

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 07/16/2026
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.			
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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3054443. Based on interview and record review, the facility failed to prevent significant medication errors in 1 of 1 resident (Resident #65) reviewed for medication errors, resulting in Resident #65 having an acute change of condition requiring hospitalization due to low blood sugar, decreased heart rate, low blood pressure, and admission to the ICU (intensive care unit). Findings include: Resident #65 Review of an admission Record revealed Resident #65 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: Bipolar (mental health condition that causes extreme shifts in mood, energy, activity levels and concentration), dementia (a decline in mental ability, memory loss, thinking difficulties and behavioral changes), insomnia (inability to sleep), anxiety, hyperlipidemia (high cholesterol), type 2 diabetes (high blood sugar/lack of insulin), hypertension (high blood pressure) and chronic kidney disease. Review of Resident #65's Incident Report dated 5/26/26 at 7:28 PM revealed, Medication Error: Resident was given the wrong medication: 40 mg Atorvastatin (common name is Lipitor: treats high cholesterol levels), 5 mg Eliquis (blood thinner), 1 mg Lorazepam (for anxiety), 1000mg Metformin (for high blood sugar), 25 mg Metoprolol (a beta blocker used for high blood pressure that causes the heart to beat more slowly and with less force), 100 mg Lyrica (for nerve pain), 4 mg Tizanidine (muscle relaxer), 34 units Toujeo (long-acting insulin for high blood sugar), 50 mg Trazodone (antidepressant). Immediate Action Taken: In house provider contacted, DON was contacted, Residents blood sugar assessed qhr (every hour), vs (vital signs) monitored, snacks and fluids given and encouraged. Sent out to the hospital for evaluation. Review of Resident #65's Medication Administration Record for medications that were ordered at bedtime on 5/26/26 revealed: Latuda (antipsychotic medication used for bipolar disorder), Melatonin (helps to sleep at night), Rosuvastatin (treats high cholesterol), Memantine (to treat dementia), Aricept (for dementia), Sennosides (treats constipation), and Depakote (to treat bipolar disorder). There were no orders for any of the medications that Resident #65 received in error on 5/26/26. The resident did not have any medications ordered for high blood pressure, high blood sugar, nerve pain and/or a blood thinner. The record also indicated that Resident #65 was allergic to Lipitor, which was one of the medications the resident received in error on 5/26/26. Review of Resident #65's Hospital Records dated 5/26/26 revealed, Chief Complaint: Received wrong medication at (facility name omitted); hypotensive (low blood pressure) and bradycardia (low heartrate); BS (blood sugar) 144; received Atropine (for severe low heart rate) 0.5 mg and Glucagon (for severely low blood sugar) from EMS (emergency medication services). presenting to the ED (emergency department) via EMS after inadvertently being given another resident's medications. Lipitor 40 mg (patient has documented allergy to Lipitor, unsure of reaction), Eliquis 5 mg, Lorazepam 1 mg, Metformin 1000mg, Metoprolol tartrate 25 mg, Lyrica 100mg, Tizanidine 4 mg, Toujeo 34 units, Trazodone 50 mg. Nursing knew within a few minutes that the wrong medications were given. He was given drinks and food, in lieu of (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0760 Level of Harm - Actual harm Residents Affected - Few	the insulin being given. Around 7:50 PM, patient seemed pale and was becoming less communicative. Vitals were significant for a HR (heart rate) in the 40s, blood pressure was 90s/50s. At this time, staff called EMS in which patient was transported to (hospital name omitted) within an hour. The patient has right-sided deficits from a prior stroke, is slow to answer questions at baseline, and is alert and oriented 1-2. He is also wheelchair bound at the NH (nursing home). Upon arrival to ED, patient is complaining of chest pain, abdominal pain, back pain, and shortness of breath. He was placed on 6L (Liters) NRB (non-rebreather) (oxygen) mask. ED Course: .given two pushes of epinephrine (used for severe allergic reactions and to improve blood flow to the heart and brain), glucagon 1 mg, D5 (fluid containing sugar) with insulin, and potassium chloride (for low blood potassium). Assessment/Plan: Patient admitted to ICU on 5/26 for symptomatic hypotension and bradycardia requiring epinephrine infusion (administered through a vein) after accidental administration of another resident's medications at nursing facility. Clinical picture is concerning for medication-induced toxicity (this occurs when a drug accumulates to harmful levels in the bloodstream or tissues, causing adverse physical or mental reactions) resulting in hemodynamic instability (a state where the circulatory system fails to maintain adequate blood pressure and blood flow to vital organs). Suspect mixed medication overdose/toxicity, particularly from beta-blocker (causes the heart to beat slower) exposure with additional CNS (central nervous system) depressant (medications used for anxiety) and antihypertensive (lowers blood pressure) effects from Lorazepam, tizanidine, trazodone, and pregabalin (Lyrica). In an interview on 7/15/26 at 9:51 AM, Licensed Practical Nurse (LPN) T reported regarding Resident #65's medication error on 5/26/26: RN X came to LPN T and reported that she had accidentally given Resident #65 his roommate's medications. LPN T reported that she carefully reviewed the medications with RN X that were given in error and then contacted the provider, Nurse Practitioner (NP) HH. NP HH instructed LPN T to monitor Resident #65 closely, check vital signs, check his blood sugar, and give him something to eat. LPN T reported that Resident #65 had been given insulin, blood pressure medication and others that he did not normally take. LPN T reported that after about 30 minutes Resident #65's heart rate started dropping, so they called 911 and had him sent to the hospital. LPN T reported that she spoke to the hospital several times that night to ensure they knew exactly what medications Resident #65 was given in error. LPN T reported that RN X was a new nurse to the facility and was not familiar with Resident #65. In an interview on 7/15/26 at 11:19 AM, NP HH reported that she had received a call from LPN T at home on 5/26/26 reporting that Resident #65 had been given another resident's medications. NP HH reported that as soon as she heard that insulin and blood pressure medication were involved, she instructed staff to monitor Resident #65's blood sugar and blood pressure closely and to call with any changes in the resident's condition. In an interview on 7/15/26 at 12:07 PM, Rehab Director (RD) JJ reported that Resident #65 was on therapy to improve his overall strength after he returned from the hospital on 6/3/26. In an interview on 7/16/26 at 10:50 AM, RN X reported that she had accidentally administered another resident's medications to Resident #65 on 5/26/26, leading to an acute change in condition and hospitalization. RN X reported that she had only been working in the facility for a couple of months and was not familiar with Resident #65 at that time. RN X reported that she had prepared the medications, walked into Resident #65's room, asked the resident if his name was (roommate's name omitted), and Resident #65 answered yes. RN X reported that she checked Resident #65's blood pressure and blood sugar, then gave the insulin injection and administered all the pills whole. Then RN X explained that when she prepared Resident #65's roommate's pills and asked if his name was (Resident #65) the roommate said No. RN X reported she realized at that time she had mixed up the residents. RN X reported that she immediately panicked and asked LPN T for assistance with the (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	medication error. RN X reported that they contacted NP HH and monitored Resident #65 closely for about 30 minutes; when Resident #65's heartrate started to decrease they made the decision to send him to the hospital for further evaluation. RN X reported that it was later that she learned Resident #65 answered yes to everything and she should had asked the resident to say his name. RN X reported that she had received extensive re-education following the incident and was no longer allowed to care for Resident #65. Review of witness statement by Registered Nurse (RN) X revealed, I knocked on the door and walked into the residents' (Resident #65) room. I walked over to the bed where the resident was laying with his back towards me. I called out (roommates name omitted) and he turned over. I asked him was he (roommates name omitted) and he said mmmm. I stated that I needed to get his BP (blood pressure) before I gave him his meds. After that I said here are you night meds, (Resident #65) grabbed the cup and took the meds. I then took his blood sugar and gave him the insulin. Once I found out that he was the wrong resident, I checked his allergies. (Company name omitted) on call was called, our house PA (physician assistant) and DON (Director of Nursing) was contacted and notified. I received orders to check his BS (blood sugar) every hour, give snacks, push fluids, and to continue to monitor, and if he