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	02/26/2025

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 0600 Level of Harm - Minimal harm or potential for 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** 41027 This citation pertains to intake #MI00149980 Based on interview and observation, the facility failed to protect the resident's right to be free from mental, verbal and physical abuse by staff for 1 resident (Resident #49) of 2 residents reviewed for abuse, resulting in verbal intimidation and physical restraint. Findings include: Resident #49 Review of an Admission Record revealed Resident #49 was originally admitted to the facility on [DATE] and expired in the facility on [DATE]. Review of Resident #49's Care Plan revealed, Resident is resistant to care (showers, alterative offered and adl (activities of daily living) care) r/t (related to) Alzheimer's. Date initiated: [DATE] .Allow resident to make decisions about treatment regimen, to provide sense of control. Revision [DATE] .If resident resists with ADLs, reassure resident, ensure safe environment, leave and return ,d+[DATE] minutes later and try again. Date initiated: [DATE]. May resist care: triggers for resisting care are (adl care and showers). De-escalate by giving time to cool down and reapproach or providing a bed bath as resident will allow. Date initiated: [DATE] . Review of a Facility Reported Incident (FRI) dated [DATE] submitted at 10:38 PM revealed, Date of Alleged Event: [DATE] at 8:30 PM .Incident Summary: It was reported to the Administrator that a CNA potentially restrained (Resident #49) during care due to the resident having aggressive behavior. CNA was suspended immediately. Resident was noted to have no injury and no signs of pain or discomfort. A full investigation to follow. In an interview on [DATE] at 10:46 AM, CNA P reported that Resident #49 typically was combative with care, and was just a little twitchy on [DATE]. CNA P reported that it took three staff to assist, in order to get the care done. CNA P reported that she helped Resident #49 by holding his hands to his chest, while CNA BBB and CNA CCC did his incontinence care. CNA P reported that later that evening during final rounds around 9:,d+[DATE]:00 PM, Director of Nursing (DON) B came in and talked to her about the allegations. CNA P reported that the incident happened right after dinner, about half way through her shift, and that she continued working on the floor until DON B came in. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:07 PM, CNA BBB reported that Resident #49 was typically combative during cares, and required at least 2 people for incontinence care. CNA BBB reported that she had been walking by the resident's room, and overheard CNA P in the room, so she stopped to offer help, and that CNA CCC came into the room to help also. CNA BBB reported that the resident was swinging his arms and name calling. CNA BBB reported that CNA P stood at the top of the bed, pinned the resident's arms down to his chest, and stated, .I know you are, but what am I . CNA BBB reported that she repeatedly told CNA P to let go of the resident's arms, but that CNA P said it was what she always had to do. CNA BBB reported that CNA P then pulled the sheet over the resident's head and used it to roll the resident. CNA BBB reported that the sheet was soiled with feces, but that CNA P reported that is was keeping the resident safe. CNA BBB reported that she immediately reported these observations as abusive treatment to the charge nurse. CNA BBB reported that after she reported the allegation of abuse, she felt threatened by NHA A, and therefore quit working at the facility. In an interview on [DATE] at 05:30 PM, CNA CCC reported that Resident #49 was yelling and being very combative, and that the other CNA's requested her help with incontinence care. CNA CCC reported that CNA P stood at the head of the bed, was yelling in the resident's face, telling him to stop, holding his arms down, and then wrapped up his face and arms with the sheet. CNA CCC reported that she pulled the sheet off and asked CNA P to stop talking to the resident that way multiple times. CNA CCC reported that she was told by the NHA that she (CNA CCC) would get in trouble too because she left CNA P alone with the resident. CNA CCC felt threatened and quit working at the facility. In an interview on [DATE] at 02:35 PM, LPN SS reported that two CNA's reported concerns related to CNA P abusing Resident #49, but that she did not remember their names. LPN SS reported that one CNA had scratches on her arms because the resident was being combative, and reported that CNA P was holding the resident down and not letting him move. LPN SS reported that both CNA's verbalized that the way CNA P was treating the resident was abusive. LPN SS told them that they should contact NHA A because they were witnesses to the abuse. LPN SS reported that CNA P continued to work on the floor after the allegation of abuse, and that LPN SS did