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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Medilodge of Westwood was surveyed for a Recertification survey on 6/11/24 to 6/13/24. Intakes: MI00143208, MI00144295, MI00144568, MI00145044. Census= 87	F0000		
F0584 SS= D	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels.	F0584	Element #1 Resident #83 Room 110 bathroom and room was cleaned removing stickiness, dirt, debris, urine and liquid. Bathroom was cleaned of possibly bowel movement, scrambled eggs, and urine. Resident #33 Room 110 room and bathroom floors were cleaned removing cookie, stickiness, liquid and odor of urine. Element #2 All residents that reside in the facility have the potential to be effected. Residents bathrooms and rooms will be audited for cleanliness. Bathrooms and rooms with identified concerns will be cleaned. Element #3 The Administrator and DON reviewed the Bathroom Cleaning Policy and Daily Patient Room Cleaning policy and deemed it appropriate. Bathroom Cleaning Policy and Daily Patient Room Cleaning Policy reviewed at QAPI. Housekeeping staff will be re- educated on Bathroom Cleaning policy and Room cleaning by the Housekeeping Manager or designee.	7/9/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/05/2024

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.

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 _____	**6/13/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00144295 Based on observation and interview, the facility failed to maintain a clean homelike environment for 2 (Resident #33 and Resident #83) of 20 sampled residents resulting in an unclean room, unclean bathroom, and the potential for a reasonable person to experience feelings of embarrassment, shame, and/or loss of self - esteem. Findings include: Resident #33 Review of an "Admission Record" revealed Resident #33 had pertinent diagnoses which included: unspecified dementia, mild cognitive impairment on uncertain or unknown etiology, and anxiety disorder. Review of a "Minimum Data Set" (MDS) assessment for Resident #33, with a reference date of 4/4/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 8/15 which indicated Resident #33 was moderately cognitively impaired. During an observation on 6/11/24 at 10:12 AM., Resident #33's room had an odor of urine, the floor was sticky while walking on it, and there appeared to be dirt and debris along the base boards of the room. Flying insects were noted in the room. During an interview on 6/11/24 at 1:56 PM., Family Member (FM) "JJ" reported that there have been "fruit flies" (a small flying insect that is		Housekeeping staff will ensure bathrooms and rooms are cleaned per policy. Element #4 The Housekeeping Manager or designee will do random audits 3x/week to ensure in compliance with bathroom and room cleanliness for 4 weeks or until substantial compliance. 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 for compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attracted to extra ripe, fermenting fruits, drains, trash bags, and other garbage: not an inclusive list) in Resident #33's room. FM "JJ" reported that floor had been sticky and there had been urine on the floor when she visited. During an interview on 6/12/24 at 08:29 AM., Resident #33 was asked about his room cleanliness. Resident #33 engaged in verbal conversation that was unintelligible and was not able to make himself understood. Resident #33 was unable to carry on a meaningful conversation with this surveyor or answer any direct questions appropriately. During an observation on 6/12/24 at 11:32 AM., Resident #33's room had an odor of urine, the floor was sticky, there was a puddle of liquid on the floor outside of the bathroom. On the bathroom floor, and on the floor in the doorway between the bathroom and room, and flying insects were noted in the bathroom. During an interview on 6/12/24 at 1:00 PM., FM "JJ" reported that she was concerned with how dirty Resident #33's bathroom floor was and the urine that was spilled on the floor. FM "JJ" reported that it was not fair that Resident #33's has to live in a room with an odor of urine and urine spilled on the floor. During an observation on 6/12/24 at 2:55 PM., flying insects were noted flying in Resident #33's bathroom. During an observation on 6/13/24 at 08:15 AM., Resident #33's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. During an observation on 6/13/24 at 11:02 AM., Resident #33's bathroom had liquid on the floor,			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. Resident #83 Review of an "Admission Record" revealed Resident #83 had pertinent diagnoses which included: bladder-neck obstruction (a blockage that does not allow urine to flow from the body), urinary tract infection, cognitive communication deficit. Review of a "Minimum Data Set" (MDS) assessment for Resident #83, with a reference date of 3/5/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 3/15 which indicated Resident #83 was severely cognitively impaired. During an observation on 6/11/24 at 10:12 AM., Resident #83's room had an odor of urine, the floor was sticky while walking on it, and there appeared to be dirt and debris along the base boards of the room. Flying insects were noted in the room. During an interview on 6/11/24 at 1:56 PM., Family Member (FM) "JJ" reported that there have been "fruit flies" (a small flying insect that is attracted to extra ripe, fermenting fruits, drains, trash bags, and other garbage: not an inclusive list) in Resident #83's room. FM "JJ" reported that floor had been sticky and there had been urine on the floor when she visited. During an observation on 6/12/24 at 11:32 AM., Resident #83's room had an odor of urine, the floor was sticky, there was a puddle of liquid on the floor outside of the bathroom. on the bathroom floor, and on the floor in the doorway between the bathroom and room, and flying insects were noted in the bathroom. Resident #83			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was observed in the bathroom emptying his urine drainage bag (a bag connected to a catheter inserted into the body to drain and collect urine). The stool in the bathroom is noted to be dirty with what appears to be bowel movement debris. There was what appeared to be scrambled eggs and a yellow in color liquid that could have been urine noted on the floor beside and behind the toilet in the bathroom in Resident #83's room. During an observation on 6/12/24 at 11:37 AM., Resident #83 was in his room with "Registered Nurse" (RN) "S" when Resident #83 stated "... there is water on the bathroom floor..." RN "S" asked Resident #83 "is there water or is it pee..." Resident #83 replied "...when the bag leaked then there was water..." During an observation and interview on 6/12/24 at 11:44 AM., Resident #83 was observed in the bathroom of his room emptying his urinary drainage bag into the toilet. Resident #83 was asked if he was able to close the clamp on the urinary drainage bag after emptying it and he replied " I don't know how to close it...". Flying insects were noted in the bathroom and in Resident #83's room. "District Housekeeping Manager" (DHM) "GG" was then observed placing a wet floor sign at the door and asked Resident #83 if he needed his room to be cleaned. Resident #83 replied "No." During an interview on 6/12/24 at 11:47 AM., RN "S" reported that Resident #83 was able to empty his urinary drainage bag by himself. RN "S" reported that Resident #83 does not have to empty his urinary drainage bag, staff will do it for him. RN "S" reported that Resident #83 places his urinary drainage bag on his wheelchair where he wants to, was rough with it, and the urinary drainage bag becomes punctured and leaks.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 6/12/24 at 1:00 PM., FM "JJ" reported that she was concerned with how dirty Resident #83's bathroom floor was and the urine that was spilled on the floor. FM "JJ" reported that Resident #83 wound not want his room to be like that. FM "JJ" reported that it was not fair that Resident #83's roommate has to live in a room with an odor of urine and urine spilled on the floor. During an observation on 6/12/24 at 2:55 PM., flying insects were noted flying in Resident #83's bathroom. During an observation on 6/13/24 at 09:56 AM., Resident #83 was observed emptying his urinary drainage bag into the toilet in his bathroom in his room. A liquid that appeared to be urine was noted on the floor in Resident #83's bathroom when he exited the room. During an observation on 6/13/24 at 08:15 AM., Resident #83's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. During an observation on 6/13/24 at 11:02 AM., Resident #83's bathroom had liquid on the floor, an odor of urine in the room, pieces of a cookie on the floor, and the floor was sticky to walk on. During an interview on 6/13/24 at 12:14 PM., "DHM" "GG" reported that A hall has an assigned housekeeper daily and that each room and common areas was to be cleaned daily. DHM "GG" reported that he started helping in the building about 3 weeks ago and had found that Resident #83's room/bathroom had an odor of urine, flying insects in the room, and frequently had liquid on the floor in the bathroom. DHM "GG" reported that Resident #83's room wound now be a room that was a high focus area for			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	checking and cleaning. During an interview on 6/13/24 at 1:00 PM., "Interim - Nursing Home Administrator" (I-NHA) "A" reported that the cleaning of resident rooms by housekeeping not being done had been a problem she was aware of and was working on resolving the situation.			