becomes unstable to send to ER (emergency room). Resident was eventually sent out for further evaluation. In an interview on 7/16/26 at 11:03 AM, DON B reported that when the medication error for Resident #65 occurred she had been on vacation and it was not until the next day that it was brought to the manager's attention. DON B reported that it was determined that Resident #65 received multiple medications, including insulin and blood pressure medications which lead to an acute change of condition, hospitalization where they found significant bradycardia (low heartrate) and hypotension (low blood pressure), admission to ICU (intensive care unit) to stabilize his vital signs, and then he returned to the facility approximately 5 days later. DON B reported that Resident #65 had since received skilled therapy and had returned to his prior level of function. DON B reported that a full investigation was performed; re-education to all staff, RN X received disciplinary action, and the facility had been performing ongoing audits of medication administration. DON B reported that staff are expected to follow the standard rights of medication administration with all residents, including verification of the right resident by using their photo in record and/or asking another staff member that is familiar with the resident to verify the right resident prior to administration of medications. Review of Fundamentals of Nursing ([NAME] and [NAME]) revealed, Professional standards such as Nursing: Scope and Standards of Practice (ANA, 2010) .apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 39307-39313). Elsevier Health Sciences. Kindle Edition. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included training for nurses, monitoring of medication administration and ongoing audits. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food items were stored, prepared, and maintained under sanitary conditions, increasing the risk of foodborne illness to all residents that consume food from the kitchen. Findings Include: On 7/14/26 at 9:28 AM, the three-compartment sink was observed with a sanitizer pre-dispense system with no test strips to ensure accuracy of the sanitizer. When asked if there were any test strips, [NAME] SS was unable to find them. On 7/14/26 at 9:35 AM, the cook line preparation table was observed with clean pots and pans stored on the underside. A review of the pans found two half pans and two quarter pans stacked and stored wet with moisture in-between. On 7/14/26 at 10:37 AM, the dish machine rinse gauge was observed cracked and loose on the dial allowing the needle to be open and exposed. On 7/14/26 at 10:50 AM, the resident fridge in the dinning room was observed with the following: a container of spaghetti dated 7/7, a baked potato and meatloaf leftovers with no name or date, an unopened container of whipped topping that states its good for two weeks under refrigeration, an open container of carmel macchiato dated 6/17/26 and manufactures instructions for discard after 7-10 days after opening, a grocery bag container of strawberries and whipped topping with no name and date and the strawberries covered in white fuzz. A review of the document on the refrigeration unit found it stated, Prepared food items will have a 3-day use-by date and then discarded. On 7/16/26 on 1:15 PM, a follow up tour of the kitchen found the plate warmer with excess accumulation of debris, crumbs, silverware, and plastic wrappers stacked up in the inside bottom of the unit. According to the 2022 FDA Food Code: Section 4-302.14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided. Section 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD. Section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. Section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3-501.17(A). Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a safe and functional entry to the building, affecting all residents that utilize the exterior spaces. Findings Include: On 07/14/26 at 8:45 AM, numerous potholes were observed while entering the facility's parking lot through the north entrance. On 07/14/26 at 10:55 AM, Maintenance Director RR was interviewed and stated the parking lot has been an ongoing challenge for the facility. He reported a repair plan is in progress but could not provide a timeline for completion. In an observation on 7/16/26 at 10:05 am, a facility resident was noted sitting outside near the driveway to enter the parking lot smoking. The resident had to cross the parking lot from the front entrance, across the unrepaired driveway to get to the required smoking area. On 07/16/26 at 12:32 PM, a tour of the parking lot with Maintenance Director RR, identified multiple areas of severe disrepair, including potholes exceeding three inches in depth. Areas observed included the south driveway entrance, back service area, employee parking, visitor parking, main entrance, and north driveway entrance. Specific locations with significant deterioration included the south entrance near the dumpster, the south drive curve to staff parking, and most of the north entrance. These conditions presented potential hazards for residents, visitors, and staff who access or travel through these areas. A review of facility records found a proposal from an asphalt vendor dated 07/09/26. The vendor's field review date was documented as 10/03/25.		

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) and Advanced Beneficiary Notice of Non-Coverage (ABN) for Medicare Part A services in 1 of 3 residents (Resident #33) reviewed for timely provision of notifications, resulting in the potential for the resident or resident representative to be unaware of changes regarding financial liability, frustration, and a delay in the ability to file an appeal. Findings include: Review of an admission Record revealed Resident #33 was originally admitted to the facility on [DATE]. Review of SNF (skilled nursing facility) Beneficiary Notification Review for Resident #33 revealed, . Medicare part A skilled services episode start date: 1/12/26, last covered day of Part A service: 4/9/26. The facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. Was NOMNC, Form CMS-10123 provided to the resident? No. Review of an Advanced Beneficiary Notice of Non-Coverage (ABN) for Resident #33 revealed . We expect Medicare may not pay for the item, test, service or care listed below, if Medicare doesn't pay, you may have to pay. Care: Room and board. Reason: Therapy is complete/benefits exhausted. Estimated Cost: TBD (to be determined). Signature: Verbal Signature dated 4/10/26. Noted the ABN was signed 1 day after coverage ceased. In an interview on 7/14/26 at 2:39pm, Business Office Manager (BOM) P reported he did not know the cost the resident would incur for room and board, so he put TBD in the box. Review of an Advance Beneficiary Notices policy with a reference date of 10/30/23 revealed It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. The facility shall inform Medicare beneficiaries of his or her potential liability for payment before the facility provides an item or service that is usually paid for by Medicare but may not be paid for in particular instance. A Notice of Medicare Non-Coverage (NOMNC) shall be issued to the resident when Medicare covered service (s) are ending, no matter if resident is leaving the facility or remaining. This informs the resident on how to request an appeal.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a clean comfortable environment for 2 (Resident #8 and Resident #94) of 5 residents reviewed for environment resulting in unclean/unkempt resident rooms, resident frustration, and the potential for cross contamination and bacterial harborage. Findings include: Resident #8 Review of an admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension (high blood pressure) and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 6/2/26 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #8 was moderately cognitively impaired. During an interview and observation on 7/14/2026 at 11:25 AM, Resident #8 reported concerns with the cleanliness of her room. Resident #8 reported she did not feel like the housekeeping staff in the facility were thoroughly cleaning her room. Resident #8's floor was noted to have several pieces of trash on the floor, and the floor was noted to be sticky. In Resident #8's bathroom, trash was noted on the floor. There were soiled wash cloths sitting in the sink. The trash was full and overflowing onto the floor. The toilet in Resident #8's bathroom (which was a bathroom shared with Resident #94) was noted to have several brown stains on the rim of the toilet. Resident #94 Review of an admission Record revealed Resident #94 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension and anxiety disorder. During an interview and observation on 7/14/2026 at 11:11 AM, Resident #94 reported that she had concerns with cleanliness of the facility. Resident #94 reported she had not observed her room cleaned by housekeeping staff since she had been admitted to the facility. Resident #94 reported she had family bring her bleach wipes so that she could clean the bathroom herself because she was concerned about infection control as the bathroom she used was a shared bathroom. Resident #94 reported she had not had her sheets changed on her bed since admission, and that she had soiled her sheets with blood shortly after she was admitted and had been laying in soiled sheets since. Noted that Resident #94's sheets were soiled with a large red stain which did appear to look like a blood stain. Resident #94's bedside tray table was soiled with food crumbs and dried liquid stains. The floor in front of Resident #94's bed was noted to have several black and brown stains and was sticky to walk on. Resident #94's trash can was full, and there were several pieces of trash on Resident #94's floor. Resident #94 voiced feelings of frustration, reporting that she had asked multiple staff to clean her room, and she felt like staff were ignoring her requests to clean her room and change her sheets. During an interview and observation on 7/15/2026 at 12:21 PM, Resident #8 and Resident #94 were sitting together in their shared room eating lunch. Resident #8 and Resident #94's room was noted to be in the same condition as previous observation from the day before. Resident #94 confirmed that staff had not yet changed her bed sheets, and the stained sheets were noted to be on her bed. During an interview and observation on 7/16/2026 at 11:51 AM, Resident #8 and Resident #94 were sitting together in their shared room. Resident #8 and Resident #94's room was noted to have trash on the floor around both of their beds. The floor around Resident #8 and Resident #94's beds were noted to have black stains and was sticky to walk on. Resident #8 and Resident #94's tray tables were noted to be soiled with food crumbs and dried liquid stains. Resident #8 and Resident #94's shared bathroom was noted to have trash overflowing, sticky floors, and the toilet was noted to have brown stains in the rim of the toilet bowl. Resident #94 reported that her sheets had not been changed and showed (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to develop and/or implement a comprehensive care plan for 3 residents (Resident #73, #3, & #65) of 18 residents reviewed for care plan development/implementation, resulting in the potential for unmet medical, physical, mental, and psychosocial needs. Findings include: Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic respiratory failure (when the lungs cannot properly oxygenate the blood). Review of a Minimum Data Set (MDS) assessment for Resident #73, with a reference date of 5/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #73 was cognitively intact. In an interview on 7/14/26 at 10:27 AM, Resident #73 reported that she had complained of tooth pain to multiple nurses for several months before she was able to see a dentist and was still waiting to have the tooth extracted; she has had to eat softer foods and was concerned about infection. Resident #73 reported that the nurses and social worker kept telling her she was on the list to see the dentist, but then when she was seen in April it was the dental hygienist (person that cleans teeth) and she did not know anything about Resident #73's tooth pain and told her that she would need to see the dentist. Resident #73 reported that she eventually saw the dentist in June but he couldn't do the extraction because it required her to be off her blood thinner medication for 3 days before the procedure. Resident #73 reported that the facility physician had prescribed pain medication and antibiotics to treat the tooth infection until she could have the tooth removed. In an interview on 07/15/2026 at 4:00 PM, Certified Nursing Assistant (CNA) NN reported that Resident #73 complained about her tooth hurting. Review of Resident #73's Care Plan revealed no care plan related to dental services and/or tooth pain. Review of Resident #73's Social Services (SS) Medically Related SS Needs note dated 5/4/26 at 2:46 PM revealed, Need: .Dentist (broken R (right) tooth). New Concern/Follow-up/Referral: Nursing was notified of broken tooth on the right, nursing notified SSD (social services director). Resident/family involvement and notification: (space is blank). Comments: SSD will fax health drive paperwork to address broken tooth at next visit. This was the first mention of the tooth issue in Resident #73's record. This note was created by SSD C. Review of Resident #73's Nurse Practitioner (NP) note dated 6/1/26 at 8:00 AM revealed, .follow-up tooth pain. Patient reports that her right upper last molar is cracked and injuring her oral mucosal lining. She was told by dentist during previous visit in the facility to call him once the tooth becomes bothersome. There is no facial swelling or signs of local dental abscess on examination . ASSESSMENTS AND PLANS: .Fracture of tooth (traumatic). Broken tooth is injuring the oral lining. Order placed for STAT (immediate) in-house dental appointment. Others relevant intervention: Monitor patient and notify provider if new pain or facial swelling. Review of Resident #73's NP Note dated 6/8/26 revealed, .Tooth ache, swelling. Right face swelling. Tooth pain at 5/10. Add augmentin (antibiotic) twice daily for 10 days. Add Ibuprofen (pain reliever). In house dentist was notified and he is scheduled to see patient on 6/12/26. Review of Resident #73's NP Note dated 6/12/26 revealed, .Follow-up tooth pain, abscess . She reports that tooth pain is controlled with as needed ibuprofen (anti-inflammatory pain reliever) and facial swelling has reduced significantly. She consulted with the dentist earlier today and is scheduled for tooth extraction in 1 week . ASSESSMENTS AND PLANS: . Periapical abscess (a painful pocket of pus at the tip of a tooth root). Continue and complete course of Augmentin (antibiotic). Continue as needed ibuprofen for pain. Fracture of tooth (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(traumatic).Continue to monitor for resolution of tooth abscess. In an interview on 7/15/26 at 4:04 PM, Social Services Director (SSD) C reported that she didn't know when Resident #73 first started having the issue with her tooth, but that SSD C contacted the dentist office yesterday and got her appointment for the extraction moved up to 7/23/26 because we were told she was having problems with the tooth. SSD C reported that she had originally faxed a referral after she entered the note on 5/4/26 and the resident was put on the dental schedule to be seen the next time the dentist was in the facility, which was in June. SSD C could not tell me when she sent the original referral, if she communicated the urgency to the dental office, or if she followed up with Resident #73 about the appointments. Resident #3Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: contractures. Review of Resident #3's Care Plan revealed, .ADL (activities of daily living) self-care performance deficit related to. contractures, and needs assistance with personal care. Date initiated: 5/24/24, Revision on: 5/11/26. Interventions: .Splint/Brace Care: Apply palm protectors to both hands/palms with AM care and removed at HS (bedtime) as tolerated. May substitute with washcloths. Monitor skin integrity with each application and removal. Date initiated: 7/6/25.During an observation of 07/14/2026 at 10:57 AM Resident #3 was lying in her bed with her eyes open. Resident #3's hands were observed closed tightly and palm protectors were not in place. During an observation on 7/15/26 at 12:27 AM in the dining room, Resident #3 was observed being assisted to eat lunch. Resident #3 was not wearing palm protectors.In an interview on 7/15/26 at 12:33 PM, Unit Manager (UM) LL reported that Resident #3 was not wearing her palm protectors, and UM LL was not sure where they were. UM LL reported that RD JJ had just contacted her to check to make sure Resident #3 was wearing the palm protectors.Resident #65Review of an admission Record revealed Resident #65 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: hemiplegia (inability to move one side of the body) and hemiparesis (muscle weakness and loss of movement on one side of the body) following cerebral infarction (stroke), affecting right dominant side.Review of Resident #65's Care Plan revealed, .ADL self-care performance deficit related to weakness.hemiplegia.Date initiated: 10/27/23. Revision on: 6/2/26. Interventions: .Splint/Brace Care: apply right hand T-bar orthosis (a medical device that helps stretch tight hand muscles and fingers) in AM and remove in afternoon, as tolerated. Monitor skin integrity with each application and removal. Date initiated: 6/30/25.During an observation on 07/14/2026 at 10:02 AM Resident #65 was lying in his bed. Resident #65's right hand/arm was observed and there was not a splint/brace in place. During an observation on 07/15/2026 at 7:45 AM Resident #65 was observed in the dining room. Resident #65's right hand/arm was observed and there was not a splint/brace in place. During an observation on 07/15/2026 at 10:35 AM Resident #65 was observed lying in his bed. Resident #65's right hand/arm was observed and there was not a splint/brace in place.During an observation on 7/15/26 at 12:25 PM Resident #65 was in the dining room. Resident #65 was not wearing a hand splint.In an interview on 7/15/26 at 12:37 PM, CNA MM reported that she had forgotten to apply Resident #65's hand splint that morning. In an interview on 7/15/26 at 12:48 PM, Licensed Practical Nurse (LPN) U reported that CNA's apply splints and perform ROM for residents. LPN U reported that she had just been informed that Resident #65's hand splint was not in place, so she notified the CNA to apply the splint.The care plan (see Chapter 18) is a map for nursing care and demonstrates your accountability for patient care. By making accurate nursing diagnoses, your subsequent care plan communicates a patient's health care problems to other professionals and ensures that you select relevant and appropriate nursing interventions. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 16159-16161). Elsevier Health Sciences. Kindle (continued on next page)		