not feel the need to talk to CNA P because she was finished caring for the resident. LPN SS reported that CNA P came to her crying later that evening and said that she was overwhelmed because she had worked a double shift. LPN SS reported that after the allegation was reported to NHA A, DON B and NHA A came into the facility and stopped CNA P from working. LPN SS reported that she was not sure if she was supposed to report the allegation herself, and/or if she was supposed to have removed CNA P from providing further care. In an interview on [DATE] at 11:30 AM, DON B reported that she called the facility when the allegation was reported, and instructed LPN SS to ensure that Resident #49 was safe, and then made her way to the facility to begin the investigation. In an interview on [DATE] at 01:13 PM, NHA A reported that when a resident was resistive or combative with care, the protocol is to back away and reapproach, but that Resident #49 was always aggressive with care. NHA A reported that the CNA's did not back away and reapproach later because he needed to be cleaned, and they could not change his brief with him grabbing and being combative. NHA A reported that she had received a phone text from a CNA, and then called the building a spoke to the nurse, who reported that a CNA had thought CNA P was being too aggressive with Resident #49. NHA A reported that she and DON B entered the facility shortly after the allegation of abuse, suspended CNA P and started an investigation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 This citation pertains to intake #MI00149980 Based on interview and record review, the facility failed to 1. investigate an allegation of abuse for 1 resident (Resident #37) 2. provide an accurate investigation and prevent the potential for further abuse after an allegation of abuse for 1 resident (Resident #49) of 2 total residents reviewed for abuse resulting in the potential for the allegation to not be thoroughly investigated and further abuse to occur. Findings include: Resident #37 (R37) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R37 admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypoxia (low level of oxygen in body tissues), chronic obstructive pulmonary disease (lung disease), diabetes {disease that affects how the body uses blood sugar (glucose)}, depression and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which indicated R37 was cognitively intact (13 to 15 cognitively intact). Resident was discharged from the facility on [DATE]. During an interview on [DATE] at 9:08 AM, R37 reported that his thumbs hurt since a staff member {Certified Nursing Assistant (CNA) UU} went into his room on [DATE] and bent both of his thumbs backwards. R37 stated that he told someone in management about it and they didn't inform him of what they were doing about it. R37 said both my thumbs still hurt and it is difficult to grip things and open pop bottles. R37 couldn't remember if anyone assessed him after the incident. Review of R37's chart revealed no information regarding the allegation on [DATE]. During an interview on [DATE] at 9:48 AM, Social Service Aide (SSA) HH stated that she wasn't aware of R37's allegation of abuse on [DATE]. SSA HH stated talk to {Nursing Home Administrator (NHA) A} since she must know about it. During an interview on [DATE] at 10:06 AM, NHA A stated that the allegation was not brought to her attention. During another interview on [DATE], SSA HH stated that she did remember the incident on [DATE] since she was the manager in the building that day. SSA HH said that she spoke with R37 regarding the allegation, wrote a statement which she gave to Director of Nursing (DON) B. During an interview on [DATE] at 11:06 AM, DON B stated that she remembered something about the allegation on [DATE] and said it was probably in a soft file and she will look for it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:23 PM, DON B stated that she didn't have a soft file for the allegation. DON B also stated that if it was something important then she would have made a soft file and kept information in there. DON B did not remember receiving a statement from SSA HH and didn't remember who told her about the allegation. During an interview on [DATE] at 9:11 AM, SSA HH stated that any allegation of abuse, neglect, staff to resident allegations and resident to resident allegations should be reported to the NHA and DON so they can conduct an investigation. During an interview on [DATE] at 9:07 AM, DON B stated that she would investigate any allegation of abuse, neglect, staff to resident allegations and resident to resident allegations and would report this to the State Agency depending on the investigation details. During an interview on [DATE] at 10:00 AM, NHA A stated that she would investigate any allegations of abuse and then report this to the State Agency if needed. There were no incidents/accident reports from the incident on [DATE]. Review of the Abuse and Neglect Policy with a revision date of [DATE] revealed Policy The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations Abuse Coordinator: The administrator is the abuse coordinator in this facility and is responsible for conducting the investigation in situations of alleged abuse/neglect. Steps of Prevention V. Investigation: Have procedures to: Investigate all allegations of abuse, neglect, misappropriation of property and incidents such as injuries of unknown source. All allegations will be investigated by the Administrator or Designee immediately. 