

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  06/13/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>41027</p> <p>This citation pertains to intake #MI00145044.</p> <p>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 &amp; #40) of 4 residents, reviewed for abuse, resulting in the potential for physical harm, pain and mental anguish.</p> <p>Findings include:</p> <p>Resident #15</p> <p>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.</p> <p>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 .</p> <p>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!</p> <p>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.</p> <p>Resident #40</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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 .</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>41027</p> <p>This citation pertains to intake #MI00145044.</p> <p>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 &amp; #40) of 4 residents, reviewed for abuse, resulting in the potential for physical harm, pain and mental anguish.</p> <p>Findings include:</p> <p>Resident #15</p> <p>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.</p> <p>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 .</p> <p>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!</p> <p>Resident #40</p> <p>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.</p> <p>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 .</p> <p>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 .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384</b></p> <p>Based on interview and record review, the facility failed to provide transfer/discharge notice upon discharge to two residents and/or representatives (R43 and R30) for transfer to the hospital of four residents reviewed for reviewed for transfers out-of-the facility, resulting in the potential for the resident to be misinformed, an inappropriate discharge, and/or not have an advocate to ensure their rights.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R43 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status) with diagnoses that included right leg amputation and septicemia.</p> <p>During an interview on 6/11/24 at 11:24 AM, R43 stated, I went to the hospital.</p> <p>Review of R43's Census indicated the resident was sent out of the facility on 1/27/24.</p> <p>Review of R43's Hospital Discharge Summary indicated the resident was admitted [DATE] until 2/9/24.</p> <p>Review of R43's medical records did not reveal transfer documentation for 1/27/24.</p> <p>Received email communication sent 6/13/24 at 3:49 AM from Nursing Home Administrator (NHA) A that stated, We do not have this regarding R43's emergent transfer notification on 1/27/24.</p> <p>48637</p> <p>Resident #30 (R30)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R30's original admitted was on 4/7/2023 with diagnoses of dysphagia (difficulty swallowing), anxiety, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (stroke). Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R30 was cognitively intact (13-15 is cognitively intact). Resident was discharged to the hospital on 3/2/2024 due to congestion and shortness of breath and returned to the facility on [DATE].</p> <p>During an interview on 6/11/2024 at 2:15 PM, R30 stated he had to go to the hospital several months ago due to pneumonia. R30 was unable to remember if he received a written transfer notice when he went to the hospital.</p> <p>Review of R30's chart revealed no evidence that R30 received a written notice of transfer when he went to the hospital and which included the following information:</p> <p>(i) The reason for transfer or discharge;</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged ;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>During an interview on 6/12/2022, Registered Nurse (RN) AA discussed the process when someone discharges to the hospital. When asked if she gives a written transfer notice to residents when they discharge to the hospital, RN AA stated that she doesn't send the written transfer notice with the resident.</p> <p>During an interview on 6/12/2024 at 1:28 PM, Director of Nursing (DON) B stated that the transfer/discharge notice paperwork should be part of the green packet that goes to the hospital with the resident and a copy should be put in the electronic medical record (EMR) but she wasn't sure if it this was being done. When it was discussed that a transfer/discharge notice wasn't found for R30 in his EMR, DON B stated If it's not in (name of EMR program) then we don't have it.</p> <p>Review of the Transfer and Discharge (including AMA) Policy with an implementation date of 7/28/2020 and a reviewed/revised date of 1/01/2022 under Policy Explanation and Compliance Guidelines #7 stated, Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified) j. Provide transfer notice as soon as practicable to resident and representative.