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00145044. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal and physical abuse by a resident for 2 residents (Resident #15 & #40) of 4 residents, reviewed for abuse, resulting in the potential for physical harm, pain and mental anguish. Findings include: Resident #15	F0600	Element #1 Resident #15 was interviewed by Social Services and no ill effects following verbal and physical altercations. Resident was left in the hallway to have other staff assist with transfer. System that has been changed is when resident is up in chair, resident will have staff monitoring resident for escalations in behaviors and intervene and resident will not be alone. Resident #40 was interviewed by Social Services and no ill effects following verbal and physical altercations. Resident is being discharged to another facility per his choice on 7/11/24. Element #2 All residents that reside in the facility have the potential to be effected. Residents with BIMS greater than were interviewed for concerns related to abuse. Residents with BIMS below skin assessments completed. Element #3 The Administrator and DON reviewed the Abuse policy and deemed it appropriate. Abuse Policy reviewed at QAPI. Staff will be re- educated on Abuse by the NHA/Designee regarding abuse.	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of a "Minimum Data Set" (MDS) assessment for Resident #15, with a reference date of 5/28/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #15 was cognitively impaired. Review of Resident #15's "Care Plan" revealed, "...Resident has behavior as evidenced by: verbally aggressive toward staff such as yelling and cursing. Resident may also become resistive or display verbal threats towards staff when providing care and/or transfers...Resident has an "antagonistic" joking relationship with another resident. Resident has a history of grabbing hair/head and staffs clothing, throwing trays. 6/9/24 resident aggressive to other resident...Date initiated: 9/15/23. Revision on: 6/11/24...INTERVENTIONS: ...Monitor resident when he is up in chair around other residents..." In an interview on 06/11/24 at 12:32 PM, Resident #15 reported that he slapped a guy and now he had to have a babysitter with him all the time and stated loudly, "...I might just do it again just because they put that sitter with me!" In an interview on 06/11/24 at 02:33 PM, Family Member (FM) "OO" reported that she was notified the day before that Resident #15 had been violent with another resident. FM "OO" reported that it had happened several times in the past. Resident #40 Review of a "Minimum Data Set" (MDS) assessment for Resident #40, with a reference date of 4/22/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #40 was cognitively impaired.		Residents will be reviewed in clinical and stand up to ensure abuse allegations are identified. Element #4 The NHA or designee will complete random audits 3x/week on abuse to ensure in compliance for 4 weeks or until substantial compliance. 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 for compliance.	

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 _____	**6/13/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 06/13/24 at 01:39 PM, Resident #40 reported that he was easily irritated with Resident #15 and stated, "...he is an idiot..." Review of Resident #15's "Incident Report" dated 6/9/24 revealed, "...heard (Resident #15) yelling at (Resident #40)...noticed (Resident #15) leaning out of his chair and grabbing (Resident #40's) chair...nurse stood between the residents... (Resident #15) punched (Resident #40) in the face with a closed fist. (Resident #15) then told (Resident #40) if he came near him again, he would knock his head off his shoulders. (Resident #15) stated that (Resident #40) called him a fat faggot and many other names, so he hit him..." Review of Resident #15's "Progress Note" dated 6/9/2024 at 4:01 PM written by Nursing Home Administrator "A" revealed, "Reported by charge nurse (Licensed Practical Nurse (LPN) "G"). This nurse was standing inside of the circle of the nurse's station when I heard (Resident #15) yelling at another resident in the Dining Room. (Resident #15) leaning out of his chair and grabbing other residents chair to bring him closer. yelled into the dining room for (Resident #15) to let chair go and at the same time went into DR (dining room) and another Nurse ran to the dining room to separate the two residents. The nurse stood between the residents... (Resident #15) swung and hit other in the face with a closed fist. (Resident #15)then told other resident If he came near him again, he was gonna knock his head off his shoulders." During an observation on 06/12/24 at 11:01 AM in the dining room, Resident #15 was sitting in his wheelchair. Resident #15 was speaking in a very loud voice, and continuously commented and antagonized several residents and staff for approximately one hour. There was a staff member nearby, that was assigned to supervise			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #15. During an observation on 06/12/24 at 11:51 AM Registered Nurse (RN) "S" wheeled Resident #15 out of the dining room and down the hall, and left him sitting in his wheelchair outside of his room. RN "S" reported that the resident had asked to be brought to his room and be laid down in bed, but would have to wait for the aides. RN "S" continued with other tasks and did not supervise Resident #15. During observations on 06/12/24 from 11:51 AM to 12:06 PM there was no one supervising Resident #15. Resident #15 was loudly speaking and singing in the hall, using condescending and sexually inappropriate words. At one point, Resident #15 looked into a female resident's room and loudly made a sexually inappropriate remark. At 12:08 PM Resident #40 came out of his room in his wheelchair, stopped near Resident #15 and stated, "Stick it up your a** you jerk!" Resident #15 immediately began name calling, and swinging his arms towards Resident #40. Certified Nursing Assistant (CNA) "PP" came out of a resident's room to redirect the residents. In an interview on 06/12/24 at 12:28 PM, CNA "PP" reported that she wished Resident #15 and Resident #40 could live on separate halls and stated, "...they just keep doing the same thing because they pass by each other all the time..." CNA "PP" reported that they cannot have someone sit and watch them all the time. In an interview on 06/12/24 at 02:59 PM, Licensed Practical Nurse (LPN) "G" reported that a lot of residents have concerns with Resident #15 and Resident #40, because they both treat staff badly. LPN "G" reported that during shift change on 6/9/24, Resident #40 called Resident #15 a couple of insulting names, and in turn Resident			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#15 hit Resident #40 in the face. LPN "G" reported that staff tried to intervene prior to the physical altercation, but were unsuccessful. LPN "G" reported that Resident #15 was always verbally inappropriate to staff and residents, when he was in the dining room. In an interview on 06/12/24 at 03:10 PM, Nursing Home Administrator (NHA) "A" reported that after the incident on 6/9/24, Resident #15 and Resident #40 had not had any additional concerning encounters with one another and stated, "...(Resident #40) has not instigated or name called..." NHA "A" was not aware that the residents had a verbal altercation earlier that day.			
