

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER Alamo Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027</p> <p>This citation pertains to intake #MI00149360.</p> <p>Based on interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of an allegation of abuse in 1 resident (Resident #114) of 15 residents reviewed for abuse reporting, resulting in the potential for a delayed investigation and further abuse.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #114 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: kidney failure.</p> <p>In an interview on 1/6/25 at 2:45 PM, Nursing Home Administrator (NHA) A reported that she had submitted a facility reported incident (FRI) that morning, after Social Worker (SW) C spoke with Family Member (FM) P. NHA A reported that FM P had informed SW C that Resident #114 alleged that he had been abused by staff at the facility. NHA A reported that she had started the 5 day investigation, but did not have any additional information at that time.</p> <p>In an interview on 1/6/25 at 3:08 PM, SW C reported that she had spoken to FM P that morning, who reported that Resident #114 was in the hospital and had sustained cracked ribs. FM P also reported that Resident #114 continued to be adamant that he had been kicked. SW C reported that Resident #114's BIMS (brief interview for mental status) score was 13, indicating that he was cognitively intact. SW C stated that she reported the allegation immediately to NHA A.</p> <p>In an interview on 1/7/25 at 12:11 PM, Registered Nurse (RN) M reported that Resident #114 was complaining of back pain on 1/6/25 at about 12:30 AM, and said that it was a result of being kicked by a staff member. Resident #114 was also requesting to be sent to the hospital. RN M reported that she contacted Unit Manager (UM) J (on-call manager), who instructed her to report the allegation of abuse to NHA A. RN M called NHA A at about 1:00 AM and then shortly afterwards, Resident #114 was discharged to the hospital.</p> <p>In an interview on 1/7/25 at 1:31 PM, UM J reported that she received a phone call on 1/6/25 around 1:00 AM from RN M, and she instructed her to call NHA A immediately to report the allegation of abuse.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow up interview on 1/7/25 at 2:37 PM, NHA A reported that RN M had notified her on 1/6/25 at about 1:00 AM that Resident #114 was requesting to leave, and had alleged that he was kicked by staff. NHA A reported that she submitted the FRI on 1/6/25 when she was informed that the resident had been admitted to the hospital and had sustained broken ribs. This was approximately 10 hours after NHA A was notified about the allegation of abuse.</p> <p>Review of Resident #114's FRI was submitted on 1/6/25 at 10:39 AM revealed, .It was reported to the Administrator that (Resident #114) went to the hospital on 1/6/24 per his request. Resident was admitted to the hospital. Resident had fallen recently and was experiencing confusion and hallucinations. Facility assessed resident at the time of the falls and resident had no complaint of pain. Upon report from the hospital the resident stated that he had been kicked in the back. Resident remains at the hospital. Facility will follow up with five-day investigation .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027</p> <p>This citation pertains to intake #MI00149360.</p> <p>Based on observations, interviews and record review, the facility failed to provide increased supervision for 3 residents (Resident #114, #108, & #106) of 5 residents reviewed for being at risk for falls, resulting in repeated falls for all 4 residents, and Resident #114 sustaining fractured ribs.</p> <p>Findings include:</p> <p>Resident #114</p> <p>Review of an Admission Record revealed Resident #114 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: kidney failure.</p> <p>Review of Resident #114's Care Plan revealed, .at risk for falls r/t (related to) weakness, impulsive with transfer, seizures. Date initiated: 1/2/25, Revision on: 1/4/25. Interventions: PA (physician assistant) to review medication r/t low BP (blood pressure). dated initiated 1/2/25. Room Closer to nurse's station. date initiated: 1/5/25 .Ensure call light is within reach, provide cueing and reminders for use as appropriate with level of cognition. date initiated: 1/2/25. Ensure resident is wearing appropriate footwear when ambulating or mobilizing in wc (wheelchair) .date initiated: 1/2/25 .Call light signage in room. date initiated: 1/3/25. Call light usage education. date initiated: 1/3/25.