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	09/22/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake: 2612703Based on interview and record review, the facility failed to ensure residents received care in accordance with professional standards upon admission for 1 resident (Resident #106) of 8 residents reviewed for quality of care, when nursing staff failed to implement hospital discharge orders timely for medication administration, resulting in the potential for worsening of health conditions and a delay in treatment.Findings include:Resident #106Review of an admission Record revealed Resident #106 was a female, with pertinent diagnoses which included: gastroparesis (delayed gastric emptying). In an interview on 9/17/25 at 8:44 AM, Resident #106 reported that she returned from the hospital on 9/4/25 and did not receive her medications that the hospital had prescribed for nausea and vomiting and ended up back in the hospital on 9/6/25.Review of Resident #106's Hospital Discharge Summary dated 9/4/25 at 12:04 PM revealed, .Start taking these medications: Dimenhydrinate 50 mg (milligrams) tablet Take 1 tablet by mouth every 6 hours as needed for NauseaMetoclopramide HCl 10 mg tablet Take 1 tablet by mouth 3 times daily before mealsPotassium Chloride 20 mEq (milliequivalents) tablet Take 1 tablet by mouth 2 times dailyAcetaminophen 500 mg tablet Take 2 tablets by mouth every 6 hours as needed for moderate pain or feverAluminum-magnesium hydroxide-simethicone 200 mg/5 mL (milliliter) suspension Take 15 mLs by mouth every 4 hours as needed for heartburnAspirin acetaminophen-caffeine 250-250-65 mg per tablet Take 2 tables by mouth every 6 hours as needed for HeadachesBaclofen 5 mg tablet Take 3 tablets by mouth every 6 hoursBuspirone 15 mg tablet Take 3 tables by mouth every 6 hoursCalcium carbonate 200 mg calcium chewable tablet Chew 2 tablets by mouth every 4 hours as needed for heartburnDiphenhydramine 50 mg tablet Take 2 tables by mouth every 8 hours as needed for itchingDocusate sodium 100 mg capsule Take 1 capsule by mouth 2 times dailyDuloxetine 30 mg capsule Take 1 capsule by mouth once dailyDuloxetine 60 mg capsule Take 1 capsule by mouth once dailyEmpagliflozin 10 mg tablet Take 1 tablet by mouth once dailyFexofenadine 180 mg tablet Take 1 tablet by mouth once dailyFlutcasone-umeclidin-vilanter 200-62.5-25 mcg (micrograms) powder for inhalation Inhale 1 puff into the lungs once dailyGabapentin 400 mg capsule Take 1 capsule by mouth at BedtimeIsosorbide Mononitrate 30 mg tablet Take 1 tablet by mouth once dailyMetoprolol Succinate 25 mg tablet Take 1 tablet by mouth once dailyMontelukast 10 mg tablet Take 1 tablet by mouth once dailyNaloxegol 25 mg tablet Take 1 tablet by mouth once dailyOndansetron 4 mg tablet Take 1 tablet by mouth every 6 hours as needed for Nausea or VomitingOxycodone 5 mg immediate release tablet Take 1 tablet by mouth every 4 hours as needed for moderate painPantoprazole 40 mg tablet Take 1 tablet by mouth once dailyPolyethylene glycol 17 gm (gram) packet Take 17 g (gram) by mouth once dailySaccharomyces Boulardii 250 mg capsule Take 1 capsule by mouth once dailySenna 8.6 mg tablet Take 1 tablet by mouth 2 times dailySodium Chloride 0.65% nasal spray 1 spray by Nasal route every 2 hours as neededSumatriptan 25 mg tablet Take 1 tablet by mouth once daily as needed for MigraineTopiramate 100 mg tablet Take 2 tablets by mouth 2 times dailyVentolin HFA 90 mcg/actuation inhaler Inhale 1 puff into the lungs every 4 hours as needed for wheezing or shortness of breath.In an interview on 9/17/25 at 9:24 AM, Licensed Practical Nurse (LPN) GG reported she had completed Resident #106's readmission assessment on 9/4/25 at approximately 2:25 PM and entered her medication orders in the computer and did not recall any concerns with entering the medications. LPN GG reported typically with an admission, the orders would get entered into the computer as soon as the resident arrived. LPN GG reported if medication orders are placed with the pharmacy before 5:00 PM, they would be delivered by 8:00 PM that evening. In an interview on 9/18/25 at 4:40 PM Pharmacy Technician (PT) MM reported any orders received by the pharmacy by 5 PM can be delivered the same day; otherwise it would be the following day. PT MM reported the pharmacy delivers medications daily at 12:00 pm and 6:00 pm. If they receive orders prior to 5:00 PM, those will be delivered to the facility with the 6:00 PM shipment. PT MM confirmed they did not receive any orders for