F0610 SS= D	Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00145044. Based on observation, interview, and record review, the facility failed to implement interventions to prevent further abuse during an	F0610	Element #1 Resident #15 was interviewed by Social Services and no ill effects following verbal and physical altercations. Residents is monitored when up in wheelchair out of his room. Resident will not be left alone in the hallway. Resident #40 was interviewed by Social Services and no ill effects following verbal and physical altercations. Resident is being discharged on 7/11/24. Element #2 All residents that reside in the facility have the potential to be effected. Residents with BIMS greater than were interviewed for concerns related to abuse. Residents with BIMS below skin assessments completed. Residents with allegations of physical and/or verbal abuse will be reported based on guidelines of reporting. Element #3	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ongoing investigation of abuse for 2 residents (Resident #15 & #40) of 4 residents, reviewed for abuse, resulting in the potential for physical harm, pain and mental anguish. Findings include: Resident #15 Review of a "Minimum Data Set" (MDS) assessment for Resident #15, with a reference date of 5/28/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #15 was cognitively impaired. Review of Resident #15's "Care Plan" revealed, "...Resident has behavior as evidenced by: verbally aggressive toward staff such as yelling and cursing. Resident may also become resistive or display verbal threats towards staff when providing care and/or transfers...Resident has an "antagonistic" joking relationship with another resident. Resident has a history of grabbing hair/head and staffs clothing, throwing trays. 6/9/24 resident aggressive to other resident...Date initiated: 9/15/23. Revision on: 6/11/24...INTERVENTIONS: ...Monitor resident when he is up in chair around other residents..." In an interview on 06/11/24 at 12:32 PM, Resident #15 reported that he slapped a guy and now he had to have a babysitter with him all the time and stated loudly, "...I might just do it again just because they put that sitter with me!" Resident #40 Review of a "Minimum Data Set" (MDS) assessment for Resident #40, with a reference date of 4/22/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total		The Administrator and DON reviewed the Abuse policy and deemed it appropriate. Abuse Policy reviewed at QAPI. Staff will be re- educated on Abuse Policy by the NHA/Designee regarding abuse. Residents will be reviewed in clinical and stand up to ensure abuse allegations are identified. Element #4 The NHA or designee will do random audits 3x/week on abuse to ensure in compliance for 4 weeks or until substantial compliance. 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 for compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	possible score of 15, which indicated Resident #40 was cognitively impaired. In an interview on 06/13/24 at 01:39 PM, Resident #40 reported that he was easily irritated with Resident #15 and stated, "...he is an idiot..." Review of Resident #15's "Incident Report" dated 6/9/24 revealed, "...heard (Resident #15) yelling at (Resident #40)...noticed (Resident #15) leaning out of his chair and grabbing (Resident #40's) chair...nurse stood between the residents... (Resident #15) punched (Resident #40) in the face with a closed fist. (Resident #15) then told (Resident #40) if he came near him again, he would knock his head off his shoulders. (Resident #15) stated that (Resident #40) called him a fat faggot and many other names, so he hit him..." During an observation on 06/12/24 at 11:01 AM in the dining room, Resident #15 was sitting in his wheelchair. Resident #15 was speaking in a very loud voice, and continuously commented and antagonized several residents and staff for approximately one hour. During an observation on 06/12/24 at 11:51 AM Registered Nurse (RN) "S" wheeled Resident #15 out of the dining room and down the hall, and left him outside of his room. RN "S" reported that the resident had asked to be brought to his room and be laid down in bed, but would have to wait for the aides. RN "S" continued with other tasks and did not supervise Resident #15. During observations on 06/12/24 from 11:51 AM to 12:06 PM Resident #15 was in the hall outside of his room, an unsupervised. Resident #15 was loudly speaking and singing in the hall, using condescending and sexually inappropriate words. At one point, Resident #15 looked into a female resident's room and loudly made a sexually			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inappropriate remark. At 12:08 PM Resident #40 came out of his room in his wheelchair, stopped near Resident #15 and stated, "Stick it up your a** you jerk!" Resident #15 immediately began name calling, and swinging his arms towards Resident #40. Certified Nursing Assistant (CNA) "PP" came out of a resident room to redirect the residents. In an interview on 06/12/24 at 12:28 PM, CNA "PP" reported that she wished Resident #15 and Resident #40 could live on separate halls and stated, "...they just keep doing the same thing because they pass by each other all the time..." CNA "PP" reported that they cannot have someone sit and watch them all the time. In an interview on 06/12/24 at 03:10 PM, Nursing Home Administrator (NHA) "A" reported that after the incident on 6/9/24, Resident #15 and Resident #40 have not had any additional concerning encounters with one another and stated, "...(Resident #40) has not instigated or name called..." NHA "A" reported that the abuse was reported to the state immediately and is still under investigation. NHA "A" was not aware that the residents had a verbal altercation earlier that day.			
F0623 SS= D	Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance	F0623	ELEMENT #1 Resident #30 returned to facility 03/07/24. Resident currently resides in the facility. No ill effects noted with not providing transfer/discharge notice. Resident #43 returned 02/09/24. Resident currently resides in the facility. No ill effects noted transfer/discharge notice. ELEMENT #2	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and		An audit by DON/Designee will be completed of residents discharged to the hospital in the past 7 days to ensure that resident discharge/transfer form was documented in the resident□s medical record as provided. Identified concerns will be reviewed and transfer/discharge form will be provided. ELEMENT #3 Transfer and Discharge Policy was reviewed by NHA/DON and reviewed at QAPI. Licensed nursing staff will be re-educated by the DON or designee on the Transfer and Discharge policies. Residents who have discharged to hospital will be reviewed during morning clinical meeting with validation that the transfer/discharge was documented in the resident□s chart that it was provided to the resident and/or representative within a reasonable time at time of discharge. ELEMENT #4 An audit will be completed of 5 hospital transfers per week by DON or designee to ensure accurate completion of transfer form which includes that a copy was provided to the resident and/or represtative within a reasonalbe time at time of discharge and appropriate documentation in residents chart. Audits will be completed weekly x 4 weeks, monthly x 3 months then monthly or until sustained compliance. Results of the audits will be reviewed at QAPI x 3 months or until sustained compliance is achieved.	