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Edition.A well-planned, comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation (see Chapter 20). The plan of care communicates nursing care priorities to nurses and other health care providers. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 16878-16882). Elsevier Health Sciences. Kindle Edition.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary ADL (activities of daily living) care to 1 resident (Resident #16) of 5 residents reviewed for ADL's, resulting in the potential for feelings of embarrassment, humiliation, and diminished self-esteem. Findings include: Review of an admission Record revealed Resident #16 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #16, with a reference date of 6/4/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #16 was cognitively intact. Review of the Functional Status revealed that Resident #16 required substantial to maximal (more than 50%) assistance with bathing. Review of Resident #16's Care Plan date initiated 12/5/26 revealed Resident #16 had an ADL (activities of daily living) self-care performance deficit related to impaired mobility and weakness. The interventions indicated that Resident #16 required assistance of 1 person for bathing, dressing, and personal hygiene. The care plan was revised on 5/28/26. During an observation and interview on 7/14/26 at 10:43 AM, Resident #16 was observed in his room with long dirty fingernails, and his shirt was on backwards. Resident #16 reported that he needed his fingernails cut and did not remember when the last time he had them cleaned. During an observation and interview on 7/15/26 at 9:34 AM, Resident #16 was observed in his room with long dirty fingernails. Resident #16 reported that he needed to get someone to cut his fingernails. During an observation and interview on 7/16/26 at 9:22 AM, Resident #16 was observed in his room; the fingernails on his left hand were cut short but the fingernails on his right hand remained long and dirty. Resident #16 reported that he had tried to cut his fingernails by himself today but was not able to cut the nails on his right hand. In an interview on 7/16/26 at 9:32 AM, Certified Nursing Assistant (CNA) NN reported that she had observed Resident #16 cutting his fingernails that morning. CNA NN explained that Resident #16 is scheduled for baths on second shift and that is when his nails would be cleaned and cut. CNA NN reported that the first shift CNA's were not responsible for taking care of his nails. CNA NN reported that Resident #16 liked a bed bath instead of a shower but did not refuse care. Review of Resident #16's Bathing Record documented in the CNA tasks indicated the resident had a bed bath on 7/15/26. There was no documentation related to fingernails.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions to prevent a decrease in ROM (range of motion) for 2 residents (Resident #3 and #65) of 2 residents reviewed for range of motion, resulting in the potential for worsening of hand contractures (a permanent shortening of muscles, tendons, skin, or other soft tissues that restricts normal joint movement and can cause deformity). Findings include: Resident #3 Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: contractures. Review of Resident #3's Care Plan revealed, .ADL (activities of daily living) self-care performance deficit related to. contractures and needs assistance with personal care. Date initiated: 5/24/24, Revision on: 5/11/26. Interventions: .Splint/Brace Care: Apply palm protectors to both hands/palms with AM care and removed at HS (bedtime) as tolerated. May substitute with washcloths. Monitor skin integrity with each application and removal. Date initiated: 7/6/25. During an observation of 07/14/2026 at 10:57 AM Resident #3 was lying in her bed with her eyes open. Resident #3's hands were observed closed tightly and palm protectors were not in place. In an interview on 07/15/2026 at 12:07 PM, Rehabilitation Director (RD) JJ reported that Resident #3 should be wearing palm protectors as much as possible to prevent skin breakdown and further contractures. During an observation on 7/15/26 at 12:27 AM in the dining room, Resident #3 was observed being assisted to eat lunch. Resident #3 was not wearing palm protectors. In an interview on 7/15/26 at 12:33 PM, Unit Manager (UM) LL reported that Resident #3 was not wearing her palm protectors, and UM LL was not sure where they were. UM LL reported that RD JJ had just contacted her to check to make sure Resident #3 was wearing the palm protectors. Review of Resident #3's Treatment Administration Record (TAR) for July 2026 revealed, Maintenance restorative nursing: Range of motion (passive: staff perform movements) to bilateral hands during AM care with application of palm protectors. The record indicated that the licensed nurse checked off and initialed 14 of 15 days, including 7/14/26 and 7/15/26. The record was not completed for 7/11/26. Review of Resident #3's Therapy to Nursing Communication Form dated 4/24/26 revealed, .Recommend PROM (passive range of motion) on BUE (bilateral upper extremities) with AM care. Donn (put on) BUE hand splint with am care and off around dinner or as tolerated. Review of Resident #3's CNA (Certified Nursing Assistant) documentation from the past 30 days revealed, multiple task orders for PROM and application of palm protectors. There was no data recorded in the tasks related to if the task was completed and/or how the resident tolerated the PROM and palm protectors. Resident #65 Review of an admission Record revealed Resident #65 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: hemiplegia (inability to move one side of the body) and hemiparesis (muscle weakness and loss of movement on one side of the body) following cerebral infarction (stroke), affecting right dominant side. Review of Resident #65's Care Plan revealed, .ADL self-care performance deficit related to weakness. hemiplegia. Date initiated: 10/27/23. Revision on: 6/2/26. Interventions: .Splint/Brace Care: apply right hand T-bar orthosis (a medical device that helps stretch tight hand muscles and fingers) in AM and remove in afternoon, as tolerated. Monitor skin integrity with each application and removal. Date initiated: 6/30/25. During an observation on 07/14/2026 at 10:02 AM Resident #65 was lying in his bed. Resident #65's right hand/arm was observed and there was not a splint/brace in place. During an observation on 07/15/2026 at 7:45 AM Resident #65 was observed in the dining room. Resident #65's right hand/arm was observed and there was not a splint/brace in (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	place. During an observation on 07/15/2026 at 10:35 AM Resident #65 was observed lying in his bed. Resident #65's right hand/arm was observed and there was not a splint/brace in place. In an interview on 7/15/26 at 12:07 PM, RD JJ reported that Resident #65 should have his hand splint applied during morning cares and could be taken off at lunch time or as tolerated. RD JJ reported that the splint was worn to prevent contracture due to his stroke that affected the right side of his body. RD JJ reported that Resident #65 was compliant with orders and did not refuse anything. During an observation on 7/15/26 at 12:25 AM Resident #65 was in the dining room. Resident #65 was not wearing a hand splint. In an interview on 7/15/26 at 12:37 PM, CNA MM reported that she had forgotten to apply Resident #65's hand splint that morning. In an interview on 7/15/26 at 4:01 PM, CNA NN reported that Resident #65 doesn't refuse wearing his hand splint. In an interview on 7/15/26 at 12:48 PM, Licensed Practical Nurse (LPN) U reported that CNA's apply splints and perform ROM for residents. LPN U reported that she had been informed that Resident #65's hand splint was not in place, so she notified the CNA to apply the splint. LPN U reported that she had not documented in the TAR yet for the day; she typically goes through the treatment orders in the afternoon, so she wasn't aware that Resident #65 did not have his brace applied that morning. Review of Resident #65's TAR for July revealed, MAINTENANCE RESTORATIVE NURSING: Range of Motion (passive) to Right HAND as tolerated prior to application of T-bar splint. in the morning for Maintenance Restorative Nursing PROM to right hand prior to application of T-bar splint in AM, Start Date 6/10/26. And also Splint/Brace care: apply right hand T-bar orthosis in AM and remove in afternoon, as tolerated. Monitor color, motion, sensation, and skin integrity with each application and removal. Start date 6/10/26. The administration records both indicated that the licensed nurse checked off and initialed 10 of 15 days, including 7/14/26 and 7/15/26. The records were not completed for 7/1, 7/6, 7/7, 7/9, and 7/13. Review of Resident #65's Therapy to Nursing Communication Form dated 6/25/26 revealed, .Recommend PROM on RUE (right upper extremity). Donn right splint, on with AM care and off at lunch or as tolerated. Review of Resident #65's CNA documentation from the past 30 days revealed, Splint/Brace assistance: Apply right hand T-bar orthosis in AM and remove in afternoon, as tolerated. Monitor skin integrity