

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235542	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Medilodge of Westwood		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>41982</p> <p>This citation pertains to intake: MI00147428.</p> <p>Based on interview and record review, the facility failed to take prompt action to resolve resident concerns of lengthy call light wait times in 3 (Resident #107, #106, and #101) of 3 residents reviewed for concern resolution, resulting in dissatisfaction with call light response and the potential for feelings of frustration as well as the potential for additional care concerns to go unaddressed.</p> <p>Findings include:</p> <p>Review of Resident Council Minutes for 7/18/24 meeting revealed concern with long call light response on 2nd shift and on all shifts on the weekends. There was no indication in the documentation that any follow up occurred.</p> <p>Review of Resident Council Minutes for 10/24/24 meeting revealed concern with call lights not being answered. The Plan/Action was continue to audit.</p> <p>Review of Resident Council Minutes for 1/15/25 meeting revealed contineud concern with long call light response on 2nd and 3rd shifts. There was no indication in the documentation that any follow up occurred.</p> <p>Resident #107</p> <p>Review of an Admission Record revealed Resident #107 was a female, with pertinent diagnoses which included: bipolar II disorder.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 1/12/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #107 was cognitively intact.</p> <p>In an interview on 2/18/25 at 9:20 AM, Resident #107 reported she has waited an hour for her call light to be answered. Resident #107 reported this has happened a couple times a week.</p> <p>Resident #106</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Admission Record revealed Resident #106 was a female, with pertinent diagnoses which included: muscle wasting, generalized.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 12/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #106 was cognitively intact.</p> <p>In an interview on 2/18/25 at 9:43 AM, Resident #106 reported there was no way to tell how long it would take for staff to answer her call light and that, at times, it has taken 30 minutes. Resident #106 reported longer wait times occurred late at night and early morning.</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included: multiple sclerosis (a disease that causes damage to the protective covering of the nerves resulting in symptoms including muscle weakness and numbness).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 11/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact.</p> <p>In an interview on 2/18/25 at 10:34 AM, Resident #101 reported call light wait times depended on whether there was 1 CNA (Certified Nurse Aide) or 2 CNAs working on the hall. Resident #101 reported when there was 1 CNA working the hall, it takes a while for her call light to be answered.</p> <p>In an interview on 2/19/25 at 8:54 AM, CNA J reported residents had complained to her about long call light wait times. CNA J reported longer call light wait times usually happened when there was only 1 CNA on the hall because the other CNA working the hall was on their break.</p> <p>In an interview on 2/19/25 at 9:59 AM, CNA F reported sometimes residents did have to wait a long time for their call light to be answered if staffing was running short that day. CNA F reported she had seen call lights sit on (meaning unanswered) for quite a long time.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982</p> <p>This citation pertains to Intakes: MI00147677 and MI00149818.</p> <p>Based on interview and record review, the facility failed to ensure the safety and 1.) fully implement a documented intervention of 1:1 supervision to prevent a fall for 1 (Resident #102) resident and 2.) ensure an enabler (grab) bar was securely engaged before moving a resident in bed for 1 (Resident #103) resident of 3 residents reviewed for accidents/hazards/falls, resulting in a preventable fall with a head injury for Resident #102 and a preventable fall with a skin tear for Resident #103.</p> <p>Findings include:</p> <p>Resident #102</p> <p>Review of an Admission Record revealed Resident #102 was a female, with pertinent diagnoses which included: Alzheimer's disease, unspecified (a form of dementia), muscle weakness (generalized), and repeated falls.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/18/24 revealed a Staff Assessment for Mental Status assessment that Resident #102 was Moderately impaired for cognitive skills for daily decision making.</p> <p>Review of Resident #102's Incident Report dated 6/2/24 revealed, Incident Description Nursing Description: Nurse found resident on the floor of C hall. Resident was self transferring down the hall without her walker . Resident Description: I was walking and tripped over my own feet. I fell on my right arm and then right leg .</p> <p>Review of Resident #102's IDT Interdisciplinary Progress Note dated 6/3/24 at 10:56 AM revealed, Note Text: IDT review of resident fall on 6/2/24. Resident found on floor, VS (vital signs) and ROM (range of motion) assessed, resident sent to ER (emergency room) for evaluation of pain in right upper and lower extremity. Immediate intervention of added 1:1 (one on one supervision) when resident returns from ER due to fall risk and resident is uncooperative with use of walker.