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 02/26/2025
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to provide care and services to promote dignity and respect in 3 of 3 residents (Resident #13, #44, & #54) reviewed for dignity/respect, and 11 of 11 residents from the confidential group meeting, resulting in unmet care needs and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 1589-1592). Elsevier Health Sciences. Kindle Edition.Time management, therapeutic communication, patient education, and compassionate implementation of bedside skills are just a few of the essential skills you need. It is important for your patients to leave the health care setting with a positive image of nursing and a feeling that they received quality care. Your patients should never feel rushed. They need to feel that they are important and are involved in decisions and that their needs are met . Resident #13 Review of an Admission Record revealed Resident #13 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 12/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #13 was cognitively impaired. Review of the Functional Abilities revealed that Resident #13 was dependent on staff for all toileting and personal hygiene needs. Review of Resident #13's Kardex (care guide) revealed, Bowel/Bladder: Apply barrier cream to perineal (private area) area after each incontinence episode and as needed. 2. Brief use: Resident uses incontinence management products. Change per protocol, preference, and as needed. 3. Brief use: Resident uses incontinence management products. Change per protocol, preference, and as needed. Brief Lg (large). 4. Check resident every two hours and assist with toileting as needed. Review of Resident #13's Kardex revealed, Special Needs: .Resident has a pocket talker (headphones attached to a voice amplifier speaker, used for residents with hearing loss) for hearing. (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

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 02/26/2025

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/25/25 at 08:09 AM Resident #13 was in his broda (specialized chair for comfort and positioning) chair in the dining room eating breakfast. At 10:22 AM the resident was observed in his room sitting bedside in his broda chair, and asked this surveyor to come into the room. Resident #13 was observed with crumbs on his shirt and his pants were wet around his groin area. Resident #13 was unable to verbalize clearly, but with his hand he patted his groin area and pointed to his bed. This surveyor urged the resident to press his call light, which he did at 10:24 AM. During an observation and interview on 02/25/25 at 10:27 AM, CNA (Certified Nursing Assistant) J answered Resident #13's call light and when the CNA asked the resident what he needed, the resident spoke quietly and pulled at his pants with his hand. CNA J responded by asking the resident if he was ready for lunch, turned off the call light and told the resident that she was going to ask his CNA, CNA P about what to do with him (Resident #13). CNA J did not meet the resident's needs prior to turning the call light off. CNA J did not speak into Resident #13's pocket talker, acknowledge the resident's non-verbal cues, and/or give the resident time to respond. CNA J reported that she did not know the resident, and did not normally work that hall. During continuous observations, no one had been in the room to check on Resident #13, until 2/25/25 at 11:32 AM when the resident pressed his call light again. At that time Director of Nursing (DON) B entered the room, and asked Resident #13 if he needed anything. DON B asked the resident what he was listening to on his headphones and then turned the television on. Resident #13 was observed with his mouth moving, trying to get words out, and pulling at his pants, which were still wet. DON B did not speak into the resident's pocket talker and/or acknowledge the residents non-verbal cues. DON B turned the call light off and exited the room. During an observation on 02/25/25 at 11:34 AM in Resident #13's room, CNA P and CNA J entered the room and boosted Resident #13 up in his broda chair, then exited his room. The CNA's did not address the resident's wet pants. In an interview and observation on 02/25/25 at 11:36 AM, CNA J reported that she saw the dark area on Resident #13's pants earlier that day and thought that it was a stain. This surveyor requested that CNA J check Resident #13 for wetness. CNA J went back into Resident #13's room and reported that his pants were wet, and then observed that his incontinence brief was bulging with urine. CNA J walked out into the hallway to find assistance. Then CNA P stated, .he spilled his water .or coffee on himself this morning . Both CNA's entered the resident's room to check him again. CNA P reported that she thought she had changed the resident's pants after he spilled, but she could be wrong. In an interview on 02/26/25 at 11:12 AM, DON B reported that she did not remember at the time that Resident #13 was using the headphones as a hearing device, and did not notice that his pants were wet. DON B reported that Resident #13 should be checked for incontinence every 2 hours and laid down to change his brief. Resident #44 Review of an Admission Record revealed Resident #44 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury and aphasia (speech disorder that effects a person's ability to communicate effectively). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a MDS assessment for Resident #44, with a reference date of 1/27/24 revealed a Staff Assessment for Mental Status indicating that the resident was severely impaired. Review of the Hearing, Speech, and Vision indicated that Resident #44 had adequate hearing and vision, but no speech. Review of Resident #44's Functional Abilities indicated that the resident was completely dependent on staff for toileting, personal hygiene and all physical mobility. During an observation on 02/24/25 at 01:26 PM in Resident #44's room, CNA Q and CNA S transferred the resident into bed. CNA Q reported that the resident could not speak, but that he could hear and see. The CNA's were talking amongst themselves, while performing incontinence care, and they were not talking to the resident. CNA S stated, I wonder what he (Resident #44) used to do .from these pictures it looks like it was something important for sure .maybe a surgeon . In an interview on 02/26/25 at 01:50 PM, Social Worker (SW) II reported that when residents admit the the facility, their psychosocial assessment includes a review of their job occupation, but that it was not currently included in the care plan. SW II reported that they currently do not have a good way to ensure staff have knowledge of the resident's life before coming to the facility. SW II reported that Resident #44 had minimal comprehension, but was able to hear everything that staff are saying. SW II agreed that talking about the resident during care, and not talking to the resident would be disrespectful. Resident #54 In an interview on 02/26/25 at 09:55 AM, Resident #54 reported that he did not sleep well the night before due to pain and reported that he had to go looking for a nurse. Resident #54 reported that when he found the nurse, she snapped at him, before he could even ask her for pain medication. Resident #54 reported that the nurse told him all the things she would have to do before she would be able to get to him. During a confidential group meeting on 02/25/25 at 01:31 PM 11 of 11 residents agreed that staff do not treat them with dignity and respect and reported, agency staff are not familiar with the resident needs; staff have their personal phones out; staff constantly complain about being short handed; third shift does not do check and changes every 2 hours; it's hard to find staff on night shift; they have to wait a long time for nurses on night shift; staff tell them that they have to wait their turn, or that it's not time for them to be changed yet.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41027 Based on observation, interview, and record review, the facility failed ensure residents did not self-adminster medications that were not assessed as safe to self-administer in 2 of 11 residents (Resident #28, #69) reviewed for self administration, resulting in the potential for mismanagement of medications and worsening medical conditions. Findings include: Resident #28 During an observation on 02/24/25 at 09:41 AM in Resident #28's room, a medication cup containing 5 pills was sitting on the resident's tray table. Resident #28 reported that the nurse had left the pills for him to take later. Review of Resident #28's Self-Administration of Medications Assessment revealed no assessment or orders in the record. Resident #69 During an observation of medication administration on 02/25/25 at 08:12 AM on north hall, Resident #69 ambulated into the hall with a medication cup. Resident #69 reported that she knew what most of her pills were and stated, .what is this one? LPN (Licensed Practical Nurse) RR reported that it was a pancreatic enzyme pill. LPN RR reported that she had given Resident #69 her pills earlier that morning, but that she must not have taken that one. LPN RR reported that Resident #69 can administer her own medications because she is alert x4. Review of Resident #69's Self-Administration of Medications Assessment revealed no assessment or orders in the record. In an interview on 02/26/25 at 03:34 PM, Director of Nursing (DON) B reported that there were no resident's in the facility that administer medications on their own, no medications should be left in the room, and that nursing staff should supervise all resident to ensure that medications are taken prior to leaving the resident's room.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to notify the resident/resident representative of the facility bed hold policy and provide a written copy upon hospital transfer for 2 residents (Resident #37, Resident #43) of 3 residents reviewed for hospitalization s, resulting in the potential of residents and/or resident representatives being uninformed of the bed hold policy. 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 2/24/2025. Review of R37's chart revealed he went to the hospital on 1/7/2025 after having a headache due to a fall. On 1/27/2025 R37 went to the hospital due to lethargy (feeling of exhaustion, drowsiness and low energy) and difficulty maintaining oxygen levels. Review of R37's chart revealed there was no documentation that R37 received a written bed hold notice upon transfer to the hospital on 1/7/2025 and 1/27/2025. During an interview on 2/25/2025 at 2:55 PM, Director of Nursing (DON) B stated that the nurses should give a bed hold form to the resident at the time of each transfer to the hospital. During an interview on 2/26/2025 at 8:52 AM, Licensed Practical Nurse (LPN) XX stated that a bed hold form was given every time a resident was sent to the hospital. During an interview on 2/26/2025 at 8:58 AM, LPN YY stated that a bed hold form was given every time a resident was sent to the hospital. On 2/26/2025 at 7:04 AM, Nursing Home Administrator (NHA) A provided the following information, For 1/7 and 1/27 we were unable to locate the documentation (bed hold policy that was given to R37). During an interview on 2/26/2025 at 10:00 AM, NHA A stated that a bed hold form should be sent with a resident every time they go to the hospital and they couldn't find any documentation that one was given to R37 on 1/7/2025 and 1/27/2025. Review of the Bed Hold Policy with a revision date of 1/21/2019 revealed Policy: Facility must provide a copy of this policy (bed hold policy) to the resident and an immediate family member or legal representative before and when a resident is transferred for hospitalization or therapeutic leave. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing Home Inc	8290 W C Ave Kalamazoo, MI 49009