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48637</p> <p>Based on interview and record review, the facility failed to notify the resident of the facility bed hold policy and provide a written copy upon hospital transfer for two residents (Resident #30, Resident #43) of four reviewed for hospitalization s, resulting in the potential of residents and/or resident representatives being uninformed of the bed hold policy.</p> <p>Finding include:</p> <p>Resident #30(R30)</p> <p>Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R30's original admitted was on 4/7/2023 with diagnoses of dysphagia (difficulty swallowing), anxiety, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (stroke). Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R30 was cognitively intact (13-15 is cognitively intact). Resident was discharged to the hospital on 3/2/2024 due to congestion and shortness of breath and returned to the facility on [DATE].</p> <p>During an interview on 6/11/2024 at 2:15 PM, R30 stated that he had to go to the hospital several months ago due to pneumonia. R30 was unable to remember if he received a bed hold policy notice when he went to the hospital.</p> <p>Review of the R30's chart revealed no documentation that he received a written bed hold policy.</p> <p>During an interview on 6/12/202, Registered Nurse (RN) AA discussed the process when someone discharges to the hospital. When asked if she gives a written bed hold policy to residents when they discharge to the hospital, RN AA stated that she doesn't send the bed hold policy with residents.</p> <p>During an interview on 6/12/2024 at 1:28 PM, Director of Nursing (DON) B stated that she wasn't sure if the nursing staff gives a written bed hold policy to the resident when they go to the hospital. When it was discussed that a written bed hold notice wasn't found for R30 in his electronic medical record (EMR), DON B stated If it's not in PCC (Point Click Care-their EMR) then we don't have it.</p> <p>38384</p> <p>R43</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R43 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status) with diagnoses that included right leg amputation and septicemia.</p> <p>During an interview on 6/11/24 at 11:24 AM, R43 stated, I went to the hospital.</p> <p>Review of R43's Census indicated the resident was sent out of the facility on 1/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R43's Hospital Discharge Summary indicated the resident was admitted [DATE] until 2/9/2/24.</p> <p>Review of R43's medical records did not reveal bed hold documentation for 1/27/24.</p> <p>Received email communication sent 6/13/24 at 3:49 AM from Nursing Home Administrator (NHA) A that stated, We do not have this regarding R43's Bed Hold for 1/27/24.</p> <p>Review of facility policy Bed Hold Notice Upon Transfer revised date 2/1/2022, revealed, Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed .Bed-Hold means the holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization .Bed Hold Notice Upon Transfer .Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies: The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility .The reserve bed payment policy in the state plan policy, if any .The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed .Conditions upon which the resident would return to the facility: In the even of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027</b></p> <p>Based on observation, interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for one (Resident #141) of 20 residents reviewed for the provision of nursing services, resulting in IV (intravenous) medications being administered outside of the physician ordered parameters.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #141 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: severe sepsis (life-threatening condition cause by infection) and cellulitis (infection in the skin).</p> <p>In an interview on 06/12/24 at 09:31 AM, Registered Nurse (RN) T reported that medication pass was running late that day.</p> <p>During an observation and interview on 06/12/24 at 11:04 AM in Resident #141's room. Resident #141 was lying in bed and there was an IV pole at the bedside with a bag and tubing attached. The tubing had a piece of tape on it that revealed, 6/12/24 10:30 (am). The bag of fluid was labeled Cefazolin (antibiotic). Resident #141 reported he was supposed to have IV antibiotics three times a day, and had gotten the antibiotics very late that morning. Resident #67 reported the medication had been administered late multiple times, and at times he wasn't even sure if he had gotten the medication at all. Resident #141 reported that he had sepsis in the hospital and was prescribed an antibiotic regimen for several months.