STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235542	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Westwood	2575 N Drake Road Kalamazoo, MI 49006

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47955 This citation pertains to intake #MI00144295 Based on observation and interview, the facility failed to maintain a clean homelike environment for 2 (Resident #33 and Resident #83) of 20 sampled residents resulting in an unclean room, unclean bathroom, and the potential for a reasonable person to experience feelings of embarrassment, shame, and/or loss of self -esteem. Findings include: Resident #33 Review of an Admission Record revealed Resident #33 had pertinent diagnoses which included: unspecified dementia, mild cognitive impairment on uncertain or unknown etiology, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #33, with a reference date of 4/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #33 was moderately cognitively impaired. During an observation on 6/11/24 at 10:12 AM., Resident #33's room had an odor of urine, the floor was sticky while walking on it, and there appeared to be dirt and debris along the base boards of the room. Flying insects were noted in the room. During an interview on 6/11/24 at 1:56 PM., Family Member (FM) JJ reported that there have been fruit flies (a small flying insect that is attracted to extra ripe, fermenting fruits, drains, trash bags, and other garbage: not an inclusive list) in Resident #33's room. FM JJ reported that floor had been sticky and there had been urine on the floor when she visited. During an interview on 6/12/24 at 08:29 AM., Resident #33 was asked about his room cleanliness. Resident #33 engaged in verbal conversation that was unintelligible and was not able to make himself understood. Resident #33 was unable to carry on a meaningful conversation with this surveyor or answer any direct questions appropriately. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/12/24 at 11:32 AM., Resident #33's room had an odor of urine, the floor was sticky, there was a puddle of liquid on the floor outside of the bathroom. On the bathroom floor, and on the floor in the doorway between the bathroom and room, and flying insects were noted in the bathroom. During an interview on 6/12/24 at 1:00 PM., FM JJ reported that she was concerned with how dirty Resident #33's bathroom floor was and the urine that was spilled on the floor. FM JJ reported that it was not fair that Resident #33's has to live in a room with an odor of urine and urine spilled on the floor. During an observation on 6/12/24 at 2:55 PM., flying insects were noted flying in Resident #33's bathroom. During an observation on 6/13/24 at 08:15 AM., Resident #33's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. During an observation on 6/13/24 at 11:02 AM., Resident #33's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. Resident #83 Review of an Admission Record revealed Resident #83 had pertinent diagnoses which included: bladder-neck obstruction (a blockage that does not allow urine to flow from the body), urinary tract infection, cognitive communication deficit. Review of a Minimum Data Set (MDS) assessment for Resident #83, with a reference date of 3/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #83 was severely cognitively impaired. During an observation on 6/11/24 at 10:12 AM., Resident #83's room had an odor of urine, the floor was sticky while walking on it, and there appeared to be dirt and debris along the base boards of the room. Flying insects were noted in the room. During an interview on 6/11/24 at 1:56 PM., Family Member (FM) JJ reported that there have been fruit flies (a small flying insect that is attracted to extra ripe, fermenting fruits, drains, trash bags, and other garbage: not an inclusive list) in Resident #83's room. FM JJ reported that floor had been sticky and there had been urine on the floor when she visited. During an observation on 6/12/24 at 11:32 AM., Resident #83's room had an odor of urine, the floor was sticky, there was a puddle of liquid on the floor outside of the bathroom. on the bathroom floor, and on the floor in the doorway between the bathroom and room, and flying insects were noted in the bathroom. Resident #83 was observed in the bathroom emptying his urine drainage bag (a bag connected to a catheter inserted into the body to drain and collect urine). The stool in the bathroom is noted to be dirty with what appears to be bowel movement debris. There was what appeared to be scrambled eggs and a yellow in color liquid that could have been urine noted on the floor beside and behind the toilet in the bathroom in Resident #83's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/12/24 at 11:37 AM., Resident #83 was in his room with Registered Nurse (RN) S when Resident #83 stated . there is water on the bathroom floor . RN S asked Resident #83 is there water or is it pee . Resident #83 replied .when the bag leaked then there was water . During an observation and interview on 6/12/24 at 11:44 AM., Resident #83 was observed in the bathroom of his room emptying his urinary drainage bag into the toilet. Resident #83 was asked if he was able to close the clamp on the urinary drainage bag after emptying it and he replied I don't know how to close it . Flying insects were noted in the bathroom and in Resident #83's room. District Housekeeping Manager (DHM) GG was then observed placing a wet floor sign at the door and asked Resident #83 if he needed his room to be cleaned. Resident #83 replied No. During an interview on 6/12/24 at 11:47 AM., RN S reported that Resident #83 was able to empty his urinary drainage bag by himself. RN S reported that Resident #83 does not have to empty his urinary drainage bag, staff will do it for him. RN S reported that Resident #83 places his urinary drainage bag on his wheelchair where he wants to, was rough with it, and the urinary drainage bag becomes punctured and leaks. During an interview on 6/12/24 at 1:00 PM., FM JJ reported that she was concerned with how dirty Resident #83's bathroom floor was and the urine that was spilled on the floor. FM JJ reported that Resident #83 wound not want his room to be like that. FM JJ reported that it was not fair that Resident #83's roommate has to live in a room with an odor of urine and urine spilled on the floor. During an observation on 6/12/24 at 2:55 PM., flying insects were noted flying in Resident #83's bathroom. During an observation on 6/13/24 at 09:56 AM., Resident #83 was observed emptying his urinary drainage bag into the toilet in his bathroom in his room. A liquid that appeared to be urine was noted on the floor in Resident #83's bathroom when he exited the room. During an observation on 6/13/24 at 08:15 AM., Resident #83's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. During an observation on 6/13/24 at 11:02 AM., Resident #83's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. During an interview on 6/13/24 at 12:14 PM., DHM GG reported that A hall has an assigned housekeeper daily and that each room and common areas was to be cleaned daily. DHM GG reported that he started helping in the building about 3 weeks ago and had found that Resident #83's room/bathroom had an odor of urine, flying insects in the room, and frequently had liquid on the floor in the bathroom. DHM GG reported that Resident #83's room wound now be a room that was a high focus area for checking and cleaning. During an interview on 6/13/24 at 1:00 PM., Interim - Nursing Home Administrator (I-NHA) A reported that the cleaning of resident rooms by housekeeping not being done had been a problem she was aware of and was working on resolving the situation.