</p> <p>Review of Resident #114's Fall Risk Assessments revealed, on 12/31/24 a score of 25, indicating a moderate risk, 1/2/25 90 indicating a high risk, and on 1/3/25 65 indicating a high risk.</p> <p>Review of Resident #114's unwitnessed fall reports revealed the following:</p> <ol style="list-style-type: none"> 1/2/25 at 12:30 AM, Registered Nurse (RN) M was called to the resident's room by a CNA (Certified Nursing Assistant), to find the resident on the floor in the bathroom. The immediate intervention was to remind the resident to use his call light, and to check on the resident often throughout the shift. The IDT (interdisciplinary team) agreed with these interventions and did not implement anything further. 1/2/25 at 2:00 PM, CNA alerted RN D that the resident was on the floor in his room. The resident had reported forgetting to ask for assistance. The IDT noted that the provider was notified to review the resident's medications due to low blood pressure. 1/3/25 at 6:00 AM, CNA alerted RN D that the resident was on the floor in his room. Resident #114 had a lump above his right eyebrow and reported hitting his head. The resident was sent to the hospital for evaluation and returned with an Aspen collar (neck brace) due to fracture of C3 (cervical vertebrae #3). The resident's room was moved closer to the nurse's station. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. 1/5/25 at 9:58 PM, Licensed Practical Nurse (LPN) T indicated that the resident was observed in his room on the floor at 5:20 PM (4.5 hours earlier) with no injuries and was educated to utilize the call light for assistance. This report was entered late.</p> <p>5. 1/5/25 at 8:13 PM, Family Member (FM) P had notified the facility by phone that the resident was on the floor in his room. LPN T found the resident on the floor next to his bed. LPN T left the room to find assistance, and the resident scooted himself into the hallway. The resident was assisted to bed and educated to use the call light for assistance.</p> <p>In an interview on 1/6/25 at 1:58 PM, RN D reported that Resident #114 resided on the rehabilitation (rehab) hall, but was currently in the hospital. RN D reported that the resident did not use his call light or request assistance when he needed to transfer out of his chair or bed, regardless of call light education. RN D reported that the resident had only been in the facility a few days, and needed constant reminders about where his belongings were, and why he was at the facility. RN D reported that along with the rehab, that her regular assignment also included part of west hall, and that she was not able to help answer call lights and get medications passed on time. RN D reported that on first shift there are 2 CNA's assigned to the rehab hall but they each also have assignments on west and south halls. RN D reported that at times all nursing staff may be off the rehab hall at the same time, and that the rehab hall is not visible from other areas of the facility.</p> <p>In an interview on 1/7/25 at 2:08 PM, CNA N reported that on 1/5/25 she was assigned to rehab hall, but was in another resident's room when Resident #114 fell the first time, and the second time he fell she was in the dining room cleaning up after dinner. CNA N reported that Resident #114 was agitated that evening and did not want to be there. CNA N reported that staff was not able to provide adequate supervision of residents like Resident #114, because of short staffing, and having assignments off of the hall.</p> <p>In an interview on 1/7/25 at 11:20 AM, CNA G reported on 1/5/25 they were working on another hall, when Licensed Practical Nurse (LPN) T requested assistance to get the resident off of the floor. CNA G reported that Resident #114 did not appear to be injured at that time but that later that evening had complained of back pain. CNA G reported that there were 2 CNA's assigned to the rehab hall that evening, but they were both assisting other resident at the time of the fall. CNA G reported that lately they are not able to spend as much time with each resident.