Resident #106 on 9/4/25 and that the first orders for Resident #106 were received at approximately 6:44 AM on 9/5/25. In an interview on 9/18/25 at 4:12 PM, LPN LL reported when she arrived for her shift on 9/5/25 at approximately 6:00 AM, Agency Licensed Practical Nurse (ALPN) KK had reported that she had not been able to confirm/activate Resident #106's medication orders that LPN GG had entered into the computer. LPN LL reported she confirmed/activated the orders herself. LPN LL reported she then gave Resident #106 the medications she had on hand right away. LPN LL reported later that afternoon, additional medications were delivered from the pharmacy and were administered to Resident #106. LPN LL reported at that time, the resident was still awaiting some

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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. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2595324.Based on observation, interview, and record review the facility failed to provide adequate care to prevent skin breakdown and worsening of pressure ulcers in 1 resident (Resident #108) of 3 residents reviewed for pressure ulcers, resulting in actual skin breakdown and worsening of pressure ulcers due to inadequate treatments, proper repositioning and incontinence care.Findings include:Review of an admission Record revealed Resident #108 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: fall and pressure ulcer of sacrum (tailbone). Review of Resident #108's Kardex (direct care guide) revealed, Gloves and Gowns (enhanced barrier precautions/EBP) (an infection control strategy that uses gloves and gowns during high-contact resident care to reduce the spread of and/or risk of acquiring drug-resistant bacteria) Required for following: dressing, bathing, showering, changing of briefs or toileting, personal hygiene, transferring, changing linens, device and/or wound care.Check resident every two hours and assist with toileting.Elevate heels off bed surface while at rest.Review of Resident #108's Braden Scale for predicting pressure sore risk dated 9/3/25 revealed, High Risk .Ability to change and control body position: Very Limited.Friction & Shear: Problem: Requires moderate to maximum assistance in moving . Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.During an observation and interview on 9/16/25 at 3:54 PM Resident #108 was lying in bed flat on her back with her feet and heels pressed on the surface of the bed. A foley catheter bag was noted hanging from the bed rail. Resident #108 reported that she would like to have an aide come and place a pillow under her butt to relieve pain. Resident #108 reported that she had a wound on her butt that was getting worse. Resident #108 reported that staff had been putting cream on the wound but they didn't have it with them when they came in that morning, so her butt was burning. Resident #108 reported that she doesn't move around in bed because of her pain but can help roll when staff provide care. Review of Resident #108's Wound Note dated 9/9/25 revealed, .right gluteal (buttock) Stage 3, 0.3 (centimeters) x 0.6.scant amount of serosanguineous drainage, area fragile and stable.Review of Resident #108's Wound Note dated 9/16/25 revealed, right gluteal (buttock) Stage 3, 6.0 (centimeters) x 2.9 x 0.1.scant amount of serosanguineous (containing blood) drainage, area fragile and declined. It was noted that the wound significantly increased in size between assessments. Review of Resident #108's Physician Orders start date 8/19/25 revealed, every shift for wound care right gluteal stage 3, cleanse with soap and water, apply barrier cream BID (twice daily).Review of Resident #108's Physician Orders start date 8/26/25 revealed, Enhanced barrier precautions r/t (related to) foley (urine catheter) and pressure wounds. In an interview on 9/16/25 at 4:06 PM Certified Nursing Assistant (CNA) S reported that she had started at 2:00 PM that day, was assigned to Resident #108 but had not checked on the resident yet. CNA S reported that Resident #108 did not have any wounds that she was aware of. During an observation and interview on 9/17/25 at 8:24 AM in Resident #108's room, the resident was lying in bed on her back with a catheter bag noted hanging on the bed frame. Resident #108 reported burning pain on her butt from her wound. Resident #108 reported that her wound was not covered with a bandage and the aides had not been in to apply the cream that day. Resident #108 reported that her catheter had