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41027 This citation pertains to intake #MI00145044. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse by a resident for 2 residents (Resident #15 & #40) of 4 residents, reviewed for abuse, resulting in the potential for physical harm, pain and mental anguish. Findings include: Resident #15 Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #15 was cognitively impaired. Review of Resident #15's Care Plan revealed, .Resident has behavior as evidenced by: verbally aggressive toward staff such as yelling and cursing. Resident may also become resistive or display verbal threats towards staff when providing care and/or transfers .Resident has an antagonistic joking relationship with another resident. Resident has a history of grabbing hair/head and staffs clothing, throwing trays. 6/9/24 resident aggressive to other resident .Date initiated: 9/15/23. Revision on: 6/11/24 .INTERVENTIONS: . Monitor resident when he is up in chair around other residents . In an interview on 06/11/24 at 12:32 PM, Resident #15 reported that he slapped a guy and now he had to have a babysitter with him all the time and stated loudly, .I might just do it again just because they put that sitter with me! In an interview on 06/11/24 at 02:33 PM, Family Member (FM) OO reported that she was notified the day before that Resident #15 had been violent with another resident. FM OO reported that it had happened several times in the past. Resident #40 Review of a Minimum Data Set (MDS) assessment for Resident #40, with a reference date of 4/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #40 was cognitively impaired. In an interview on 06/13/24 at 01:39 PM, Resident #40 reported that he was easily irritated with Resident #15 and stated, .he is an idiot . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's Incident Report dated 6/9/24 revealed, .heard (Resident #15) yelling at (Resident #40) .noticed (Resident #15) leaning out of his chair and grabbing (Resident #40's) chair .nurse stood between the residents .(Resident #15) punched (Resident #40) in the face with a closed fist. (Resident #15) then told (Resident #40) if he came near him again, he would knock his head off his shoulders. (Resident #15) stated that (Resident #40) called him a fat faggot and many other names, so he hit him . Review of Resident #15's Progress Note dated 6/9/2024 at 4:01 PM written by Nursing Home Administrator A revealed, Reported by charge nurse (Licensed Practical Nurse (LPN) G). This nurse was standing inside of the circle of the nurse's station when I heard (Resident #15) yelling at another resident in the Dining Room. (Resident #15) leaning out of his chair and grabbing other residents chair to bring him closer. yelled into the dining room for (Resident #15) to let chair go and at the same time went into DR (dining room) and another Nurse ran to the dining room to separate the two residents. The nurse stood between the residents . (Resident #15) swung and hit other in the face with a closed fist. (Resident #15)then told other resident If he came near him again, he was gonna knock his head off his shoulders. During an observation on 06/12/24 at 11:01 AM in the dining room, Resident #15 was sitting in his wheelchair. Resident #15 was speaking in a very loud voice, and continuously commented and antagonized several residents and staff for approximately one hour. There was a staff member nearby, that was assigned to supervise Resident #15. During an observation on 06/12/24 at 11:51 AM Registered Nurse (RN) S wheeled Resident #15 out of the dining room and down the hall, and left him sitting in his wheelchair outside of his room. RN S reported that the resident had asked to be brought to his room and be laid down in bed, but would have to wait for the aides. RN S continued with other tasks and did not supervise Resident #15. During observations on 06/12/24 from 11:51 AM to 12:06 PM there was no one supervising Resident #15. Resident #15 was loudly speaking and singing in the hall, using condescending and sexually inappropriate words. At one point, Resident #15 looked into a female resident's room and loudly made a sexually inappropriate remark. At 12:08 PM Resident #40 came out of his room in his wheelchair, stopped near Resident #15 and stated, Stick it up your a** you jerk! Resident #15 immediately began name calling, and swinging his arms towards Resident #40. Certified Nursing Assistant (CNA) PP came out of a resident's room to redirect the residents. In an interview on 06/12/24 at 12:28 PM, CNA PP reported that she wished Resident #15 and Resident #40 could live on separate halls and stated, .they just keep doing the same thing because they pass by each other all the time . CNA PP reported that they cannot have someone sit and watch them all the time. In an interview on 06/12/24 at 02:59 PM, Licensed Practical Nurse (LPN) G reported that a lot of residents have concerns with Resident #15 and Resident #40, because they both treat staff badly. LPN G reported that during shift change on 6/9/24, Resident #40 called Resident #15 a couple of insulting names, and in turn Resident #15 hit Resident #40 in the face. LPN G reported that staff tried to intervene prior to the physical altercation, but were unsuccessful. LPN G reported that Resident #15 was always verbally inappropriate to staff and residents, when he was in the dining room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/12/24 at 03:10 PM, Nursing Home Administrator (NHA) A reported that after the incident on 6/9/24, Resident #15 and Resident #40 had not had any additional concerning encounters with one another and stated, .(Resident #40) has not instigated or name called . NHA A was not aware that the residents had a verbal altercation earlier that day.