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 _____	**6/13/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide transfer/discharge notice upon discharge to two residents and/or representatives (R43 and R30) for transfer to the hospital of four residents reviewed for reviewed for transfers out-of-the facility, resulting in the potential for the		DON is responsible for sustained compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident to be misinformed, an inappropriate discharge, and/or not have an advocate to ensure their rights. Findings include: According to the Minimum Data Set (MDS) dated 4/5/24, R43 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status) with diagnoses that included right leg amputation and septicemia. During an interview on 6/11/24 at 11:24 AM, R43 stated, "I went to the hospital." Review of R43's "Census" indicated the resident was sent out of the facility on 1/27/24. Review of R43's "Hospital Discharge Summary" indicated the resident was admitted 1/27/24 until 2/9/2/24. Review of R43's medical records did not reveal transfer documentation for 1/27/24. Received email communication sent 6/13/24 at 3:49 AM from Nursing Home Administrator (NHA) "A that stated, "We do not have this" regarding R43's emergent transfer notification on 1/27/24. Resident #30 (R30) Review of the Face Sheet and Minimum Data Set (MDS) dated 3/25/2024 revealed R30's original admission date was on 4/7/2023 with diagnoses of dysphagia (difficulty swallowing), anxiety, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (stroke). Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R30 was cognitively intact (13-15 is			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cognitively intact). Resident was discharged to the hospital on 3/2/2024 due to congestion and shortness of breath and returned to the facility on 3/7/2024. During an interview on 6/11/2024 at 2:15 PM, R30 stated he had to go to the hospital several months ago due to pneumonia. R30 was unable to remember if he received a written transfer notice when he went to the hospital. Review of R30's chart revealed no evidence that R30 received a written notice of transfer when he went to the hospital and which included the following information: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. During an interview on 6/12/202, Registered Nurse (RN) "AA" discussed the process when someone discharges to the hospital. When asked if she gives a written transfer notice to residents when they discharge to the hospital, RN "AA" stated that she doesn't send the written transfer notice with the resident. During an interview on 6/12/2024 at 1:28 PM, Director of Nursing (DON) "B" stated that the transfer/discharge notice paperwork should be part of the green packet that goes to the hospital with the resident and a copy should be put in the electronic medical record (EMR) but she wasn't sure if it this was being done. When it was discussed that a transfer/discharge notice wasn't found for R30 in his EMR, DON "B" stated "If it's not in (name of EMR program) then we don't have it." Review of the Transfer and Discharge (including AMA) Policy with an implementation date of 7/28/2020 and a reviewed/revised date of 1/01/2022 under Policy Explanation and Compliance Guidelines #7 stated, "Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified) j. Provide transfer notice as soon as practicable to resident and representative. "			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0625 SS= D	Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the resident of the facility bed hold policy and provide a written copy upon hospital transfer for two residents (Resident #30, Resident #43) of four reviewed for hospitalizations, resulting in the potential of residents and/or resident representatives being uninformed of the bed hold policy. Finding include:	F0625	ELEMENT #1 Resident #30 returned to facility 03/07/24. Resident currently resides in the facility. No ill effects noted from not receiving the bed hold policy. Resident #43 returned 02/09/24. Resident currently resides in the facility. No ill effects noted from not receiving the bed hold policy. ELEMENT #2 An audit by DON/Designee will be completed of residents discharged to the hospital in the past 7 days to ensure that resident bed hold form were documented in the residents medical record as provided. Identified concerns will be reviewed and Bed hold form will be provided. ELEMENT #3 NHA and DON reviewed Bed Hold Policy and reviewed at QAPI and deemed appropriate. Licensed nursing staff will be re-educated by the DON or designee on the Bed Hold Notice Upon Transfer policy. Residents who have discharged to hospital will be reviewed during morning clinical meeting with validation that the bed hold was documented in the resident□s chart. ELEMENT #4 An audit will be completed of 5 hospital transfers per week by DON or designee to ensure accurate completion of Bed Hold and appropriate documentation in resident□s chart ensuring a copy of the bed hold was provided	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #30(R30) Review of the Face Sheet and Minimum Data Set (MDS) dated 3/25/2024 revealed R30's original admission date was on 4/7/2023 with diagnoses of dysphagia (difficulty swallowing), anxiety, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (stroke). Brief Interview for Mental Status (BIMS) reflected a score of 14 out of 15 which indicated R30 was cognitively intact (13-15 is cognitively intact). Resident was discharged to the hospital on 3/2/2024 due to congestion and shortness of breath and returned to the facility on 3/7/2024. During an interview on 6/11/2024 at 2:15 PM, R30 stated that he had to go to the hospital several months ago due to pneumonia. R30 was unable to remember if he received a bed hold policy notice when he went to the hospital. Review of the R30's chart revealed no documentation that he received a written bed hold policy. During an interview on 6/12/202, Registered Nurse (RN) "AA" discussed the process when someone discharges to the hospital. When asked if she gives a written bed hold policy to residents when they discharge to the hospital, RN "AA" stated that she doesn't send the bed hold policy with residents. During an interview on 6/12/2024 at 1:28 PM, Director of Nursing (DON) "B" stated that she wasn't sure if the nursing staff gives a written bed hold policy to the resident when they go to the hospital. When it was discussed that a written bed hold notice wasn't found for R30 in his electronic medical record (EMR), DON "B" stated "If it's not in PCC (Point Click Care-their EMR) then we		to the resident and/or representative at or within a reasonable time at time of discharge. Audits will be completed weekly x 4 weeks, monthly x 3 months then monthly or until sustained compliance. Results of the audits will be reviewed at QAPI x 3 months or until sustained compliance is achieved. DON is responsible for sustained compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	don't have it." R43 According to the Minimum Data Set (MDS) dated 4/5/24, R43 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status) with diagnoses that included right leg amputation and septicemia. During an interview on 6/11/24 at 11:24 AM, R43 stated, "I went to the hospital." Review of R43's "Census" indicated the resident was sent out of the facility on 1/27/24. Review of R43's "Hospital Discharge Summary" indicated the resident was admitted 1/27/24 until 2/9/2/24. Review of R43's medical records did not reveal bed hold documentation for 1/27/24. Received email communication sent 6/13/24 at 3:49 AM from Nursing Home Administrator (NHA) "A that stated, "We do not have this" regarding R43's Bed Hold for 1/27/24. Review of facility policy "Bed Hold Notice Upon Transfer" revised date 2/1/2022, revealed, "Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed ..."Bed-Hold" means the holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization ...Bed Hold Notice Upon Transfer ...Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to the resident and/or the resident representative written information that specifies: The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility ...The reserve bed payment policy in the state plan policy, if any ...The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed ...Conditions upon which the resident would return to the facility: In the even of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan ..."			
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for one (Resident #141) of 20 residents reviewed for the provision of nursing services, resulting in IV (intravenous) medications being administered outside of the physician ordered parameters. Findings include: Review of an "Admission Record" revealed Resident #141 was originally admitted to the facility on 6/5/24, with pertinent diagnoses which included: severe sepsis (life-threatening condition cause by infection) and cellulitis (infection in the skin).	F0658	Element #1 Resident #141 had their I.V. antibiotic orders reviewed by the provider and new orders received. Resident had no ill effects related to IV medication times. Element #2 Residents who are receiving I.V. antibiotics in the facility have the potential to be affected. A one-time audit will be completed by the DON/designee to identify residents that receive I.V. antibiotics to ensure IV ATB was completed per order. Identified concerns will be reported to provider. Element #3 The administrator and DON reviewed the Provision of Quality Care policy and deemed it appropriate. Policy reviewed at QAPI. Licensed nurses were re-educated on following physician orders for I.V. antibiotics.	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview on 06/12/24 at 09:31 AM, Registered Nurse (RN) "T" reported that medication pass was "running late" that day. During an observation and interview on 06/12/24 at 11:04 AM in Resident #141's room. Resident #141 was lying in bed and there was an IV pole at the bedside with a bag and tubing attached. The tubing had a piece of tape on it that revealed, "6/12/24 10:30 (am)." The bag of fluid was labeled Cefazolin (antibiotic). Resident #141 reported he was supposed to have IV antibiotics three times a day, and had gotten the antibiotics very late that morning. Resident #67 reported the medication had been administered late multiple times, and at times he wasn't even sure if he had gotten the medication at all. Resident #141 reported that he had sepsis in the hospital and was prescribed an antibiotic regimen for several months. Review of Resident #141's "Medication Administration Record" revealed the following order, "Cefazolin...intravenously three times a day...until 8/25/2024...At 8:00 AM, 12:00 PM, 6:00 PM. Start date 6/6/24 at 12:00 PM, D/C (discontinue date) 6/12/24 at 11:26 AM." The doses of medication were not scheduled to be administered evenly throughout the day. In an interview on 06/12/24 at 11:14 AM, RN "T" reported she had administered Resident #141's IV antibiotic Cefazolin late that morning at about 10:00 AM, but she did not label or date the bag or tubing, and did not know who did. In an interview on 06/12/24 at 11:20 AM, Director of Nursing (DON) "B" reported that Resident #141's IV medication can be administered up to an hour before or after the designated time frame.		When a resident receives an order for an I.V. antibiotic identified, residents will receive antibiotic per MD order. During the next scheduled clinical meeting, residents will be reviewed by the IDT to ensure that I.V. antibiotic orders have been followed. Element #4 The DON/designee will audit and observe 2 residents per week with I.V. antibiotic orders to ensure administration is per provider specifications. Audits will be conducted x4 weeks and then monthly until sustained compliance. 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 DON is responsible for sustained compliance.	

