STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	394160	A. BUILDING _____ B. WING _____	**1/18/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDILODGE OF WESTWOOD	**2575 N DRAKE ROAD KALAMAZOO, MI 49006**

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F0000 SS=	INITIAL COMMENTS /Medilodge of Westwood was surveyed for an abbreviated survey from 1/17/24-1/18/24. Intakes: MI100141735 Census: 86	F0000		
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00141735 Based on interview, and record review, the facility failed to assess a resident after a outpatient medical procedure in 1 (Resident #100) of 4 residents reviewed for quality of care, resulting in a delay of treatment for Resident #100, who ultimately passed away. Findings include: Review of an "Admission Record" dated 10/18/23 revealed Resident #100 was admitted to the facility with the following pertinent diagnoses: wedge compression fracture of second lumbar vertebra (fracture of the spine), dependence on renal dialysis (procedure to remove waste products and excessive fluid from the blood),	F0684	Element 1: Resident #100 no longer resides in the facility. Element 2: On 1/18/2024, any resident who had gone out of the facility for a procedure in the past 30 days was identified. Residents identified had a chart review for the completion of an assessment post procedure or change in condition post procedure. No negative findings were identified. Residents with upcoming procedures have been identified and will be assessed post procedure timely; within 30 minutes, upon returning into facility. The assessment will be documented in the residents medical record. Any abnormal findings will be reported to the MD. Element 3: On 1/22/2024, the Notification of Change policy was reviewed by the NHA and DON and deemed appropriate. On 1/22/2024, an Ad-Hoc QAPI was meeting was held to review the Notification of Change Policy and this plan. Beginning on 1/22/2024, Nurses are being re-educated on Assessment, including education regarding assessment of a resident status post procedures to include notification of Physician as needed. No Nurse will be allowed to work without education. Element 4: Residents with procedures returning to the facility will be reviewed 5x per week by the DON/designee to ensure that the	1/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/05/2024

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.

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	chronic systolic heart failure (condition in which the heart does not properly circulate the blood), peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), chronic respiratory failure (chronic respiratory condition causing inadequate exchange of oxygen and carbon dioxide in the body), hypertension (condition in which the force of the blood against the artery walls is too high), and diabetes with hyperosmolarity (condition resulting elevated blood sugar levels over a long period of time often with serious and potentially fatal complications). Review of a Minimum Data Set (MDS) assessment dated 10/23/23 revealed Resident #100 was admitted from an acute care hospital, required assistance with dressing, toileting, transferring from one surface to another, and changing position in bed. The MDS reflected Resident #100 used a power wheelchair for mobility. The primary diagnosis for this admission was indicated as fractures. Review of hospital records for Resident #100, dated 10/26/23, revealed the resident underwent replacement of an internal jugular catheter (an indwelling device inserted into a large, central vein in the neck) due to occlusion at 12:10pm. A nursing report was given to Unit Manager "Q" at 12:42pm via telephone. The records revealed Resident #100 was "anxious, restless, drowsy, and complained of pain at a level as high as "8" on the pain scale. Resident #100 had a rapid heart rate ranging from 95-120 beats per minute during the outpatient stay. According to the American Nephrology Nurses Association (https://www.annanurse.org/download/reference/practice/vascularAccessFactSheet.pdf), "A Central Venous Catheter (CVC) is a narrow,		resident was assessed timely upon return and documentation of assessment was completed. Weekly x 4 and then monthly the DON/designee will conduct an audit of residents with outside procedures to ensure return assessment is completed timely and that the follow up documentation was completed. Audit findings will be presented to the facility QAPI Committee and will only be discontinued with substantial compliance and with approval of the facility QAPI Committee. The Administrator is responsible to maintain compliance.	

