

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 11/24/2025
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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise a care plan in 1 of 3 residents (Resident #105) reviewed for comprehensive care plans and accuracy of medical records, resulting in an inaccurate reflection of the resident's status and the potential for care and services to be provided that are inconsistent with the resident's needs. Findings include: Resident #105 Review of an admission Record revealed Resident #105 was a female, with pertinent diagnoses which included dementia, intellectual disability, high blood pressure, heart failure, epilepsy (a seizure disorder), anxiety, muscle weakness, and reduced mobility. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 9/5/25, revealed she had severe cognitive impairment. No history of falls noted since the prior assessment. Review of a current Care Plan (accessed 10/29/25) for Resident #105 revealed the focus . Resident is at risk for falls/injury related to history of falls, pain, epilepsy, (atrial fibrillation - an irregular heart rhythm that results in poor blood flow), intellectual disabilities, respiratory failure, dementia and osteoarthritis . revised 10/27/23, with interventions which included . floor mat next to bed . and .scoop mattress (a mattress with raised/contoured edges that creates a concave center to prevent the user from falling out of bed) . both initiated 3/27/24. In an observation on 10/29/25 at 11:04 AM, Resident #105 was noted in bed in her room with her eyes closed. No fall mats were observed beside Resident #105's bed. Noted Resident #105 had a regular mattress. In an observation on 10/29/25 at 3:10 PM, Resident #105 was noted in bed in her room. No fall mats were observed beside Resident #105's bed. Noted Resident #105 had a regular mattress. In an observation on 10/29/25 at 3:40 PM, Resident #105 was noted in bed in her room. No fall mats were observed beside Resident #105's bed. Noted Resident #105 had a regular mattress. In an observation on 10/30/25 at 8:21 AM, Resident #105 was noted in her wheelchair in the hallway, just outside of her room. Noted Resident #105 had a regular mattress. No fall mats were observed beside Resident #105's bed, or anywhere visible in her room. In an interview on 10/30/25 at 8:52 AM, Certified Nursing Assistant (CNA) H reported Resident #105 previously had fall mats in her room that were placed along the sides of her bed (when she was in bed). CNA H reported she was unsure where the mats were at this time. CNA H reported she did not recall a scoop mattress in use for Resident #105. In an interview on 11/3/25 at 12:51 PM, Director of Nursing (DON) B reported the interventions for Resident #105 related to the fall mats and scoop mattress were put in place after a fall more than a year prior. DON B reported Resident #105 no longer required these interventions, and the decision was made to remove them from the care plan. DON B reported the care plan should be reviewed and updated quarterly, and when any changes happen.		

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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