with each application and removal. Question #1 was how well did resident tolerate; 13 of 30 days indicated tolerated well and 13/30 days indicated did not occur. Question #3 was why did the restorative program not occur; 9 of 30 days indicated not scheduled this shift, 5 of 30 days indicated resident refused. Review of Resident #65's CNA documentation from the past 30 days revealed, Maintenance Restorative Nursing: Range of motion (passive) to right hand as tolerated prior to application of T-bar splint. There was no documentation related to if the task was performed, how well the resident tolerated it and/or how many minutes were spent providing the ROM. In an interview on 7/16/26 at 11:53 AM, Director of Nursing (DON) B reported that the licensed nurses are expected to verify that residents had splints in place per orders and then check the order off in the TAR. DON B reported that nurses should not be waiting to go through the treatment orders in the afternoon because there are orders scheduled for the morning. Review of the facility's policy for Range of Motion dated 10/21/24 revealed, .1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care. 3. Care Planning a. Based on the comprehensive assessment, the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance). ii. Appropriate equipment (braces or splints). iii. Assistance as needed (active assisted, passive, (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision). c. Care plan interventions will be developed and delivered through the facility's restorative program, or through specialized rehabilitative services as ordered by the attending practitioner. d. Interventions shall be documented on the resident's person-centered care plan/restorative care plan e. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion exercises will be documented in the medical record. 4. Preventive Care a. Staff will be educated on the risk factors for a decline in range of motion. b. Staff will be educated on basic, restorative nursing care that does not require the use of a qualified therapist or licensed nurse oversight. c. Residents will receive services from restorative aides or therapists as needed.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain weights and ensure nutritional preferences were met in 1 of 1 resident (R5) reviewed for nutrition, resulting in the potential for decreased nutritional status. Findings include: Review of R5's medical records indicated the resident was admitted on [DATE] weighing 126 pounds. The resident did not have documentation in his medical records that he had been weighed from 6/25/26 until beginning of survey 7/14/26. According to R5's Minimum Data Set (MDS) dated , 7/1/26, the resident scored 5/15 on the BIMS (Brief Interview Mental Status) indicating he was severely cognitively impaired. Diagnoses of medically complex conditions included cancer, malnutrition, pressure ulcer of sacral region, acquired absence of right and left legs above knee, ulcer of esophagus (a muscular tube in the digestive system that connects the throat (pharynx) to the stomach) with bleeding, peripheral vascular disease, and renal disease. Section K-Swallowing/Nutritional Status revealed the resident was 69 inches and weighed 126 pounds. R5 was not on a physician-prescribed weight-loss program and had a loss of 5% or more of his total body weight in the last month. Review of R5's Hospital After Visit Summary, dated 5/30/26-6/25/26, revealed, Diet Instructions-Nutrition Recommendations. General diet, Trial vanilla magic cup (a high-calorie, high-protein frozen dessert designed to help prevent involuntary weight loss. It resembles ice cream when frozen and turns into a soft, pudding-like consistency when thawed) with lunch and vanilla ice cream with dinner. Review of Order Summary dated 6/25/26 at 10:00 PM revealed, Regular diet, regular texture, regular fluid, thin consistently. Dietary-Supplements included Health Shake (specialized nutrition shakes) three times a day for Protein calorie malnutrition and Prostat AWC (medical-grade concentrated liquid protein supplement designed to manage wounds and muscle loss) two times a day related to pressure ulcer of sacral region (dated 7/1/25). Review of R5's Care Plan, dated 6/30/26 with revision on 7/6/26, revealed, Focus-At Risk for Altered Nutritional Status-related to hospital course with sepsis, chronic osteomyelitis (infection in bone) with multiple impaired skin sites present, bilateral AKA (above knee amputation), esophageal ulcers noted with complicating diagnosis DMII (diabetes), COPD (chronic obstructive pulmonary disease), afib (atrial fibrillation), HTN (hypertension), PVD (peripheral vascular disease), metastatic prostate cancer, poor intake during hospital course (stay) with weight loss. Goal- was to have adequate nutrition to meet nutritional needs and have no signs/symptoms of malnutrition. Interventions to meet goals included-periodically obtain resident's weight, evaluate, and report to Dietician, Physician/NP/PA (nurse practitioner, physician's assistant) provide meals/fluids based on resident food preferences and as ordered, provide nutritional supplement(s) as ordered, update and honor resident's food preferences on tray ticket, encourage/provide intake of fluids throughout the day if not contraindicated. Review of R5's Care Plan, revision on 7/6/26, revealed, Focus-Malnourished as evidenced by Mini Nutritional Assessment. Has diagnosis of moderate protein calorie malnutrition. Goal-will have adequate nutrition to meet nutritional needs and have improved as evidenced by Mini Nutritional Assessment score. Interventions to meet goal included-monitor weight and obtain food preferences. Review of R5's Mini Nutritional assessment dated [DATE] indicated the resident with a score of 5.0 indicating he was malnourished. R5 had a severe decrease in food intake, with a weight loss greater than 6.6 pounds in the last 3 months. Review of R5's Nutrition Data Collection/Evaluation, Admission, dated 6/30/26, indicated he admitted to the facility with malnutrition. During R5's hospitalization the resident had sepsis, chronic osteomyelitis with multiple impaired skin sites present, bilateral above knee amputations, esophageal ulcers, metastatic prostate (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cancer, poor intake during hospital course with weight loss. R5 stated his appetite was back denying pain or discomfort related to esophageal ulcers and was eating well. Health shakes three times a day on admission to meet caloric intake needs as related to variable intake, noted weight loss, and wounds present. During an observation and interview on 7/14/26 at 10:56 AM, R5 had 3-unopened cartons of Health Shakes on bedside table room temperature to touch. Bedside table was out of sight and reach of resident along with Styrofoam drinking cup. R5 stated he would drink his water but did not like the taste of the Health Shakes and did not drink them. R5 appeared thin and gaunt (someone who is extremely thin, bony, and [NAME], often because of suffering, hunger, or illness). During an observation and interview on 7/15/26 at 8:45 AM, R5 was awake in his bed stating had eaten every bit of his breakfast and it was good. No Healthy Shake was at bedside. R5 stated he did not like the taste of the Health Shakes and does not usually drink them. A foam cup with water dated 7/15 was on the bedside table in front of him. During an interview and record review on 7/15/2026 at 10:48 AM, Director of Nursing (DON) B stated, (R5) has been refusing his weights. Reviewed R5's progress notes that did not have documented refusals. DON B then stated CNAs (Certified Nursing Assistants) Tasks would indicate when CNAs were to weigh resident. DON B reviewed R5's Tasks for weight monitoring. DON B stated, R5 Task for Weight indicates on 6/28/26 NA (not applicable). I don't know what that means. There is a spot to indicate refusal but that was not indicated. CNAs are to take the weights when indicated and nurses help when they can. In R5's Tasks there was only one date for the CNA to take weight on 6/28/26. R5's admission weekly weights were not set up for the CNAs or nurses to know to take them weekly x4 weeks. Knowing R5's weight and nutritional status is important because he has multiple health concerns including cancer and wounds. I've heard (R5) likes vanilla and the facility can give him the Magic Cups which will help him with nutrition and weight. During an interview and record review on 7/15/2026 at 3:19 PM, Corporate Registered Dietician (RD) O stated while reviewing R5's medical records, It is important with (R5's) critical condition to monitor his weight. Unfortunately, his weights were not done weekly. He should be weighed upon admission and then weekly for 4 weeks to get a baseline weight on him. His nutritional needs are very important. If he does not like the Health Shakes, we can work on finding him something he likes to make sure he gets the protein and nutrition he needs. Reviewed R5's After Visit Summary, stating, The facility can give him the Magic Cup in Vanilla. Review of facility policy, Weight Monitoring, dated 10/26/2023, revealed, Policy: Reviewed/ Revised By: PHC Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. A weight monitoring schedule will be developed upon admission for all residents: a. Weights should be recorded at the time obtained. b. Newly admitted residents - monitor weight weekly for 4 weeks. 6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight.		