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47955 Resident #43 Review of an Admission Record revealed Resident #43 was a male who initially admitted to the facility on [DATE] and had pertinent diagnoses which included: encephalopathy (a disease when an outside agent or infection affects the functioning of the brain) and urinary tract infection. Review of General Progress Note for Resident #43 dated 2/16/25 at 14:17 (2:17 pm) revealed Resident's wife requested that resident be sent to (Name Omitted) acute care hospital for evaluation d/t (due to) resident continuing to not eat very much or sometimes at all for meals and not yet back to overall baseline . Review of Resident #43's record revealed no noted documented bed hold notice provided to the resident or resident's representative prior to transfer to acute care hospital. Email sent to Nursing Home Administrator (NHA) A on 2/26/25 at 10:44 AM., requested a copy of the bed hold notice provided to Resident #43 prior to transfer to acute care hospital on 2/16/25. Email response from NHA A on 2/26/25 at 11:10 AM revealed we are unable to locate the requested documentation. No bed hold notice was provided by the facility for Resident #43 for the date of 2/16/25 by the time of exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans in 4 of 19 residents (Resident #13, #38, #44, & #76) reviewed for comprehensive care plans, resulting in the unmet needs related to incontinence care, pressure ulcer prevention, skin integrity, respiratory care, and the potential for an overall decline in physical, mental, and psychosocial wellness. Findings include: Resident #13 Review of an Admission Record revealed Resident #13 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 12/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #13 was cognitively impaired. Review of the Functional Abilities revealed that Resident #13 was dependent on staff for all toileting and personal hygiene needs. Review of Resident #13's Braden Scale for Predicting Pressure Sore Risk dated 12/11/24 revealed, 11, which indicated that the resident was at high risk for developing a pressure sore. Review of Resident #13's Pressure Sore Care Plan revealed, no care plan developed related to his high pressure sore risk or preventative interventions. There was a skin care plan that indicated Resident #13 had an actual or potential for risk to skin integrity related to skin tears. Review of Resident #13's Kardex (care guide) revealed, Skin Care: 1. Apply barrier cream to perineal (privates) area as needed. 2. Bilateral geri-sleeves (arm protection) while out of bed and transferring. There were no interventions related to pressure sore prevention. During an observation on 02/24/25 at 08:52 AM Resident #13 was in the dining room in his broda chair (special wheelchair that provides comfort and postural support). During subsequent observations the resident remained in his broda chair in the hallway, activity room, and then at his bedside until 11:30 AM when the resident was brought to the dining room for lunch. At 1:12 PM Certified Nursing Assistant (CNA) P and CNA S transferred Resident #13 into his bed using a hoyer (mechanical lift), lowered the bed and left the room. Resident #13 was lying on his back with the HOB (head of bed) raised to approximately 30 degrees, the hoyer sling underneath him and his heels flat on the surface of the bed. The CNA's did not check or change Resident #13's brief, and did not float the resident's heels. CNA P reported that they would lay everyone down and then go back and do incontinence care to those that need it. During an observation and interview on 02/24/25 at 04:36 PM, Family Member (FM) WW was at Resident #13's bedside. Resident #13 was in the same position as last seen at 1:12 PM, with his heels on the surface of the bed, and the hoyer sling still underneath him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/25/25 at 08:09 AM Resident #13 was in his broda chair in the dining room eating breakfast. At 10:22 AM the resident was observed in his room sitting bedside in his broda chair. Resident #13 signaled this surveyor to come in the room. Resident #13 was observed with crumbs on his shirt and pants with wetness around his groin area. Resident #13 was not wearing geri-sleeves, and there was a bandage on his left forearm. In an interview on 02/25/25 at 10:53 AM, CNA P reported that Resident #13 had been up in his chair since early that morning, and normally did not lay down until after lunch. CNA P reported that the resident wore an incontinence brief but was not a frequent wetter, and it was not unheard for him to not urinate all shift. CNA P reported that Resident #13 should be repositioned every 2 hours while in his chair, and that is done by boosting him up 3-4 times a shift. CNA P reported that the resident had a new skin tear on his left arm that was identified that morning. CNA P did not check on the resident or reposition him at that time. During continuous observations, no one had been in the room to check on Resident #13, until 2/25/25 at 11:32 AM when the resident pressed his call light again. At that time Director of Nursing (DON) B entered the room, and asked Resident #13 if he needed anything. DON B turned the TV on and asked the resident what he was listening to on his headphones. (Resident #13 had hearing loss, and wore headphones that were attached to a pocket talker that amplified voices) Resident #13 was observed with his mouth moving, trying to get words out, and pulling at his pants, which were still wet. During an observation on 02/25/25 at 11:34 AM in Resident #13's room, CNA P and CNA J entered the room and boosted Resident #13 up in his broda chair, then exited his room. Resident #13 was not wearing geri-sleeves. The CNA's did not address the resident's wet pants. In an interview on 02/26/25 at 11:12 AM, DON B reported that Resident #13 should be checked for incontinence every 2 hours and laid down to change his brief, and repositioned to offload pressure every 2 hours. DON B reported that Resident #13 should have a care plan that identified interventions related to pressure ulcer prevention. Resident #38 Review of an Admission Record revealed Resident #38 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: alzheimer's disease (destroys memory and other mental functions). Review of a Minimum Data Set (MDS) assessment for Resident #38, with a reference date of 1/17/25 indicated that the resident was receiving hospice services. In an interview on 02/25/25 at 10:32 AM, Hospice Nurse AAA reported that the resident was receiving hospice visits three times a week. Review of Resident #38's electronic health record indicated that hospice services had been in place since 1/10/25. Review of Resident #38's Care Plan revealed, no mention of hospice services. Resident #44 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #44 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury and aphasia (speech disorder that effects a person's ability to communicate effectively). Review of a Minimum Data Set (MDS) assessment for Resident #44, with a reference date of 1/27/24 revealed a Staff Assessment for Mental Status indicating that the resident was severely impaired. Review of the Hearing, Speech, and Vision indicated that Resident #44 had adequate hearing and vision, but no speech. Review of Resident #44's Functional Abilities indicated that the resident was completely dependent on staff for toileting, personal hygiene and all physical mobility. Review of Resident #44's Braden Scale for Predicting Pressure Sore Risk dated 12/2/24 revealed, 9 indicating that the resident was at very high risk for developing a pressure sore. Review of Resident #44's Care Plan for Pressure Sore Prevention revealed there was no information related to the resident's high risk for developing pressure sores. Review of Resident #44's Kardex revealed, .Daily Routine: Bed mobility: The resident is totally dependent on 1-2 staff for repositioning and turning in bed every 2 hours and as necessary .Skin Care: Elevate heels off bed surface while at rest in bed as tolerated. Resident needs pressure reduction interventions: roho (used in the wheelchair to relieve pressure) cushion .Bowel/Bladder: Apply barrier cream to perineal area after each incontinence episode and as needed. Brief use: Resident used incontinence management products, change per protocol, preference, and as needed. Brief XLg (extra large) During an observation on 02/24/25 at 01:26 PM in Resident #44's room, CNA Q and CNA S transferred the resident into bed. CNA Q reported that the resident could not speak, but that he could hear and see. The CNA's were talking amongst themselves and not talking to the resident. CNA S stated, I wonder what he (Resident #44) used to do .from these pictures, it looks like it was something important for sure .maybe a surgeon . After incontinence care was provided, Resident #44 was positioned in bed lying on his back, with his heels laying flat on the bed surface and no devices or pillows used for offloading areas of pressure. During an observation on 02/26/25 at 7:45 AM Resident #44 was sitting in his broda chair in the dining room. The resident had rolled up washcloths placed in both hands. During subsequent observations on 02/26/25 from 09:53 AM-11:37 AM Resident #44 was sitting in his broda chair in his room, with the curtain pulled and only his feet visible from the doorway. There were washcloths rolled up and placed in Resident #44's hands. There was a pillow under his knees, and his heels were resting on the surface of the foot rest. Resident #44 had been in his chair without incontinence care and/or repositioning for approximately 4 hours. During an observation and interview on 02/26/25 at 11:37 AM in Resident #44's room, FM ZZ reported that she was very upset because the resident was soaking wet, did not have his right arm elevated and had not been laid down after breakfast. Observed Resident #44's incontinence brief bulging and his pants wet. FM ZZ pointed out that there was a sign in the resident's room indicating to keep right arm elevated at all times. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44's Orders revealed, Ensure placement of bilateral palm guards every shift for comfort and contracture (joint stiffness and immobility) prevention. Pt (patient) to wear as tolerated. may remove every shift to provide care and check skin integrity. Active 2/21/2025. Review of Resident #44's Care Plan did not include any information related to contractures, the use of palm protectors, and/or keeping his right arm elevated. Resident #44's care plan did not include any personalized information related to his life prior to coming to the facility. In an interview on 02/26/25 at 01:50 PM, Social Worker (SW) II reported that when residents admit the the facility, their psychosocial assessment includes a review of their job occupation, but that it was not currently included in the care plan. SW II reported that they currently do not have a good way to ensure staff have knowledge of the resident's life before coming to the facility. SW II reported that Resident #44 had minimal comprehension, but was able to hear everything that staff are saying. SW II agreed that talking about the resident during care, and not talking to the resident would be disrespectful. Resident #76 Review of an Admission Record revealed Resident #76 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: obstructive sleep apnea (when someone stopped breathing on and off in their sleep). Review of a Minimum Data Set (MDS) assessment for Resident #76's, with a reference date of 1/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #76 was cognitively intact. Review of the Special Treatments revealed that Resident #76 had a CPAP machine upon admission. During an observation and interview on 02/24/25 at 09:28 AM Resident #76 was lying in bed, and reported that he was waiting for a shower. There was a CPAP machine observed on the tray table powered on; the hose was laying on the ground, and the mask was laying on the bed. The machine, hose, and mask were heavily soiled with dirt and grime, and the water container was observed empty with dried white substance in it. Resident #76 reported that no one cleaned the CPAP machine. At 09:40 AM Registered Nurse (RN) GG walked into Resident #76's room and administered his medication. RN GG did not address the running CPAP machine, or offer any assistance to the resident. Review of Resident #76's Care Plan did not indicate that he had sleep apnea and/or used a CPAP machine at night. Review of Resident #76's Orders revealed, Cleanse CPAP equipment. Wash with warm soapy water and rinse in A.M., leave out to dry for night time use. every day shift every Sun (Sunday) for equipment maintenance. Active 1/26/2025 CPAP via full mask with 11 CWP (power level). at bedtime for sleep apnea and as needed for sleep apnea whenever asleep. Active 1/21/2025. The record indicated that nursing staff had documented that the machine was cleaned on 2/23/25, and that it was checked every day and night in February. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/25/25 at 11:28 AM, Director of Nursing (DON) B reported that Resident #76's CPAP machine should be cleaned by the nursing staff weekly. DON B reported that there are also orders to make sure that he had the mask in place properly at night, and that it is removed and stored in a plastic bag in the morning. DON B observed the residents CPAP equipment and reported that she could not get it clean, but would call the durable medical equipment company to bring replacement equipment. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.19.1, Chapter 4: Care Area Assessment (CAA) Process and Care Planning, dated October 2024, revealed .the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 15861 of 76897). Elsevier Health Sciences.A nursing care plan includes nursing diagnoses, goals and/or expected outcomes, individualized nursing interventions, and a section for evaluation findings .The plan promotes continuity of care and better communication because it informs all health care providers about a patient's needs and interventions and reduces the risk for incomplete, incorrect, or inappropriate care measures. Nurses revise a plan when a patient's status changes . The plan of care communicates nursing care priorities to nurses and other health care providers. It also identifies and coordinates resources for delivering nursing care .