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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. 41027 This citation pertains to intake #MI00145044. Based on observation, interview, and record review, the facility failed to implement interventions to prevent further abuse during an ongoing investigation of abuse for 2 residents (Resident #15 & #40) of 4 residents, reviewed for abuse, resulting in the potential for physical harm, pain and mental anguish. Findings include: Resident #15 Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #15 was cognitively impaired. Review of Resident #15's Care Plan revealed, .Resident has behavior as evidenced by: verbally aggressive toward staff such as yelling and cursing. Resident may also become resistive or display verbal threats towards staff when providing care and/or transfers .Resident has an antagonistic joking relationship with another resident. Resident has a history of grabbing hair/head and staffs clothing, throwing trays. 6/9/24 resident aggressive to other resident .Date initiated: 9/15/23. Revision on: 6/11/24 .INTERVENTIONS: . Monitor resident when he is up in chair around other residents . In an interview on 06/11/24 at 12:32 PM, Resident #15 reported that he slapped a guy and now he had to have a babysitter with him all the time and stated loudly, .I might just do it again just because they put that sitter with me! Resident #40 Review of a Minimum Data Set (MDS) assessment for Resident #40, with a reference date of 4/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #40 was cognitively impaired. In an interview on 06/13/24 at 01:39 PM, Resident #40 reported that he was easily irritated with Resident #15 and stated, .he is an idiot . Review of Resident #15's Incident Report dated 6/9/24 revealed, .heard (Resident #15) yelling at (Resident #40) .noticed (Resident #15) leaning out of his chair and grabbing (Resident #40's) chair .nurse stood between the residents .(Resident #15) punched (Resident #40) in the face with a closed fist. (Resident #15) then told (Resident #40) if he came near him again, he would knock his head off his shoulders. (Resident #15) stated that (Resident #40) called him a fat faggot and many other names, so he hit him . (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 observation on 06/12/24 at 11:01 AM in the dining room, Resident #15 was sitting in his wheelchair. Resident #15 was speaking in a very loud voice, and continuously commented and antagonized several residents and staff for approximately one hour. During an observation on 06/12/24 at 11:51 AM Registered Nurse (RN) S wheeled Resident #15 out of the dining room and down the hall, and left him outside of his room. RN S reported that the resident had asked to be brought to his room and be laid down in bed, but would have to wait for the aides. RN S continued with other tasks and did not supervise Resident #15. During observations on 06/12/24 from 11:51 AM to 12:06 PM Resident #15 was in the hall outside of his room, an unsupervised. Resident #15 was loudly speaking and singing in the hall, using condescending and sexually inappropriate words. At one point, Resident #15 looked into a female resident's room and loudly made a sexually inappropriate remark. At 12:08 PM Resident #40 came out of his room in his wheelchair, stopped near Resident #15 and stated, Stick it up your a** you jerk! Resident #15 immediately began name calling, and swinging his arms towards Resident #40. Certified Nursing Assistant (CNA) PP came out of a resident room to redirect the residents. In an interview on 06/12/24 at 12:28 PM, CNA PP reported that she wished Resident #15 and Resident #40 could live on separate halls and stated, .they just keep doing the same thing because they pass by each other all the time . CNA PP reported that they cannot have someone sit and watch them all the time. In an interview on 06/12/24 at 03:10 PM, Nursing Home Administrator (NHA) A reported that after the incident on 6/9/24, Resident #15 and Resident #40 have not had any additional concerning encounters with one another and stated, .(Resident #40) has not instigated or name called . NHA A reported that the abuse was reported to the state immediately and is still under investigation. NHA A was not aware that the residents had a verbal altercation earlier that day.

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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 This citation pertains to intake # MI00143208 Based on observation, interview and record review, the facility failed to ensure residents received the necessary care and services to prevent the worsening of pressure ulcers in onr resident (Resident #15) of four residents reviewed for pressure ulcers, resulting in not receiving wound treatments per physician orders for pressure ulcers, and the potential for infection and worsening of pressure ulcers. Findings include: Resident #15 Review of an Admission Record revealed Resident #15 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart and respiratory failure. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 5/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #15 was cognitively impaired. Review of Resident #15's Pressure Ulcer Care Plan revealed, .Chronic surgical ulcer stage 4 to left trochanter (hip), unstageable left heel .Date initiated 9/15/23, Revised on 6/8/24. Interventions: .administer treatments per orders. Date initiated: 9/15/23 . In an interview on 06/11/24 at 12:32 PM, Resident #15 reported he was very unhappy with the care he received for his wounds. In an interview on 06/11/24 at 02:33 PM, Family Member (FM) OO reported Resident #15's wound dressings did not get changed as frequently as they should and she felt like that was why his wounds had not healed. FM OO reported Resident #15's wounds stink with infection. Review of Resident #15's Progress Note dated 6/6/24 indicated that the resident had returned from the hospital at 4:45 PM. During an observation and interview on 06/12/24 at 12:15 PM in Resident #15's room. Registered Nurse (RN) S detached Resident #15's incontinence brief and a large white dressing was observed, dated June 7th with Wound Nurse (WN) X's initials on it. RN S removed the resident's sock on his left foot and a large white dressing was observed, dated June 7th with WN X's initials on it. Resident #15 reported that the wound dressings are supposed to be changed every day, but its more like every month. RN S reported that WN X completes the wound care and dressing changes on Monday, Wednesday and Friday, and then the floor nurses are supposed to do them the other days. (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 06/12/24 at 01:08 PM, WN X reported that Resident #15 has had the wound on his left hip for a very long time and the wound on his left heel is almost healed. WN X reported Resident #15's wound dressings on his left hip and left heel should be changed daily and as needed. WN X reported he typically completed wound care on Mondays, Wednesdays and Fridays, but the floor nurse was ultimately responsible for ensuring the wound care was competed as ordered on a daily basis. WN X reported he had performed wound care for Resident #15 on Friday 6/7/24, but did not see documentation in the record, and could not remember if he had seen Resident #15 on Monday 6/10/24, but must not have since the dressing was dated June 7th. Review of Resident #15's Physician Orders revealed, Left trochanter wound: cleanse with wound wash, pat dry, apply collagen (aids in healing) in undermined area, then apply thin coat of triad cream (skin protectant) on base of wound, cover with bordered dressing daily and PRN (as needed) if soiled or missing. Order/Start date 6/9/24. There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's Treatment Administration Record (TAR) for the dressing noted above on the left trochanter indicated that the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. That was inaccurate documentation, considering the dressing on 6/12/24 was dated 6/7/24. Review of Resident #15's Physician Orders revealed, Left heel: cleanse with wound wash, pat dry, apply Santyl (removes damaged tissue and aids in healing) to slough (dead skin cells), cover with collagen pad, secure with ABD (thick cotton) pad, foam and stretchy kerlix (wrap), daily PRN application along with floating heel while in bed all times as tolerated. Every evening shift for left heel wound. Order/Start date 6/9/24. There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's TAR for the dressing noted above on the left heel indicated the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. During an observation on 06/12/24 at 02:00 PM in Resident #15's room along with WN X to complete wound care and dressing changes. WN X removed the dressing from Resident #15's left hip was dated June 7th, which revealed a deep wound with black crusting covering the wound. WN X reported the black crusting was a dried scab. At 2:17 PM WN X removed the dressing dated June 7th from Resident #15's left heel, which revealed multiple small areas of open skin, and a dried piece of collagen. When NW X cleaned the wound, the resident yelled and jerked his foot away. WN X reported that the wound was still unstageable, there was some maceration, light drainage, no odor after it was cleaned, and approximately 80% slough. Review of Resident #15's Progress Note dated 6/8/24 at 1:31 PM revealed, Nurses Note: Resident has impaired skin integrity as evidenced by: chronic surgical ulcer stage 4 to left trochanter, unstageable left heel .Resident is at risk for further impaired skin integrity .Wound treatment in place . Review of Resident #15's Weekly Skin assessment dated [DATE] indicated there was nothing new, and to see skin and wound notes for further information. Review of Resident #15's records, indicated no further documentation from 6/9/24-6/11/24 related to skin and wounds.