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 _____	**6/13/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #141's " Medication Administration Record" revealed the following order, "Cefazolin...Intravenously every shift...Day, Evening, Night...Start date: 6/12/24 at 2:00 PM". This was a change to the existing order. It was noted there were no time frames indicated in the new order. In an interview on 06/13/24 at 10:12 AM, Licensed Practical Nurse (LPN) "D" reported he administered Resident #141's IV Cefazolin at 8:00 AM that morning, because that was the time he thought it should be given, but he did not know when the previous dose had been administered. LPN "D" reported the order did not indicate a specific time to be administered. In an interview on 06/13/24 at 10:17 AM, Nurse Practitioner (NP) "II" reported that Resident #141's IV Cefazolin should be administered every 8 hours around the clock to ensure the medication is consistently in the resident's blood. NP "II" reported she had clarified this to nursing staff the day before. NP "II" reported the IV medication order should reflect a specific time to administer the medication, so the doses are evenly spaced apart. Review of Resident #141's "Medication Administration Record" indicated following entries for Cefazolin. It was noted that 17 out of 17 doses of the IV medication were outside of the recommended timeframe, per NP "II". 6/6/24 at 5:06 PM 6/7/24 at 8:14 AM (15 hours apart) 6/7/24 at 1:05 PM (5 hours apart) 6/7/24 at 5:04 PM (4 hours apart)			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6/8/24 at 9:15 AM (15 hours apart) 6/8/24 at 12:29 PM (3.25 hours apart) 6/8/24 at 9:24 PM (9 hours apart) 6/9/24 at 8:44 AM (11 hours apart) 6/9/24 at 1:52 PM (5 hours apart) 6/9/24 at 6:48 PM (5 hours apart) 6/10/24 at 8:16 AM (13.5 hours apart) 6/10/24 at 11:04 AM (2.75 hours apart) 6/10/24 at 5:10 PM (6 hours apart) 6/11/24 at 8:19 AM (13 hours apart) 6/11/24 at 12:11 PM (4 hours apart) 6/11/24 at 5:08 PM (5 hours apart) 6/12/24 at 9:56 AM (14.5 hours apart)			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify a need for increased assistance with Activities of Daily Living (ADL) care and provide the necessary	F0677	ELEMENT #1 Resident #67 currently resides in facility. Resident had a therapy screen completed on 06/10/2024 and was picked up for PT on 06/15/24 and OT on 06/14/2024. Resident #67s Care Plan has been updated. Resident has been provided a wheelchair. ELEMENT #2 An audit was completed to identify residents	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assistive devices, for one resident (Resident #67) of six reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for residents who are dependent on staff for assistance. Findings include: Resident #67 Review of an "Admission Record" revealed Resident #67 was originally admitted to the facility on 11/15/23, with pertinent diagnoses which included: pyogenic (infected) arthritis (inflammation of the joints). Review of a "Minimum Data Set" (MDS) assessment for Resident #67, with a reference date of 5/23/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #67 was cognitively intact. Review of Resident #67's "ADL Care Plan" revealed, "...ADL self-care performance deficit related to pyogenic arthritis...weakness, deconditioning. Date Initiated: 11/15/23...Interventions: Ambulation: Independent - offer setup help as needed, Dressing: Independent - offer setup help as needed, Personal hygiene: Independent - offer setup help as needed, Toileting: Independent - offer set up help as needed, Transfers: Independent: offer setup help as needed with two wheeled walker..." During an interview and observation on 06/11/24 at 12:26 PM Resident #67 was lying in his bed and reported the arthritis in his knee got really bad a couple weeks ago and he can no longer walk with his walker safely. Resident #67 reported that he had spoken to the nursing staff,		with decline in needing assistance. A Therapy screen will be completed for residents with a need for increased assistance with ADL□s. Care Plans updated as needed. ELEMENT #3 DON and NHA reviewed and approved ADL policy. QAPI committee has reviewed the Activities of Daily Living policy and deemed appropriate. Nursing staff received education on reporting residents with a need for increased assistance with ADL□s to the Nurse and the Nurse reporting this change to the MD. Residents with new or reported need for increased assistance with ADL□s will be reviewed in Clinical Meeting for possible referral to therapy services. ELEMENT #4 DON or designee will complete and audit of 5 residents with potential need for increased assistance weekly. Audits will be completed weekly x4 then monthly thereafter. 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. DON is responsible for continued compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	saw the doctor, and spoke with the therapy department at the facility, but no one was able to find a wheelchair for him to use. Resident #67 reported that he had struggled to get to the bathroom, had incontinence, and had not been able to clean himself adequately for the past couple weeks. Resident #67 reported that he had an x-ray about a week ago. In an interview on 06/13/24 at 12:01 PM, Certified Occupational Therapy Assistance (COTA) "MM" reported Resident #67 discharged from therapy services about a month ago, and was able to walk long distances with his walker at that time. COTA "MM" reported that Resident #67 recently reported to her he had been having trouble walking and asked for a wheelchair to use. COTA "MM" stated, "...I assumed that he said something to the nurses...we have been expecting a referral to see him..." In an interview on 06/13/24 at 12:06 PM, Resident #67 reported he still had not heard anything about his knee x-ray, and he did not have a wheelchair to use. Resident #67 reported that nursing staff is aware of his pain, and had been applying topical pain reliever on his knee. The resident reported his son had visited the night before and helped him get out of bed to use the bathroom and that he had made a mess in the bathroom and the nurse was going to help him get in the shower, but she did not come back. In an interview on 06/13/24 at 12:12 PM, Certified Nursing Assistant (CNA) "PP" reported working regularly with Resident #67, and the resident was completely independent, and able to walk into the bathroom by himself. CNA "PP" reported she was not aware that Resident #67 needed increased assistance recently. In an interview on 06/13/24 at 12:15 PM,			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Registered Nurse (RN) "S" reported Resident #67 had been complaining of knee pain, had an x-ray last week, and was prescribed topical pain reliever. RN "S" reported the therapy department would handle getting a wheelchair for a resident, and they did not know how to refer a resident to the therapy department. In an interview on 06/13/24 at 12:19 PM, Unit Manager (UM) "DD" reported she was aware Resident #67 had received therapy for his knee pain in the past, and he had been prescribed medication. UM "DD" reported she was not aware that Resident #67 was in need of more assistance. UM "DD" reported she could easily get Resident #67 a wheelchair, but she was not aware that he wanted or needed one. In an interview on 06/13/24 at 02:42 PM, Family Member (FM) "RR" reported he had driven Resident #67 to the bank a couple days earlier and Resident #67 was not able to walk and stated, "...I had to do everything for him...I told someone when we got back..." FM "RR" reported when he visited Resident #67 on 6/12/24, the resident was trying to get himself to the bathroom, but was not able to get there, and ended up having a accident. FM "RR" reported Resident #67 had fallen multiple times prior to admitting to the facility. Review of Resident #67's "Progress Note" dated 6/4/24 revealed, "...being seen this morning per request of nursing staff for follow-up on his knee pain...says his knee pain is back and is worse this morning...Voltaren (reduces inflammation) external gel 1 % added to his regimen and patient encouraged to request it for his pain..." Review of Resident #67's "Left Knee X-Ray" dated 6/5/24 revealed, "...Findings: ...Mild osteoarthritis (degenerative joint disease) ...If there is further concern, recommend follow-up			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	radiographs (images) or MRI (more detailed image than an x-ray) for complete assessment..." Review of Resident #67's "Progress Note" dated 6/11/24 revealed, "...Patient reported his right (sic) knee hurt due to arthritis....Assessments and Plans: ...arthritis left knee...Continue daily lidocaine (pain reliever) patch..." Review of Resident #67's "Fall Risk Evaluation" dated 5/16/24 indicated, a high risk for falling.			