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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. 41027 Based on observation, interview the facility failed follow professional standards for medication administration for 1 out of 11 residents (Resident #332) reviewed for standards of practice, resulting in the potential for cross contamination. Findings include: During an observation of medication administration on 02/25/25 at 08:30 AM in Resident #332's room, LPN RR was observed administering and insulin injection (medication that is administered using a needle and injected under the skin) with no gloves on. LPN RR then left the resident's room and returned to the medication cart, but did not perform any hand hygiene. At 08:32 AM LPN RR walked into a different resident's room, discussed pain medication, and then carried that resident's meal tray to the cart in the hallway. LPN RR did not perform hand hygiene prior to entering the resident's room. In an interview on 02/25/25 at 08:41 AM, LPN RR reported that she did not wear gloves for the insulin injection and/or perform hand hygiene, because she was not dealing with blood or body fluids. According to the Centers for Disease Control, Infection Prevention during Blood Glucose Monitoring and Insulin Administration revealed, Wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids .Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other persons.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on observation, interview, and record review the facility failed to provide activities of daily living (ADL) to dependent residents, including showers, shaving, nail care, and the application of ted hose (stocking) to 2 (Resident #19 and Resident #76) of 4 residents reviewed for activities of daily living, resulting in an unkempt appearance and the potential for unmet care needs. Findings include: Resident #19 Review of an Admission Record revealed Resident #19 was a female who initially admitted to the facility on [DATE] and had pertinent diagnoses which included: localized edema (edema noted in one area of the body), atrial fibrillation (an irregular and fast heartbeat that can lead to blood clots), and aphasia following a cerebral infarct (difficulty speaking following a stroke). Review of Order Summary for Resident #19 revealed ted hose (compression style stockings) to resident on in am/off at hs (evening) every morning and at bedtime with a start date of 7/5/2024. Review of Kardex (a quick reference sheet for staff with resident specific needs) for Resident #19 revealed special needs ted hose for edema, on in am and off in pm. Review of Care Plan for Resident #19 revealed Focus/Goal/Interventions: Resident has an ADL (activities of daily living) self-care deficient r/t (related to) bilateral (both sides of the body) LE (lower extremities / legs) edema (swelling) . will maintain current level of functioning, provide supportive care, dependent assistance with daily care needs .Resident requires extensive-dependent assistance dressing upper/lower/foot ware . initiated on 6/30/2024 On 2/24/2025 at 10:34 AM., Resident #19 was observed sitting in her wheelchair, in her room, she was not wearing ted hose. Noted taped to the headboard of Resident #19's bed was a laminated sign, yellow in color, with red and green writing and a picture of a leg and foot and hands applying a sock to the foot with the words Reminder ted hose on every morning and off every night. On 2/25/25 at 9:53 AM., Resident #19 was sitting in her wheelchair in her room wearing socks and shoes, no ted hose noted. In an interview on 2/25/25 at 9:45 AM., Licensed Practical Nurse (LPN) AA reported that the nurse must document in the medication administration record (MAR) that Resident #19's ted hose was applied and taken off each day. In an interview on 2/25/25 at 10:13 AM., Certified Nurse Assistant (CNA) R reported that CNAs were responsible for putting a resident's ted hose on in the morning with morning ADL care. On 2/25/25 at 12:19 PM., Resident #19 was observed in the dining room eating lunch and she did not have ted hose on. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of MAR for Resident #19 for the dates of 2/24/25 and 2/25/25 revealed [NAME] hose to resident on in am/off at hs every morning and at bedtime; Day shift documented by LPN AA as ted hose were on Resident #19. In an interview on 2/25/25 at 2:16 PM., CNA T reported that CNAs were to put on ted hose during morning ADL care for residents who wore them, and the nurse was to verify that the resident did have them on. CNA T reported Resident #19 did not refuse to wear her ted hose. In an interview on 2/25/25 at 2:27 PM., LPN AA confirmed that Resident #19 was not wearing her ted hose. LPN AA confirmed that she had documented that she was wearing them on 2/24/25 and 2/25/25 and stated, I will have to change that. LPN AA reported she trusted the CNAs to put Resident #19's ted hose on with morning care and she did not check to see if it was done. In an interview on 2/26/25 at 9:44 AM., Director of Nursing (DON) B reported her expectations were that the nurse applies a resident's ted hose as they were physician ordered, and after application the nurse should then document in the MAR they were applied. DON B reported a nurse should not document the application of ted hose if they did not confirm that the resident was wearing them. Review of facility policy Elastic Stockings (TED Hose) with a date of 7/11/2018 revealed .the policy of this facility to ensure that residents who need elastic stockings will receive them according to physician orders . Draw the stocking up the resident's leg until stocking is fully extended .check the physician's order for removal instructions .document all appropriate information in the medical record . 41027 Resident #76 Review of an Admission Record revealed Resident #76 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #76's, with a reference date of 1/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #76 was cognitively intact. Review of the Functional Abilities revealed that Resident #76 required substantial/maximal assistance (helper does more than 50% the effort) for showers, and partial/moderate (helper does less than half the effort) up to substantial/maximal assistance to get dressed and perform personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/24/25 at 09:28 AM Resident #76 was lying in bed, and reported that he was waiting for a shower. Resident #76's shirt was observed soiled with food, his hair was messy, black substance under his long fingernails, hands with dark substance on fingers, and his facial hair was overgrown. Resident #76 reported that he had not received a shower for approximately 2-3 weeks, and that was the last time that staff helped him shave. Resident #76 reported that he had been wearing the same shirt for 2 days, and was going to ask to have it changed today, but that he had asked to have a shower instead. Resident #76 reported that he did not know when his showers were scheduled, but that he would like to have one at least once a week. Resident #76 reported that he does not get a bed bath, unless he was incontinent and the bed was wet, but that he would appreciate at least a wash cloth to clean his face and hands everyday. At 09:40 AM Registered Nurse (RN) GG walked into Resident #76's room and administered his medication. RN GG did not offer any assistance to the resident. During an observation on 02/24/25 at 12:39 PM Resident #76 was walking back to his room from having lunch in the dining room. Resident #76 was still dressed in the same dirty shirt, his hair was messy, and his facial hair overgrown. In an interview on 02/24/25 at 12:40 PM, Shower Aide (SA) R reported that Resident #76 was scheduled for a shower that day, but had refused that morning. SA R reported that it was very early when she asked Resident #76 if he wanted a shower, and that maybe he was tired. SA R reported that she had given Resident #76 one or two showers since he had admitted , but that the last time she did not have a shaver to use on him. During an observation on 02/24/25 at 01:00 PM in Resident #76's room, SA R offered to assist the resident with a shower. Resident #76 replied, I waited all morning for you .I am leaving for an appointment at 1:30 PM . SA R reported that she could give him a quick shower before his appointment, and the resident said yes. While they were walking to the shower room, SA R stopped and grabbed washcloths and towels from the linen closet. Resident #76 noticed and reported that it would be nice to have washcloths in his room. In an interview on 02/24/25 at 01:08 PM, Certified Nursing Assistant (CNA) P reported that she typically set up Resident #76 in the morning with washcloths, a basin of water, and his toothbrush. CNA P reported that she had not assisted the resident that day, because he had gotten a shower that morning. CNA P was not aware that Resident #76 had not gotten a shower that morning. CNA P did not assist the resident with ADL's. Review of Resident #76's Shower Task Record indicated that the resident had received showers on 1/27/25 and 2/3/25. There were no bed baths recorded.