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	235542	A. Building B. Wing	06/13/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41027 This citation pertains to intake #MI00143208. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the documentation of pressure ulcer care and dressings changes for one (Resident #15) of four residents reviewed for pressure ulcers, resulting in the potential for inappropriate follow up care, lack of continued assessment, and worsening of the skin injury. Findings include: Resident #15 In an interview on 06/11/24 at 02:33 PM, Family Member (FM) OO reported that Resident #15's wound dressings did not get changed as frequently as they should and that she felt like that was why his wounds had not healed. Review of Resident #15's Progress Note dated 6/6/24 indicated that the resident had returned from the hospital at 4:45 PM that day. During an observation and interview on 06/12/24 at 12:15 PM in Resident #15's room. Registered Nurse (RN) S detached Resident #15's incontinence brief and a large white dressing was observed, dated June 7th with Wound Nurse (WN) X's initials on it. RN S removed the resident's sock on his left foot and a large white dressing was observed, dated June 7th with WN X's initials on it. Resident #15 reported the wound dressings are supposed to be changed every day, but its more like every month. RN S reported that WN X completes the wound care and dressing changes on Monday, Wednesday and Friday, and then the floor nurses are supposed to do them the other days. Resident #15's wound care had not been completed for the past 5 days. In an interview on 06/12/24 at 01:08 PM, WN X reported Resident #15 had the wound on his left hip for a very long time, and a wound on his left heel, and both have orders for daily wound care and dressing changes. WN X reported that he had performed wound care for Resident #15 on Friday 6/7/24, but did not see documentation in the record, and could not remember if he had seen Resident #15 on Monday 6/10/24, but must not have since the dressing was dated June 7th. Review of Resident #15's Physician Orders revealed, Left trochanter wound: cleanse with wound wash, pat dry, apply collagen (aids in healing) in undermined area, then apply thin coat of triad cream (skin protectant) on base of wound, cover with bordered dressing daily and PRN (as needed) if soiled or missing. Order/Start date 6/9/24. There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's Treatment Administration Record (TAR) for the dressing noted above on the left trochanter indicated the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. That was inaccurate documentation, considering the dressing on 6/12/24 was dated 6/7/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's Physician Orders revealed, Left heel: cleanse with wound wash, pat dry, apply Santyl (removes damaged tissue and aids in healing) to slough (dead skin cells), cover with collagen pad, secure with ABD (thick cotton) pad, foam and stretchy kerlix (wrap), daily PRN application along with floating heel while in bed all times as tolerated. Every evening shift for left heel wound. Order/Start date 6/9/24. There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's TAR for the dressing noted above on the left heel indicated the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. That was inaccurate documentation, considering the dressing on 6/12/24 was dated 6/7/24. Review of Resident #15's Pressure Ulcer Care Plan revealed, .Chronic surgical ulcer stage 4 to left trochanter (hip), unstageable left heel .Date initiated 9/15/23, Revised on 6/8/24. Interventions: .administer treatments per orders. Date initiated: 9/15/23 .