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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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide prompt dental services for 1 of 1 resident (Resident #73) reviewed for dental care, resulting in Resident #73 experiencing pain, difficulty eating and the potential for spread of infection. Findings include: Resident #73 Review of an admission Record revealed Resident #73 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic respiratory failure (when the lungs cannot properly oxygenate the blood). Review of a Minimum Data Set (MDS) assessment for Resident #73, with a reference date of 5/19/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #73 was cognitively intact. In an interview on 7/14/26 at 10:27 AM, Resident #73 reported that she had complained of tooth pain to multiple nurses for several months before she was able to see a dentist and was still waiting to have the tooth extracted; she has had to eat softer foods and was concerned about infection. Resident #73 reported that the nurses and social worker kept telling her she was on the list to see the dentist, but then when she was seen in April it was the dental hygienist (person that cleans teeth) and she did not know anything about Resident #73's tooth pain and told her that she would need to see the dentist. Resident #73 reported that she eventually saw the dentist in June but he couldn't do the extraction because it required her to be off her blood thinner medication for 3 days before the procedure. Resident #73 reported that the facility physician had prescribed pain medication and antibiotics to treat the tooth infection until she could have the tooth removed. In an interview on 07/15/2026 at 4:00 PM, Certified Nursing Assistant (CNA) NN reported that Resident #73 complained about her tooth hurting. Review of Resident #73's Care Plan revealed no care plan related to dental services and/or tooth pain. Review of Resident #73's Social Services (SS) Medically Related SS Needs note dated 5/4/26 at 2:46 PM revealed, Need: .Dentist (broken R (right) tooth). New Concern/Follow-up/Referral: Nursing was notified of broken tooth on the right, nursing notified SSD (social services director). Resident/family involvement and notification: (space is blank). Comments: SSD will fax health drive paperwork to address broken tooth at next visit. This was the first mention of the tooth issue in Resident #73's record. This note was created by SSD C. Review of Resident #73's record for a referral or fax related to the resident's broken tooth; no documentation found until the provider note below dated 6/1/26. Review of Resident #73's Nurse Practitioner (NP) note dated 6/1/26 at 8:00 AM revealed, .follow-up tooth pain. Patient reports that her right upper last molar is cracked and injuring her oral mucosal lining. She was told by dentist during previous visit in the facility to call him once the tooth becomes bothersome. There is no facial swelling or signs of local dental abscess on examination. ASSESSMENTS AND PLANS: .Fracture of tooth (traumatic). Broken tooth is injuring the oral lining. Order placed for STAT (immediate) in-house dental appointment. Others relevant intervention: Monitor patient and notify provider if new pain or facial swelling. Review of Resident #73's record for notes related to status of the resident having an appointment scheduled with the dentist; no documentation found. Review of Resident #73's NP Note dated 6/8/26 revealed, .Tooth ache, swelling. Right face swelling. Tooth pain at 5/0. Add augmentin (antibiotic) twice daily for 10 days. Add Ibuprofen (pain reliever). In house dentist was notified and he is scheduled to see patient on 6/12/26. Review of Resident #73's NP Note dated 6/12/26 revealed, .Follow-up tooth pain, abscess. She reports that tooth pain is controlled with as needed ibuprofen (anti-inflammatory pain reliever) and facial swelling has reduced significantly. She consulted with the dentist earlier today and is scheduled for tooth extraction in 1 week. ASSESSMENTS AND PLANS: .Periapical abscess (a painful pocket of pus at the tip of a tooth (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	root). Continue and complete course of Augmentin (antibiotic). Continue as needed ibuprofen for pain. Fracture of tooth (traumatic).Continue to monitor for resolution of tooth abscess.Review of Resident #73's record for a visit note and/or progress notes related to the resident being seen by the dentist and/or being scheduled for a tooth extraction; no documentation found. Review of Resident #73's Progress Note dated 6/19/26 at 11:01 AM revealed, (Resident #73) completed her course of oral antibiotic for her tooth infection on 6/18/26. No adverse reaction to medication noted throughout treatment. S&S (signs and symptoms) are resolved at this time. (Resident #73) is to see the dentist for tooth extraction. In an interview on 7/15/26 at 4:04 PM, Social Services Director (SSD) C reported that she didn't know when Resident #73 first started having the issue with her tooth, but that SSD C contacted the dentist office yesterday and got her appointment for the extraction moved up to 7/23/26 because we were told she was having problems with the tooth. SSD C reported that she had originally faxed a referral after she entered the note on 5/4/26 and the resident was put on the dental schedule to be seen the next time the dentist was in the facility, which was in June. SSD C could not tell me when she sent the original referral, if she communicated the urgency to the dental office, or if she followed up with Resident #73 about the appointments. This surveyor requested all dental visit notes from April 2026 through to present date, including all communication notes between SSD C and the dental office.In a subsequent interview on 7/15/26 at 4:36 PM, SSD C reported that she had found a dental visit note from 4/29/26 when Resident #73 was seen for a cleaning; the notes indicate that the resident was going to be getting her #2 tooth fixed and had a small area noted at the gumline of #14. SSD C reported that she did not know what that information meant and that she does not follow up with residents after they are seen by dental services; the dental office sends the facility their plans for the next time they visit the facility. SSD C could not find any additional visit notes and or communication notes.In an interview on 7/16/26 at 10:33 AM, Resident #73 reported that SSD C finally came into her room after this surveyor left on 7/14/26 and notified her that she was scheduled to have the tooth extracted on 8/7/26. Resident #73 reported that she was concerned about the timing and asked for the appointment to be moved up; the appointment was rescheduled for 7/23/26. Resident #73 reported that NP HH saw her today and prescribed another antibiotic to prevent infection until she can have the tooth removed.In an interview on 7/16/26 at 11:32 AM, Director of Nursing (DON) B reported that the dental provider they use was supposed to upload their visit notes to the record. This surveyor requested any documentation that the facility had promptly arranged for Resident #73 to see the dentist.The following documentation was provided by DON B just prior to survey exit:A dental visit note from 4/29/26 revealed, .Phophylaxis (routine teeth cleaning).Treatment notes: will be having #2 fixed and also while cleaning today, noticed a small area at the gumline #14.An email that was received on 6/8/26 which included a schedule from the dental office indicating that Resident #73 was on the schedule to be seen for a visit on 6/12/26.A dental visit note dated 6/12/26 revealed, . Patient has been taking antibiotic for the past week for a possible infection of tooth #2. The tooth has fractured further and is non-restorable. She would like to have it extracted (removed). She is taking Xarelto (blood thinner) which will have to be adjusted before the extraction. I smoothed the rough potion of the tooth.she though it felt more comfortable.Action Required by nursing home staff: .please have responsible party sign consent for extraction form; Xarelto prescription might need to be adjusted before the extraction - check with physician or nurse practitioner.An email that was received on 6/29/26 which included a schedule from the dental office indicating that Resident #73 was on the schedule to be seen for an extraction on 8/7/26.An email that was received on 7/15/26 at 11:33 AM that included a schedule from the dental office indicating that Resident #73 was now on the schedule to be seen for an extraction on 7/23/26.