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F 0686 Level of Harm - Minimal harm or potential for 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** 41027 Based on observation, interview and record review, the facility failed to provide preventative care, consistent with professional standards of practice for 2 of 2 residents (Resident #13 & #44) reviewed for at risk to develop pressure injuries, resulting in the potential for the development of an avoidable pressure ulcer, infection, and overall deterioration in health status. Findings include: Resident #13 Review of an Admission Record revealed Resident #13 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 12/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #13 was cognitively impaired. Review of the Functional Abilities revealed that Resident #13 was dependent on staff for all toileting and personal hygiene needs. Review of Resident #13's Braden Scale for Predicting Pressure Sore Risk dated 12/11/24 revealed, 11, which indicated that the resident was at high risk for developing a pressure sore. Review of Resident #13's Pressure Sore Care Plan revealed, no care plan developed related to pressure sore risk or preventative interventions. There was a skin care plan that indicated Resident #13 had an actual or potential for risk to skin integrity related to skin tears. Review of Resident #13's Kardex (care guide) revealed, Skin Care: 1. Apply barrier cream to perineal (privates) area as needed. 2. Bilateral geri-sleeves (arm protection) while out of bed and transferring. There were no interventions related to pressure sore prevention. During an observation on 02/24/25 at 08:52 AM Resident #13 was in the dining room in his broda chair (special wheelchair that provides comfort and postural support). During subsequent observations the resident remained in his broda chair in the hallway, activity room, and then at his bedside until 11:30 AM when the resident was brought to the dining room for lunch. At 1:12 PM Certified Nursing Assistant (CNA) P and CNA S transferred Resident #13 into his bed using a hoyer (mechanical lift), lowered the bed and left the room. Resident #13 was lying on his back with the HOB (head of bed) raised to approximately 30 degrees, the hoyer sling underneath him and his heels flat on the surface of the bed. The CNA's did not check or change Resident #13's brief, and did not float the resident's heels. In an interview on 02/24/25 at 04:32 PM, CNA K reported that she was working Resident #13's hall by herself until 6:00 PM, and had at least 6 resident's that needed two assist to get out of bed for supper, so she was going to be very busy. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/24/25 at 04:36 PM, Family Member (FM) WW was at Resident #13's bedside. Resident #13 was in the same position as last seen at 1:12 PM, with his heels on the surface of the bed, and the hoyer sling still underneath him. During an observation on 02/25/25 at 08:09 AM Resident #13 was in his broda chair in the dining room eating breakfast. At 10:22 AM the resident was observed in his room sitting bedside in his broda chair. Resident #13 signaled this surveyor to come in the room. Resident #13 was observed with crumbs on his shirt and pants with wetness around his groin area. During an observation and interview on 02/25/25 at 10:27 AM, CNA J answered Resident #13's call light and when she asked the resident was he needed, the resident was speaking quietly and pulling at his pants. CNA J responded by asking the resident if he was ready for lunch, turned off the call light and told the resident that she was going to ask his CNA, CNA P about what to do with him (Resident #13). CNA J reported that she did not know the resident, and did not normally work that hall. In an interview on 02/25/25 at 10:53 AM, CNA P reported that Resident #13 had been up in his chair since early that morning, and normally did not lay down until after lunch. CNA P reported that the resident wore an incontinence brief but was not a frequent wetter, and it was not unheard for him to not urinate all shift. CNA P reported that Resident #13 should be repositioned every 2 hours while in his chair, and that is done by boosting him up 3-4 times a shift. CNA P did not check on the resident or reposition him at that time. During continuous observations, no one had been in the room to check on Resident #13, until 2/25/25 at 11:32 AM when the resident pressed his call light again. At that time Director of Nursing (DON) B entered the room, and asked Resident #13 if he needed anything. Resident #13 was observed with his mouth moving, trying to get words out, and pulling at his pants, which were still wet. DON B turned the call light off and exited the room. During an observation on 02/25/25 at 11:34 AM in Resident #13's room, CNA P and CNA J entered the room and boosted Resident #13 up in his broda chair, then exited his room. The CNA's did not address the resident's wet pants. In an interview and observation on 02/25/25 at 11:36 AM, in resident #13's room, CNA P and CNA J transferred the resident into his bed to provide incontinence care. CNA P removed Resident #13's saturated incontinence brief, and began cleaning Resident #13's bottom. There was feces observed on the disposable wipes and CNA P reported that the resident had a bowel movement. Resident #13's buttocks were observed with red wrinkled skin in the sacral (tailbone) area and white macerated (condition that occurs when skin is exposed to moisture for too long) skin in the perineum (area between anus and scrotum). In an interview on 02/26/25 at 11:12 AM, DON B reported that Resident #13 should be checked for incontinence every 2 hours and laid down to change his brief, and repositioned to offload pressure every 2 hours. DON B reported that Resident #13 should have a care plan that identified interventions related to pressure ulcer prevention. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #13's Progress Notes revealed the following notes related to MASD (moisture associated skin damage), 2/19/2025 at 10:03 AM .Assessed MASD coccyx (tailbone). No open areas or drainage peri (around) wound fragile and erythemic (red). Stable at this time. Interventions in place. Care plan and orders reviewed .2/12/2025 at 08:14 AM .MASD to coccyx, no drainage, no open areas, peri-wound fragile, and erythemic, stable at this time. CP (care plan) reviewed, interventions in place, cont. current orders . 2/5/2025 at 3:40 PM . MASD to coccyx, no drainage, no open areas, peri-wound fragile, and erythemic, stable at this time. CP reviewed, interventions in place, no new orders . Resident #44 Review of an Admission Record revealed Resident #44 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury and aphasia (speech disorder that effects a person's ability to communicate effectively). Review of a Minimum Data Set (MDS) assessment for Resident #44, with a reference date of 1/27/24 revealed a Staff Assessment for Mental Status indicating that the resident was severely impaired. Review of the Hearing, Speech, and Vision indicated that Resident #44 had adequate hearing and vision, but no speech. Review of Resident #44's Functional Abilities indicated that the resident was completely dependent on staff for toileting, personal hygiene and all physical mobility. Review of Resident #44's Braden Scale for Predicting Pressure Sore Risk dated 12/2/24 revealed, 9 indicating that the resident was at very high risk for developing a pressure sore. Review of Resident #44's Care Plan for Pressure Sore Prevention revealed there was no information related to the resident's risk of pressure sore development. Review of Resident #44's Kardex revealed, .Daily Routine: Bed mobility: The resident is totally dependent on 1-2 staff for repositioning and turning in bed every 2 hours and as necessary .Skin Care: Elevate heels off bed surface while at rest in bed as tolerated. Resident needs pressure reduction interventions: roho cushion (to reduce pressure while in wheelchair) .Bowel/Bladder: Apply barrier cream to perineal area after each incontinence episode and as needed. Brief use: Resident used incontinence management products, change per protocol, preference, and as needed. Brief XLg (extra large) During an observation on 02/24/25 at 01:26 PM in Resident #44's room, CNA Q and CNA S transferred the resident into bed. Both CNA's donned gloves. CNA Q reported that the resident could not speak, but that he could hear and see. CNA Q reported that the resident had been up in his chair since early that morning. CNA Q cleaned Resident #44's peri area using disposable wipes and then applied a clean brief. Resident #44 was left positioned in bed lying on his back, with his heels laying flat on the bed surface and no devices or pillows used for offloading areas of pressure. During an observation on 02/25/25 at 07:45 AM Resident #44 was in his broda chair sitting in the dining room. During an observation on 02/25/25 at 09:04 AM Resident #44 was in his broda chair in his room. Continuous observations were made until 11:53 AM, and Resident #44 remained in the same position and location. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/25/25 at 10:32 AM, Hospice Nurse AAA reported that Resident #44 received services twice a week, and was seen the day before for a shower. During an observation and interview on 02/25/25 at 11:53 AM in Resident #44's room, FM ZZ was visiting. FM ZZ reported that her worst fear was that Resident #44 would get a pressure wound, therefore she insists that staff lay the resident down after every meal, and did not sit in his chair all morning. During an observation on 02/26/25 at 7:45 AM Resident #44 was sitting in his broda chair in the dining room. The resident had rolled up washcloths placed in both hands. During an observation on 02/26/25 at 09:53 AM Resident #44 was sitting in his broda chair in his room, with the curtain pulled and only his feet were visible from the doorway. There were washcloths rolled up and placed in Resident #44's hands. There was a pillow under his knees, and his heels were resting on the surface of the foot rest. At 10:25 AM the resident was in the same place and position. CNA W was the only CNA working on the hall, and observed walking up and down the hall, sitting at the charting station, but was not observed providing care to Resident #44. At 11:04 AM CNA K came onto the hall to help, but was not observed checking on, or providing care to Resident #44. In an interview on 02/26/25 at 11:12 AM, DON B reported that Resident #44 should be laid down in bed after meals, and checked and changed every 2 hours. DON B reported that the resident should not be left sitting in his chair for more than a couple hours at a time. During an observation and interview on 02/26/25 at 11:37 AM in Resident #44's room, FM ZZ reported that she was very upset because the resident was soaking wet, did not have his right arm elevated and had not been laid down after breakfast. Observed Resident #44's incontinence brief bulging and his pants were wet. FM ZZ pointed out that there was a sign in the resident's room indicating to keep right arm elevated at all times. Review of Fundamentals of Nursing ([NAME] and [NAME]) 9th edition revealed, The presence and duration of moisture on the skin increases the risk of ulcer formation. Moisture reduces the resistance of the skin to other physical factors such as pressure and/ or shear force. Prolonged moisture softens skin, making it more susceptible to damage. Immobilized patients who are unable to perform their own hygiene needs depend on nurses to keep the skin dry and intact. Skin moisture originates from wound drainage, excessive perspiration, and fecal or urinary incontinence. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 71334-71338). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 9th edition revealed, Usually the time that a patient sits uninterrupted in a chair is limited to 1 hour. This interval is shortened in patients who are at very high risk for skin breakdown. Reposition patients frequently because uninterrupted pressure causes skin breakdown. Teach patients to shift their weight in a chair every 15 minutes. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 28081-28083). Elsevier Health Sciences. Kindle Edition.