</p> <p>Review of Resident #141's Medication Administration Record revealed the following order, Cefazolin . intravenously three times a day .until 8/25/2024 .At 8:00 AM, 12:00 PM, 6:00 PM. Start date 6/6/24 at 12:00 PM, D/C (discontinue date) 6/12/24 at 11:26 AM. The doses of medication were not scheduled to be administered evenly throughout the day.</p> <p>In an interview on 06/12/24 at 11:14 AM, RN T reported she had administered Resident #141's IV antibiotic Cefazolin late that morning at about 10:00 AM, but she did not label or date the bag or tubing, and did not know who did.</p> <p>In an interview on 06/12/24 at 11:20 AM, Director of Nursing (DON) B reported that Resident #141's IV medication can be administered up to an hour before or after the designated time frame.</p> <p>Review of Resident #141's Medication Administration Record revealed the following order, Cefazolin . Intravenously every shift .Day, Evening, Night .Start date: 6/12/24 at 2:00 PM. This was a change to the existing order. It was noted there were no time frames indicated in the new order.</p> <p>In an interview on 06/13/24 at 10:12 AM, Licensed Practical Nurse (LPN) D reported he administered Resident #141's IV Cefazolin at 8:00 AM that morning, because that was the time he thought it should be given, but he did not know when the previous dose had been administered. LPN D reported the order did not indicate a specific time to be administered.</p> <p>(continued on next page)</p>		

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

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/13/24 at 10:17 AM, Nurse Practitioner (NP) II reported that Resident #141's IV Cefazolin should be administered every 8 hours around the clock to ensure the medication is consistently in the resident's blood. NP II reported she had clarified this to nursing staff the day before. NP II reported the IV medication order should reflect a specific time to administer the medication, so the doses are evenly spaced apart.</p> <p>Review of Resident #141's Medication Administration Record indicated following entries for Cefazolin. It was noted that 17 out of 17 doses of the IV medication were outside of the recommended timeframe, per NP II.</p> <p>6/6/24 at 5:06 PM</p> <p>6/7/24 at 8:14 AM (15 hours apart)</p> <p>6/7/24 at 1:05 PM (5 hours apart)</p> <p>6/7/24 at 5:04 PM (4 hours apart)</p> <p>6/8/24 at 9:15 AM (15 hours apart)</p> <p>6/8/24 at 12:29 PM (3.25 hours apart)</p> <p>6/8/24 at 9:24 PM (9 hours apart)</p> <p>6/9/24 at 8:44 AM (11 hours apart)</p> <p>6/9/24 at 1:52 PM (5 hours apart)</p> <p>6/9/24 at 6:48 PM (5 hours apart)</p> <p>6/10/24 at 8:16 AM (13.5 hours apart)</p> <p>6/10/24 at 11:04 AM (2.75 hours apart)</p> <p>6/10/24 at 5:10 PM (6 hours apart)</p> <p>6/11/24 at 8:19 AM (13 hours apart)</p> <p>6/11/24 at 12:11 PM (4 hours apart)</p> <p>6/11/24 at 5:08 PM (5 hours apart)</p> <p>6/12/24 at 9:56 AM (14.5 hours apart)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027</b></p> <p>Based on observation, interview, and record review, the facility failed to identify a need for increased assistance with Activities of Daily Living (ADL) care and provide the necessary assistive devices, for one resident (Resident #67) of six reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for residents who are dependent on staff for assistance.</p> <p>Findings include:</p> <p>Resident #67</p> <p>Review of an Admission Record revealed Resident #67 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pyogenic (infected) arthritis (inflammation of the joints).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #67, with a reference date of 5/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #67 was cognitively intact.</p> <p>Review of Resident #67's ADL Care Plan revealed, .ADL self-care performance deficit related to pyogenic arthritis .weakness, deconditioning. Date Initiated: 11/15/23 .Interventions: Ambulation: Independent - offer setup help as needed, Dressing: Independent - offer setup help as needed, Personal hygiene: Independent - offer setup help as needed, Toileting: Independent - offer set up help as needed, Transfers: Independent: offer setup help as needed with two wheeled walker .</p> <p>During an interview and observation on 06/11/24 at 12:26 PM Resident #67 was lying in his bed and reported the arthritis in his knee got really bad a couple weeks ago and he can no longer walk with his walker safely. Resident #67 reported that he had spoken to the nursing staff, saw the doctor, and spoke with the therapy department at the facility, but no one was able to find a wheelchair for him to use. Resident #67 reported that he had struggled to get to the bathroom, had incontinence, and had not been able to clean himself adequately for the past couple weeks. Resident #67 reported that he had an x-ray about a week ago.</p> <p>In an interview on 06/13/24 at 12:01 PM, Certified Occupational Therapy Assistance (COTA) MM reported Resident #67 discharged from therapy services about a month ago, and was able to walk long distances with his walker at that time. COTA MM reported that Resident #67 recently reported to her he had been having trouble walking and asked for a wheelchair to use. COTA MM stated, .I assumed that he said something to the nurses .we have been expecting a referral to see him .