</p> <p>In an interview on 1/7/25 at 2:59 PM, LPN T reported that on 1/5/25 she had found Resident #114 on the floor around dinner time, and that the resident was agitated. LPN T reported that later that evening FM P called the facility and reported that Resident #114 had called her by phone and said that he needed assistance. When LPN T entered the resident's room, she found him on the floor again. LPN T reported that she was not able to find a CNA to assist with Resident #114's fall right away, and by the time she got back to assist him off the floor, he had crawled into the hallway. LPN T reported that she was employed by an agency and that 1/5/25 was her third shift working at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/7/25 at 12:11 PM, RN M reported that Resident #114 was very new to the facility and was sometimes confused and other times seemed very alert and oriented. RN M reported that Resident #114 had fallen twice on 1/5/25 during second shift, and then a few hours later, around midnight on 1/6/25 was extremely agitated, complained of severe back pain, and requested to go to the hospital. RN M reported that on third shift, the nurse was responsible for rehab, west and south hall, and that she was in a room on west hall when Resident #114 had reported the pain. RN M reported that the facility recently decreased the number of nurses on third shift from 3 to 2, which made it difficult to take care of residents during urgent situations.</p> <p>Review of Resident #114's Hospital Records indicated that on 1/3/25 the resident had been evaluated in the hospital following back-to-back falls in the facility, and revealed a finding of cervical (neck) fracture, that could not be confirmed as a new finding. Then on 1/6/25 indicated that the resident was admitted to the hospital after multiple falls and confirmed a finding of acute (new) fractures of right ribs 8 and 9, and subacute (recent) fracture of left rib 7.</p> <p>In an interview on 1/6/25 at 2:17 PM, CNA EE reported that the rehab hall had a lot of residents that required 2 person assistance. CNA EE reported that along with her assignment on rehab hall, she also had to assist west hall with 2 person assists, for transfers and check and changes, to answer call lights, and then to the dining room to assist with meals. CNA EE reported that for one of Resident #114's falls, she was helping on a different hall.</p> <p>In an interview on 1/7/25 at 10:24 AM, CNA F reported that Resident #114 did not remember to use his call light. CNA F reported that the rehab hall residents were constantly putting their call lights on for assistance, and demanded help immediately, or they just tried to do it themselves and stated, .they are here to rehab and are used to doing things on their own at home . CNA F reported that she was not able to supervise residents sufficiently, considering that she had to leave the rehab hall and help on other halls. CNA F reported that she was not able to hear or see the rehab hall when she was helping on another hall. CNA F reported that the rehab hall only had one CNA on third shift, and that CNA also had residents on west hall.</p> <p>In an interview on 1/6/25 at 3:57 PM, CNA I reported that Resident #114 had fallen several times during her shifts, and that during those times, she had been partnered up with other staff, so that they could do cares on residents that required 2 person assistance. CNA I reported that staff often have to leave the rehab hall to complete cares on other halls, and/or answer call lights. CNA I reported that Resident #114 was able to follow cues, but did not remember to use his call light when he needed to use the bathroom. CNA I reported that one of the times Resident #114 had fallen, he had been found in the bathroom and had messed himself. CNA I reported that at times she had to leave her assigned hall for 30 minutes at a time to assist on other halls with residents, and during those times, she hoped the nurse didn't also get called away.</p> <p>Resident #108</p> <p>Review of an Admission Record revealed Resident #108 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: partial paralysis following a stroke.</p> <p>Review of Resident #108's Fall Risk Assessments revealed, upon admission on 10/15/24 a score of 40 which was a moderate risk for falls, on 10/29/24 35 a moderate risk, on 10/31/24 75 a high risk for falls, on 11/9/24 75, on 11/10/24 75, and on 12/24/24 55 also a high risk for falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #108's Fall Reports revealed the following:</p> <ol style="list-style-type: none"> 10/31/24 at 3:42 PM the resident was found on the floor beside his bed, with no injuries. Resident #108 was relocated to a common area to monitor. 10/31/24 at 11:12 PM the resident was found on the floor beside his bed, with the nightstand on top of his head. The resident was sent to the hospital for evaluation of head trauma. 11/9/24 at 2:45 AM the resident was found on the floor in his room, incontinent of urine and had a wet brief on. Resident had a bruise noted on his left shoulder. Resident #108 was placed in his wheelchair and was to be kept in eye view of nurse's station. 11/10/24 at 2:30 AM the resident was found on the floor in his room, lying on his stomach. The resident was assisted into bed and educated to use call light. 