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intake # MI00143208 Based on observation, interview and record review, the facility failed to ensure residents received the necessary care and services to prevent the worsening of pressure ulcers in onr resident (Resident #15) of four residents reviewed for pressure ulcers, resulting in not receiving wound treatments per physician orders for	F0686	Element #1 Resident #15 had their wound dressings changed and documented per MD order. Element #2 Residents who are receiving wound dressing changes in the facility have the potential to be affected. A one-time audit was completed by DON/Designee to ensure wound dressings were changed and documentation of wound dressing change per MD order. Identified concerns will be reported to provider. Element #3 The administrator and DON reviewed the Clean Dressing Change policy and deemed it appropriate. Policy reviewed at QAPI. Licensed nurses were re-educated on following physician orders, including documentation of wound dressing changes. Residents with wound dressing changes will be audited by Wound Nurse/designee 5 days	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure ulcers, and the potential for infection and worsening of pressure ulcers. Findings include: Resident #15 Review of an "Admission Record" revealed Resident #15 was originally admitted to the facility on 4/28/2020, with pertinent diagnoses which included: heart and respiratory failure. Review of a "Minimum Data Set" (MDS) assessment for Resident #15, with a reference date of 5/28/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 11, out of a total possible score of 15, which indicated Resident #15 was cognitively impaired. Review of Resident #15's "Pressure Ulcer Care Plan" revealed, "...Chronic surgical ulcer stage 4 to left trochanter (hip), unstageable left heel...Date initiated 9/15/23, Revised on 6/8/24. Interventions: ...administer treatments per orders. Date initiated: 9/15/23..." In an interview on 06/11/24 at 12:32 PM, Resident #15 reported he was very unhappy with the care he received for his wounds. In an interview on 06/11/24 at 02:33 PM, Family Member (FM) "OO" reported Resident #15's wound dressings did not get changed as frequently as they should and she felt like that was why his wounds had not healed. FM "OO" reported Resident #15's wounds stink with infection. Review of Resident #15's "Progress Note" dated 6/6/24 indicated that the resident had returned from the hospital at 4:45 PM.		per week. Element #4 The DON/designee will audit and observe 5 residents per week with wound dressing change orders to ensure treatment is documented. Audits will be conducted x4 weeks and then monthly until sustained compliance. 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 DON is responsible for sustained compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation and interview on 06/12/24 at 12:15 PM in Resident #15's room. Registered Nurse (RN) "S" detached Resident #15's incontinence brief and a large white dressing was observed, dated June 7th with Wound Nurse (WN) "X's" initials on it. RN "S" removed the resident's sock on his left foot and a large white dressing was observed, dated June 7th with WN "X's" initials on it. Resident #15 reported that the wound dressings are supposed to be changed every day, but its more like every month. RN "S" reported that WN "X" completes the wound care and dressing changes on Monday, Wednesday and Friday, and then the floor nurses are supposed to do them the other days. In an interview on 06/12/24 at 01:08 PM, WN "X" reported that Resident #15 has had the wound on his left hip for a very long time and the wound on his left heel is almost healed. WN "X" reported Resident #15's wound dressings on his left hip and left heel should be changed daily and as needed. WN "X" reported he typically completed wound care on Mondays, Wednesdays and Fridays, but the floor nurse was ultimately responsible for ensuring the wound care was competed as ordered on a daily basis. WN "X" reported he had performed wound care for Resident #15 on Friday 6/7/24, but did not see documentation in the record, and could not remember if he had seen Resident #15 on Monday 6/10/24, but must not have since the dressing was dated June 7th. Review of Resident #15's "Physician Orders" revealed, "Left trochanter wound: cleanse with wound wash, pat dry, apply collagen (aids in healing) in undermined area, then apply thin coat of triad cream (skin protectant) on base of wound, cover with bordered dressing daily and PRN (as needed) if soiled or missing. Order/Start date 6/9/24." There was no order to complete the wound care on 6/7/24 or 6/8/24.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #15's "Treatment Administration Record (TAR)" for the dressing noted above on the left trochanter indicated that the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. That was inaccurate documentation, considering the dressing on 6/12/24 was dated 6/7/24. Review of Resident #15's "Physician Orders" revealed, "Left heel: cleanse with wound wash, pat dry, apply Santyl (removes damaged tissue and aids in healing) to slough (dead skin cells), cover with collagen pad, secure with ABD (thick cotton) pad, foam and stretchy kerlix (wrap), daily PRN application along with floating heel while in bed all times as tolerated. Every evening shift for left heel wound. Order/Start date 6/9/24." There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's "TAR" for the dressing noted above on the left heel indicated the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. During an observation on 06/12/24 at 02:00 PM in Resident #15's room along with WN "X" to complete wound care and dressing changes. WN "X" removed the dressing from Resident #15's left hip was dated June 7th, which revealed a deep wound with black crusting covering the wound. WN "X" reported the black crusting was a dried scab. At 2:17 PM WN "X" removed the dressing dated June 7th from Resident #15's left heel, which revealed multiple small areas of open skin, and a dried piece of collagen. When NW "X" cleaned the wound, the resident yelled and jerked his foot away. WN "X" reported that the wound was still unstageable, there was some maceration, light drainage, no odor after it was cleaned, and approximately 80% slough.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #15's "Progress Note" dated 6/8/24 at 1:31 PM revealed, "Nurses Note: Resident has impaired skin integrity as evidenced by: chronic surgical ulcer stage 4 to left trochanter, unstageable left heel...Resident is at risk for further impaired skin integrity...Wound treatment in place..." Review of Resident #15's "Weekly Skin Assessment" dated 6/9/24 indicated there was nothing new, and to see skin and wound notes for further information. Review of Resident #15's records, indicated no further documentation from 6/9/24-6/11/24 related to skin and wounds.			