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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** 48637 This citation has two deficient practice statements. Deficient Practice Number 1. Based on observation, interview, and record review, the facility failed to ensure proper infection control protocols and practices in seven of 20 residents reviewed for infection control (Resident #46, Resident #57, Resident #48, Resident #49, Resident #65, Resident #15, Resident #83) including 1. Enhanced Barrier Precautions (EBP) per national standards of practice, 2. Routine cleaning and proper storage of continuous positive airway pressure (CPAP) machines and tubing 3. Proper use of PPE (Personal Protective Equipment) during catheter care and dressing changes, 4. Keeping an intravenous therapy (IV) pole clean, 5. Tube feeding practices and 6. Proper wheelchair cleaning resulting in the potential for the spread of infection, cross-contamination, and disease transmission for residents residing in the facility. Findings include: During an observation on 6/11/2024 at 10:14 AM down D-Hall, one cart with PPE was noted to not have any hand sanitizer on it. Another cart with PPE down the hall had a push sanitizer device on the cart but it was empty. Enhanced Barrier Precautions Review of Centers for Disease Control and Prevention (CDC) dated March 20, 2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing .EBP are indicated for residents with any of the following: *Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 . Resident #46 (R46) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R46's admitted was on 8/17/2022 with diagnoses of benign prostatic hypertrophy (BPH, enlarged prostate gland that causes urination difficulty) and urinary retention. Brief Interview for Mental Status (BIMS) reflected a score of 4 out of 15 which indicated R46 was severely impaired (0-7 severe impairment). During initial screening on 6/11/2024 at 9:40 AM, it was observed that R46 had an indwelling medical device (catheter) and didn't have an enhanced barrier precaution sign posted outside his door or personal protective equipment (PPE) available. (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 R46's chart revealed the following physician order Monitor foley cath (catheter) 16F (French size) with 10cc (volume) balloon to dependent drainage every shift for urinary retention. And Foley cath care and check to see cath in secure every shift for urinary retention. Review of R46's care plan revealed, Resident has a need for an indwelling catheter (16F, inflate balloon 10 ml (milliliters)) related to BPH and urinary retention, bladder calculus (bladder stone in urinary bladder), frequent UTIs (urinary tract infections). Resident requires enhanced barrier precautions related to urinary catheter. Under Interventions, Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis). Resident #57 (R57) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R57's admitted was on 11/5/2022 with diagnoses of neurogenic bladder, neuromuscular dysfunction of the bladder and chronic respiratory failure with hypoxia (low oxygen). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R57 was cognitively intact (13-15 cognitively intact). During initial screening on 6/11/2024 at 10:12 AM, it was observed that R57 had an indwelling medical device (catheter) and didn't have an enhanced barrier precaution sign posted outside her door or personal protective equipment (PPE). Review of R57's chart revealed the following physician order Change indwelling Foley catheter 14 fr (French size); balloon:10cc r/t (related to) neuromuscular dysfunction of bladder PRN (as needed) as clinically indicated: s/s (signs/symptoms) of obstruction (leakage, increased sediment, etc.), infection, or if closed system was compromised. Change catheter drainage bag as needed. And Use enhanced barriers while performing high-contact activity with the resident every shift for urinary catheter. Another order related to the CPAP, Wash C-pap straps and hand to dry in the morning every Fri (Friday). And Remove C-pap and rinse out mask in the morning due to chronic respiratory failure with hypoxia. Review of R57's care plan revealed, Resident has a need for an indwelling catheter related to neurogenic bladder and neuromuscular dysfunction of the bladder. Also, Resident requires enhanced barrier precautions related to urinary catheter. Under Interventions, Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis). During an interview on 6/11/2024 at 10:12 AM, in R57's room, it was observed she had a CPAP machine, mask and tubing without any barrier or stored in a plastic bag on her bedside table. R57 stated her CPAP wasn't cleaned in a long time. R57 was also observed to have an indwelling catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2024 at 1:52 PM, R57 stated staff don't wear gowns when providing care and she said they only wear gloves sometimes. Resident #48 (R48) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R48's admitted was on 7/19/2023 with diagnoses of obstructive sleep apnea and shortness of breath. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R48 was cognitively intact (13-15 cognitively intact). Review of R48's chart revealed the following physician order, Wash C-pap straps and hand to dry in the morning every Mon (Monday). And Remove C-pap and rinse out mask in the morning due to obstructive sleep apnea. During an interview on 6/11/2024 at 9:43 PM, in R48's room, it was observed that the CPAP machine, mask and tubing were on his bedside table and without a barrier and it wasn't put in a plastic bag. R48 stated that it was always laying on the bedside table during the day. During another observation on 6/12/2024 at1:54 PM, in R48's room, it was observed that the CPAP machine, mask and tubing were on his bedside table and without a barrier and it wasn't put in a plastic bag. During an interview on 6/11/2024 at 12:30 PM, Registered Nurse (RN) AA stated EBP is used when a resident has any indwelling device such as a PEG tube (percutaneous endoscopic tube for nutrition) and catheter and the staff should gown up when giving care. RN AA stated that R46 and R57 should both have EBP signs outside their room since they have catheters and she didn't know why they didn't have signs. She stated she would get a sign up outside their rooms. RN AA also stated that she thought Certified Nursing Assistants (CNAs) were responsible for cleaning CPAP machines and tubing. She also said, CPAP cleaning uses sterile water. During an interview on 6/12/2024, CNA F stated she doesn't do anything with the cleaning of CPAP machines, masks, or tubing. CNA F said nurses should be taking care of CPAP machines and tubing not CNAs. During an interview on 6/12/2024 at 1:28 PM, Director of Nursing (DON) B stated residents with open sores, central lines and ports should be on EBP, signs should be posted outside the door and the resident's name plate is colored green with a green highlighter. When discussing CPAP machines and tubing, DON 'B said CPAP masks and tubing should be cleaned by nurses after each use in the morning when it's taken off. During an interview on 6/13/2024, Licensed Practical Nurse (LPN) BB stated the CPAP process should be that it should be cleaned and rinsed every morning when it's taken off and that she wasn't sure who was responsible to do it but she does it on her shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/2024 at 10:02 AM, Infection Preventionist (IP) DD and DON B stated a resident should be on EBP when they have a feeding tube, catheter, IV (intravenous) access