</p> <p>Review of Resident #102's Incident Report dated 6/7/24 revealed, resident was walking out of her room towards the nursing station, she stumbled over her own feet looking dizzy, then fell on to her right side hitting her hip, shoulder then head. immediately after the fall she was unresponsive for 6 min (minutes), breathing normally .Immediate Action Taken Description: called 911, placed into spinal precautions and laid resident on back as directed by 911 dispatch .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a statement dated 6/7/24 by Certified Nurse Aide (CNA) E (the staff assigned to provide 1:1 supervision for Resident #102 at the time of the fall) revealed, At approximately 3:30 p.m. (Resident #102) was in her bed watching T.V. Went to let her nurse know that her brace on the L (Left) leg was taken off and roommate needed something for pain. When I returned to room, she was on the floor in the hall. She landed on her R (right) side sorning (sic). Vital (sic) were taken lot of movement on L side. She was communicating with staff EMS (Emergency Medical Services) was called .Additional Questions: 1. Do you know that you should never leave a 1:1? Answer: I know I should never leave a 1:1 .</p> <p>In an interview on 2/19/25 at 2:16 PM, CNA E reported she had been the staff providing the 1:1 supervision for Resident #102 at the time of the fall on 6/7/24. CNA E reported Resident #102 had been complaining about the brace on her leg and wanted to take it off. CNA E reported the other resident in the room needed assistance and she (CNA E) had gone to find somebody to assist the other resident and to look at Resident #102's brace. CNA E reported as soon as she walked out of the room, Resident #102 was on the floor.</p> <p>Review of Resident #102's Emergency Department report dated 6/7/24 at 4:28 PM revealed, HPI (history of present illness) .Patient is an [AGE] year-old female presents from (Facility Name) with concerns for a ground-level fall today with loss of consciousness and subsequent altered mental status .Patient is anticoagulated on Eliquis .</p> <p>Review of a Radiology CT (a form of imaging that uses x-rays) Trauma Brain Without Contrast report from (hospital name omitted) for Resident #102 signed on 6/7/24 at 6:62 PM revealed, Final Result 1. Acute focal hematoma (blood clot) in the right middle cranial fossa (a depression in the inner surface of the skull that houses the brain)/right anterior temporal lobe (a part of the brain on the sides of the head) measuring up to 0.8 cm (centimeters) .2. Additional focal hematomas in the right [NAME] (a part of the brain stem) measuring up to 0.5 cm .4. Moderate to large right-sided scalp hematoma (bruise) and soft tissue swelling .</p> <p>In an interview on 2/19/25 at 10:57 AM, Regional Nurse Consultant (RNC) G reported Resident #102 had been on 1:1 supervision on 6/7/24 at the time of her fall because she was a fall risk. RNC G reported a 1:1 supervision entails that the CNA should be sitting at the bedside with the resident watching for the resident to get up or try to walk and to walk with the resident if the resident chose to do so. RNC G reported the resident fell because the CNA had turned her back and was not watching the resident at the time of the fall.</p> <p>Resident #103</p> <p>Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included: morbid (severe) obesity due to excess calories, pain in right knee, and gout (a form of arthritis resulting in severe pain and swelling in the joints).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 11/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #103 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #103's Incident Report dated 12/3/24 revealed, Incident Description Nursing Description: CNA (Certified Nurse Aide) was in room performing AM (morning) care, resident rolled to the right, grab bar was not locked in place, as the resident rolled he grabbed the bar and it moved causing resident to roll out of bed, resident was laying prone (lying face-down on the stomach). Resident Description: I just rolled out of bed and banged up my elbow .Immediate Action Taken Description: resident was assessed for injury, found skin tear on right forearm .</p> <p>In an interview on 2/13/25 at 11:47 AM, Resident #103 reported a CNA was giving him a bed bath and when she told him to roll over, he rolled out of bed and onto the floor. Resident #103 reported when he fell , he had blood all over his elbow and a lot of black and blue marks on his shoulder.</p> <p>In an interview on 2/18/25 at 1:43 PM, Nursing Home Administrator (NHA) A reported Resident #103 had fallen out of bed on 12/3/24 because one of the enabler bars on the side of Resident #103's bed wasn't latched properly and had moved when he rolled over.</p> <p>In an interview on 2/19/25 at 9:59 AM, CNA F reported she was the staff member giving Resident #103 a bed bath when he fell out of bed on 12/3/24. CNA F reported Resident #103 was turning toward the door and the enabler bar was not properly engaged. CNA F reported when Resident #103 went to grab the bar, the bar went flying in the opposite direction and he fell on to the floor.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>41982</p> <p>This citation pertains to intake MI00147428.</p> <p>Based on interview and record review, the facility failed to provide food products at a palatable temperature for 2 (Resident #106 and Resident #101) of 3 residents reviewed for food, resulting in dissatisfaction with meals and the potential for nutritional decline.</p> <p>Findings include:</p> <p>Resident #106</p> <p>Review of an Admission Record revealed Resident #106 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) with diabetic nephropathy (diabetic kidney disease) and long term (current) use of insulin.