F0689 SS= E	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to minimize the risk of scalding and burns by allowing domestic hot water to exceed 120°F. This resulted in an increased risk of injury among residents who reside in the B hall. Findings Include: During a tour of the B hall shower room, at 10:07 AM on 6/12/24, the hot water was checked with a rapid read digital thermometer and found to be 127F. When asked if hot water temperatures were	F0689	Element #1 Boiler system was immediately dialed to a lower setting. B hall shower room sink was closed down until temperature was below 120 degrees. B Hall soiled utility room was dialed to a lower setting until temperature was below 120. Element #2 Residents that are at risk to be affected are residents that reside in the facility Contracted company reviewed boiler system. One time audit of the water system was conducted to ensure water temperatures were within range. Element #3 The Administrator and DON reviewed The safe water temperature policy and deemed them appropriate.	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	taken today, Maintenance Director (MD) "FF" stated yes, Maintenance (M) "O" usually does it in the morning. Observation of the B hall soiled utility room sink, at 10:09 AM on 6/12/24, found the hot water to reach 128F. When asked if each hall has their own hot water system, MD "FF" stated yes. Observation of the B hall boiler room, at 10:11 AM on 6/12/24, found that the thermometer showing outgoing hot water to the B hall domestic fixtures read 128F with no mixing valves at point of use to further temper the water. An interview with MD "FF", at 10:15 AM on 6/12/24, found that M "O" checked the water temperatures this morning and found it under 120F in the B hall. When asked if he varies his temperatures, or usually takes them in the morning. MD "FF" was unsure. An interview with M "O" at 10:40 AM on 6/12/24, found that he typically checks hot water temperatures each morning when he gets to work and has not tracked how hot water temperatures might fluctuate during the day as demand for hot water changes.		Maintenance director/designee to record sink water temperature in shower rooms and utility room 5 days/week 2 times per day Element #4 Maintenance Director/ designee to audit water temperatures weekly- to ensure within appropriate limits x 4 weeks then monthly or until sustained compliance. 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 NHA is responsible for compliance.	
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that pre and post dialysis	F0698	Element #1 Resident #17 dialysis binder was updated with dialysis communication form. Resident to provide to dialysis center. Element #2 Current residents receiving dialysis residing in the facility have the potential to be affected. Residents receiving Dialysis will be audited to ensure binder contains communication form for the dialysis center. Concerns identified will	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(procedure that removes excess water, solutes, and toxins from the blood for people whose kidneys cannot perform these functions) treatment assessment and monitoring communication between themselves (the facility) and the dialysis provider (Name Omitted) was maintained in one (Resident #17) of one resident reviewed for dialysis services resulting in the potential for unrecognized adverse reactions and/or resident decline related to adverse reactions of dialysis treatments. Findings include: Resident #17 Review of an "Admission Record" revealed Resident #17 had pertinent diagnoses which included: end stage renal disease and dependence on renal dialysis. Review of a "Minimum Data Set" (MDS) assessment for Resident #17, with a reference date of 5/17/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 15/15 which indicated Resident #17 was cognitively intact. Review of "Dialysis" section of miscellaneous documents in Resident #17's medical record revealed the last uploaded dialysis communication was dated 2/17/2024. During an interview on 6/13/24 at 8:22 AM., "Registered Nurse" (RN) "S" reported the nurse should complete the (dialysis) communication packet to send with Resident #17 to dialysis and the dialysis center (Name Omitted) should complete their section of the communication packet and send it back. RN "S" reported the dialysis center (Name Omitted) does complete the communication packet. RN "S" reported that the dialysis communication form should be given to		be addressed by calling the dialysis center and documenting. Element #3 DON and NHA reviewed the Care Planning Dialysis Special Needs Policy and the Special Needs policy and deemed them appropriate. Policies to be reviewed at QAPI. Nursing staff will be educated on the Care Planning Dialysis Special Needs policy and the Special Needs Policy. Residents receiving dialysis will be reviewed during clinical meeting to ensure communication forms was provided. Element #4 Director of Nursing/Designee will audit dialysis residents 2 x weekly for 4 weeks for incomplete dialysis communication. After which, these items will be audited for dialysis residents at least 1 x weekly for 3 months. Results of audits will be brought to monthly QAPI x3 months or until substantial compliance is achieved. DON will be responsible for oversight and continued compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medical records to be scanned into Resident #17's medical record. During an interview on 6/13/24 at 8:29 AM., "Medical Records" (MR) "N" reported when she received dialysis communication forms she would scan them into Resident #17's medical chart under miscellaneous documents, dialysis. MR "N" reported Resident #17 had a binder the communication forms were kept in while she traveled between the facility and the dialysis treatment center. During an interview on 6/13/24 at 9:11 AM., MR "N" reported Resident #17's binder for dialysis communication was missing. MR "N" reported that she was unaware the dialysis communication binder was missing. When asked if MR "N" had received any dialysis communication forms for Resident #17 since the last uploaded communication form from 2/17/24, MR "N" stated "No, I have not received communication forms for the last 3 months." MR "N" reported as of today (6/13/24), Resident #17 had a new communication binder and it was with her on the way to dialysis treatment. During an interview on 6/13/24 at 9:37 AM., "Licensed Practical Nurse" (LPN) "BB" reported that a dialysis communication form should be sent with Resident #17 when she goes for dialysis treatment. LPN "BB" reported if she does not receive the communication form when Resident #17 returned from dialysis treatment, she would call the dialysis treatment center (Name Omitted) for a report. When asked if telephone communication should be documented in Resident #17's medical record, LPN "BB" stated, "Yes, it should be". During an interview on 6/13/24 at 09:00 AM., "Director of Nursing" (DON) "B" reported her			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	expectations were if a dialysis communication form did not come back with Resident #17 after dialysis treatment, the nurse should call the dialysis center and request a report be faxed to the facility. DON "B" reported if the binder was missing then no communication was occurring between the facility and the dialysis center (Name Omitted). DON "B" reported her expectation was the nurse should document their communication and documentation request from the dialysis center (Name Omitted) in Resident #17's medical record. DON "B" stated "...if they are not documenting that, then it is not happening..." The facility was unable to provided any documentation regarding communication about Resident #17's dialysis treatments between the facility and the dialysis center (Name Omitted) between the dates of 2/18/24 and the date of exit by the time of survey exit.			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than five percent in 2 of 4 residents (Resident #7 & #340) reviewed for medication administration, resulting in a medication error rate of 16% (4 errors from a total of 25 opportunities for error). Findings include: Review of Resident #7's "Physician Orders" revealed an active order for Aripiprazole 5 mg 1	F0759	Element #1 Resident #340 was discharged from the facility. No ill effects noted from failure to administer medications correctly. Resident #7 was assessed by a Nurse Manager and did not have any ill side effects from the failure to administer medications correctly. Resident has medications available as ordered by MD. Element #2 Residents who reside in the facility have the potential to be effected. Residents were audited to ensure medications are available per MD order. If concerns noted will medication available pharmacy will be notified. If medication is not available at the time of administration MD will be notified.	