and wounds. IP DD said that gowns and gloves should be used for direct care. DON B stated that the resident name should be highlighted green, a EBP sign should be posted outside the door and a cart with PPE should be outside the room for staff to put on PPE before entering resident's room. IP DD and DON B were notified of D-Hall residents not having appropriate EBP signs outside of their door. When asked when the last EBP education was done DON B stated that it has been about 1-2 months when the last IP was there. DON B said that staff needs reeducation on EBP procedures. DON B also stated that each cart should have a bottle of sanitizer on it. DON B said the last education on CPAP cleaning and care was done about 6 months ago. 38384 R49 According to the Minimum Data Set (MDS) dated [DATE], R49 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), had an impairment on left side of his upper and lower body, was dependent on staff for ADLs (activities of daily living) which included toileting, bathing, and transfers. He was incontinent of bowel and bladder. Diagnoses included cancer, diabetes, stroke, dementia, and partial paralysis. Further review of R49's MDS included Section M-Skin Conditions indicating the resident was at risk for developing a pressure ulcer and had in fact had developed a stage 3 pressure ulcer. Enhanced Barrier Precautions (EBP)/ Wound Dressing Change Review of R49's Order Summary dated 4/11/2024 revealed, Use Enhanced Barriers while performing high-contact activity with the resident every shift for pressure ulcer. Review of R49's MAR/TAR dated 6/1/2024-6/30/14 indicated RN S documented he had documented in agreement with Use enhanced barriers while performing high-contact activity with the resident every shift for pressure ulcer (start dated 4/11/2024). Review of R49's Care Plan, dated 4/11/2024, indicated a Focus of Enhanced Barrier Precautions related to pressure ulcer. The goal was for the resident to have reduced risk of acquiring an infection with interventions that included Utilize Enhanced Barrier Precautions when providing high contact resident care activities . wound care .use gown and gloves when providing direct care . During an interview on 6/12/24 at 8:17 AM, Registered Nurse/Wound Nurse (RN) X stated, There is no wound doctor that comes in. Between myself, the doctor and two nurse practitioners, we follow the residents with wounds. (R49) has a stage 3 wound identified on his left lateral knee. The other wound is on the left leg above his ankle. Observed on 6/12/2024 at 1:00 PM, Enhanced Barrier Precautions signage including the direction CDC (Centers for Disease Control) guidance of wearing gown and gloves when performing direct care for residents with wound care. (continued on next page)

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	235542	A. Building B. Wing	06/13/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/12/24 at 1:00 PM, RN S gathered supplies to change wound dressings for R49's left popliteal fossa (behind left knee) and anterior left lower calf and entered the resident's room. -RN laid supplies on top of resident's blankets at the foot of the bed without a barrier. -No garbage can was placed within reach of the RN. - No barrier was placed underneath either wound. -RN used green handled scissors to remove gauze around knee then placed them on the bed sheets and removed a small square dressing directly touching the wound that was seeping serosanguinous drainage. RN laid the soiled dressing directly on the resident's bottom sheet then picked it and held onto it in right hand. -The would appeared to be smaller than a quarter in size with a scab that had sloughed off leaving a red wound that was had serosanguinous drainage. -With a soiled gauze in hand, the RN cleaned the wound with wound cleaner. -RN placed the small gauze and gauze used for cleaning the wound on the bed. Both were soiled with serosanguinous drainage that left a drop of the drainage on resident's sheet. -RN placed clean small gauze over wound then wrapped with kerlix using the unclean scissors to cut it to length. -RN placed contaminated scissors on resident's blanket at foot of bed. -RN then went to the left lower calf and used the contaminated scissors to cut off the kerlix then placed them back on the blanket at the end of bed. -RN removed dressing from lower calf wound that presented draining serosanguinous drainage, then removed the gauze immediately covering the wound which was soiled with the drainage. -Without changing gloves, the RN cleaned the wound, applied ointment, covered it with a square of gauze and then wrapped it with kerlix. The RN used the contaminated scissors to cut to length. -RN gathered soiled dressings and placed in garbage. Then gathered supplies and placed them in the wound treatment cart. -Without changing resident's bottom sheet that had come into contact with soiled dressing, the RN smoothed a sheet over the resident's legs and left the room. During an interview on 6/13/24 at 2:30 PM, RN S stated, I know (R49) is on Enhanced Barrier Precautions. When doing direct care or treatments a gown and gloves need to be worn. I did not wear a gown when doing the dressing change. I have had infection control training at nursing school and here at the facility, but I do not remember when. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R65 According to the MDS dated [DATE], R65 scored 10/15 (moderately cognitively impaired) on his BIMS. Section K-Swallowing/Nutrition Status indicated the resident had difficulty swallowing and required a feeding tube. His diagnoses included partial paralysis related to stroke. Nebulizer Review of R65's Order Summary dated 2/14/24, indicated the resident was receiving nebulizer (breathing treatment machine) treatments two times a day. Review of R65's MAR/TAR dated 6/1/24-6/30/24, indicated the resident received the nebulizer treatment at 6:00 AM 6/12/24 and 6/13/24. Observed on 6/11/24 at 11:45 AM, R65's nebulizer machine and mask that was not attached to tubing were laying on the windowsill. The machine and mask were covered with splatters of clear liquid and dust. Observed on 6/12/24 at 11:15 AM, R65's nebulizer machine and mask were not attached to tubing and were laying on the windowsill. The machine and mask were covered with splatters of clear liquid and dust. Observed on 6/13/24 at 8:50 AM, R65's nebulizer machine and mask were not attached to tubing, were laying on the windowsill. The machine and mask were covered with splatters of clear liquid, fuzz, and dust and completely covered by a fleece blanket. EBP/Enteral (Tube) Feeding Review of R65's Order Summary dated 4/14/2023 indicated the resident was to receive enteral feeding every 6 hours via a G-tube (gastrostomy tube/PEG (feeding tube)). Review of R65's Care Plan, dated Observed on 6/11/24 at 10:20 AM, R65 had an Enhanced Barrier Precautions (EBP) sign outside his room next to his door. His name on the plaque also outside his door was not highlighted in any color. The EBP CDE guidelines (Centers for Disease Control) indicated PPE (Personal Protection Equipment) of gown and gloves must be work while performing direct care with a resident in the room. During an interview and record review on 06/11/24 10:22 AM, RN R stated, I have (R65) on my assignment. I saw he was on Enhanced Barrier Precautions, but I do not know why. Reviewed resident's MDS provided by the facility [NAME]. RN stated, I did not know he had shingles. (continued on next page)