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	flexible tube used to access the bloodstream. The CVC may be inserted into a large vein in the neck, chest, back, or groin. There are tunneled and non-tunneled catheters. Sites preferred for tunneled catheter insertion are the right internal jugular or the right external jugular. While CVCs have the advantage of being ready for use immediately after placement, CVCs: Have a greater chance of becoming infected or clotted. Have a slower blood flow, thus not adequately cleaning the blood. Are at greater risk for central vein thrombosis or stenosis. Cause high risk for sepsis, hemorrhage, or air embolism." In an interview on 1/17/24 at 4:39 pm, Business Owner (BO) "T", owner of the transportation service that transported Resident #100 back to the facility on 10/26/23, reported the company uses a GPS (global positioning system) that was time stamped to track customer pick up and drop off times. Review of a transportation record provided by BO "T" revealed Resident #100 left the hospital at 1:33pm and returned to the facility at 1:55pm on 10/26/23. In an interview on 1/18/24 at 4:45pm, Nursing Home Administrator (NHA) "A" reported she reviewed the facility's video surveillance footage and confirmed that Resident #100 returned to the facility at 1:55pm on 10/26/23. In an interview on 1/17/24 at 3:41pm, Unit Manager (UM) "Q" reported he received a			

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	telephoned report from a nurse at the hospital regarding Resident #100. UM "Q" reported Resident #100's assigned facility nurse, Registered Nurse (RN) "K", was too busy to take the call, so UM "Q" assisted by taking the report. UM "Q" reported the hospital nurse told him Resident #100 did not tolerate the procedure well, that the resident "didn't seem very healthy", and had been approached at the hospital about signing on for end-of-life care. UM "Q" reported he share the nursing report with RN "K" but was unsure what time he did so. UM "Q" reported he did not see Resident #100 when he returned to the facility because he was in his office in a meeting regarding employee insurance benefits. When queried about the facility's process for ensuring nursing staff is aware when a resident is returned to the facility, UM "Q" reported "sometimes the staff see them come in, I don't really know if there's a process". In an interview on 1/17/24 at 3:03pm, Registered Nurse (RN) "K" reported Resident #100 was on his caseload on 10/26/23. RN "K" reported he was unsure what type of procedure Resident #100 had on 10/26/23 but received a summary of a nursing report for Resident #100 from Unit Manager (UM) "Q" upon returning from a break. RN "K" reported he did not know what time Resident #100 returned from the procedure, but that the resident "must have returned while I was on my break". RN "K" reported he went to check on Resident #100 for the first time at approximately 3:15pm (1 hour and 20 minutes after returning from the hospital) and found the resident unresponsive. In an interview on 1/18/24 at 4:45pm, Nursing Home Administrator (NHA) "A" reported she reviewed the facility's video surveillance and confirmed that Registered Nurse (RN) "K" went on a 30-minute break at 2:30pm (35 minutes after Resident #100 had returned from hospital) on			

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	10/26/23. In an interview on 1/18/24 at 2:14pm Registered Nurse (RN) "H" reported he was the nurse covering Resident #100's hall on 10/26/23 while RN "K" took his break. RN "H" reported he recalled giving Resident #100 pain medication while covering for RN "K" but was unsure how he became aware that Resident #100 was experiencing pain. RN "K" reported the resident's complaint of pain may have been reported by a staff member or the resident may have put his call light on. RN "K" reported he did not do a full assessment of Resident #100 when he provided the pain medication and was unsure what type of procedure the resident had. RN "K" reported he was unsure what time Resident #100 returned to the facility on 10/26/23 then added that overall notification of a resident's return to the facility was "not very well communicated". RN "K" reported it was not uncommon for a resident to return to the facility following a medical appointment or procedure and the nurse was unaware. In an interview on 1/18/24 at 9:20am Confidential Informant (CI) "C" reported Resident #100 reported pain and difficulty breathing upon returning to the facility on 10/26/23. CI "C" reported Resident #100 sat with his eyes closed, head down and had a pale complexion. CI "C" stated "something just looked off about him (Resident #100)." When queried as to whether a nurse was informed about Resident #100's condition, CI "C" reported "I told several nurses, but they didn't come". In an interview on 1/18/24 at 10:19am, Certified Nursing Assistant (CENA) "I" reported she heard Confidential Informant (CI) "C" tell Registered Nurse "K" on 10/26/23 that Resident #100 was not feeling well and needed to be assessed. CENA			

