when wound vac is not connected or fail, as needed for wound care change daily if wound vac is not in use. -Not documented as done 7/20 to 7/23 then it was discontinued. 7/23/24- Wound Care for Stage 4 on Sacrum and Stage 3 on right hip: Cleanse with Dakins solution; Apply wet to dry dressing. when wound vac is not connected or fail, as needed for wound care change daily if wound vac is not in use. -Not documented as done on the TAR 7/24 to 7/31 when it was discontinued. 7/23/24- H-Chlor 12 External Solution (Sodium Hypochlorite) Apply to coccyx topically every day shift every 3 day(s) for stage 3 wound too be used with dressing change. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Not documented as done on 7/24, 7/27, or 7/30 and was discontinued on 7/31/24. 7/31/24- Right trochanter wound- cleanse with dakins and soak for 5 minutes apply flagyl 250 mg crushed tablet to wound bed and apply wet to dry drsg daily every day shift. (sic) - not documented as done on 7/31 or 8/1. 7/31/24- Sacral wound- cleanse with dakins solution 0.125% and let soak for 5 minutes. Apply flagyl 250 mg crushed tablet to wound bed and apply wound vac every tues, thurs, sat. use wet to dry drsg (dressing) if wound vac is not working properly daily as needed for daily wet to dry drsg change. (sic) -Not documented as done on 7/31 and discontinued 8/1. 7/31/24- Sacral wound- cleanse with dakins solution 0.125% and let soak for 5 minutes. Apply flagyl 250 mg crushed tablet to wound bed and apply wound vac every tues, thurs, sat. use wet to dry drsg if wound vac is not working properly daily every day shift every Tue, Thu, Sat. (sic) -Not documented as done on 8/1. In an interview on 11/28/24 at 11:20 AM, the Assistant Director of Nursing (ADON) L reported it had been a very long time since the facility took care of a resident who had a wound vac before R2. She confirmed the staff did not have any training for the wound vac R2 needed for her wounds. When asked if staff knew how to care for a resident with a wound vac, she reported she was not told specifically that staff didn't know how to use a wound vac but knew they were not comfortable doing it. ADON L reported she was not aware of any concerns that R2 was not receiving her pressure ulcer dressing changes. In an interview on 8/28/24 at 12:30 PM, the Director of Nursing (DON) reported she has been here since April and is not aware of nursing staff having any training on wound Vacs. When asked about the wound Vac not working for R2 and wound care not being done for several days in July and August, the DON reported she did not know about it. The DON expected her staff to report to her if there were any complications with the wound vac and notify the physician. The staff are to do a wet to dry dressing when the wound vac is not working and confirmed that it was not done. The DON does expect to see documentation regarding the missed treatments and notify the physician. Review of a Skin Monitoring and Management - Pressure Ulcer adopted 7/11/18 revealed: It is the policy of this facility that: A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intakes: MI00146486 and 146502 Based on interview and record review the facility failed to provide supervision and assistance in 1 of 4 residents (R1) reviewed for falls/safety, resulting in falls and injuries. Findings included: Review of R1's face sheet dated 8/26/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: personal history of traumatic brain injury, mild neurocognitive disorder, severe protein-calorie malnutrition, post-traumatic stress disorder and repeated falls. R1 was not his own responsible party. Review of R1's fall care plan dated 4/26/24 revealed, resident at risk for falls r/t (related to) weakness, repeated falls encephalopathy and debility. HX (history) of TBI (traumatic brain injury) with cognitive deficit, removing socks and shoes, impulsive with transfer. Actual fall on 4/26/24 review of interventions revealed no interventions for supervision. Review of R1's incident and accident reports from 4/24/24 to 5/15/24 revealed R1 had 9 unwitnessed (unsupervised) falls. Review of the incident/accident reports and the post fall evaluations for these falls revealed the facility did not add any supervision interventions to R1's care plan. Review of R1's incident and accident report dated 4/26/24 at 21:45 (9:45 PM) revealed he was found in bed with blood coming from above his right eyebrow and his right elbow. He reported he fell and got into bed. He required medical treatment to stop the bleeding. The report documented he was noncompliant and forgetful to call for assistance. There was no indication of any supervision being added to his plan of care. Review of the Progress Noted dated 5/6/24 at 1:00PM revealed the Nurse Practitioner had seen R1 due to having multiple falls and need for medication changes. There was no mention of an injury of any type (including right elbow) for R1 due to falls but that an xray of the ribs had been completed with no negative results. Review of R1's incident and accident report dated 5/14/24 at 1:37 AM revealed R1 had an unwitnessed fall. R1 said he made it to the toilet but did not know exactly where he fell , he did not know what happened. R1 was educated to use the call light. No new intervention for supervision or assistance was located. Under injury, skin tear to the right elbow was listed. Review of R1's fall report dated 5/14/24 at 1:37 AM and locked on 5/23/24 revealed, pt (patient) has a large skin tear on right elbow. Cleaned and bandaged. Review of the Progress Noted dated 5/15/24 at 1:00PM revealed the Nurse Practitioner had seen R1 due to having multiple falls and an xray of his elbow was ordered due to swelling and limited mobility in the right elbow that had begun after R1's fall on 5/14/24. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Noted dated 5/17/24 at 1:00PM revealed the Nurse Practitioner (NP) had seen R1 as a follow up to the xray of his right elbow. Xray showed no acute fracute, but did show olecranon bursitis. R1 had redness and swelling and warmth in his right elbow indicative of cellulitis. The NP wrote that R1's frequent falls and injury to his elbow could have caused the cellulitis due to the skin tear which would have allowed bacteria in. The practitioner wrote there was a concern for a septic elbow and ordered labs for a C-reactive protein and uric acid levels. Review of R1's Emergency Department History and Physical Note dated 5/19/24 revealed he had been treated at the nursing home for 2 weeks for cellulitis of his right arm and a urinary tract infection. Orthopedic surgery was consulted for irrigation and debridement of the right olecranon septic bursitis with bursectomy as well as irrigation and debridement of the right foream abscess that was deep and multiloculated. Review of R1's hospital discharge summary dated 5/31/24 revealed he had surgical treatment for a septic olecranon bursitis (elbow injury resulting in infection), he was treated for urinary tract infection, he had a feeding tube placed on 5/26/24. Outpatient follow up issues included: 1:1 feeding, ortho follow up for suture removal. Keep are wound open to air, ongoing wound care, and complete IV (intravenous) antibiotics. During an interview with the Assistant Director of Nursing (ADON) V on 8/27/24 at 11:10 AM she recalled caring for R1 during his stay at the facility. ADON V recalled R1 having multiple falls and did not recall any time the treatment team recommended activities or any way to supervise R1 when he was awake. During an interview with the Director of Nursing (DON) on 8/27/24 at 12:30 PM R1's 9 falls and post fall evaluations were reviewed. The DON confirmed that R1 was not his own responsible party, he was impulsive and unsafe. The DON could not locate any documentation that the facility implemented any care plan to supervise R1 when he was awake. The DON could not find any summary of an interdisciplinary review post fall or any investigation into R1's status prior to each fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235311	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing Home Inc	8290 W C Ave 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)
F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake MI00146486. Based on interview and record review, the facility failed to ensure adequate care for a resident who required tube feeding in 1 of 1 resident (R1) reviewed for tube feeding, resulting in an acute change of condition immediate need for ambulance transport to the hospital. Findings include: Review of R1's face sheet dated 8/26/24 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: personal history of traumatic brain injury, mild neurocognitive disorder, severe protein-calorie malnutrition, post-traumatic stress disorder and repeated falls. R1 was not his own responsible party. Review of R1's hospital discharge summary dated 5/31/24 revealed he had surgical treatment for a septic olecranon bursitis (elbow injury resulting in infection), he was treated for urinary tract infection, he had a feeding tube placed on 5/26/24. Review of R1's Emergency department history and physical note dated 6/3/24 revealed, Patient was residing at nursing home facility, was on tube feeds and per daughter was supposed to have his head elevated at 30 degrees. However, when she arrived, he was not responsive, irregular breathing while lying flat. In transit to the hospital, pulses were lost, and family had elected to allow natural death. Patient pronounced upon arrival to the emergency department. Review of R1's progress noted dated 6/4/24 at 00:38 (12:38 AM) revealed, when I arrived for my shift (10:00PM), I was alerted that the patient needs to be assessed. Pt (patient) was grayish in color, gurgling, and short of breath, sweating profusely. T (temperature) 97.4, HR (heart rate) 27 then 115, unable to get O2 reading, reading as low. Put on 4 L (liters) NC (nasal canula) and sat patient up completely from his 45-degree angle that increased to 63 %. Unable to obtain BP. Patient left with (name of ambulance company and his sister at 10:58 PM. Name of hospital ER (emergency room) called at 12:34 AM and informed us that patient passed away en route. Signed electronically by, Licensed Practical Nurse (LPN) T During a telephone interview with LPN T on 8/27/24 at 8:33 AM, LPN T said she started her shift on 6/3/24 at approximately 10:00 PM. She could not recall which certified nurse told her R1 was distress and recalled the nurse in charge at the time was an agency nurse but could not recall her name. LPN T recalled R1 was lying flat in bed when she arrived with his tube feeding running. LPN T said R1 was known to scoot down and slide down in bed with his tube feeding running. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235311	A. Building B. Wing	08/28/2024