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	235542	A. Building B. Wing	06/13/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/11/24 at 11:45 AM, R65 was in his bed with shirt pulled up. There was no dressing at PEG (feeding tube) insertion site. A bottle of enteral feeding was hung on an IV pole to the right of the resident's head. The feeding was not running. A bag of clear liquid flush was hanging next to it. The tubing was wrapped back up on the IV pole with no end cap and a dribble of feeding was dried on the end. The feeding pump was sitting on a bedside table next to the IV pole. The table and pump were covered with splatters of tan substance resembling tube feeding. The IV pole was also covered with splatters of tan substance resembling tube feeding as was base of pole along with dirt, dust, debris on it and the floor. During an observation on 6/12/24 at 9:55 AM, R65 was in bed with an IV pole next to the right side of him along with an enteral feeding pump on a bedside table. A bottle of enteral feeding was hung on the IV pole but not running. The tubing was hung over the top of the bottle with no end cap. During an observation on 6/12/24 at 11:15 AM, R65 was sitting in a high-backed chair in his room. Behind the resident was an IV pole with tube feeding hung. The tubing was running into a feeding pump on a bedside table with the end of the tubing lying on the floor without an end cap. The IV pole, base of the pole, and feeding pump were covered with dried tan substance resembling tube feeding. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. Observed on 6/12/24 at 12:30 PM R65's tube feeding tubing on floor with no end cap. The IV pole and its base had splatters of the same substance. The base had dirt, dust, and debris on it. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. Observed on 6/12/24 at 1:15 PM R65's tube feeding tubing on floor with no end cap. IV pole and pump splattered with tan substance. The IV pole and its base had splatters of the same substance. The base had dirt, dust, and debris on it. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. During an interview on 6/13/24 at 8:41 AM, ICP DD stated, I am the Infection Control Preventionist, scheduler, Unit Manager, and Staff Education. During dressing change a barrier should be put under the wound in case there is drainage which you do not want contaminating bed linens. The same for supplies; they need to be placed on a barrier to. A garbage can should be close to the nurse doing the dressing change to put soiled dressings and not contaminate the clean field. Scissors should be cleaned after each use so they do not contaminate other areas. Infection can spread this way. There have been no audits done on wound care. All staff have been educated on infection control practices in the last 2 months plus they learn this in nursing school. If a soiled dressing touches the bed, staff should change the bedding. When a resident is on EBP for any kind of direct care PPE of gown and glove must be worn. IV poles, bases, and pumps should be cleaned each time something is dripped on them to prevent the spread of infection. The end of a tube feeding line should have an end cap so contaminates do not travel in the line to the resident. The end of the line should be kept sterile. If the tubing is on the floor or no end cap is on it the entire system should be changed. Observed on 6/13/24 at 8:50 AM R65's tube feeding pump had splatters of tan substance resembling tube feeding all over it. The IV pole and its base had splatters of the same substance. The base had dirt, dust, and debris on it. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. The tubing laid on the floor with no end cap. A drop of feeding was dribbling out onto the floor. (continued on next page)

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	235542	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Westwood	2575 N Drake Road Kalamazoo, MI 49006

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 at 9:35 AM, DON B stated, When staff enter a resident room to perform direct care that has Enhanced Barrier Precautions (EBP) signage and orders for EBP, they should be wearing PPE including gown and gloves. The resident's name on the name plaque should be highlighted in green. Observed R141's name at doorway not highlighted in green. DON B indicated it should have been done to alert staff. DON B stated, A PICC (, central line, catheter, and PEG should all be on EBP. All licensed staff have received infection control training/education within the last 2 months. Observed on 6/13/24 at 1:20 PM, R65's tube feeding tubing was connected to the feeding bottle that was hanging on the IV pole. The tubing ran through the pump and was lying on the floor. The tubing was not dated and there was no end cap. A drop of feeding had dribbled out of the end onto the floor. The pump, IV pole, and base had splatters of a tan dried substance on them. The base had dirt, dust, and debris on it. Observed on 6/13/24 at 2:10 PM R65's tube feeding tubing was connected to his PEG. A new dressing at site dated 6/12. No tubing was in any of the three garbage cans. The feeding pump, IV pole and base had splatters of tan substance that resembled tube feeding. The base had dirt, dust, and debris on it. During an interview on 6/13/24 at 2:12 PM, RN S stated, I connected (R65's) feeding tube just a few minutes ago. I used the tubing that was connected to the tube feeding. I guess I picked the tubing up off the floor and did not change it. I did not need to change the tubing because it was done last night. It did not have an end cap on it. During an interview on 6/13/24 at 2:30 PM, RN S stated, I know (R49) is on Enhanced Barrier Precautions. When doing direct care or treatments a gown and gloves need to be worn. I did not wear a gown when doing the dressing change at PEG site or hooking up the tubing. I have had infection control training. R141 According to R141's Admission Record, he had been recently admitted on [DATE] with diagnoses that included cellulitis of right hand and severe sepsis. Further review of R141's medical record revealed a MDS with a BIMS had not been completed. It was noted during observations and interviews with the resident he was focused on conversation and able to communicate verbally with clear and concise verbalization. Resident Equipment/PICC (Peripherally Inserted Central Catheter) Review of R141's Care Plan, Peripherally Inserted Central Catheter (PICC) line, related to cellulitis, dated 6/6/24, include the goal of the resident having no signs/symptoms of IV related complications (e.g., (such as) infection, pain, redness, swelling, drainage, fever, etc. Interventions to meet this goal included IV catheter care and maintenance. Review of R141's Progress Note 6/5/24 at 22:11 (11:11 PM), Nursing Evaluation Summary indicated the resident had an IV (intravenous line) in his upper right arm. (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 R141's Order Summary indicated he received an antibiotic solution every shift to the right upper limb. Observed on 6/11/24 at 11:35 AM, R141 was in bed with a bandage on his right hand. An IV pole was to his right side. The pole, base, and IV pump had splatters of dried tan, white, and dark brown substances. A PICC line was observed in his upper right arm. During an observation and interview on 6/12/24 at 8:56 AM, R141 stated, I had an operation on my right hand and had 15 stitches which they removed yesterday. I am on IV antibiotics, and the staff is late today with it. Observed an IV pole with splatters of tan substance resembling tube feeding which the resident does not receive. An empty, undated/unlabeled IV bag of antibiotic