</p> <p>In an interview on 06/13/24 at 12:06 PM, Resident #67 reported he still had not heard anything about his knee x-ray, and he did not have a wheelchair to use. Resident #67 reported that nursing staff is aware of his pain, and had been applying topical pain reliever on his knee. The resident reported his son had visited the night before and helped him get out of bed to use the bathroom and that he had made a mess in the bathroom and the nurse was going to help him get in the shower, but she did not come back.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/13/24 at 12:12 PM, Certified Nursing Assistant (CNA) PP reported working regularly with Resident #67, and the resident was completely independent, and able to walk into the bathroom by himself. CNA PP reported she was not aware that Resident #67 needed increased assistance recently.</p> <p>In an interview on 06/13/24 at 12:15 PM, Registered Nurse (RN) S reported Resident #67 had been complaining of knee pain, had an x-ray last week, and was prescribed topical pain reliever. RN S reported the therapy department would handle getting a wheelchair for a resident, and they did not know how to refer a resident to the therapy department.</p> <p>In an interview on 06/13/24 at 12:19 PM, Unit Manager (UM) DD reported she was aware Resident #67 had received therapy for his knee pain in the past, and he had been prescribed medication. UM DD reported she was not aware that Resident #67 was in need of more assistance. UM DD reported she could easily get Resident #67 a wheelchair, but she was not aware that he wanted or needed one.</p> <p>In an interview on 06/13/24 at 02:42 PM, Family Member (FM) RR reported he had driven Resident #67 to the bank a couple days earlier and Resident #67 was not able to walk and stated, .I had to do everything for him .I told someone when we got back . FM RR reported when he visited Resident #67 on 6/12/24, the resident was trying to get himself to the bathroom, but was not able to get there, and ended up having a accident. FM RR reported Resident #67 had fallen multiple times prior to admitting to the facility.</p> <p>Review of Resident #67's Progress Note dated 6/4/24 revealed, .being seen this morning per request of nursing staff for follow-up on his knee pain .says his knee pain is back and is worse this morning .Voltaren (reduces inflammation) external gel 1 % added to his regimen and patient encouraged to request it for his pain .</p> <p>Review of Resident #67's Left Knee X-Ray dated 6/5/24 revealed, .Findings: .Mild osteoarthritis (degenerative joint disease) .If there is further concern, recommend follow-up radiographs (images) or MRI (more detailed image than an x-ray) for complete assessment .</p> <p>Review of Resident #67's Progress Note dated 6/11/24 revealed, .Patient reported his right (sic) knee hurt due to arthritis Assessments and Plans: .arthritis left knee .Continue daily lidocaine (pain reliever) patch .</p> <p>Review of Resident #67's Fall Risk Evaluation dated 5/16/24 indicated, a high risk for falling.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027</b></p> <p>This citation pertains to intake # MI00143208</p> <p>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.</p> <p>Findings include:</p> <p>Resident #15</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>Review of Resident #15's Progress Note dated 6/6/24 indicated that the resident had returned from the hospital at 4:45 PM.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 completed 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>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.</p> <p>Review of Resident #15's records, indicated no further documentation from 6/9/24-6/11/24 related to skin and wounds.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38905</p> <p>Based on observation and interview the facility failed to minimize the risk of scalding and burns by allowing domestic hot water to exceed 120 F. This resulted in an increased risk of injury among residents who reside in the B hall.</p> <p>Findings Include:</p> <p>During a tour of the B hall shower room, at 10:07 AM on 6/12/24, the hot water was checked with a rapid read digital thermometer and found to be 127F. When asked if hot water temperatures were taken today, Maintenance Director (MD) FF stated yes, Maintenance (M) O usually does it in the morning.</p> <p>Observation of the B hall soiled utility room sink, at 10:09 AM on 6/12/24, found the hot water to reach 128F. When asked if each hall has their own hot water system, MD FF stated yes.</p> <p>Observation of the B hall boiler room, at 10:11 AM on 6/12/24, found that the thermometer showing outgoing hot water to the B hall domestic fixtures read 128F with no mixing valves at point of use to further temper the water.