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F 0689 Level of Harm - Minimal harm or potential for 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** 47955 Based on observation, interview, and record review the facility failed to 1.) ensure safe transport in a wheelchair with foot pedals in place for 1 resident (Resident #63); 2.) implement gait belt (a device put on a resident who has mobility issues, by a caregiver, prior to that caregiver moving the resident) use for safety during transfers for 2 (Resident #63 and Resident #37) of 3 total residents reviewed for transport safety and transfers resulting in the potential for injury. Findings include: Resident #63 Review of an Admission Record revealed Resident #63 was a female who initially admitted to the facility on [DATE] and had pertinent diagnoses which included: repeated falls and weakness. Review of a Minimum Data Set (MDS) assessment for Resident #63, with a reference date of 11/22/2024 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #63 was cognitively intact. (BIMS score 12-15 indicates cognitively intact). On 2/24/25 at 12:03 PM., Certified Nurse Assistant (CNA) T was observed pushing Resident #63 in her wheelchair down the hallway from her room to the communal bathroom. There were no foot pedals in place on the wheelchair and the resident was observed holding her feet off the floor while in motion. On 2/24/25 at 12:04 PM., CNA T was observed transferring Resident #63 from her wheelchair onto the commode in the bathroom. CNA T did not use a gait belt. On 2/24/25 at 12:07 PM., CNA T was observed transferring Resident #63 from the commode in the bathroom into her wheelchair. CNA T did not use a gait belt. On 2/24/25 at 12:08 PM., CNA T was observed pushing Resident #63 in her wheelchair in the hallway from the communal bathroom to her room. There were no foot pedals in place on the wheelchair and the resident was observed holding her feet off the floor while in motion. On 2/24/25 at 12:10 PM., Resident #63 reported the staff does not use a gait belt when transferring her. Two gait belts were observe hanging from hooks on the back of the door in Resident #63's room. In an interview on 2/25/25 at 12:07 PM., Licensed Practical Nurse (LPN) AA reported a gait belt should be used for all transfers that do not require a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/25/25 at 12:10 PM., CNA T reported that Resident #63 should have a gait belt for all transfers. CNA T reported Resident #63's gait belt was on the back of the door in her room. CNA T then pulled a gait belt from her scrub top pocket and displayed it to this surveyor. When queried, CNA T confirmed that she did not use a gait belt when transferring Resident #63, nor did she have the foot pedals in place on her wheelchair when she pushed Resident #63 in the hallway to and from the bathroom. In an interview on 2/25/25 at 2:47 PM., Registered Nurse/Unit Manager (RN/UM) GG reported Resident #63 should have a gait belt in use when she was transferred. In an interview on 2/26/25 at 9:51 AM., Director of Rehab Services (DRS) PP reported every resident transfer should use a gait belt unless it was a mechanical lift transfer. In an interview on 2/26/25 at 10:15 AM., RN/UM FF reported a gait belt should be used for all transfers and when assisting a resident to walk. RN/UM FF reported each resident who needed a gait belt should have one in their room. RN/UM FF reported that a gait belt should be used when there was movement from one position to another such as wheelchair to commode transfers. RN/UM FF reported all wheelchairs should have foot pedals in place if the resident was being pushed by someone. In an interview on 2/26/25 at 10:20 AM., Director of Nursing (DON) B reported that her expectations were that gait belts be used for all transfers that were not mechanical lifts and that all wheelchairs have foot pedals in place when being pushed by someone. Review of facility policy Gait Belt - Transfer Belt with a date of 7/11/2018 revealed provide safety .aid in transfer .prevent injuries .prevent resident falls .place gait belt around resident's waist . 48637 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 (COPD-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 2/24/2025. Review of R37's incident report dated 1/21/2025 revealed Incident Description: this nurse was called to resident's room by CNA ({Certified Nursing Assistant (CNA) V}. Observed resident laying on the floor on his back with his pants around his ankles. CNA stated that she was changing resident's brief and he went to sit down before she was done changing him and she lowered him to the floor Notes .IDT agrees with education to staff about utilizing gait belt for safety. Review of CNA V's New Employee Performance Evaluation revealed her date of hire was 1/16/2025. Review of CNA V's Employee 1:1 Education dated 1/21/2025 revealed Topic: Falls-use of GB (Gait Belt): when transferring resident use a gait belt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/25/2025 at 2:55 PM, Director of Nursing (DON) B stated that CNA V was a new hire at the facility and she did not use a gait belt with R37 when the fall occurred on 1/21/2025. DON B said that CNA V should have used a gait belt and didn't so she received education on gait belt use.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to provide timely incontinence care and perform hand hygiene in accordance with standard infection control practices in 2 residents (Resident #13 & #44) of 2 residents reviewed for bowel/bladder incontinence, resulting in the potential for skin breakdown and UTI (urinary tract infection). Findings include: Resident #13 Review of an Admission Record revealed Resident #13 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 12/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #13 was cognitively impaired. Review of the Functional Abilities revealed that Resident #13 was dependent on staff for all toileting and personal hygiene needs. Review of Resident #13's Kardex (care guide) revealed, Bowel/Bladder: Apply barrier cream to perineal area after each incontinence episode and as needed. 2. Brief use: Resident uses incontinence management products. Change per protocol, preference, and as needed. 3. Brief use: Resident uses incontinence management products. Change per protocol, preference, and as needed. Brief Lg (large). 4. Check resident every two hours and assist with toileting as needed. During an observation on 02/24/25 at 08:52 AM Resident #13 was in the dining room in his broda chair (special wheelchair that provides comfort and postural support). During subsequent observations the resident remained in his broda chair in the hallway, activity room, and then at his bedside until 11:30 AM when the resident was brought to the dining room for lunch. At 1:12 PM CNA P and CNA S transferred Resident #13 into his bed using a hoyer (mechanical lift), lowered the bed and left the room. Resident #13 was lying on his back with the HOB (head of bed) raised to approximately 30 degrees, the hoyer sling was underneath him and his heels flat on the surface of the bed. The CNA's did not check or change Resident #13's brief, and did not float the resident's heels. In an interview on 02/24/25 at 04:32 PM, CNA K reported that she was working Resident #13's hall by herself until 6:00 PM, and had at least 6 resident's that needed two assist to get out of bed for supper, so she was going to be very busy. During an observation and interview on 02/24/25 at 04:36 PM, Family Member (FM) WW was at Resident #13's bedside. Resident #13 was in the same position as last seen at 1:12 PM. FM WW reported that Resident #13 had a history of severe UTI's and that he had recently been more confused. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/25/25 at 08:09 AM Resident #13 was in his broda chair in the dining room eating breakfast. At 10:22 AM the resident was observed in his room sitting bedside in his broda chair. Resident #13 signaled this surveyor to come in the room. Resident #13 was observed with crumbs on his shirt and his pants were wet around his groin area. Resident #13 was unable to verbalize clearly, but with his hand he patted his groin area and pointed to his bed. This surveyor urged the resident to press his call light, which he did at 10:24 AM. During an observation and interview on 02/25/25 at 10:27 AM, CNA J answered Resident #13's call light and when she asked the resident was he needed, the resident was speaking quietly and pulling at his pants. CNA J responded by asking the resident if he was ready for lunch, turned off the call light and told the resident that she was going to ask his CNA, CNA P about what to do with him (Resident #13). CNA J did not meet the resident's needs prior to turning the call light off. CNA J reported that she did not know the resident, and did not normally work that hall. In an interview on 02/25/25 at 10:53 AM, CNA P reported that Resident #13 had been up in his chair since early that morning, and normally did not lay down until after lunch. CNA P reported that the resident wore an incontinence brief but was not a frequent wetter, and it was not unheard for him to not urinate all shift. CNA P reported that Resident #13 should be repositioned every 2 hours while in his chair, and that is done by boosting him up 3-4 times a shift. CNA P did not check on the resident or reposition him at that time. During continuous observations, no one had been in the room to check on Resident #13, until 2/25/25 at 11:32 AM when the resident pressed his call light again. At that time Director of Nursing (DON) B entered the room, and asked Resident #13 if he needed anything. DON B asked the resident what he was listening to on his headphones and then turned the television on. (Resident #13 had hearing loss, and wore headphones that were attached to a voice amplifier that was clipped to his shirt, which helped him to hear.) Resident #13 was observed with his mouth moving, trying to get words out, and pulling at his pants, which were still wet. DON B turned the call light off and exited the room. In an interview on 02/26/25 at 11:12 AM, DON B reported that she did not notice that his pants were wet when she answered his call light the day before. DON B reported that Resident #13 should be checked for incontinence every 2 hours and laid down to change his brief. During an observation on 02/25/25 at 11:34 AM in Resident #13's room, CNA P and CNA J entered the room and boosted Resident #13 up in his broda chair, then exited his room. The CNA's did not address the resident's wet pants. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Alamo Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 8290 W C Ave Kalamazoo, MI 49009	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 02/25/25 at 11:36 AM, CNA J reported that she saw the dark area on Resident #13's pants earlier that day and thought that it was a stain. This surveyor requested that CNA J check Resident #13 for wetness. CNA J went back into Resident #13's room and reported that his pants were wet, and then observed that his incontinence brief was bulging with urine. CNA J walked out into the hallway to find assistance. Then CNA P stated, .he spilled his water .or coffee on himself this morning . Both CNA's entered the resident's room to check him again. CNA P reported that she thought she had changed the resident's pants after he spilled, but she could be wrong. The CNA's transferred Resident #13 into his bed to provide incontinence care. Both CNA's donned gloves, and CNA P was designated to wash the resident. With gloves on CNA P pulled down Resident #13's heavily saturated brief, and with CNA J's assistance rolled the resident onto his right side. CNA P then removed the brief, and began cleaning Resident #13's bottom. There was feces observed on the disposable wipes and CNA P reported that the resident had a bowel movement. Resident #13's buttocks were observed with red wrinkled skin in the sacral (tailbone) area and white macerated (condition that occurs when skin is exposed to moisture for too long) skin in the perineum (area between anus and scrotum). After CNA P was finished cleaning the resident's bottom, she requested that CNA J grab the skin barrier cream from the nightstand. CNA P was observed applying barrier cream on the resident's bottom, while still wearing soiled gloves. CNA P then assisted CNA J to turn Resident #13 onto his back, and began washing his front peri area (penis and groin), while still wearing soiled gloves. The CNA's worked together to get clean pants on the resident, and positioning the hoyer sling underneath the resident. The CNA's both removed their gloves just before they transferred the resident back to his chair. CNA P did not clean the resident from front to back during incontinence care, per standards of practice. CNA P used soiled gloves to apply barrier cream, to wash the resident's penis, and while handling clothing and the hoyer sling. Review of Resident #13's Progress Notes revealed the following notes related to MASD (moisture associated skin damage), 2/19/2025 at 10:03 AM .Assessed MASD coccyx (tailbone). No open areas or drainage peri (around) wound fragile and erythemic (red). Stable at this time. Interventions in place. Care plan and orders reviewed .2/12/2025 at 08:14 AM .MASD to coccyx, no drainage, no open areas, peri-wound fragile, and erythemic, stable at this time. CP (Care pan) reviewed, interventions in place, cont. current orders . 2/5/2025 at 3:40 PM . MASD to coccyx, no drainage, no open areas, peri-wound fragile, and erythemic, stable at this time. CP reviewed, interventions in place, no new orders . Review of Resident #13's Provider Visit Note dated 02/21/2025 revealed, .seen today for follow up on bilateral flank (lower back) pain . Assessment and Plan: . Obtain UA (urine test) and reflex UCx (urine culture if UA positive), await results for UCx to start abx (antibiotic) . In an interview on 02/26/25 at 10:35 AM, Registered Nurse (RN) FF reported that Resident #13's urine test results were not in his record yet. Then at 10:56 AM RN FF reported that the results were negative for infection, and that the provider would be following up with the resident later today regarding the lower back pain. Resident #44 Review of an Admission Record revealed Resident #44 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury and aphasia (speech disorder that effects a person's ability to communicate effectively). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a MDS assessment for Resident #44, with a reference date of 1/27/24 revealed a Staff Assessment for Mental Status indicating that the resident was severely impaired. Review of Resident #44's Functional Abilities indicated that the resident was completely dependent on staff for toileting, personal hygiene and all physical mobility. Review of Resident #44's Kardex revealed, .Daily Routine: .Bowel/Bladder: Apply barrier cream to perineal area after each incontinence episode and as needed. Brief use: Resident used incontinence management products, change per protocol, preference, and as needed. Brief XLg (extra large) During an observation on 02/24/25 at 01:26 PM in Resident #44's room, CNA Q and CNA S transferred the resident into bed. CNA Q reported that the resident had been up in his chair since early that morning. During an observation on 02/25/25 at 07:45 AM Resident #44 was in his broda chair sitting in the dining room. During an observation on 02/25/25 at 09:04 AM Resident #44 was sitting in his broda chair in his room. Continuous observations were made until 11:53 AM, and Resident #44 remained in the same position and location. During an observation on 02/26/25 at 7:45 AM Resident #44 was sitting in his broda chair in the dining room. During an observation on 02/26/25 at 09:53 AM Resident #44 was sitting in his broda chair in his room, with the curtain pulled and only his feet visible from the doorway. At 10:25 AM the resident was in the same place and position. CNA W was the only CNA working on the hall, and observed walking up and down the hall, sitting at the charting station, but did not provide any care to Resident #44. At 11:04 AM CNA K came onto the hall to help, but did not provide any care to Resident #44. In an interview on 02/26/25 at 11:12 AM, DON B reported that Resident #44 should be laid down in bed after meals, and checked and changed every 2 hours. During an observation and interview on 02/26/25 at 11:37 AM in Resident #44's room, FM ZZ reported that she was very upset because the resident was soaking wet and had not been laid down after breakfast. Observed Resident #44's incontinence brief bulging and his pants were wet.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to ensure the maintenance, and storage in a sanitary manner of CPAP (continuous positive airway pressure machine increases the air pressure in the throat to prevent airway collapse) machine equipment according to professional standards for 1 of 18 residents (Resident #76) reviewed for respiratory care, resulting in an increased potential for respiratory infection and respiratory distress. Findings include: Review of an Admission Record revealed Resident #76 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: obstructive sleep apnea (when someone stops breathing in their sleep). Review of a Minimum Data Set (MDS) assessment for Resident #76's, with a reference date of 1/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #76 was cognitively intact. Review of the Special Treatments revealed that Resident #76 had a CPAP machine upon admission. Review of Resident #76's Orders revealed, Cleanse CPAP equipment. Wash with warm soapy water and rinse in A.M., leave out to dry for night time use. every day shift every Sun (Sunday) for equipment maintenance. Active 1/26/2025 CPAP via full mask with 11 CWP (power level). at bedtime for sleep apnea AND as needed for sleep apnea whenever asleep. Active 1/21/2025. The record indicated that nursing staff had documented that the machine was cleaned on 2/23/25, and that it was checked every day and night in February. During an observation and interview on 02/24/25 at 09:28 AM Resident #76 was lying in bed. There was a CPAP machine observed on the tray table still powered on; the hose was laying on the ground, and the mask was laying on the bed. The machine, hose and mask were heavily soiled with dirt and grime, and water container was observed empty with dried white substance in it. Resident #76 reported that no one cleans the CPAP machine. At 09:40 AM Registered Nurse (RN) GG walked into Resident #76's room and administered his medication. RN GG did not address the running CPAP machine, or offer any assistance to the resident. During an observation on 02/25/25 at 11:20 AM Resident #76's CPAP machine was observed running and still heavily soiled with dirt and grime. Resident #76 was not in his room. In an interview on 02/25/25 at 11:28 AM, Director of Nursing (DON) B reported that Resident #76's CPAP machine should be cleaned by the nursing staff weekly. DON B reported that there are also orders to make sure that he has the mask in place properly at night and that it is removed and stored in a plastic bag in the morning. DON B observed the residents CPAP equipment and reported that she could not get it clean, but would call to have the equipment replaced by the durable medical equipment company. Review of Resident #76's Care Plan did not indicate that he had sleep apnea and/or used a CPAP machine at night.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on interview and record review the facility failed to ensure that PRN (as needed) psychotropic medications were limited to 14 days unless documented rationale by the physician was present in the medical record in 1 (Resident #9) of 5 residents reviewed for unnecessary medications. Findings include: Resident #9 Review of an Admission Record revealed Resident #9 was a female who initially admitted to the facility on [DATE] and had pertinent diagnoses which included: PTSD (Post traumatic stress disorder), bipolar disorder (mental health disorder that causes extreme mood swings), anxiety disorder, and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #9, with a reference date of 11/29/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #9 was cognitively intact. (BIMS score 12-15 indicates cognitively intact). Review of Physician Recommendations for Resident #9 dated 12/27/24 revealed This resident is currently receiving Xanax 1mg (milligram) BID (twice a day) at 0800 (8:00 am) and 2000 (8:00 pm) and Ativan 1mg at 2000 was added 12/10/24 .Please consider treating this resident's anxiety with a single medication . Hand written response from the provider on this same paper revealed Xanax 1mg BID to Xanax 1mg BID PRN attempting to GDR/DC (gradual dose reduction/discontinue) dated 12/30/2024. Review of Physician Order for Resident #9 dated 12/30/2024 revealed .Xanax give 1 mg by mouth as needed every 24 hours for anxiety .indefinite. The order was not for 14 days and there was no noted stop date. In an interview on 2/26/25 at 1:53 PM., Social [NAME] Director (SSD) II reported all as needed psychotropic medications, which included Xanax, should be ordered for 14 days at a time, unless the provider documents a reason for extension. SSD II confirmed Resident #9's Xanax order from 12/30/24 was not ordered for only 14 days and did not have a stop date. Review of facility policy Psychoactive Drug Use with a date of 7/11/2018 revealed .psychotropic PRN (as needed) orders are limited to 14 days, if the attending physician or prescribing practitioner believe it is appropriate for the PRN to be extended beyond 14 days he/she will document the rationale in the resident's medical record and indicate the duration of the PRN order. Review of Resident #9's record revealed no noted documented rationale for a psychoactive drug to be prescribed longer than 14 days.