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appetizing and palatable food at a palatable food temperature for 2 (Resident #8 and Resident 94) of 4 residents reviewed for food palatability and 4 of 4 residents from a confidential resident council meeting resulting in dissatisfaction with the food served and the potential for decreased intake and weight loss. Findings include: Resident #8 Review of an admission Record revealed Resident #8 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension (high blood pressure) and need for assistance with personal care. Review of a Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 6/2/26 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #8 was moderately cognitively impaired. During an interview on 7/14/2026 at 11:25 AM, Resident #8 reported concerns with food that was served at the facility. Resident #8 reported her food was often served cold, and when it was cold, she would not eat it. During an interview on 7/15/2026 at 12:54 PM, Resident #8 reported she had been served eggs and toast for breakfast that morning, but the eggs were too cold to eat, so she only ate the toast. Resident #8 reported that she felt like the eggs were cold because they had sat in the food cart (cart that holds meal trays) for too long as residents waited to have staff pass out the trays. Resident #8 reported since her room was towards the end of the hall, she was often one of the last residents to get her meal tray served. During an observation on 7/15/2026 at 1:15 PM, on the B hall, a test tray was tested as if it were the last meal on the unit. The meal tray had been sitting in the food cart until this writer checked the temperature. On the meal tray, there was a large piece of ham that had a temperature of 113 degrees. During an interview and observation on 7/15/2026 at 12:21 PM, Resident #8 reported that she had taken one bite of her ham and it was too cold to eat so she did not eat any more of it. Resident #94 Review of an admission Record revealed Resident #94 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension and anxiety disorder. During an interview and observation on 7/14/2026 at 11:11 AM, Resident #94 reported ongoing concerns with the food served at the facility. Resident #94 reported she had been served cold eggs and cereal this morning, and when she asked for something else because she did not like eggs, staff brought her back oatmeal and bacon, but the oatmeal was bland and the bacon was swimming in grease. Resident #94 showed this writer the bacon that she had been served that was sitting in a sandwich bag covered in an estimated 1/4 cup size of grease. Resident #94 reported she had saved the bacon to show staff how greasy it was. Resident #94 then stated, I would have terrible stomach pain if I ate that much grease. Resident #94 reported the facility would provide alternate options when she did not like the food being served, but the options were worse. Resident #94 showed this writer a photo of a peanut butter and jelly sandwich that she reported she had been served as an alternate option for a few days prior. The photo showed two pieces of bread opened with a small dab of jelly and a large amount of peanut butter on the open bread pieces. Resident #94 reported she had given up on the food at the facility and had started ordering food out a lot more. Resident #94 voiced frustration that she had to spend money on food because the facility continued to serve food that was not palatable. During an interview on 7/16/2026 at 11:11 AM, Registered Nurse (RN) PP reported she was aware that Resident #94 had ongoing concerns with the food at the facility. RN PP reported that Resident #94 seemed to only order food and have it delivered now. In a confidential resident council meeting on 7/15/26 at 1:30 PM, 4 of 4 residents reported that they had received cold food that should have been served hot. Review of Resident Council Meeting Minutes (continued on next page)		

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 7/10/26 revealed, Issue: Meals not being delivered timely . Outcome: Not resolved, action still needed .Review of Resident Council Meeting Minutes dated 4/9/26 revealed, Issue: Food trays are still an issue. Not getting passed out fast enough and the food is cold .		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate medical records for 3 residents (Resident #3, #65, and #46) of 18 residents reviewed for complete and accurate medical record documentation, resulting in incomplete and inaccurate documentation of treatments completed by the licensed nurse and tasks performed by the CNA's (Certified Nursing Assistant). Finding include: Resident #3 Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: contractures (a permanent shortening of muscles, tendons, skin, or other soft tissues that restricts normal joint movement and can cause deformity). Review of Resident #3's Care Plan revealed, .ADL (activities of daily living) self-care performance deficit related to. contractures, and needs assistance with personal care. Date initiated: 5/24/24, Revision on: 5/11/26. Interventions: .Splint/Brace Care: Apply palm protectors to both hands/palms with AM care and removed at HS (bedtime) as tolerated. May substitute with washcloths. Monitor skin integrity with each application and removal. Date initiated: 7/6/25. During an observation of 07/14/2026 at 10:57 AM Resident #3 was lying in her bed with her eyes open. Resident #3's hands were observed closed tightly and palm protectors were not in place. During an observation on 7/15/26 at 12:27 AM in the dining room, Resident #3 was observed being assisted to eat lunch. Resident #3 was not wearing palm protectors. Review of Resident #3's Treatment Administration Record (TAR) for July 2026 revealed, Maintenance restorative nursing: Range of motion (passive: staff perform movements) to bilateral hands during AM care with application of palm protectors. The record indicated that the licensed nurse checked off and initialed 14 of 15 days, including 7/14/26 and 7/15/26. The record was not completed for 7/11/26. Review of Resident #3's CNA documentation from the past 30 days revealed, multiple task orders for PROM and application of palm protectors. There was no data recorded in the tasks related to if the task was completed and/or how the resident tolerated the PROM and palm protectors. Resident #65 Review of an admission Record revealed Resident #65 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: hemiplegia (inability to move one side of the body) and hemiparesis (muscle weakness and loss of movement on one side of the body) following cerebral infarction (stroke), affecting right dominant side. Review of Resident #65's Care Plan revealed, .ADL self-care performance deficit related to weakness.hemiplegia.Date initiated: 10/27/23. Revision on: 6/2/26. Interventions: .Splint/Brace Care: apply right hand T-bar orthosis (a medical device that helps stretch tight hand muscles and fingers) in (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM and remove in afternoon, as tolerated. Monitor skin integrity with each application and removal. Date initiated: 6/30/25. During an observation on 07/14/2026 at 10:02 AM Resident #65 was lying in his bed. Resident #65's right hand/arm was observed and there was not a splint/brace in place. During an observation on 07/15/2026 at 7:45 AM Resident #65 was observed in the dining room. Resident #65's right hand/arm was observed and there was not a splint/brace in place. During an observation on 07/15/2026 at 10:35 AM Resident #65 was observed lying in his bed. Resident #65's right hand/arm was observed and there was not a splint/brace in place. During an observation on 7/15/26 at 12:25 AM Resident #65 was in the dining room. Resident #65 was not wearing a hand splint. In an interview on 7/15/26 at 4:01 PM, CNA NN reported that Resident #65 doesn't refuse wearing his hand splint. In an interview on 7/15/26 at 12:48 PM, Licensed Practical Nurse (LPN) U reported that she had not documented in the TAR yet for that day. LPN U reported she typically went through the treatment orders in the afternoon, so she wasn't aware that Resident #65 did not have his brace applied that morning. Review of Resident #65's TAR for July revealed, MAINTENANCE RESTORATIVE NURSING: Range of Motion (passive) to Right HAND as tolerated prior to application of T-bar splint. in the morning for Maintenance Restorative Nursing PROM to right hand prior to application of T-bar splint in AM, Start Date 6/10/26. And also Splint/Brace care: apply right hand T-bar orthosis in AM and remove in afternoon, as tolerated. Monitor color, motion, sensation, and skin integrity with each application and removal. Start date 6/10/26. The administration records both indicated that the licensed nurse checked off and initialed 10 of 15 days, including 7/14/26 and 7/15/26. The records were not completed for 7/1, 7/6, 7/7, 7/9, and 7/13. Review of Resident #65's CNA documentation from the past 30 days revealed, Splint/Brace assistance: Apply right hand T-bar orthosis in AM and remove in afternoon, as tolerated. Monitor skin integrity with each application and removal. Question #1 was how well did resident tolerate; 13 of 30 days indicated tolerated well and 13/30 days indicated did not occur. Question #3 was why did the restorative program not occur; 9 of 30 days indicated not scheduled this shift, 5 of 30 days indicated resident refused. Review of Resident #65's CNA documentation from the past 30 days revealed, Maintenance Restorative Nursing: Range of motion (passive) to right hand as tolerated prior to application of T-bar splint. There was no documentation related to if the task was performed, how well the resident tolerated it and/or how many minutes were spent providing the ROM. In an interview on 7/16/26 at 11:53 AM, Director of Nursing (DON) B reported that the licensed nurses (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are expected to verify that residents had splints in place per orders and then check the order off in the TAR. DON B reported that nurses should not be waiting to go through the treatment orders in the afternoon because there are orders scheduled for the morning. In Legal and Ethical Issues in Nursing by G. [NAME] (2001), it documents that