41027 Resident #49 Review of an Admission Record revealed Resident #49 was originally admitted to the facility on [DATE] and expired in the facility on [DATE]. Review of Resident #49's Care Plan revealed, Resident is resistant to care (showers, alterative offered and adl (activities of daily living) care) r/t (related to) Alzheimer's. Date initiated: [DATE] .Allow resident to make decisions about treatment regimen, to provide sense of control. Revision [DATE] .If resident resists with ADLs, reassure resident, ensure safe environment, leave and return ,d+[DATE] minutes later and try again. Date initiated: [DATE]. May resist care: triggers for resisting care are (adl care and showers). De-escalate by giving time to cool down and reapproach or providing a bed bath as resident will allow. Date initiated: [DATE] . Review of a Facility Reported Incident (FRI) dated [DATE] submitted at 10:38 PM revealed, Date of Alleged Event: [DATE] at 8:30 PM .Incident Summary: It was reported to the Administrator that a CNA potentially restrained (Resident #49) during care due to the resident having aggressive behavior. CNA was suspended immediately. Resident was noted to have no injury and no signs of pain or discomfort. A full investigation to follow. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:46 AM, CNA P reported that Resident #49 typically was combative with care, and was just a little twitchy on [DATE]. CNA P reported that it took three staff to assist, in order to get the care done. CNA P reported that she helped Resident #49 by holding his hands to his chest, while CNA BBB and CNA CCC did his incontinence care. CNA P reported that later that evening during final rounds around 9:,d+[DATE]:00 PM, Director of Nursing (DON) B came in and talked to her about the allegations. CNA P reported that the incident happened right after dinner, about half way through her shift, and that she continued working on the floor until DON B came in. In an interview on [DATE] at 1:07 PM, CNA BBB reported that Resident #49 was typically combative during cares, and required at least 2 people for incontinence care. CNA BBB reported that she had been walking by the resident's room, and overheard CNA P in the room, so she stopped to offer help, and that CNA CCC came into the room to help also. CNA BBB reported that the resident was swinging his arms and name calling. CNA BBB reported that CNA P stood at the top of the bed, pinned the resident's arms down to his chest, and stated, .I know you are, but what am I . CNA BBB reported that she repeatedly told CNA P to let go of the resident's arms, but that CNA P said it was what she always had to do. CNA BBB reported that CNA P then pulled the sheet over the resident's head and used it to roll the resident. CNA BBB reported that the sheet was soiled with feces, but that CNA P reported that is was keeping the resident safe. CNA BBB reported that she immediately reported these observations as abusive treatment to the charge nurse. CNA BBB reported that after she reported the allegation of abuse, she felt threatened by NHA A, and therefore quit working at the facility. In an interview on [DATE] at 05:30 PM, CNA CCC reported that Resident #49 was yelling and being very combative, and that the other CNA's requested her help with incontinence care. CNA CCC reported that CNA P stood at the head of the bed, was yelling in the resident's face, telling him to stop, holding his arms down, and then wrapped up his face and arms with the sheet. CNA CCC reported that she pulled the sheet off and asked CNA P to stop talking to the resident that way multiple times. CNA CCC reported that she was told by the NHA that she (CNA CCC) would get in trouble too because she left CNA P alone with the resident. CNA CCC felt threatened and quit working at the facility. In an interview on [DATE] at 02:35 PM, LPN SS reported that two CNA's reported concerns related to CNA P abusing Resident #49, but that she did not remember their names. LPN SS reported that one CNA had scratches on her arms because the resident was being combative, and reported that CNA P was holding the resident down and not letting him move. LPN SS reported that both CNA's verbalized that the way CNA P was treating the resident was abusive. LPN SS told them that they should contact NHA A because they were witnesses to the abuse. LPN SS reported that CNA P continued to work on the floor after the allegation of abuse, and that LPN SS did not feel the need to talk to CNA