</p> <p>An interview with MD FF, at 10:15 AM on 6/12/24, found that M O checked the water temperatures this morning and found it under 120F in the B hall. When asked if he varies his temperatures, or usually takes them in the morning. MD FF was unsure.</p> <p>An interview with M O at 10:40 AM on 6/12/24, found that he typically checks hot water temperatures each morning when he gets to work and has not tracked how hot water temperatures might fluctuate during the day as demand for hot water changes.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>47955</p> <p>Based on interview and record review, the facility failed to ensure that pre and post dialysis (procedure that removes excess water, solutes, and toxins from the blood for people whose kidneys cannot perform these functions) treatment assessment and monitoring communication between themselves (the facility) and the dialysis provider (Name Omitted) was maintained in one (Resident #17) of one resident reviewed for dialysis services resulting in the potential for unrecognized adverse reactions and/or resident decline related to adverse reactions of dialysis treatments.</p> <p>Findings include:</p> <p>Resident #17</p> <p>Review of an Admission Record revealed Resident #17 had pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #17, with a reference date of 5/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #17 was cognitively intact.</p> <p>Review of Dialysis section of miscellaneous documents in Resident #17's medical record revealed the last uploaded dialysis communication was dated 2/17/2024.</p> <p>During an interview on 6/13/24 at 8:22 AM., Registered Nurse (RN) S reported the nurse should complete the (dialysis) communication packet to send with Resident #17 to dialysis and the dialysis center (Name Omitted) should complete their section of the communication packet and send it back. RN S reported the dialysis center (Name Omitted) does complete the communication packet. RN S reported that the dialysis communication form should be given to medical records to be scanned into Resident #17's medical record.</p> <p>During an interview on 6/13/24 at 8:29 AM., Medical Records (MR) N reported when she received dialysis communication forms she would scan them into Resident #17's medical chart under miscellaneous documents, dialysis. MR N reported Resident #17 had a binder the communication forms were kept in while she traveled between the facility and the dialysis treatment center.</p> <p>During an interview on 6/13/24 at 9:11 AM., MR N reported Resident #17's binder for dialysis communication was missing. MR N reported that she was unaware the dialysis communication binder was missing. When asked if MR N had received any dialysis communication forms for Resident #17 since the last uploaded communication form from 2/17/24, MR N stated No, I have not received communication forms for the last 3 months. MR N reported as of today (6/13/24), Resident #17 had a new communication binder and it was with her on the way to dialysis treatment.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/24 at 9:37 AM., Licensed Practical Nurse (LPN) BB reported that a dialysis communication form should be sent with Resident #17 when she goes for dialysis treatment. LPN BB reported if she does not receive the communication form when Resident #17 returned from dialysis treatment, she would call the dialysis treatment center (Name Omitted) for a report. When asked if telephone communication should be documented in Resident #17's medical record, LPN BB stated, Yes, it should be.</p> <p>During an interview on 6/13/24 at 09:00 AM., Director of Nursing (DON) B reported her expectations were if a dialysis communication form did not come back with Resident #17 after dialysis treatment, the nurse should call the dialysis center and request a report be faxed to the facility. DON B reported if the binder was missing then no communication was occurring between the facility and the dialysis center (Name Omitted). DON B reported her expectation was the nurse should document their communication and documentation request from the dialysis center (Name Omitted) in Resident #17's medical record. DON B stated .if they are not documenting that, then it is not happening .</p> <p>The facility was unable to provided any documentation regarding communication about Resident #17's dialysis treatments between the facility and the dialysis center (Name Omitted) between the dates of 2/18/24 and the date of exit by the time of survey exit.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>41027</p> <p>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent in 2 of 4 residents (Resident #7 &amp; #340) reviewed for medication administration, resulting in a medication error rate of 16% (4 errors from a total of 25 opportunities for error).