12/21/24 at 3:39 AM the resident was found on the floor in his room. Resident #108 was assisted into his chair and placed in the hallway. 12/24/24 at 5:02 PM the resident was found on the floor in the hallway, halfway out of his room. Resident #108 had been noted with increased restlessness, agitation and combativeness, and was sent to the hospital for evaluation. <p>During an observation on 1/6/25 at 1:54 PM Resident #108 was lying in his bed, undressing himself and rolling side to side in bed. There was no staff in the hall to monitor the resident.</p> <p>In an interview on 1/7/25 at 11:20 AM, CNA G reported that Resident #108 was very restless almost all of the time, constantly tried to get out of bed, therefore they try to keep the resident up in his chair in the hall. CNA G reported that Resident #108 resided on south hall, and that there were several residents on the hall that required 2 person assistance. CNA G reported that on third shift there was only one CNA assigned to south hall, and the nurse was also responsible for rehab and west hall.</p> <p>In an interview on 1/7/25 at 9:45 AM, CNA Q reported that it was very hard to keep Resident #108 in bed, and at night with only one CNA on the south hall, we are in rooms and helping other CNA's and cannot watch him all the time.</p> <p>Resident #106</p> <p>Review of an Admission Record revealed Resident #106 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia.</p> <p>Review of Resident #106's Fall Risk Assessments revealed, upon admission on 9/13/24 a score of 65 a high risk for falling, and on 10/28/24 75 a high risk for falling.</p> <p>Review of Resident #106's Fall Reports revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. 9/25/24 at 5:55 PM the resident was found on the floor between the foot pedals of her wheelchair in the sun room. Resident #106 was placed back into her chair and was to be monitored in the sun room. 2. 10/1/24 at 9:00 AM the resident was found on the floor in front of her wheelchair in the hallway, and the wheelchair was tipped over. Resident #106 was placed in a common area while up in wheelchair. 3. 10/7/24 at 10:04 PM the resident was found in her room, hanging off the bed, with the bottom half of her body on the floor. Resident #108's bed was placed in the lowest position and anti-anxiety medications were administered. A new intervention of body pillow on left side while in bed was started. 4. 10/16/24 at 5:00 PM the resident was found sitting on the floor next to her bed. The CNA had reported that the resident was on the edge of her bed trying to stand, and she lowered her to the floor. Intervention was to keep resident in line of sight when restless. 5. 10/2/24 at 6:30 PM the resident was observed on the floor near her bedroom door. Intervention was to assist out of bed and provide activities in staff line of sight. 6. 10/28/24 at 9:35 AM the resident was found on the floor next to her bed and reported having to use the bathroom. 7. 10/28/24 at 8:00 PM the resident was found on the floor next to her bed. 8. 11/16/24 at 3:55 PM the resident was observed by staff sliding out of her bed and onto the floor. A new intervention of gripper socks was started. <p>During an observation on 1/6/25 at 9:07 AM Resident #106 was observed sleeping in her wheelchair near the nurse's station. Subsequent observations until 11:41 AM the resident remained in the same place, sleeping.</p> <p>In an interview on 1/6/25 at 12:00 PM, CNA K reported that Resident #106 resided on west hall, and that the resident just sits in her chair all day by the nurse's station due to her risk of falling. CNA K reported that the resident did not participate in any activities. CNA K reported that west hall is only staffed with 1 CNA on all shifts, and that there were 7 residents that required 2 assist for mechanical lift transfers.</p> <p>In an interview on 1/7/25 at 10:00 AM, Director of Nursing (DON) B reported that she had started a fall improvement plan on 12/24/24, due to the high number of falls in the facility. Review of the plan document, indicated information related to improving documentation of falls, identifying residents that are at risk, implementing interventions, and did not include a review of staffing levels or staff competency.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>41027</p> <p>This citation pertains to intake # MI00147413</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet resident needs in 3 residents (Resident #114, #108, & #106) of 15 residents reviewed for sufficient staffing, with the potential for all residents to be affected, resulting in a lack of supervision of residents at risk for falls. For additional information see citations F689.