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	03/12/2026

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 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # 2746228.Based on interview, and record review, the facility failed to ensure a safe/appropriate discharge in 1 of 3 residents (Resident #103) reviewed for discharge planning, resulting in an unsuccessful discharge to the community, resident distress, and rehospitalization.Findings include:Resident #103Review of an admission Record revealed Resident #103 was a female, with pertinent diagnoses which included left lower limb cellulitis (an infection of the deep skin layers and underlying tissue), diabetes, morbid obesity, atherosclerosis (plaque build-up resulting in hardening/narrowing of the arteries) in the left leg with gangrene (death of body tissue caused by a severe lack of blood flow or a serious bacterial infection), heart disease, high blood pressure, anemia (a lack of healthy red blood cells or hemoglobin), anxiety, and severe chronic kidney disease. Noted the resident was discharged from the facility on 2/14/26.Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 1/21/26, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact.Review of a Care Plan for Resident #103 revealed the focus .Resident plans to discharge to home . with interventions which included .Encourage resident/family/responsible party to participate in the discharge planning process .Involve specialized home care agencies and appropriate community support services as needed for safe discharge .Provide resident/family/responsible party with written instructions upon discharge to ensure a safe return to the community . all initiated 1/16/26.In an interview on 3/10/26 at 10:22 AM, Ombudsman V reported concerns related to Resident #103's discharge home on Saturday, 2/14/26. Ombudsman V reported Resident #103 called prior to the discharge and was upset because the facility was planning to discharge her home and she did not feel safe to do so. Ombudsman V reported Resident #103 verbalized that she had told several staff members that she was concerned about not being able to get into the home. Ombudsman V reported when the transport service brought Resident #103 to the home, the resident's wheelchair was too wide to fit through the door, and she could not get inside. Ombudsman V reported at that point Resident #103 was not feeling well, and was experiencing some pain, so Family Member R called for an ambulance and Resident #103 was transported to the hospital. Ombudsman V reported prior to the discharge, Family Member R attempted to pay for Resident #103 to stay a few additional days at the facility, but Director of Nursing (DON) B would not accept a personal check as payment, telling Family Member R she needed to bring in cash or a certified check. Ombudsman V reported Family Member R received a phone call while Resident #103 was in the hospital letting her know that a second-level appeal was approved and the resident could continue to stay at the nursing home.In an interview on 3/10/26 at 1:44 PM, Registered Nurse (RN) P reported she assisted RN G with Resident #103's discharge home on Saturday, 2/14/26. RN P reported RN G came to the desk, stating they needed to call DON B because R #103 was upset and crying about the upcoming discharge. RN P reported she overheard the phone call between DON B and RN G, and stated .it sounded like (DON B) had no choice (but to discharge the resident) . RN P reported she assisted Resident #103 with wheelchair mobility to the transport vehicle (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 0627 Level of Harm - Actual harm Residents Affected - Few	at the time of discharge, and stated .She was distraught .She was crying .I felt horrible . RN P reported she had concerns with Resident #103's discharge and stated .If I knew someone was going to go home without care I would not have discharged them .In an interview on 3/10/26 at 2:57 PM, RN G reported she completed Resident #103's discharge from the facility to home on Saturday, 2/14/26. RN G stated .It was planned, but I didn't know about it until I came in and saw I was the discharge nurse . RN G reported she saw Family Member R on Friday, 2/13/26, talking with DON B. RN G reported Family Member R was tearful, asking DON B how she was supposed to get a certified check after 5:00 PM on a Friday. RN G reported she spoke with Family Member R on Saturday, 2/14/26, and stated .she was clearly distraught. She said she didn't know what to do. Her daughter was supposed to come home and there was no way to get into the house . RN G reported she went to speak to Resident #103 in her room prior to the discharge and stated .She was distraught. She was crying. She couldn't take care of herself . RN G reported she .didn't feel safe . discharging Resident #103 to the home. RN G reported she called DON B to express her concerns regarding an unsafe discharge and was told that if Family Member R did not provide a certified check upfront to pay for the additional days, Resident #103 had to leave. RN G reported when the transport driver came to pick up Resident #103, she was crying and did not want to leave. RN G reported she herself refused to sign Resident #103's discharge paperwork because she felt it was inappropriate.Review of a Nurses Note for Resident #103, dated 2/14/26 at 12:26 PM, revealed .This nurse and (RN G) assist(ed) with resident discharge .