Documentation must show continuity of care, interventions that were used, and patient responses to the therapies implemented. Nurse's notes are to be concise, clear, timely, and complete. (pg. 171) Resident #46(R46) Review of an Face Sheet revealed R46 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: frontal lobe (area of the brain responsible for decision-making, reasoning and expressive language) and executive function (planning, remembering instructions and multi-tasking skills) deficits following a cerebral infarction (stroke), chronic pain and bed confinement status (inability to tolerate being out of bed). Review of a Minimum Data Set(MDS) assessment for R46 with a reference date of 5/14/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section GG revealed R46 required maximal assistance (helper provides more than half the effort) roll in bed and set up assistance for eating. Review of a Care Plan for R46 with a reference date of 9/19/23 revealed the following focus/goal/interventions: Focus: (R46) is at risk for impaired skin integrity r/t (related to) type 2 diabetes.preferences to remain in bed.chronic pain.decreased mobility.Goal: Resident will have intact skin to extent allowed by resident.Interventions: monitor skin integrity during weekly/routine skin nursing assessments, notify nurse of any new areas of skin impairment.redness, blisters.notify physician/NP (nurse practitioner) of any new areas of skin impairment. In an interview on 7/14/26 at 9:51am, R46 reported he suffered pain when a staff member recently knocked a hot beverage off his breakfast tray and it spilled on his groin and legs. R46 reported he was not sure if he had any open areas on his skin following the accident. Review of a Provider Note for R46 with a reference date of 6/24/26 revealed [AGE] year-old male.complains of pain in his groin due to spilling hot coffee yesterday. No areas of open or erythematous (abnormal redness) skin.skin is tender to touch. In an interview on 7/15/26 at 3:14pm, Certified Nursing Assistant (CNA) R reported on 6/23/26 she was setting up R46's breakfast tray as he sat supported in bed when she bumped a cup of hot water with her hand and it spilled into R46's lap. CNA R reported R46 was covered by a blanket, sheet and incontinence brief when the accident occurred, and she immediately removed the blanket and sheet. CNA R reported R46 complained of pain and she alerted the nurse. CNA R confirmed she told the nurse about the incident immediately. CNA R reported R46 continued talking about the incident later that same day and reported he was frustrated about it. Review of Skin Assessments for R46 revealed the last skin assessment for the resident was (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed on 4/28/26. Via electronic communication on 7/15/26 at 8:41am, all skin assessments for R46 for the last 30 days were requested. No assessments were provided by the conclusion of the survey In an interview on 7/15/26 at 3:45pm, Director of Nursing (DON) B it was the expectation that nurses complete a skin assessment on each resident weekly and as needed, and incident/accident reports with every occurrence. DON B confirmed R46's skin had not been assessed since 4/28/26 and she was not aware of the issue prior to the survey. DON B reported she was aware R46 recently reported an accident in which a hot beverage was spilled onto his groin. In an interview on 7/16/26 at 10:00am, DON B reported due to a computer issue, nurses were not receiving prompts to complete skin assessments, but regardless, nurses were expected to know they should complete weekly skin assessments for every resident.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to explain terms of and ensure the validity of understanding/consent to enter into the agreement for an Alternate Dispute Resolution Agreement (ADR)- a legally binding contract that specifies the use of an ADR process - such as arbitration instead of going to court) for 2 (Resident # 32 and Resident #94) of 3 residents reviewed for arbitration agreements resulting in Resident #32 and Resident #94 signing ADR agreements when they did not wish to. Findings include: Resident #32Review of an admission Record revealed Resident #32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain and anemia (Anemia is a condition characterized by a deficiency of healthy red blood cells or hemoglobin, leading to insufficient oxygen delivery to the body's tissues.)Review of a Minimum Data Set (MDS) assessment for Resident #32, with a reference date of 5/18/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #32 was cognitively intact. Review of Resident #32's ADR Agreement dated 12/22/25 revealed, . Consent Decision: I (Resident #32) consent to the ADR agreement. This ADR form was signed by Resident #32 and Former Admissions Director (FAD) AA on 12/23/25. During an interview on 7/15/2026 at 12:05 PM, Resident #32 reported she did not recall staff educating her on ADR agreements. Resident #32 was unable to report what her understanding of the arbitration process with the facility was. Resident #32 was unable to report what her understanding of the arbitration process was when a dispute arises. Resident #32 reported that she did not know that signing the ADR form was giving up her right to litigation in a court proceeding. Resident #32 reported she did not feel that the ADR form was explained in a process that she understood, and that she would have not wanted to sign the ADR form if she had known that she was giving up her right to litigation in a court proceeding. On 7/16/2026 at 11:39 AM, This writer attempted to reach FAD AA via telephone. FAD AA did not return this writer's call prior to survey exit. Resident #94Review of an admission Record revealed Resident #94 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension (high blood pressure) and anxiety disorder. Review of Resident #94's ADR Agreement dated 7/7/26 revealed, . Consent Decision: I (Resident #94) consent to the ADR agreement. This ADR form was signed by Resident #94 on 7/8/26. During an interview on 7/14/2026 at 9:02 AM, Nursing Home Administrator (NHA) A reported that the facility did offer arbitration agreements, but that they did not have any residents that had entered into an arbitration agreement with the facility. NHA A reported that the facility's Admissions Director was responsible for educating and completing arbitration agreements with residents upon admission, but the facility did not have a current Admissions Director, so she was providing the education on arbitration agreements to new residents when they admitted . NHA A reported that she had not had any residents sign an arbitration agreement since she had taken over completing them with residents 3 weeks prior. On 7/15/2026 at 9:26 AM, This writer requested a list of all residents residing in the facility that had signed an ADR agreement at admission via email to NHA A. Review of the Arbitration List revealed that there were 14 residents in the facility that had signed an ADR agreement upon admission to the facility. Noted that Resident #94 had admitted to the facility on [DATE] when NHA A was responsible for completing the education on ADR agreements. During an interview on 7/15/2026 at 12:21 PM, Resident #94 reported she had not received any education on the ADR form. When this writer reviewed the ADR form that was signed by Resident #94 on 7/8/26, Resident #94 reported that she was unaware of what the ADR process was, and that she (continued on next page)		

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 07/16/2026
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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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would never have signed away her right to litigation in a court proceeding. Resident #94 reported she did not feel that the ADR form was explained in a process that she understood. During a follow up interview on 7/15/2026 at 12:52 PM, This writer queried NHA A about Resident #94's signed ADR form dated 7/7/26, as NHA A had previously reported that she was completing the ADR education with residents upon admission. NHA A reported that she was completing all admission documentation except ADR forms, but if a resident was interested in signing an ADR form, that Regional Director of Business Development (RDBD) N would complete the education on the ADR form and witness the resident sign the form. NHA A reported Resident #94's ADR education had been completed with RDBD N. During an interview on 7/16/2026 at 2:56 PM, RDBD NN reported that she was responsible for educating Admissions Directors on the ADR process and how they were supposed to educate any resident prior to the resident signing the ADR form. RDBD reported that the Admissions Director was supposed to verbally educate residents on the ADR process and then show residents a video the facility had that further explained and educated on the ADR process. RDBD N reported that she did not complete the education on ADR with new residents at the facility, and that she had not provided education on the ADR process to Resident #94. RDBD N reviewed Resident #94's ADR form dated 7/8/26 and confirmed that there was not a facility representative signature, but that NHA A had generated the form. During a subsequent interview on 7/16/2026 at 3:03 PM, Resident #94 reported that the facility had not provided her with a video to review regarding the ADR process.		