</p> <p>Findings include:</p> <p>In an interview on 1/8/25 at 10:52 AM, Scheduler (SCH) FF reported that she is only able to schedule staff based off of the census, and that the facility is currently using agency for licensed nurses, and not for Certified Nursing Assistants (CNA). SCH FF reported that on third shift for a census of 80 residents, she schedules 1 CNA for North hall, 1 for South hall, 1 for Rehabilitation hall, 1 for the Basic unit. There is no CNA scheduled for [NAME] hall, but there is a float CNA that is responsible for [NAME] hall, to help North hall, and cover all lunch breaks. SCH FF reported that there are 2 licensed nurses scheduled on third shift, 1 to cover Basic unit and North hall, and the other to cover Rehab hall, South hall and [NAME] hall. SCH FF reported that every hall had residents that require 2 person assist, and the float CNA would also be responsible for helping with those residents. SCH FF reported that occasionally they are not able to schedule a float CNA. SCH FF reported that when the facility is fully staffed on third shift, each CNA would have approximately 17 residents on their assignment. SCH FF reported that she knows that staff are overwhelmed some days, and at this time she is aware of 3 CNA's that are leaving the facility for various reasons.</p> <p>In an interview on 1/7/25 at 10:00 AM, Director of Nursing (DON) B reported that she had started a fall improvement plan on 12/24/24, due to the high number of falls in the facility. Review of the plan document, indicated information related to improving documentation of falls, identifying residents that are at risk, implementing interventions, and did not include a review of staffing levels or staff competency.</p> <p>In an interview on 1/6/25 at 12:00 PM, CNA K reported that the facility is short staffed, and management does not help.</p> <p>Resident #114</p> <p>In an interview on 1/6/25 at 1:58 PM, Registered Nurse (RN) D reported that Resident #114 resided on the rehab hall, and that was where she normally was scheduled. RN D reported that along with the rehab, her regular assignment also included part of west hall, and that she was not able to help answer call lights and get medications passed on time. RN D reported that on first shift there are 2 CNA's assigned to the rehab hall, but they each also have assignments on west and south halls. RN D reported that at times all nursing staff may be off the rehab hall at the same time, and that the rehab hall is not visible from other areas of the facility.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/7/25 at 2:08 PM, CNA N reported that on 1/5/25 she was assigned to rehab hall, but was in another resident's room when Resident #114 fell the first time, and the second time he fell she was in the dining room cleaning up after dinner. CNA N reported that staff was not able to provide adequate supervision of resident's like Resident #114, because of short staffing, and having assignments off of the hall.</p> <p>In an interview on 1/7/25 at 11:20 AM, CNA G reported on 1/5/25 they were working on another hall, when Licensed Practical Nurse (LPN) T requested assistance to get the resident off of the floor. CNA G reported that CNA G reported that there were 2 CNA's assigned to the rehab hall that evening, but they were both assisting other resident at the time of the fall. CNA G reported that lately they are not able to spend as much time with each resident.</p> <p>In an interview on 1/7/25 at 2:59 PM, LPN T reported that she was not able to find a CNA to assist with Resident #114's fall right away on 1/5/25 around dinner time, and by the time she got back to assist him off of the floor, he had crawled into the hallway. LPN T reported that she was employed by an agency and that 1/5/25 was her third shift working at the facility.</p> <p>In an interview on 1/7/25 at 12:11 PM, RN M reported that on third shift, the nurse was responsible for rehab, west and south hall, and that she was in a room on west hall when Resident #114 had reported pain in his back. RN M reported that the facility recently decreased the number of nurses on third shift from 3 to 2, which made it difficult to take care of residents during urgent situations.</p> <p>In an interview on 1/6/25 at 2:17 PM, CNA EE reported that the rehab hall had a lot of residents that required 2 person assistance. CNA EE reported that along with her assignment on rehab hall, she also had to assist west hall with 2 person assists, for transfers and check and changes, to answer call lights, and then to the dining room to assist with meals. CNA EE reported that for one of Resident #114's falls, she was helping on a different hall.