</p> <p>Findings include:</p> <p>Review of Resident #7's Physician Orders revealed an active order for Aripiprazole 5 mg 1 pill every morning for intermittent explosive disorder.</p> <p>Review of Resident #7's Physician Orders revealed an active order for 3 tablets of Calcitriol (Vitamin D) 0.25 mcg to be administered every morning on Monday, Wednesday and Friday for end stage renal disease.</p> <p>Review of Resident #7's Physician Orders revealed an active order for Nepro (supplemental drink) 1 can in the morning for supplement.</p> <p>During medication administration observation and interview on 06/12/24 at 08:12 AM, Registered Nurse (RN) AA was preparing morning medications for Resident #7, and reported that Aripiprazole 5 mg was not available to administer as ordered, and that she had used the last dose the day before. RN AA reported that Calcitriol was not available, and that Resident #7 was supposed to get the medication prior to dialysis (treatment to remove toxins and fluids in someone with kidney failure), which was scheduled later that morning. RN A reported that Nepro supplemental drink was not in the medication cart, and/or in the supply closet, and that the resident usually received one can of it in the morning. RN AA reported that a refill of Resident #7's Aripiprazole was ordered 1 day ago, and Calcitriol was ordered on 5/31/24. RN AA reported that there is usually extra Nepro in the supplement closet, but it was gone too.</p> <p>Review of Resident #7's Medication Administration Record (MAR) indicated that Aripiprazole 5 mg, Calcitriol, and Nepro were not given on 6/12/24, due to being unavailable.</p> <p>Resident #340</p> <p>Review of Resident #340's Physician Orders revealed an active order for Fexofenadine (for allergies) 180 mg, 1 pill in the morning.</p> <p>During medication administration observation on 06/12/24 at 09:31 AM, RN T was preparing morning medications for Resident #340. RN T administered Allergy relief (Fexofenadine) 60 mg, 1 pill to Resident #340.</p> <p>In an interview on 06/12/24 at 09:51 AM, RN T reported that the Fexofenadine pill strength that was administered to Resident #340 was 60 mg. After review of the order, RN T reported that she would give Resident #340 two more of the 60 mg pills to total the actual ordered dose of 180 mg.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38384</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate storage of medication and a self-administration of medications evaluation was conducted for two (R140 and R49) of two residents reviewed for self-administration of medications, including narcotics, resulting in the potential for adverse reactions and overdose.</p> <p>Findings include:</p> <p>R140</p> <p>According to the Minimum Data Set (MDS) dated [DATE], R140's BIMS (Brief Interview of Mental Status) had not been conducted as of 6/11/24. However, during observation and interview revealed the resident was attentive and interested during the interviews the surveyor conducted displaying a concrete thought process, with clear and concise speech.</p> <p>During an observation and interview on 6/12/24 at 8:37 AM, Registered Nurse (RN) T was observed leaving a medication cup (med cup) with various pills on R140's bedside table and exiting room without observing the resident taking them. R140 stated, The nurses do not normally leave meds with me. I've never met the nurse that left these medications with me.</p> <p>During an interview on 6/12/24 at 8:43 AM, RN T stated, I don't know of any residents that take their medications on their own. The RN did not respond when asked if she had left medications with R140 to take on her own.</p> <p>Review of R140's Order Summary did not reveal the resident had orders to self-administer medications.</p> <p>Review of R140's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated June 2024, indicated five medications including one controlled substance were documented as being administered to the resident during the morning pass on 6/12/24. No orders or assessments indicated the resident was able to self-administer medications.</p> <p>Review of R140's Care Plan did not include a focus regarding self-administering medications.</p> <p>Review of R140's medical chart did not reveal a Self-Administer Medications evaluation had been done.</p> <p>R49</p> <p>During an observation on 6/12/24 at 1:00 PM, RN S left a med cup of medications including two different kinds of controlled substances, in front of R49 on a bedside table before beginning wound care. Multiple times, the RN exited the room for more than 3 minutes at a time, completely out-of-sight with the door closed and privacy curtain pulled to gather wound care supplies.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the MDS dated [DATE], R49 scored 15/15 (cognitively intact) on his BIMS and had diagnoses that included anxiety and depression.</p> <p>Review of R49's Order Summary did not reveal the resident had orders to self-administer medications.