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	"I" was unsure what time this occurred. In an interview on 1/18/24 at 2:06pm, Certified Nursing Assistant (CENA) "L" reported she saw Resident #100 after he returned from his procedure on 10/26/23. CENA "L" reported the resident was sitting in his wheelchair in his room with his head down, eyes closed, appeared sleepy. CENA "L" described Resident #100's appearance as "tired and worn out". CENA "L" reported she heard Confidential Informant (CI) "C" tell a nurse that Resident #100 said he "didn't feel right". In an interview on 10/18/23 at 2:43pm, Unit Manager (UM) "P" reported she was unaware Resident #100 had returned from his procedure on 10/26/23 but responded to his room when a code blue (cardiac arrest) was called. UM "P" reported a resident who had undergone placement of an intrajugular catheter would need a full nursing assessment upon their return to the facility. When queried, UN "P" confirmed that it was a concern that Resident #100 had not been assessed following his return to the facility. In an interview on 10/18/23 at 3:44pm, Director of Nursing (DON) "B" reported the facility did not have a specific process it followed regarding alerting nursing staff when a resident returned from a procedure. DON "B" stated "our nurses are always on the floor, so they see them". DON "B" reported when a resident returns from a procedure the floor nurse would complete an assessment when they did rounds and passed medications. Regarding Resident #100, DON "B" stated "he was alert and oriented so he could tell the nurses what he needs, and it doesn't sound like he seeked (sic) out anybody". DON "B" reported she did not see Resident #100 when he returned from the hospital on 10/26/23. When further queried regarding what actions a nurse should take when caring for a resident who had just undergone			

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	placement of an internal jugular catheter, DON "B" stated "assessing the dressing to ensure it's dry and intact, getting a good set of vitals and writing a progress note detailing how they're doing". In an interview on 10/18/24 at 2:21pm, Registered Nurse (RN) "K" reported he did not complete an assessment on Resident #100 when the resident came back to the facility following a procedure because he "did not have time". RN "K". RN "K" upon returning from a break at approximately 3:15pm, he went to check on Resident #100 and "he had passed out". RN "K" confirmed that a resident should be assessed following the procedure Resident #100 had, and that assessment should include monitoring of blood pressure, pulse oxygenation and pulses. Review of nursing assessments for Resident #100 revealed the only assessment completed for the resident on 10/26/23 was a "Fall Assessment" with an effective date and time of 10/26/23 at 3:34pm (after the resident had a cardiac arrest on 10/26/23 at 3:17pm). The assessment contains the most recent vital signs which were taken at 1:38am on 10/26/23. Review of a nursing progress note written by Registered Nurse (RN) "K" for Resident #100, dated 10/26/23 at 3:17pm, revealed a statement: "nurse came back from a 15-minute break and went down to assess resident following graft procedure at (name of local hospital) ...(Resident #100) leaving the building early AM and returning at approx (sic) 3pm. Nurse observed resident face down ...nurse did not find a pulse and initiated code blue ...". Review of a nursing progress note written by Unit Manager (UM) "Q", for Resident #100 dated 10/26/23 at 5:38pm, revealed a statement: "This			

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	writer was in a meeting ...a code blue was called overhead ...this writer arrived, and a nurse was doing compressions ...EMS arrived at 1548 ...first responds (sic) continued care until 1604 when time of death was called by the first responder team". Review of a "Prehospital Care Report Summary" provided the emergency medical service, dated 10/26/23, revealed under a section titled "Narrative History Text" a statement: "Patient (Resident #100) had right tunneled dialysis catheter replacement performed in hospital this morning ...discharged back to SNF (skilled nursing facility) ...last seen by staff looking unwell." Review of "Completing a Health Assessment in Nursing"" written by Nalea Ko, MFA, 9/22/22 revealed ...Nursing health assessments help health professionals diagnose diseases and illnesses. Assessments also inform preventative care plans... A complete nursing health assessment requires a health professional to examine a patient in a systematic fashion, from head to toe. Nurses rely on self-reported symptoms, visual observation, reported health histories, and a physical medical examination to make a health assessment. This data then informs the nursing care plan... A proper nursing health assessment can lead to early intervention, which saves lives..." https://nursejournal.org/resources/nursing-health-assessment/			