</p> <p>In an interview on 1/7/25 at 10:24 AM, CNA F reported that the rehab hall residents were constantly putting their call lights on for assistance, and demanded help immediately, or they just tried to do it themselves and stated, .they are here to rehab and are used to doing things on their own at home . CNA F reported that she was not able to supervise residents sufficiently, considering that she had to leave the rehab hall and help on other halls. CNA F reported that she was not able to hear or see the rehab hall when she was helping on another hall. CNA F reported that the rehab hall only had one CNA on third shift, and that CNA also had residents on west hall. CNA F reported that staff are quitting due to burn out and not being able to provide adequate care to the residents.</p> <p>In an interview on 1/6/25 at 3:57 PM, CNA I reported that Resident #114 had fallen several times during her shifts, and that during those times, she had been partnered up with other staff, so that they could do cares on residents that required 2 person assistance. CNA I reported that staff often have to leave the rehab hall to complete cares on other halls, and/or answer call lights. CNA I reported that at times she had to leave her assigned hall for 30 minutes at a time to assist on other halls with residents, and during those times, she hoped the nurse didn't also get called away. CNA I reported that the regular staff is getting burned out.</p> <p>Review of Resident #114's unwitnessed fall reports revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. 1/2/25 at 12:30 AM, Registered Nurse (RN) M was called to the resident's room by a CNA (Certified Nursing Assistant), to find the resident on the floor in the bathroom.</p> <p>2. 1/2/25 at 2:00 PM, CNA alerted RN D that the resident was on the floor in his room. The resident had reported forgetting to ask for assistance.</p> <p>3. 1/3/25 at 6:00 AM, CNA alerted RN D that the resident was on the floor in his room. Resident #114 had a lump above his right eyebrow and reported hitting his head. The resident was sent to the hospital for evaluation, and returned with an Aspen collar (neck brace) due to fracture of C3 (cervical vertebrae #3).</p> <p>4. 1/5/25 at 9:58 PM, Licensed Practical Nurse (LPN) T indicated that the resident was observed in his room on the floor at 5:20 PM (4.5 hours earlier) with no injuries.</p> <p>5. 1/5/25 at 8:13 PM, Family Member (FM) P had notified the facility by phone that the resident was on the floor in his room. LPN T found the resident on the floor next to his bed. LPN T left the room to find assistance, and the resident scooted himself into the hallway.</p> <p>Resident #108</p> <p>During an observation on 1/6/25 at 1:54 PM Resident #108 was lying in his bed, undressing himself and rolling side to side in bed. There was no staff in the hall to monitor the resident.</p> <p>In an interview on 1/7/25 at 11:20 AM, CNA G reported that Resident #108 was very restless almost all of the time, constantly tried to get out of bed, therefore they try to keep the resident up in his chair in the hall. CNA G reported that Resident #108 resided on south hall, and that there were several residents on the hall that required 2 person assistance. CNA G reported that on third shift there was only one CNA assigned to south hall, and the nurse was also responsible for rehab and west hall.</p> <p>In an interview on 1/7/25 at 9:45 AM, CNA Q reported that it was very hard to keep Resident #108 in bed, and at night with only one CNA on the south hall, they are in rooms and helping other CNA's and cannot watch him all the time. CNA Q reported the facility had reduced the number of staff that work at night, and the work load was nearly impossible.</p> <p>Review of Resident #108's Fall Reports revealed the following:</p> <ol style="list-style-type: none"> 10/31/24 at 3:42 PM the resident was found on the floor beside his bed, with no injuries. 10/31/24 at 11:12 PM the resident was found on the floor beside his bed, with the nightstand on top of his head. The resident was sent to the hospital for evaluation of head trauma. 11/9/24 at 2:45 AM the resident was found on the floor in his room, incontinent of urine and had a wet brief on. Resident had a bruise noted on his left shoulder. 11/10/24 at 2:30 AM the resident was found on the floor in his room, lying on his stomach. The 12/21/24 at 3:39 AM the resident was found on the floor in his room. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. 12/24/24 at 5:02 PM the resident was found on the floor in the hallway, halfway out of his room.