</p> <p>Review of R49's MAR/TAR dated 6/1/2024-6/30/14 indicated RN S documented he had signed out and administered 2-controlled substance at the time of the observation.</p> <p>Review of R49's Care Plan did not include a focus regarding self-administrating medications.</p> <p>Review of R49's medical chart did not reveal a Self-Administer Medications evaluation had been done.</p> <p>During an interview on 6/13/24 at 9:35 AM, Director of Nursing (DON) B stated, There are no residents in the facility that self-administer their medications. Nor should medications, including controlled substances, be left at bedside for any amount of time.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48637</p> <p>Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential to spread food borne illness potentially affecting all 87 residents that reside in the facility.</p> <p>Findings Include:</p> <p>During an initial kitchen tour on 6/11/2024 at 8:33 AM, the following was observed in the reach in refrigerator:</p> <p>The outside temperature gauge temperature was at 53 degrees.</p> <p>The inside temperature gauge was at 46 degrees.</p> <p>On 6/11/2024 at 11:52 AM, it was observed the reach in refrigerator outside temperature gauge was 52 degrees and the inside temperature gauge was 45 degrees. The reach in refrigerator was still packed with food.</p> <p>During an interview on 6/11/2024 at 12:25 PM, Maintenance Director (MD) FF stated that ice froze up on the fan in the reach in refrigerator and he was trying to chip it away so it could start working again and the temperatures should come back down.</p> <p>On 6/11/2024 at 1:41 PM, it was observed the reach in refrigerator outside temperature gauge was 58 degrees and the inside temperature gauge was 50 degrees. The reach in refrigerator was still packed with food.</p> <p>During an interview on 6/11/2024 at 1:56 PM, Dietary Director (DD) Z stated that she told her kitchen staff to stay out of the reach in refrigerator so the temperature doesn't go up more. When asked what she was going to do with the food in the reach in refrigerator, she stated she would throw out all perishable food items.</p> <p>During an interview on 6/11/2024 at 2:15 PM, MD FF stated that he put a flame in the reach in refrigerator to get rid of the ice so he said, Of course the temperature would go up in the reach in refrigerator.</p> <p>On 6/11/2024 at 2:31 PM, it was observed that the reach in refrigerator was cleared out except for one metal container of condiments and two boxes of tomatoes which were on the bottom shelf. The dietary staff said that they would get rid of the condiments and move the tomatoes to another refrigerator.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 6/11/2024 at 2:35 PM, Nursing Home Administrator (NHA) A stated she wasn't aware of the reach in refrigerator temperatures being high since no one told her. NHA A said she would follow up and make sure things are cleaned out in the reach in refrigerator.</p> <p>On 6/11/2024 at 3:30 PM, it was observed with DD Z that all food in the reach in refrigerator was cleaned out.</p> <p>Review of the Food Receiving and Storage Policy with an implementation date of 7/31/2020 and a reviewed/revised date of 01/01/2022 states, Foods shall be received and stored in a manner that complies with safe food handling practices, as outlined in the FDA Food Code. Under Policy Explanation and Compliance Guidelines #8, Refrigerated foods should be stored at or below 41(degrees) F (Fahrenheit) unless otherwise specified by law.</p> <p>According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C ) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: .(2) At 5C (41F) or less.</p> <p>38905</p> <p>During a follow up tour of the kitchen, at 8:18 AM on 6/12/24, an interview with DD Z and Maintenance Director FF, found that the three-door continental refrigeration unit was having a hard time keeping temperature yesterday. When asked what was going to happen to the unit, MD FF stated that they have a vendor coming out to check on the unit, but its looking like it's going to have to get replaced. When asked if they had to discard any food yesterday, DD Z stated they did.</p> <p>During a revisit to the kitchen, at 8:42 AM on 6/12/24, it was observed that a spray bottle was tucked into the bottom left side of the three-compartment sink. Upon grabbing the spray bottle, it was observed it stated H2O and contained a green solution. MD FF removed the bottle from the kitchen.</p> <p>According to the 2017 FDA Food Code section 7-102.11 Common Name. Working containers used for storing POISONOUS OR TOXICMATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material.</p> <p>During a revisit to the kitchen, at 11:55 AM on 6/12/24, observation of the three door [NAME] refrigeration unit found shredded lettuce stored on the bottom shelf behind a couple cases of raw pork chops. When asked if this was were the lettuce is normally, DD Z stated No.