P because she was finished caring for the resident. LPN SS reported that CNA P came to her crying later that evening and said that she was overwhelmed because she had worked a double shift. LPN SS reported that after the allegation was reported to NHA A, DON B and NHA A came into the facility and stopped CNA P from working. LPN SS reported that she was not sure if she was supposed to report the allegation herself, and/or if she was supposed to have removed CNA P from providing further care. In an interview on [DATE] at 11:30 AM, DON B reported that she called the facility when the allegation was reported, and instructed LPN SS to ensure that Resident #49 was safe, and then made her way to the facility to begin the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 01:13 PM, NHA A reported that when a resident is resistive or combative with care, the protocol is to back away and reapproach, but that Resident #49 was always aggressive with care. NHA A reported that the CNA's did not back away and reapproach later because he needed to be cleaned, and they could not change his brief with him grabbing and being combative. NHA A reported that she had received a phone text from a CNA, and then called the building a spoke to the nurse, who reported that a CNA had thought CNA P was being too aggressive with Resident #49. NHA A reported that she and DON B entered the facility shortly after the allegation of abuse, suspended CNA P and started an investigation. Review of Facility Reported Investigation Summary submitted by NHA A on [DATE] at 4:07 PM revealed, . Incident: It was reported to the Administrator that a CNA potentially restrained a resident having aggressive behavior. (Resident #49) was found to have had a bowel movement by his CNA (CNA P). During the brief change (CNA BBB and CNA CCC) assisted (CNA P) .During the care (Resident #49) became physically and verbally aggressive. (CNA P) asked (Resident #49) to stop and calm down placing her hands on his arm. He calmed down, brief change was completed. After brief change was completed, it was noticed there was BM (bowel movement) on the bottom sheet, so they proceeded to change the sheet releasing it and replacing it with a clean bottom sheet. During the bed change (Resident #49) became aggressive again as he does not like to be rolled. The CNAs rolled the sheet and used it to help turn him back and forth. The care was completed, (Resident #49) was made comfortable, and staff left the room. Review of Facility Reported Investigation Summary submitted by NHA A revealed, Interviews: (CNA P) .with the assistance of (CNA CCC and CNA BBB) .took the bottom sheet off using it to roll him to prevent injury to resident and staff during this time he was being verbally and physically aggressive. Using sheet resident was rolled towards (CNA P) first. The clean fitted sheet was secured to the bed. Then, we released the dirty sheet and rolled it up tucking the sheet and placed a chuck pad under him on the side where (CNA P) was. (CNA P) lifted his hips and buttocks up and (CNA BBB) pulled the dirty sheet out. The clean sheet was applied There was no information related to the allegation of CNA P yelling at the resident, and/or holding the resident down. Review of Facility Reported Investigation Summary submitted by NHA A revealed, Interviews: (CNA BBB) . (CNA P) was in (Resident #49's) room starting to provide care .(Resident #49) was becoming more agitated and flailing his arms and legs . (CNA P) then went to the head of the bed, crossed (Resident #49's) arms over his chest and held them in place while stating No, Stop in a calm/direct tone .After applying the brief, we noticed BM on the fitted sheet. (CNA P) rolled (Resident #49) over with the fitted sheet which covered his body and face. (CNA CCC) and I removed the sheet from his face area ,d+[DATE] times Subsequent review of CNA BBB's Written Witness Statement did not include that CNA P spoke to Resident #49 in a calm/direct tone, as noted in the NHA's interview with CNA BBB. Review of Facility Reported Investigation Summary submitted by NHA A revealed, Interviews: (CNA CCC) revealed (CNA P) asked (CNA CCC) to help with care for (Resident #49) (CNA P) was standing over him and holding his arms as he was flailing them about, so he did not hit into anything. (Resident #49) was being very physically and verbally aggressive Subsequent review of CNA CCC's Written Witness Statement revealed, .(CNA P) was standing over him and holding his arms crisscross as we were turning him. (CNA P) stated I know I am but what are you. This information was not include in the summary of NHA's interview CNA CCC. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Facility Reported Investigation Summary submitted by NHA A revealed, Determination of findings: After careful review of the medical records and staff/resident interviews, the facility determined the event was not a result of abuse or neglect .The evidence supports that (Resident #49) was not restrained at any time .