</p> <p>Resident #106</p> <p>In an interview on 1/6/25 at 12:00 PM, CNA K reported that Resident #106 was on west hall, and that the resident just sits in her chair all day by the nurse's station due to her risk of falling. CNA K reported that west hall is only staffed with 1 CNA on all shifts, and that there were 7 residents that required 2 assist for mechanical lift transfers.</p> <p>Review of Resident #106's Fall Reports revealed the following:</p> <ol style="list-style-type: none"> 1. 9/25/24 at 5:55 PM the resident was found on the floor between the foot pedals of her wheelchair in the sun room. 2. 10/1/24 at 9:00 AM the resident was found on the floor in front of her wheelchair in the hallway, and the wheelchair was tipped over. 3. 10/7/24 at 10:04 PM the resident was found in her room, hanging off the bed, with the bottom half of her body on the floor. 4. 10/16/24 at 5:00 PM the resident was found sitting on the floor next to her bed. The CNA had reported that the resident was on the edge of her bed trying to stand, and she lowered her to the floor. 5. 10/2/24 at 6:30 PM the resident was observed on the floor near her bedroom door. 6. 10/28/24 at 9:35 AM the resident was found on the floor next to her bed, and reported having to use the bathroom. 7. 10/28/24 at 8:00 PM the resident was found on the floor next to her bed. 8. 11/16/24 at 3:55 PM the resident was observed by staff sliding out of her bed and onto the floor.

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>41027</p> <p>Based on observation, interview and record review, the facility failed to consistently offer/provide HS (hour of sleep) snacks to 2 residents (Resident #102 & #113) of 4 residents reviewed for snacks, resulting in resident dissatisfaction.</p> <p>Findings include:</p> <p>In an interview on 1/2/25 at 11:35 AM, Resident #102 reported that the facility does not have snacks available in the evening.</p> <p>In an interview on 1/6/25 at 11:45 AM, Resident #113 reported that snacks are very limited in the facility, and that if your name isn't on the list when they are passed out at night, you do not get anything. Resident #113 reported that staff does not offer snacks in the evening.</p> <p>In an interview on 1/6/25 at 3:57 PM, CNA I reported that sandwiches are not available for residents after the kitchen closed at 8:00 PM, and that often times the kitchen only brought snacks for diabetic residents. CNA I reported that she could usually find a snack somewhere if a resident asked for one, but sometimes she had to go to the vending machine.</p> <p>In an interview on 1/6/25 at 12:00 PM CNA K reported that the kitchen was supposed to bring snacks out for second and third shift, but they have not been. CNA K reported that the kitchen is locked and if residents request snacks, sometimes staff drive to the gas station and buy them.</p> <p>In an interview on 1/6/25 at 12:16 PM, Dietary Manager (DM) GG reported that the kitchen staff was recently reduced in the evening, therefore it had been harder to get dinner and beverages served on time. DM GG reported that snacks are delivered around 7:30 PM to the halls for diabetic residents, and the kitchen closed at 8:00 PM. DM GG reported that the nourishment rooms should be stocked with extra snacks, along with bread and peanut butter for sandwiches.</p> <p>During an observation on 1/6/25 at 12:20 PM of the nourishment room in the hall nearest to the kitchen, revealed a locked door and DM GG had to ask staff for the code. After opening the door, in the cabinet located above the refrigerator there was a plastic bag with 4 slices of bread, and a basket of (single serve) peanut butter containers. The refrigerator was soiled with liquid spillage and contained mostly juice and applesauce for the nurses to use for medication administration. There were ice cream cups in the freezer. DM GG reported that the nurses should have snack bars on their medication carts, left over from when snacks are passed in the evening.</p> <p>In an interview on 1/6/25 at 2:17 PM, CNA EE reported that only diabetic residents get snacks, and that the rehab hall never had extra snacks to give other residents, unless the kitchen was open. CNA EE reported that the nourishment room was only used for resident's personal food, and that the kitchen did not stock the room with sandwiches or snacks.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/6/25 at 2:17 PM of the Nourishment Room on rehab hall, revealed no snacks or sandwiches.