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 22050

Based on observation, interview, record review the facility failed to provide palatable food products in 2 (#17, #45) of 18 sampled residents, and 11 of 11 residents from the confidential group meeting, effecting 84 residents, resulting in the increased likelihood for decreased resident food acceptance and nutritional decline.

Findings include:

On 02/25/25 at 11:33 A.M., An interview was conducted with Dietary Director X regarding the resident food tray delivery schedule. Dietary Director X stated: We deliver to 400 Hall, 200 Hall, 100 Hall, 500-600 Hall, 300 Hall, Sunroom, and Main Dining Room last.

On 02/25/25 at 11:47 A.M., Resident lunch meal food trays were observed leaving the food production kitchen, within an insulated Cambro food transportation cart.

On 02/25/25 at 11:50 A.M., Resident lunch meal food trays were observed arriving to the 100 Hall corridor, within an insulated Cambro food transportation cart.

On 02/25/25 at 11:55 A.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #45's lunch meal food tray:

Pork Fritter - 128.0*

Mashed Potatoes - 125.3*

Peas - 124.7*

Cake - Room Temperature

Beverage (Coffee) - 127.5

Beverage (Ice Water) - 41.8*

(*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less.

On 02/25/25 at 12:00 P.M., Resident lunch meal food trays were observed leaving the food production kitchen, within an insulated Cambro food transportation cart.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/25/25 at 12:03 P.M., Resident lunch meal food trays were observed arriving to the 600 Hall corridor, within an insulated Cambro food transportation cart. On 02/25/25 at 12:05 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #63's lunch meal food tray: Pork Fritter (Mechanical Soft) - 118.9* Mashed Potatoes - 127.6* Apple Sauce - 44.5* Peas - 122.5* Beverage (Chocolate Mighty Shake) - 49.8* Beverage (Whole Milk) - 48.0* (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. On 02/27/25 at 08:45 A.M., review of the Policy/Procedure entitled: Maintaining a Sanitary Tray Line dated 07/10/18 revealed under Policy: This facility prioritizes tray assembly to ensure foods are handled safely and held at proper temperatures in order to prevent the spread of bacteria that may cause foodborne illness. On 02/27/25 at 11:00 A.M., review of the Policy/Procedure entitled: Proper Food Portion and Plating dated (no date) revealed under Policy: It is the policy of this facility to ensure that all meals are portioned appropriately according to standardized recipes and plating procedures, providing adequate food quantity while maintaining palatability and visual appeal. 41027 During a confidential group meeting on 02/25/25 at 01:31 PM, 11 of 11 residents agreed that hot food is not served hot enough, meals are of poor quality, and they are constantly missing items on their meal trays. 41982 Resident #17 Review of an Admission Record revealed Resident #17 was a female, with pertinent diagnoses which included: major depressive disorder and anxiety disorder. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for Resident #17, with a reference date of 1/31/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #17 was cognitively intact. In an interview on 2/24/25 at 9:45 AM, Resident #17 reported the food served was not hot enough, especially for the evening meals. In an interview on 2/25/25 at 8:49 AM, Resident #17 reported she had ordered an egg sandwich for dinner the night before and the egg was undercooked as evidenced by the fact that the white part of the egg was still slimy. Resident #17 reported she had complained to the Dietary Manager about the egg. In an interview on 2/25/25 at 1:25 PM, Dietary Manager (DM) X reported Resident #17 had complained to her that the egg on her egg sandwich was not thoroughly cooked. DM X confirmed the egg was not thoroughly cooked and reported the cook hadn't cooked it all the way prior to serving it. DM X reported residents have complained about the food temperatures. 48637 Resident #45 Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R45's initial admitted was 3/6/2024. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R45 was cognitively intact (13 to 15 cognitively intact). During an interview on 2/24/2025 at 9:37 AM, R45 stated that she eats in her room and the food is cold a lot. During an interview on 2/25/2025 at 8:42 AM, R45 reported that she spoke to Dietary Manager (DM) X in the past and told her that she needed to do something to keep the food warm when it leaves the kitchen. R45 said that she told DM X that the food temperatures need to be warmer on the steam tables before it gets plated and goes down the halls. During an interview on 2/25/2025 at 8:45 AM, DM X stated that she takes the temperature of all food items before it leaves the kitchen. DM X stated that they don't have plate warmers underneath each plate that can keep the food warm when it goes down the halls, but they do have a warmer in the kitchen for the plates before the food gets plated. DM X said that they don't have a food committee where residents with food concerns can bring these concerns to her.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observation, interview, record review the facility failed to honor resident food choice preferences in 5 (#63, #44, #73, #17, and #21) of 18 residents and 2 of 11 residents from the confidential group meeting, resulting in the increased likelihood for decreased resident food acceptance and nutritional decline. Findings include: Resident #63 On 02/25/25 at 12:10 P.M., An interview was conducted with Resident #63 regarding facility food products. Resident #63 stated: Gravy and Peas., referring to her lunch meal card dislikes list. On 02/25/25 at 12:20 P.M., Record review of Resident #63's lunch meal card revealed the following: Dislikes: Corn, Onions; Other-All Condiments and Gravy; Other-Small Veggies; Peas. On 02/27/25 at 11:15 A.M., Record review of the Policy/Procedure entitled: Resident Allergies, Preferences, and Substitutes dated 11/01/17 revealed under Policy: To identify and record food allergies of residents prior to feeding in an attempt to prevent allergic reactions. Food service staff will work in a manner that promotes safety of residents and avoids cross-contamination. Record review of the Policy/Procedure entitled: Resident Allergies, Preferences, and Substitutes dated 11/01/17 further revealed under Policy Explanation and Compliance Guidelines: (4) Food served will accommodate resident's allergies, intolerances, and preferences. (5) Alternate options will be available of similar nutritive value to residents who have allergies, choose not to eat food that is initially served, or who request a different meal choice. On 02/27/25 at 11:30 A.M., Record review of the Policy/Procedure entitled: Food Preparation Guidelines dated 04/05/22 revealed under Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition and hydration status. Record review of the Policy/Procedure entitled: Food Preparation Guidelines dated 04/05/22 further revealed under Policy Explanation and Compliance Guidelines: (5) Staff shall accommodate resident allergies, intolerances, and preferences, providing appropriate alternatives when needed: (a) Alternatives shall be appealing and of similar nutritive value to the food that is being substituted. (b) Alternatives shall be consistent with the usual and/or ordinary food items provided by the facility. 41027 Resident #44 Review of an Admission Record revealed Resident #44 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury and aphasia (speech disorder that effects a person's ability to communicate effectively). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44's Care Plan revealed, Resident has nutritional problem or potential nutritional problem .need for thickened liquids, altered texture and therapeutic diet .Interventions: .Diet: enhanced, 2x meat portions, fruit for dessert, no mixed consistencies . During an observation and interview on 02/25/25 at 11:53 AM in Resident #44's room, Family Member (FM) ZZ was visiting the resident. Staff brought Resident #44's lunch tray in the room. Whole peas and applesauce were observed on the tray. FM ZZ reported that the resident was not supposed to have gotten peas, unless they are pureed. FM ZZ also reported that she had requested that he did not get applesauce. Review of Resident #44's Meal tray ticket indicated peas and applesauce as dislikes. Resident #73 Review of an Admission Record revealed Resident #73 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #73, with a reference date of 1/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #73 was mildly cognitively impaired. In an interview on 02/24/25 at 09:06 AM, Resident #73 reported that food portions were small. Resident #73 reported that he had requested large portions for all meals, and often had to ask for them because the tray did not come that way. Resident #73 reported that he had lost 50 unintentional pounds since admission, and that it was because of not getting enough food. During an observation on 02/24/25 at 12:11 PM Resident #73 received his lunch, and had the entire meal and drinks gone in less than 10 minutes. At 12:21 PM, Certified Nursing Assistant (CNA) TT entered the resident's room to pick up his tray. In an interview on 02/24/25 at 12:21 PM, Resident #73 reported that he finished lunch very fast, because there was not enough food on his tray, and that he would like more to eat. Review of Resident #73's Meal Ticket indicated large portions. Review of Resident #73's Weight Record indicated that he weighed 276 pounds on 12/13/24, and last recorded weight on 2/12/2025 was 259 pounds. During a confidential group meeting on 02/25/25 at 01:31 PM, 11 of 11 residents reported that they are constantly missing items on their meal trays. 41982 Resident #17 Review of an Admission Record revealed Resident #17 was a female, with pertinent diagnoses which included: major depressive disorder and anxiety disorder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Alamo Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 8290 W C Ave Kalamazoo, MI 49009	