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 12/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #106 was cognitively intact.</p> <p>In an interview on 2/18/25 at 9:43 AM, Resident #106 reported the food was hardly ever hot enough and that the residents deserved to have a decent meal.</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included: type 2 diabetes mellitus.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 11/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact.</p> <p>In an interview on 2/18/25 at 10:34 AM, Resident #101 reported the food was not always hot enough with breakfast being the worst for temperatures.</p> <p>In an interview on 2/19/25 at 8:29 AM, Certified Nurse Aide (CNA) K reported residents had complained to her that the food was not hot enough.</p> <p>In an interview on 2/19/25 at 8:54 AM, CNA J reported residents have complained that the food served was cold.</p> <p>In an interview on 2/19/25 at 8:59 AM, Registered Nurse (RN) N reported the residents have complained about the food temperature not being hot enough when the food was served.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/19/25 at 9:59 AM, CNA F reported residents have complained that their food was served cold.</p> <p>In an interview on 2/19/25 at 1:02 PM, CNA D reported residents complain that their food was not hot enough.</p> <p>In an interview on 2/19/25 at 2:16 PM, CNA E reported residents complain that food was cold when it was served to them.</p> <p>Review of the Temperature Logs revealed that temperature was taken for 2/16/25 with no concerns. No documented temps for 2/17/25. No documented temps for breakfast or lunch on 2/18/25.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>41982</p> <p>This citation pertains to intake MI00147428.</p> <p>Based on interview and record review, the facility failed to ensure residents received requested food items for 2 (Resident #106 and Resident #101) of 3 residents reviewed for food, resulting in dissatisfaction with meals and the potential for nutritional decline.</p> <p>Findings include:</p> <p>Resident #106</p> <p>Review of an Admission Record revealed Resident #106 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) with diabetic nephropathy (diabetic kidney disease) and long term (current) use of insulin.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 12/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #106 was cognitively intact.</p> <p>In an interview on 2/18/25 at 9:43 AM, Resident #106 reported she often did not receive what she ordered on her meal tray. Resident #106 reported this morning for breakfast she was supposed to get 2 eggs and 2 pieces of toast, but she got 1 egg and 1 piece of toast. Resident #106 reported she had to ask for her second egg and that they never did bring her second piece of toast. Resident #106 reported she didn't eat pork or shellfish so when they had those items on the menu, the kitchen gave her substituted items that she didn't want and hadn't ordered instead of giving her what she had previously asked for (a chef salad or chicken noodle soup) because they never wrote it down. Resident #106 reported it was frustrating.</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101 was a female, with pertinent diagnoses which included: type 2 diabetes mellitus.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 11/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact.</p> <p>In an interview on 2/18/25 at 10:34 AM, Resident #101 reported she did not always get what she ordered for her meals. Resident #101 gave the example of the previous evening and that she had just wanted some cottage cheese and pineapple because she had already eaten food from her family. Resident #101 reported she got pineapple, a hot dog, and coleslaw but not the cottage cheese.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/19/25 at 8:33 AM, Licensed Practical Nurse (LPN) M reported residents complained to her that they don't get what they order. LPN M reported when a resident relayed their food preferences to the nursing staff and they relayed the preference to the dietary manager, sometimes it took a few days for the preference to be updated on the tray ticket because tickets were printed in advance. LPN M reported sometimes the resident preferences didn't get communicated to the kitchen.</p> <p>In an interview on 2/19/25 at 8:54 AM, CNA J reported residents complained occasionally that they don't get what they order but that was because the kitchen didn't have it.</p> <p>In an interview on 2/19/25 at 8:59 AM, Registered Nurse (RN) N reported sometimes the residents did not receive their requested beverages, nutritional supplements, or ice cream on their meal trays.</p> <p>In an interview on 2/19/25 at 9:59 AM, CNA F reported residents have complained that they don't get what they order and when the CNA attempted to retrieve it from the kitchen, they were told they didn't have it.</p> <p>In an interview on 2/19/25 at 2:16 PM, CNA E reported the other day residents were supposed to get a grilled ham and cheese sandwich and they received a cold ham and cheese sandwich instead and that some residents ended up ordering food from local restaurants and had it delivered instead of eating the cold ham and cheese sandwich. CNA E reported residents complained about not getting what they ordered and then get frustrated that they had to wait while the CNA went back to the kitchen to get the item.</p> <p>Review of the facility Menu for February 18, 2025, revealed, DINNER Grilled Ham & Cheese Sandwich .</p>		