leaked and soaked her clothes multiple times over the past few days. During an observation on 9/17/25 at 8:45 AM in Resident #108's room with CNA Y and LPN OO. Resident #108 is reporting that her pants are soaking wet. Observed catheter tubing twisted on Resident #108's leg and tubing full of urine. LPN OO reported that the resident's urine was flowing back to her bladder because the placement of the catheter tubing is not below her bladder and therefore overflowing onto the bed. LPN OO adjusted the catheter and removed the catheter securement device from the resident's leg. Observed Resident #108's buttocks with a large non-blanchable area in the middle and a large open wound on the right buttocks. The wound on the right buttocks had an area of eschar (dead tissue) and a bright red linear (line) open wound approximately 4 inches long that was actively bleeding. CNA Y reported that the red wound was new. CNA Y performed incontinence care, rolled up the wet pad underneath the resident and then pulled it out from under the resident's butt. CNA Y obtained a tube of barrier cream that was sitting on the resident's nightstand and applied the cream over the wounds. CNA Y reported that the day before the barrier cream was missing, but normally the CNA's apply cream to wounds during incontinence care. CNA Y reported that Resident #108 did not use incontinence briefs and was always continent of bowel and bladder. It was observed that CNA Y and LPN OO did not maintain EBP and wear a gown prior to providing direct care. In an interview on 9/17/25 at

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1359687.Based on observation, interview and record review the facility failed to implement physician orders for Enhanced Barrier Precautions (EBP: an infection control strategy where gloves and gowns are worn during high-contact resident care to reduce the spread of and/or risk of acquiring drug-resistant bacteria) for 1 resident (Resident #108) of 3 residents reviewed for infection control, resulting in the potential for residents to acquire avoidable drug-resistant infections.Findings include: Review of an admission Record revealed Resident #108 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacrum (tailbone). Review of Resident #108's Physician Orders start date 8/26/25 revealed, Enhanced barrier precautions r/t (related to) foley (urine catheter) and pressure wounds.Review of Resident #108's Kardex (direct care guide) revealed, Gloves and Gowns (enhanced barrier precautions/EBP) Required for following: dressing, bathing, showering, changing of briefs or toileting, personal hygiene, transferring, changing linens, device and/or wound care .Review of Resident #108's Wound Note dated 9/16/25 revealed, right gluteal (buttock) Stage 3, 6.0 (centimeters) x 2.9 x 0.1.scant amount of serosanguineous (containing blood) drainage, area fragile and declined. It was noted that the wound significantly increased in size between assessments. During an observation on 9/17/25 at 8:45 AM in Resident #108's room with CNA Y and LPN OO. CNA Y and LPN OO did not don gowns prior to care. Resident #108 was reporting that her pants are soaking wet. Observed catheter tubing twisted on Resident #108's leg and tubing full of urine. LPN OO reported that the resident's urine was flowing back to her bladder because the placement of the catheter tubing is not below her bladder and therefore overflowing onto the bed. LPN OO adjusted the catheter and removed the catheter securement device from the resident's leg. Observed Resident #108's buttocks with a large non-blanchable area in the middle and a large open wound on the right buttocks. CNA Y performed incontinence care, rolled up the wet pad underneath the resident and then pulled it out from under the resident's butt. CNA Y obtained a tube of barrier cream that was sitting on the resident's nightstand and applied the cream over the wounds. It was observed that CNA Y and LPN OO did not maintain EBP and wear a gown prior to providing direct care. In an interview on 9/17/25 at 10:06 AM, Unit Manager (UM) X reported she had assessed Resident #108's wound on 9/16/25 and it had worsened since the previous assessment. Resident #108's wound was observed at 10:10 AM along with UM X who reported the wound looked much worse than the day before. UM X was not wearing a gown while she assisted the resident to reposition in bed for the observation. UM X reported that Resident #108 required EBP due to wounds and catheter, but that it was not posted at the door.