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for Resident #17, with a reference date of 1/31/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #17 was cognitively intact. In an interview on 2/24/25 at 9:45 AM, Resident #17 reported the kitchen was often out of everyday items and gave the example of fruit or yogurt. Resident #17 also reported she did not always receive what she had ordered. Resident #17 gave the example of an evening when she had requested French fries with her dinner meal and received potato chips instead. Resident #17 reported she had not been informed of the substitution prior to receiving her meal. Review of Resident #17's Grievance and Satisfaction Form dated 11/27/24 revealed, .Describe Grievance or Satisfaction Happens a lot, main dining room always runs out of food and has to be changed to something else . Review of Resident #17's Grievance and Satisfaction Form dated 1/14/25 revealed, .Describe Grievance or Satisfaction States we are always out of everyday items - example shredded cheese, jelly, bread, butter . Resident #21 Review of an Admission Record revealed Resident #21 was a female, with pertinent diagnoses which included: type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood). Review of a Minimum Data Set (MDS) assessment for Resident #21, with a reference date of 11/27/24, revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #21 was cognitively intact. In an interview and record review on 2/24/25 at 10:41 AM, Resident #21 was queried as to how her breakfast was that morning. Resident #21 reported she had not received her grapes. Review of Resident #21's Tray Ticket revealed, Breakfast .Notes: red grapes with meal, cream of wheat, rice Krispies or corn [NAME] (sic); ketchup for eggs, sf (sugar free) strawberry jelly . Resident #21 reported no alternate fruit had been offered to her. In an interview on 2/25/25 at 8:44 AM, Resident #21 reported she had not received grapes on her tray for breakfast that morning. Resident reported no alternate fruit had been offered to her. In an interview on 2/25/25 at 1:21 PM, Dietary Manager (DM) X reported she knew Resident #21 well and knew she liked grapes. DM X reported grapes had just come in on the truck and that they had been out of them. DM X reported if a resident has something on their tray tickets that the kitchen was out of, staff should offer the resident an alternate item. Review of the Resident Council Meeting Minutes dated 2/7/25 revealed, .Dietary .Kitchen not asking what residents want (sic) to eat or changing the menu and not telling residents .

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	235311	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observation, interview, and record review, the facility failed to: (1) effectively clean and maintain food service equipment, (2) label and store food products, (3) date mark all potentially hazardous ready-to-eat food products, and (4) maintain plumbing fixtures effecting 84 residents, resulting in the increased potential for cross-contamination, bacterial harborage, and resident foodborne illness. Findings include: On 02/25/25 at 10:10 A.M., A comprehensive tour of the kitchen was conducted with Dietary Director X. The following items were noted: 1 of 2 hand sink basins were observed draining slowly. Dietary Director X indicated she would contact maintenance for necessary repairs as soon as possible. The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. Pantry: Plastic forks were observed uncovered resting within a plastic sleeved clear container without an appropriate cover lid. Plastic spoons were also observed uncovered resting within two clear plastic containers without appropriate cover lids. Dietary Director X indicated she would purchase appropriate cover lids for both plastic fork and spoon containers as soon as possible. The 2022 FDA Model Food Code section 4-903.11 states: (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean EQUIPMENT and UTENSILS shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. (C) SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored as specified under (A) of this section and shall be kept in the original protective PACKAGE or stored by using other means that afford protection from contamination until used. (D) Items that are kept in closed PACKAGES may be stored less than 15 cm (6 inches) above the floor on dollies, pallets, racks, and skids that are designed as specified under S 4-204.122. Pantry: Two light gray plastic resin food transportation carts were observed soiled with accumulated and encrusted food residue. Dietary Director X indicated she would have staff thoroughly clean and sanitize the food transportation carts as soon as possible. The interior and exterior surfaces of the Coffee Machine were observed soiled with accumulated and encrusted food residue. The underplash and backsplash were also observed soiled with accumulated and encrusted food residue. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The [NAME] one-door refrigerator interior door gasket was observed soiled with accumulated and encrusted (dust, dirt, and food residue). Dietary Director X indicated she would have staff thoroughly clean and sanitize the soiled door gasket as soon as possible. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Two 5-pound containers of Glenview Farms sour cream were observed within the walk-in cooler with a best-by-date that read 02/22/2025. One of the two 5-pound containers of Glenview Farms sour cream was also observed open, without an effective open or discard date written on the container. One gallon of Country Fresh whole milk was observed without an effective open or discard date. The whole milk container manufacturer's best-by-date was also observed to read 3/2/25. The 2022 FDA Model Food section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. On 02/25/25 at 02:15 P.M., A comprehensive tour of the food service was continued with Dietary Director X. The following items were noted: The [NAME] convection oven interior surfaces were observed heavily soiled with accumulated and encrusted food residue. The Vulcan Automix mini stand mixer was observed soiled with accumulated and encrusted food residue. The backsplash and spindle guard assembly were also observed soiled with accumulated and encrusted food residue. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The [NAME] convection oven interior light bulbs (2) were observed missing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2022 FDA Model Food Code section 6-303.11 states: The light intensity shall be: (A) At least 108 lux (10 foot candles) at a distance of 75 cm (30 inches) above the floor, in walk-in refrigeration units and dry FOOD storage areas and in other areas and rooms during periods of cleaning; (B) At least 215 lux (20 foot candles): (1) At a surface where FOOD is provided for CONSUMER self-service such as buffets and salad bars or where fresh produce or PACKAGED FOODS are sold or offered for consumption, (2) Inside EQUIPMENT such as reach-in and under-counter refrigerators; and (3) At a distance of 75 cm (30 inches) above the floor in areas used for handwashing, WAREWASHING, and EQUIPMENT and UTENSIL storage, and in toilet rooms; and (C) At least 540 lux (50 foot candles) at a surface where a FOOD EMPLOYEE is working with FOOD or working with UTENSILS or EQUIPMENT such as knives, slicers, grinders, or saws where EMPLOYEE safety is a factor. The [NAME] convection oven interior lighting glass globe covers (2) were observed missing, exposing the electrical socket opening. Dietary Director X indicated she would contact maintenance for necessary repairs as soon as possible. The 2022 FDA Model Food Code section 6-202.11 states: (A) Except as specified in (B) of this section, light bulbs shall be shielded, coated, or otherwise shatter-resistant in areas where there is exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; or unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) Shielded, coated, or otherwise shatter-resistant bulbs need not be used in areas used only for storing FOOD in unopened packages, if: (1) The integrity of the packages cannot be affected by broken glass falling onto them; and (2) The packages are capable of being cleaned of debris from broken bulbs before the packages are opened. (C) An infrared or other heat lamp shall be protected against breakage by a shield surrounding and extending beyond the bulb so that only the face of the bulb is exposed. Skilled Nourishment Room: The hand sink gooseneck faucet assembly was observed lose-to-mount. Dietary Director X indicated she would contact maintenance for necessary repairs as soon as possible. The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. On 02/27/25 at 08:00 A.M., Record review of the Policy/Procedure entitled: Date Marking for Food Safety dated 04/05/22 revealed under Policy: The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. Record review of the Policy/Procedure entitled: Date Marking for Food Safety dated 04/05/22 further revealed under Policy Explanation and Compliance Guidelines for Staffing: (1) Refrigerated, ready-to-eat, time/temperature control for safety food (i.e. perishable food) shall be held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. (2) The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. (5) The discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.) On 02/27/25 at 08:15 A.M., Record review of the Policy/Procedure entitled: Food Receiving and Storage dated 07/11/2018 revealed under Policy: It is the policy of this facility that foods shall be received and stored in a manner that complies with safe food handling practices. Record review of the Policy/Procedure entitled: Food Receiving and Storage dated 07/11/2018 further revealed under Procedures: (8) All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/27/25 at 08:30 A.M., Record review of the Policy/Procedure entitled: Sanitation dated 07/11/2018 revealed under Policy: It is the policy of this facility that food service areas shall be maintained in a clean and sanitary manner. Record review of the Policy/Procedure entitled: Sanitation dated 07/11/2018 further revealed under Procedures: (1) All kitchens, kitchen areas, and dining areas shall be kept clean, free from litter and rubbish, and protected from rodents, flies, and other insects. (2) All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair, and shall be free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Seals, hinges, and fasteners will be kept in good repair. (3) All equipment, food contact surfaces, and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. 41982 An initial kitchen/food service tour was conducted on 2/24/25 beginning at 8:23 AM with Dietary Manager (DM) X. The following observations/interviews were completed: At 8:30 AM in the storeroom, it was noted that a bag of chocolate chips, a bag of cake mix, and a bag of spaghetti pasta were opened but not securely sealed. At 8:34 AM in the walk-in freezer, it was noted that a box of hamburger patties was opened but not securely sealed. A case of bread was stored on the freezer floor. At 8:36 AM in the walk-in cooler, it was noted that there was an uncovered plate with a half-eaten piece of cheesecake located on top of a box of processed cheese on the shelf in the corner. DM X reported the cheesecake should not have been there. There was a container of cut-up lettuce that was not labeled or dated. There was a container of what DM X reported to be pimento and cheese with a use by date of 2/22/25. DM X reported it should have already been discarded. At 8:42 AM in the refrigerator in the nourishment room on the main hall across from facility entrance, it was noted that there was an opened bottle of juice dated 2/7/25. There was an opened box of honey thickened water that was not labeled with an opened or discard date. There were opened bottles of ranch dressing and barbecue sauce that were not labeled with opened or discard dates. There was a styrofoam container of food with a resident's name written on it but no discard date. There was gel-like spillage on one of the shelves of the refrigerator. DM X reported housekeeping was responsible for cleaning the refrigerator. DM X reported items should be labeled with the opened date and the discard date and that items past the discard date should have already been discarded. There was a shelf above the refrigerator that had a loaf of bread with a best by date of 12/19/24. At 8:48 AM in the basic nourishment room, there was a prepared coffee drink that was not labeled or dated. There was a box of honey thickened water and a container of prepared tea, both of which were not labeled with opened or discard dates.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to ensure proper glove use during incontinence care and injection administration, and ensure sanitary storage of respiratory equipment in 3 residents (Resident #13, #44, and #76) of 18 residents reviewed for infection control, resulting in the potential for skin breakdown, UTI (urinary tract infection), bacterial harborage, cross contamination and the spread of disease to a vulnerable population. Findings include: Resident #13 Review of an Admission Record revealed Resident #13 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 12/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #13 was cognitively impaired. Review of the Functional Abilities revealed that Resident #13 was dependent on staff for all toileting and personal hygiene needs. During an observation and interview on 02/24/25 at 04:36 PM, Family Member (FM) WW was at Resident #13's bedside. FM WW reported that Resident #13 had a history of severe UTI's (urinary tract infections) and that he had recently been more confused. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview and observation on 02/25/25 at 11:36 AM, CNA J reported that she saw the dark area on Resident #13's pants earlier that day and thought that it was a stain. This surveyor requested that CNA J check Resident #13 for wetness. CNA J went back into Resident #13's room and reported that his pants were wet, and then observed that his incontinence brief was bulging with urine. CNA J walked out into the hallway to find assistance. CNA P stated, .he spilled his water .or coffee on himself this morning . The CNAs both entered the resident's room to check him again. CNA P reported that she thought she had changed the resident's pants after he spilled, but she could be wrong. The CNA's transferred Resident #13 into his bed to provide incontinence care. Both CNA's donned gloves, and CNA P was designated to wash the resident. With gloves on CNA P pulled down Resident #13's heavily saturated brief, and with CNA J's assistance rolled the resident onto his right side. CNA P then removed the brief, and began cleaning Resident #13's bottom. There was feces observed on the disposable wipes and CNA P reported that the resident had a bowel movement. Resident #13's buttocks were observed with red wrinkled skin in the sacral (tailbone) area and white macerated (condition that occurs when skin is exposed to moisture for too long) skin in the perineum (area between anus and scrotum). After CNA P was finished cleaning the resident's bottom, she requested that CNA J grab the skin barrier cream from the nightstand. CNA P was observed applying barrier cream on the resident's bottom, while still wearing soiled gloves. CNA P then assisted CNA J to turn Resident #13 onto his back, and began washing his front peri area (penis and groin), while still wearing soiled gloves. The CNA's worked together to get clean pants on the resident, and positioning the hoyer sling underneath the resident. The CNA's both removed their gloves just before they transferred the resident back to his chair. CNA P did not clean the resident from front to back during incontinence care, per standards of practice. CNA P used soiled gloves to apply barrier cream, to wash the resident's penis, and while handling clothing and the hoyer sling.