</p> <p>According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41027</p> <p>This citation pertains to intake #MI00143208.</p> <p>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.</p> <p>Findings include:</p> <p>Resident #15</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637</b></p> <p>This citation has two deficient practice statements.</p> <p>Deficient Practice Number 1.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>Enhanced Barrier Precautions</p> <p>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 .</p> <p>Resident #46 (R46)</p> <p>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).</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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).</p> <p>Resident #57 (R57)</p> <p>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).</p> <p>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).</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Resident #48 (R48)</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>During another observation on 6/12/2024 at 1:54 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>38384</p> <p>R49</p> <p>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.</p> <p>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.</p> <p>Enhanced Barrier Precautions (EBP)/ Wound Dressing Change</p> <p>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.</p> <p>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).</p> <p>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 .</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <ul style="list-style-type: none"> <li>-RN laid supplies on top of resident's blankets at the foot of the bed without a barrier.</li> <li>-No garbage can was placed within reach of the RN.</li> <li>- No barrier was placed underneath either wound.</li> <li>-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.</li> <li>-The wound 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.</li> <li>-With a soiled gauze in hand, the RN cleaned the wound with wound cleaner.</li> <li>-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.</li> <li>-RN placed clean small gauze over wound then wrapped with kerlix using the unclean scissors to cut it to length.</li> <li>-RN placed contaminated scissors on resident's blanket at foot of bed.</li> <li>-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.</li> <li>-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.</li> <li>-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.</li> <li>-RN gathered soiled dressings and placed in garbage. Then gathered supplies and placed them in the wound treatment cart.</li> <li>-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.</li> </ul> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R65</p> <p>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.</p> <p>Nebulizer</p> <p>Review of R65's Order Summary dated 2/14/24, indicated the resident was receiving nebulizer (breathing treatment machine) treatments two times a day.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>EBP/Enteral (Tube) Feeding</p> <p>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)).</p> <p>Review of R65's Care Plan, dated</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R141</p> <p>According to R141's Admission Record, he had been recently admitted on [DATE] with diagnoses that included cellulitis of right hand and severe sepsis.</p> <p>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.</p> <p>Resident Equipment/PICC (Peripherally Inserted Central Catheter)</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R141's Order Summary indicated he received an antibiotic solution every shift to the right upper limb.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Resident Equipment/Wheelchair</p> <p>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.</p> <p>R43</p> <p>According to R43's MDS dated [DATE], the resident scored 15/15 (cognitively intact) on his BIMS and required the use of a wheelchair for ambulation related to the amputation of his right leg.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>41027</p> <p>Resident #15</p> <p>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.</p> <p>Review of Resident #15's Physician Orders revealed, no orders for Enhanced Barrier Precautions.</p> <p>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.</p> <p>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.</p> <p>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 hoier 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.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>Resident #65</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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 .</p> <p>47955</p> <p>Resident #83</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>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])</p>		