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Alamo Nursing Home Inc	8290 W C Ave Kalamazoo, MI 49009

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F 0693 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with LPN B on 8/28/24 LPN B confirmed she was the nurse on R1's unit 6/3/24. Record review showed LPN B gave R1 medications at 6:00 PM that night. LPN B could not recall what R1 was like between 6:00 PM and 10:00 PM when he was found flat and unresponsive in bed. LPN B did not recall why she did not document on R1 condition in the medical record. LPN B did not recall why other nurses did the transfer notes and did the assessment on R1. LPN B was aware R1 slid down in bed when his tube feeding was running. LPN B said she tried to do frequent checks due to his unsafe behaviors but had no recall of the last time she saw him on 6/3/24. During a telephone interview with LPN U on 8/28/24 at 9:42 AM, LPN U recalled doing the hospital transfer sheet for R1 on 6/3/24. LPN U had no recall of seeing R1 at any time on 6/3/24. During an interview with the Assistant Director of Nursing (ADON) V on 8/27/24 at 11:10 AM she recalled caring for R1 during his stay at the facility. ADON V said she did not know R1 was scooting down or sliding down in his bed when his tube feeding was running. During an interview on 8/27/24 at 12:30 PM, Director of Nursing (DON) denied any knowledge of R1 sliding or scooting down in bed when his tube feeding was running. The DON did not have any investigation or documentation of any care provided for R1 from 6:00 PM to 10:00 PM on 6/3/24 when he was found lying flat in bed, tube feeding running and in respiratory distress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37573 This citation pertains to intake M100146395. Based on interview and record review, the facility failed to ensure there was adequate competencies to provide nursing related services for 1 (Resident #2) of 1 resident reviewed for skilled nursing services. Findings include: In an interview on 8/28/24, Family Member (FM) M reported R2 was sent to the facility for care of her pressure ulcers. There was a malfunction with the wound vac (vacuum assisted closure) for at least 3 days and R2 did not receive any wound care when it was not working. She is now in the hospital because of it. FM M reported he and R2 did express concerns to staff that wound care was not being done. In an interview on 8/27/24 at 4:00 PM, Confidential Informant (CI) N reported R2 did not have wound care services as ordered. The wound vac was not working because the nursing staff did not know how to use it. One time the wound vac was not working and R2 had a wet to dry dressing in place that was in place for several days. When it was finally changed, the dressing was dry and hard to get out of the wound. In an interview on 11/28/24 at 11:20 AM, the Assistant Director of Nursing (ADON) L reported it had been a very long time since the facility took care of a resident who had a wound vac before R2. She confirmed the staff did not have any training for the wound vac R2 needed for her wounds. When asked if staff knew how to care for a resident with a wound vac, she reported she was not told specifically that staff didn't know how to use a wound vac but knew they were not comfortable doing it. ADON L reported she was not aware of any concerns that R2 was not receiving her pressure ulcer dressing changes. In an interview on 8/28/24 at 12:30 PM, the Director of Nursing (DON) reported she has been here since April and is not aware of nursing staff having any training on wound Vacs before or after R2 admitted to the facility with a wound vac. When asked about the wound Vac not working for R2 and wound care not being done for several days in July and August, the DON reported she did not know about it. The DON expected her staff to report to her if there were any complications with the wound vac and notify the physician. The staff are to do a wet to dry dressing when the wound vac is not working and confirmed that it was not done. The DON does expect to see documentation regarding the missed treatments and notify the physician. When queried about the last time nursing competency skills and education was done, the DON did not know the answer. The nursing management received in service education for skin management on 7/16/24 but the floor nursing staff had not received this education yet. Review of the Medication/Treatment Administration Record (MAR/TAR) revealed R2 missed several wound vac treatments and pressure ulcer dressing treatments in July and August 2024.