Review of Resident #13's Provider Visit Note dated 02/21/2025 revealed, .seen today for follow up on bilateral flank (lower back) pain . Assessment and Plan: . Obtain UA (urine test) and reflex UCx (urine culture if UA positive), await results for UCx to start abx (antibiotic) .

In an interview on 02/26/25 at 10:35 AM, Registered Nurse (RN) FF reported that Resident #13's urine test results were not in his record yet. At 10:56 AM RN FF reported that results were negative for infection, and that the provider would be following up with the resident later today regarding the flank pain.

Resident #44

Review of an Admission Record revealed Resident #44 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury and aphasia (speech disorder that effects a person's ability to communicate effectively).

During an observation on 02/24/25 at 01:26 PM in Resident #44's room, CNA Q and CNA S transferred the resident into bed. Both CNA's donned gloves. CNA Q cleaned Resident #44's peri area using disposable wipes and then applied a clean brief. CNA Q was looking for a blanket in Resident #44's closet, and handling clean objects while still wearing soiled gloves. When there was no blanket found, CNA Q opened the door, then removed her gloves and exited the room to find a blanket.

Resident #76

(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #76 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: obstructive sleep apnea (when someone stops breathing in their sleep). Review of Resident #76's Orders revealed, Cleanse CPAP equipment. Wash with warm soapy water and rinse in A.M., leave out to dry for night time use. every day shift every Sun (Sunday) for equipment maintenance. Active 1/26/2025 CPAP via full mask with 11 CWP (power level). at bedtime for sleep apnea AND as needed for sleep apnea whenever asleep. Active 1/21/2025. The record indicated that nursing staff had documented that the machine was cleaned on 2/23/25, and that it was checked every day and night in February. During an observation and interview on 02/24/25 at 09:28 AM Resident #76 was lying in bed. There was a CPAP machine observed on the tray table still powered on; the hose was laying on the ground, and the mask was laying on the bed. The machine, hose and mask were heavily soiled with dirt and grime, and water container was observed empty with dried white substance in it. Resident #76 reported that no one cleans the CPAP machine. At 09:40 AM Registered Nurse (RN) GG walked into Resident #76's room and administered his medication. RN GG did not address the running CPAP machine, or offer any assistance to the resident. During an observation on 02/25/25 at 11:20 AM Resident #76's CPAP machine was observed running and still heavily soiled with dirt and grime. Resident #76 was not in his room. In an interview on 02/25/25 at 11:28 AM, Director of Nursing (DON) B reported that Resident #76's CPAP machine should be cleaned by the nursing staff weekly. DON B reported that there are also orders to make sure that he has the mask in place properly at night and that it is removed and stored in a plastic bag in the morning. DON B observed the residents CPAP equipment and reported that she could not get it clean, but would call to have the equipment replaced by the durable medical equipment company. During an observation of medication administration on 02/25/25 at 08:30 AM in Resident #332's room, Licensed Practical Nurse (LPN) RR was observed administering and insulin injection (medication that is administered using a needle and injected under the skin) with no gloves on. LPN RR then left the resident's room and returned to the medication cart, but did not perform any hand hygiene. At 08:32 AM LPN RR walked into a different resident's room, discussed pain medication, and then carried that resident's meal tray to the cart in the hallway. LPN RR did not perform hand hygiene prior to entering the resident's room. In an interview on 02/25/25 at 08:41 AM, LPN RR reported that she did not wear gloves for the insulin injection and/or perform hand hygiene, because she was not dealing with blood or body fluids. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Centers for Disease Control website (https://www.cdc.gov/handhygiene/providers/index.html) last revised on June 25, 2018 revealed, When to Perform Hand Hygiene .before and after having direct contact with a patient ' s intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed) .After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient .If hands will be moving from a contaminated body site to a clean body site during patient care .The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: .Wearing gloves is not a substitute for hand hygiene. Dirty gloves can soil hands .Steps for Glove Use .Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) .Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Failure to remove gloves after caring for a patient may lead to the spread of potentially deadly germs from one patient to another.

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 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 Based on observation, interview, and record review, the facility failed to effectively clean and maintain the physical plant effecting 84 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 02/26/25 at 09:30 A.M., A common area environmental tour was conducted with Maintenance Aide CC. The following items were noted: Service Corridor Staff Break Room: 2 of 2 microwave ovens were observed (etched, scored, corroded, particulate). The [NAME] toaster interior was also observed (corroded, burnt, soiled). Janitor Closet: The flooring surface was observed soiled with accumulated dust and dirt deposits. The room was also observed in complete disarray. Maintenance Aide CC stated: I will have staff take care of the room. 100 Hall Soiled Utility Room: The countertop was observed missing laminate, adjacent to the waste hopper. The missing laminate surface measured approximately 30-inches-long. Maintenance Aide CC indicated he would make necessary repairs as soon as possible. Skilled Equipment Room: The hand sink faucet assembly was observed loose-to-mount. 200 Hall Janitor Closet: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust and dirt deposits. Activity Room: 3 of 5 chairs were observed were observed (etched, scored, particulate). The refrigerator/freezer door gaskets were also observed heavily soiled with accumulated and encrusted (dust, dirt, food residue). 400 Hall (Rehabilitation) Janitor Closet: The flooring surface was observed soiled with dust and dirt deposits. The return-air-exhaust ventilation grill was also observed heavily soiled with accumulated dust and dirt deposits. Maintenance Aide CC stated: I will have staff clean the room. 300 Hall (continued on next page)

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 02/26/2025
NAME OF PROVIDER OR SUPPLIER Alamo Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 8290 W C Ave Kalamazoo, MI 49009	

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Shower/Bathroom: The commode support was observed loose-to-mount. The commode base caulking was also observed (etched, scored, stained, particulate). 600 Hall Nourishment Room: The front edge of the 60-inch-long laminate desktop surface was observed (etched, scored, particulate). The damaged laminate surface measured approximately 30-inches-long. 1 of 2 chairs were also observed (etched, scored, particulate), exposing the inner Styrofoam padding. Maintenance Aide CC indicated he would have staff remove the damaged chair and repair the laminate desktop surface as soon as possible. Day Room: 1 of 9 chairs were observed (etched, scored, particulate). Janitor Closet: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. The oscillating wall mounted fan was observed heavily soiled with accumulated dust and dirt deposits. Oxygen Supply Closet: The flooring surface was observed soiled with accumulated dust, dirt, and debris. The closet was also observed in disarray. Maintenance Aide CC indicated he would have staff clean and organize the room as soon as possible. On 02/26/25 at 11:20 A.M., An interview was conducted with Maintenance Aide CC regarding the facility maintenance work order system. Maintenance Aide CC stated: We have the TELS program. On 02/26/25 at 12:35 P.M., An environmental tour of sampled resident rooms was conducted with Maintenance Aide EE. The following items were noted: 204: The Bed 2 oscillating desk fan was observed soiled with accumulated dust and dirt deposits. Maintenance Aide EE indicated he would have housekeeping staff clean the desk fan as soon as possible. 205: The Bed 2 stationary desk fan was observed soiled with accumulated dust and dirt deposits. Maintenance Aide EE indicated he would have housekeeping staff clean the desk fan as soon as possible. 300: The commode base caulking was observed (etched, scored, particulate). Maintenance Aide EE indicated he would have staff remove and replace the worn caulking as soon as possible. 303: The commode support was observed loose-to-mount. Maintenance Aide EE indicated he would have staff make necessary repairs as soon as possible. On 02/27/25 at 11:45 A.M., Record review of the Policy/Procedure entitled: Preventative Maintenance dated 04/12/2021 revealed under Policy: Each facility will have a preventative maintenance program in place that scheduled preventative maintenance on equipment and the physical plant. On 02/27/25 at 12:00 P.M., Record review of the Policy/Procedure entitled: Housekeeping Guidelines dated 03/08/2021 revealed under Policy: To provide guidelines to maintain a safe and sanitary environment for residents, facility staff, and visitors. (continued on next page)

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 02/26/2025
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/27/25 at 12:15 P.M., Record review of the Policy/Procedure entitled: Environmental Services Cleaning Schedule dated 03/08/2021 revealed under Policy: To establish a schedule which ensures the building and equipment is maintained in a clean and sanitary manner. All items may be cleaned more frequently, if necessary. Record review of the Policy/Procedure entitled: Environmental Services Cleaning Schedule dated 03/08/2021 further revealed under Procedure: (4) Quarterly: (a) Cubicle curtains in bathing areas. (b) Linen closets. (c) Air vents. On 02/27/25 at 12:30 P.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.