</p> <p>In an interview on 1/7/25 at 10:24 AM, CNA F reported that there are no snacks available for residents, except for the diabetic people. CNA F reported that the staff use their own money and buy snacks from the vending machines. CNA F reported that the rehab nourishment room is not ever stocked with food or snacks, and that the kitchen sometimes leaves bread and peanut butter in the nourishment room by the front offices.</p> <p>In an interview on 1/7/25 at 11:20 AM, CNA G reported that the kitchen usually sends snacks for certain residents, and then if other residents request snacks, the staff have to try to find extras.</p> <p>In an interview on 1/7/25 at 12:11 PM, Registered Nurse (RN) M reported that the kitchen sent snacks for diabetic residents, but that during the night residents ask for additional snack and get very hungry. RN M reported that the kitchen was supposed to send snacks and sandwiches, but at times there was nothing.</p> <p>1/8/25 at 11:24 DON reported that she was not aware that there were concerns about residents not having access to snacks after the kitchen is closed. There should always be sandwiches available.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41027</p> <p>Based on interview and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for residents with chronic wounds or indwelling medical devices in 2 residents (Resident #112 & #115) of 5 residents reviewed for infection control practice, resulting in the potential for transmission of MDRO (multidrug-resistant organisms).</p> <p>Findings include:</p> <p>Review of the CDC (Centers for Medicare & Medicaid Services) Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memorandum (Ref: QSO-24-08-NH) with an effective Date of April 1, 2024 revealed, .The new guidance related to EBP is being incorporated into F-880 Infection Prevention and Control .GUIDANCE Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are indicated for residents with any of the following: .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, .Wound care: any skin opening requiring a dressing .</p> <p>Resident #112</p> <p>During an observation on 1/2/25 at 11:35 AM in Resident #112's room. The room was posted with EBP signage, and there was a PPE (personal protective equipment cart) with gowns and gloves outside of the room. Certified Nursing Assistant (CNA) H was repositioning the resident, hooking up a hoier (mechanical lift) sling, and preparing to transfer the resident to her chair via the hoier lift. CNA H had just finished getting the resident ready for the day, and was at the bedside waiting for help from another CNA. CNA H was not wearing gloves or a gown. Resident #112's right heel was covered with a bandage and with a wound vac (a medical device that helps wounds to heal) attached to the residents foot. CNA L was observed assisting with the hoier lift transfer, and positioning Resident #112 in her wheelchair. CNA L was not wearing a gown or gloves.</p> <p>Review of Resident #112's Physician Orders revealed, Wound vac (Change wound vac canister) every day shift every 7 day(s) for wound care and as needed. Active 12/3/2024.</p> <p>In an interview on 1/2/25 at 2:09 PM, CNA H reported that the CNA's do not have to wear PPE for Resident #112, only the nurses when they provide wound care.</p> <p>In an interview on 1/2/25 at 2:20 PM, Infection Preventionist (IP) E reported that it was her understanding that EBP for wounds only needed to be implemented when providing wound care when the wound is covered.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/2/25 at 2:58 PM, Director of Nursing (DON) B reported that it was also her understanding that EBP was only required when a wound had drainage and was not contained, and that Resident #112's wound was covered. This surveyor reviewed the regulation and CDC recommendations with DON B, and she reported that they would be starting EBP re-education.</p> <p>Resident #115</p> <p>During an observation and interview on 1/2/25 at 2:31 PM Resident #115's room was posted with Contact Precaution signage. CNA N reported that Resident #115 had a large wound on her bottom, that was covered with a dressing. CNA N did not know if the wound was infected.</p> <p>During an observation on 1/2/25 at 3:23 PM in Resident #115's room, CNA N was standing at the resident's bedside, and removing the resident's incontinence brief. CNA N was wearing gloves, but was not wearing a gown. CNA N reported that the PPE usage was confusing and that without a cart in the hall, she did not know when to use it.</p> <p>In an interview on 1/2/25 at 4:15 PM, IP E reported that when residents have orders for EBP, the PPE is located inside of the room, on the back of the door. IP E also added that Resident #115 is not on contact precautions, and that the signaga would be changed to EBP for her chronic wound.</p>