(resident's) advocate and mother (Family Member R) called facility at approximately (9:03 AM) tearful and distressed related to discharge. (Family Member R) explained that she was unable to take care of resident being discharged . (Family Member R) explained that her electric wheelchair is in front of the door and (she is) unable to move it in the home which makes the resident being discharged unable to get into the home .(Family Member R) cried and stated that she cannot care for her (Resident #103) and can barely take care of herself. (Family Member R) also explained that she was told by (DON B) that she will need to pay ($1200) .(but) when the check was brought to the facility (DON B) explained to (Family Member R) that checks were not a reliable source of payment and (Family Member R) would need to bring a (cashier's) check .(RN G) approached resident with concerns that were expressed by (Family Member R) and resident was crying and distraught regarding discharge arrangements .(RN G) contacted (DON B) .related to questions regarding discharge plan. (DON B) explained .that resident has no choice (but to) discharge if money was not obtained .Resident was discharged at (12:02 PM) via (transport company name) with all belongings .resident was crying when leaving facility and stated that she was going to have to contact 911 .because she is unable to take care of herself .In an interview on 3/10/26 at 4:00 PM, Business Office Manager (BOM) J reported Resident #103 was here under a managed insurance plan, and her insurance was cut with a last covered day of 2/13/26. BOM J reported Resident #103 was issued a Notice of Medicare Non-Coverage on 2/11/26 which she appealed. BOM J reported Resident #103 had no secondary payer source. BOM J reported they explained the private pay rate for the room and offered assistance to apply for Medicaid which Resident #103 declined. BOM J reported when Resident #103's insurance appeal was rejected, the facility started working on a discharge plan. BOM J reported Resident #103 completed a .second-level appeal . which he was not aware of and found out the week after Resident #103 discharged that the second-level appeal had been approved. BOM J reported Resident #103 and Family Member R inquired about paying privately and stated .We asked for a week or two up front . BOM J reported the facility is pretty flexible with the payment method, however .We try and stay away from personal checks because those frequently bounce . BOM J reported when he came into work on Monday, 2/16/26, and learned Resident #103 had discharged he was .shocked . because that didn't appear to be the plan the Friday before (2/13/26). BOM J reported on Friday, 2/13/26, it was anticipated that Resident #103 was going to stay at the facility for an additional period of time.In an interview on 3/11/26 at 8:10 AM, RN E reported she was Resident #103's assigned nurse on Saturday, 2/14/26. RN E reported RN G completed Resident #103's (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	discharge. RN E stated Resident #103 .seemed like she was a little anxious about having the right equipment at home . RN E reported Resident #103's equipment concerns were related to a wheelchair and not being able to get into her house.In an interview on 3/11/26 at 8:26 AM, Family Member R reported concerns with Resident #103's discharge on [DATE]. Family Member R reported she spoke with DON B on 2/13/26, prior to Resident #103's discharge, and stated .I said (that) she (Resident #103) was in no condition to be discharged . (DON B) said there (was) no more they can do for her . Family Member R reported DON B told her that Resident #103 could stay for an additional three days if she paid $1200 up front. Family Member R reported she attempted to make the payment with a personal check, but DON B told her (Family Member R) that the facility would only accept a certified check. Family Member R reported she contacted her bank to confirm the money was available but was not able to get to the bank in time to get a certified check (since at that point it was Friday 2/13/26 and the bank closed in fifteen minutes). Family Member R reported she was unable to obtain a certified check and the facility .ended up sending (Resident #103) home . on Saturday 2/14/26 via a transport service. Family Member R reported when Resident #103 arrived at home, her wheelchair would not fit through the door because it was too wide. Family Member R stated .It was so cold out .I ended up calling (an ambulance) and sent her to (the hospital) .She is still in there . Family Member R reported Resident #103 had appealed the insurance decision prior to her discharge, and they found out while Resident #103 was in the hospital that the appeal had been approved. Family Member R reported Resident #103 did not feel ready to discharge home on 2/14/26 and wanted to remain in the facility.In an interview on 3/11/26 at 9:24 AM, Social Services Director Q reported Resident #103's insurance coverage ended, and a discharge was planned for 2/14/26. Social Services Director Q reported Resident #103 had a managed insurance plan, which only gave a 48-hour notice prior to the insurance ending. Social Services Director Q reported Resident #103's discharge plan had always been to return