was hung on the pole. Tubing hanging from antibiotic bag was not labeled or dated. The end of the tubing was touching the floor without an end cap. The IV pump had splatters of tan substance resembling tube feeding as well. Observed on 6/13/24 at 9:35 AM, R141 was in bed with antibiotic running via a pump through a tube into a PICC in his upper right arm. The pump was attached to an IV pole. The IV bag of antibiotics was not dated or labeled. The IV pole, base, and pump had splatters of tan, white, and brown substances. The base of the IV pole had accumulation of dust, dirt, and debris. Resident Equipment/Wheelchair Observed on 6/11/24 at 11:35 AM, 6/12/24 at 8:56 AM, and 6/13/24 at 9:35 AM, R141's wheelchair area where the foot pedals attached to the frame of wheelchair, left brake handle, and exposed screws on the seat frame wrapped with a non-cleanable kerlix (stretchable wound wrap). On the frame of the wheelchair, seat, and arm rests were splatters of various dried substances along with dirt, dust, and debris. R43 According to R43's MDS dated [DATE], the resident scored 15/15 (cognitivey intact) on his BIMS and required the use of a wheelchair for ambulation related to the amputation of his right leg. During an observation on 6/11/24 at 11:40 AM, R43 was in the hall using his wheelchair, the push ring had black tape wrapped around it that was frayed and falling apart. During an observation on 6/12/24 at 8:47 AM, R43 was in his room sitting in his wheelchair. The push ring had black tape wrapped around it was frayed and falling apart. During an observation and interview on 6/13/24 at 8:55 AM R43 was in his room sitting in his wheelchair. The push ring had black tape wrapped around it and was frayed, falling apart with rough edges. R43 stated, I got this wheelchair from another resident. He had this tape on it. It is sharp sometimes where it is peeling off. Staff are to clean it at least weekly, and they should know that it is falling apart. During an interview on 6/13/24 at 9:35 AM, Director of Nursing (DON) B stated, There should be no bandage wrap on (R141's) wheelchair for infection control because it is a non-cleanable surface. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/13/24 at 1:50 PM, Nursing Home Administrator (NHA) A reported during QAPI meeting, Infection control practices should be monitored with rounding, and they are tracked with rounds and infection rates. The ICP and DON B are responsible for monitoring. 41027 Resident #15 During an observation on 06/11/24 at 12:32 PM Enhanced Barrier Precautions signage was on the wall outside of Resident #15's room and his name was highlighted on the name plate. There was a cart located a few rooms down the hallway that contained the necessary PPE. Review of Resident #15's Physician Orders revealed, no orders for Enhanced Barrier Precautions. Review of Resident #15's Physician Orders revealed, Left trochanter (hip) wound: cleanse with wound wash, pat dry, apply collagen (aids in healing) in undermined area, then apply thin coat of triad cream (skin protectant) on base of wound, cover with bordered dressing daily and PRN (as needed) if soiled or missing. Order/Start date 6/9/24. Review of Resident #15's Physician Orders revealed, Left heel: cleanse with wound wash, pat dry, apply Santyl (removes damaged tissue and aids in healing) to slough (dead skin cells), cover with collagen pad, secure with ABD (thick cotton) pad, foam and stretchy kerlix (wrap), daily PRN application along with floating heel while in bed all times as tolerated. Every evening shift for left heel wound. Order/Start date 6/9/24. During an observation and interview on 06/12/24 at 12:15 PM in the hall outside of Resident #15's room and in his room, Registered Nurse (RN) S, DON B and Certified Nursing Assistant (CNA) PP were preparing to transfer the resident from his chair to bed, using the mechanical hoyer lift. Staff were wearing gloves, but did not don gowns. All 3 staff were physically involved in the transfer as it was difficult to maneuver Resident #15 out of his chair, through the doorway and then into his bed. RN S detached Resident #15's incontinence brief to visualize his wound dressing and also removed the resident's sock. During an observation on 06/12/24 at 02:00 PM in Resident #15's room along with Wound Nurse (WN) X to complete wound care and dressing changes. Enhanced Barrier Precautions signage was observed posted outside of Resident #15's room. WN X donned gloves, but did not don a gown. WN X removed the dressing from Resident #15's left hip that was dated June 7th, which revealed a deep wound with black crusting covering the wound. At 2:17 PM WN X removed the dressing dated June 7th from Resident #15's left heel, which revealed multiple small areas of open skin, and a dried piece of collagen. In an interview on 06/12/24 at 02:38 PM, WM X reported that he did not know what Enhanced Barrier Precautions meant, and/or why there were signs posted outside of several resident's rooms. In an interview on 06/12/24 at 02:40 PM, CNA PP reported that a gown was not needed to perform transfers for someone that was on enhanced barrier precautions and stated, .only when you are working with their catheter or wounds . Resident #65 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 06/12/24 at 01:44 PM RN S was observed entering Resident #65's room, that had signage indicating Enhanced Barrier Precautions, and was carrying peroxide and gauze. In a subsequent interview on 06/12/24 at 01:48 PM, RN S reported that he had cleaned up Resident #65's peg tube (feeding tube in stomach), because there was some drainage around it and stated, .I was in a hurry, but with enhanced barrier precautions I should have worn a gown . 47955 Resident #83 Review of an Admission Record revealed Resident #83 had pertinent diagnoses which included: bladder-neck obstruction (a blockage that does not allow urine to flow from the body), urinary tract infection, cognitive communication deficit. Review of a Minimum Data Set (MDS) assessment for Resident #83, with a reference date of 3/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #83 was severely cognitively impaired. On 6/12/24 at 11:35 AM., an observation of signage posted outside of Resident #83's room indicated enhanced barrier precautions, per Centers for Disease Control and Prevention (CDC), should be used by staff when providing care. The signage revealed .everyone must clean their hands including before entering and when leaving the room . provider and staff must also wear gloves and gowns for the following high-contact resident care activities .device care or use: . urinary catheter . During an observation on 6/12/24 at 11:37 AM., Registered Nurse (RN) S entered Resident #83's room to change Resident #83's catheter drainage bag (a bag that collects urine from a catheter) due to leakage. RN S entered Resident #83's room carrying an unopened packaged urinary drainage bag. RN S closed the door to the room and applied gloves. Resident #83 placed drainage bag into the garbage can. RN S opened the packaging of the new catheter drainage bag, removed the end cap, pinched the catheter that was inserted into Resident #83's body, disconnected the leaking drainage bag and dropped the tubing into the garbage can. RN S then connected the new catheter drainage bag to the catheter inserted into Resident #83's body. RN S then removed his gloves, gathered the garbage bag containing the discard urinary drainage bag and exited the room. At no time did RN S perform hand hygiene, nor did RN S apply personal protective equipment (to include gown [TRUNCATED]