home with Family Member R. Social Services Director Q reported she ordered a wheelchair and a bedside commode for Resident #103 prior to her discharge and set up home health services. Social Services Director Q reported Resident #103 was feeling .anxious . prior to the discharge, and Family Member R was also concerned and requested to speak with BOM J about the potential to stay at the facility for a while longer. Social Services Director Q reported Resident #103 did not have a secondary payer source, so if she wanted to stay at the facility longer, she would have been private pay. Social Services Director Q reported Resident #103 and Family Member R expressed concerns prior to the discharge about not being able to get into the home, and stated .I think they really just wanted to have her stay at the facility .In an interview on 3/11/26 at 10:29 AM, Certified Nursing Assistant (CNA) O reported she worked with Resident #103 on the day of her discharge home, 2/14/26. CNA O reported Resident #103 was upset and crying about the upcoming discharge, and stated .She was saying she had nowhere to go .She was talking about a check .and that if she didn't have the money she had to leave (the facility) .She was really upset .In an interview on 3/11/26 at 10:38 AM, DON B reported Resident #103 had reached the end of her insurance-covered stay, so a discharge was planned for Saturday, 2/14/26. DON B reported she talked with Family Member R on Friday, 2/13/26, regarding Family Member R and Resident #103's concerns related to the upcoming discharge, and them wanting Resident #103 to stay at the facility for a few more days. DON B reported the facility policy is to not accept personal checks due to the risk for nonpayment. DON B reported she discussed the situation with BOM J, and they informed Family Member R of the amount of money needed for Resident #103 to remain in the facility. DON B reported Family Member R was unable to provide cash or a certified check prior to Resident #103's scheduled discharge date /time, so when transportation arrived, Resident #103 was discharged home.In an interview on 3/11/26 at 11:00 AM, Regional Director of Operations X reported he was contacted by DON B on Friday, 2/13/26 at approximately 4:10 PM, regarding Resident #103's upcoming discharge on [DATE], and her wanting to stay at the facility for a few more days. Regional Director of Operations X reported he discussed with DON B that the facility policy is to not accept personal checks for room and board. Regional (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Director of Operations X stated the facility accepts debit card, credit card, cash, or certified check for payment. Regional Director of Operations X reported if a resident has a discharge location, and the discharge was pre-planned, they would be required to either pay ahead of time to remain in the facility, or discharge.In an interview on 3/12/26 at 10:28 AM, Therapy Director Y reported on the last day of Resident #103's physical therapy, Family Member R reported a concern about Resident #103 being able to enter the home. Therapy Director Y reported Resident #103 and Family Member R wanted Resident #103 to remain in the facility for a few more days so they had more time to prepare for her discharge, and stated .They vocalized that loud and clear . Therapy Director Y reported DON B and BOM J were aware of Family Member R and Resident #103's concerns, and DON B told her (Therapy Director Y) that the facility had made arrangements for someone to bring Resident #103 into the house.Review of a Physical Therapy Treatment Encounter Note for Resident #103, dated 2/13/26, revealed .Pt (patient) up on w/c (wheelchair), very (emotional), stating I cannot go home, I cannot get into the house .Much consoling provided .requesting to please ask nursing and BOM to allow her to pay to stay until (Tuesday) .DON and BOM were notified about this request .In an interview on 3/12/26 at 11:05 AM, Transport Driver AA reported he picked up Resident #103 with a transport van and took her home when she discharged from the facility on 2/14/26. Transport Driver AA stated .When we got to the door (of the home) I couldn't get her chair through the door. It was too wide . Transport Driver AA reported Resident #103 became upset and started complaining of pain in her arm and in her chest. Transport Driver AA reported Family Member R called an ambulance at that point, and they arrived within ten minutes to take Resident #103 to the hospital. Transport Driver AA stated that when he picked Resident #103 up from the facility, staff were .rushing her out the door . Transport Driver AA reported Resident #103 appeared apprehensive about the discharge and started crying after they arrived at the home. Transport Driver AA reported that even if Resident #103's wheelchair had fit through the door, there were items blocking her path within the home.Review of the policy/procedure Discharge Planning Process, dated 10/30/23, revealed .It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions .The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge .The ongoing process of developing the discharge plan will include a regular re-evaluation of the resident to identify changes that require modification of the discharge plan, and updating of the discharge plan, as needed, to reflect the modifications .