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pill every morning for intermittent explosive disorder. Review of Resident #7's "Physician Orders" revealed an active order for 3 tablets of Calcitriol (Vitamin D) 0.25 mcg to be administered every morning on Monday, Wednesday and Friday for end stage renal disease. Review of Resident #7's "Physician Orders" revealed an active order for Nepro (supplemental drink) 1 can in the morning for supplement. During medication administration observation and interview on 06/12/24 at 08:12 AM, Registered Nurse (RN) "AA" was preparing morning medications for Resident #7, and reported that Aripiprazole 5 mg was not available to administer as ordered, and that she had used the last dose the day before. RN "AA" reported that Calcitriol was not available, and that Resident #7 was supposed to get the medication prior to dialysis (treatment to remove toxins and fluids in someone with kidney failure), which was scheduled later that morning. RN "A" reported that Nepro supplemental drink was not in the medication cart, and/or in the supply closet, and that the resident usually received one can of it in the morning. RN "AA" reported that a refill of Resident #7's Ariprazole was ordered 1 day ago, and Calcitriol was ordered on 5/31/24. RN "AA" reported that there is usually extra Nepro in the supplement closet, but it was gone too. Review of Resident #7's "Medication Administration Record (MAR)" indicated that Ariprazole 5 mg, Calcitriol, and Nepro were not given on 6/12/24, due to being unavailable. Resident #340 Review of Resident #340's "Physician Orders"		Residents audited to ensure medications administered at appropriate dosage. MD will notified with concerns identified. Element #3 Director of nursing and NHA reviewed the policy on Medication Administration and deemed it appropriate. Medication Administration Policy was reviewed by QAPI. The Staff Development Coordinator/designee re-educated licensed nurses on the Medication Administration Policy . During Clinical rounding nurse managers to ensure medication available and if not available physician will be notified. Element #4 A weekly audit will be completed by the Director of Nursing and/or designee with 10 residents to ensure medications are administered correctly, available and dosage per MD order for 4 weeks then monthly until substantial compliance is achieved 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. Any instances of noncompliance that are identified will be addressed and the nurse will be re-educated. The DON is responsible for achieving and sustaining compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	revealed an active order for Fexofenadine (for allergies) 180 mg, 1 pill in the morning. During medication administration observation on 06/12/24 at 09:31 AM, RN "T" was preparing morning medications for Resident #340. RN "T" administered Allergy relief (Fexofenadine) 60 mg, 1 pill to Resident #340. In an interview on 06/12/24 at 09:51 AM, RN "T" reported that the Fexofenadine pill strength that was administered to Resident #340 was 60 mg. After review of the order, RN "T" reported that she would give Resident #340 two more of the 60 mg pills to total the actual ordered dose of 180 mg.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761	Element #1 Resident #140 is unable to self-administer medication per assessment. An observation of their room was completed on 06.18.24 and no medications were found at bedside. Resident had no ill effects of medications left at bedside. Resident #49 is unable to self-administer medication per assessment. An observation of their room was completed on 06.18.24 and no medications were found at bedside. Resident had no ill effects of medications left at bedside. Element #2 Residents that have medications left at bedside have the potential to be affected. Resident rooms were audited for medications at bedside. If medications were found at bedside they will be removed.	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate storage of medication and a self-administration of medications evaluation was conducted for two (R140 and R49) of two residents reviewed for self-administration of medications, including narcotics, resulting in the potential for adverse reactions and overdose. Findings include: R140 According to the Minimum Data Set (MDS) dated 5/28/24, R140's BIMS (Brief Interview of Mental Status) had not been conducted as of 6/11/24. However, during observation and interview revealed the resident was attentive and interested during the interviews the surveyor conducted displaying a concrete thought process, with clear and concise speech. During an observation and interview on 6/12/24 at 8:37 AM, Registered Nurse (RN) "T" was observed leaving a medication cup (med cup) with various pills on R140's bedside table and exiting room without observing the resident taking them. R140 stated, "The nurses do not normally leave meds with me. I've never met the nurse that left these medications with me". During an interview on 6/12/24 at 8:43 AM, RN "T" stated, "I don't know of any residents that take their medications on their own." The RN did not respond when asked if she had left medications with R140 to take on her own. Review of R140's Order Summary did not reveal		Residents with BIMS 10 or higher were interviewed and residents at this time do not want to self-administer. Element #3 The Administrator and DON reviewed Resident right to self-administer medication policy and deemed it appropriate Policy reviewed at QAPI. Nursing staff will be re- educated on the Residents right to self-administer medication policy and not leaving medications at bedside by the DON/Designee. Residents with the preference to self-administer medication will be reviewed in the next morning clinical meeting to ensure that the assessment was completed, the MD was notified, and the care plan was updated. Element #4 The Director of Nursing /Designee will audit 8 residents weekly x 4 weeks and then monthly to ensure no medications are at bedside. 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 Director of Nursing is responsible for compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the resident had orders to self-administer medications. Review of R140's Medication Administration Record/Treatment Administration Record (MAR/TAR) dated June 2024, indicated five medications including one controlled substance were documented as being administered to the resident during the morning pass on 6/12/24. No orders or assessments indicated the resident was able to self-administer medications. Review of R140's Care Plan did not include a focus regarding self-administrating medications. Review of R140's medical chart did not reveal a "Self-Administer Medications" evaluation had been done. R49 During an observation on 6/12/24 at 1:00 PM, RN "S" left a med cup of medications including two different kinds of controlled substances, in front of R49 on a bedside table before beginning wound care. Multiple times, the RN exited the room for more than 3 minutes at a time, completely out-of-sight with the door closed and privacy curtain pulled to gather wound care supplies. According to the MDS dated 2/25/24, R49 scored 15/15 (cognitively intact) on his BIMS and had diagnoses that included anxiety and depression. Review of R49's Order Summary did not reveal the resident had orders to self-administer medications. Review of R49's MAR/TAR dated 6/1/2024-6/30/14 indicated RN "S" documented he had signed out and administered 2-controlled			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	substance at the time of the observation. Review of R49's Care Plan did not include a focus regarding self-administrating medications. Review of R49's medical chart did not reveal a "Self-Administer Medications" evaluation had been done. During an interview on 6/13/24 at 9:35 AM, Director of Nursing (DON) "B" stated, "There are no residents in the facility that self-administer their medications. Nor should medications, including controlled substances, be left at bedside for any amount of time."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen resulting in the potential	F0812	Element #1 No residents were identified. Food was discarded that was in the refrigerator. Element #2 Residents that are at risk to be affected are residents that reside in the facility 3 door reach in refrigerator was locked out and no longer able to use. New refrigerator ordered and delivered. Food that was in the reach in was thrown in the trash. Refrigerators were audited to ensure remaining Kitchen refrigerators were at appropriate temperatures. Refrigerators will be audited to ensure raw food products are not on the same level as other food products. Chemical under the 3 compartment sink was	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to spread food borne illness potentially affecting all 87 residents that reside in the facility. Findings Include: During an initial kitchen tour on 6/11/2024 at 8:33 AM, the following was observed in the reach in refrigerator: The outside temperature gauge temperature was at 53 degrees. The inside temperature gauge was at 46 degrees. On 6/11/2024 at 11:52 AM, it was observed the reach in refrigerator outside temperature gauge was 52 degrees and the inside temperature gauge was 45 degrees. The reach in refrigerator was still packed with food. During an interview on 6/11/2024 at 12:25 PM, Maintenance Director (MD) "FF" stated that ice froze up on the fan in the reach in refrigerator and he was trying to chip it away so it could start working again and the temperatures should come back down. On 6/11/2024 at 1:41 PM, it was observed the reach in refrigerator outside temperature gauge was 58 degrees and the inside temperature gauge was 50 degrees. The reach in refrigerator was still packed with food. During an interview on 6/11/2024 at 1:56 PM, Dietary Director (DD) "Z" stated that she told her kitchen staff to stay out of the reach in refrigerator so the temperature doesn't go up more. When asked what she was going to do with the food in the reach in refrigerator, she stated she would throw out all perishable food items.		immediately removed and discarded. Audit of the kitchen area will be completed to ensure chemicals are labeled. Identified concerns will be addressed. Element #3 The Administrator and DON reviewed Food Receiving and Storage policy and deemed them appropriate. Dietary staff will be educated on Policy to ensure staff are discarding food if temperatures are above appropriate temps, raw food products are separated and chemicals are labeled appropriately. Dietary Manager will ensure refrigerator temps are within appropriate range, food is stored appropriately, and chemicals are stored and labeled appropriately in the dietary department. Element #4 Dietary Manager/ designee to audit 3 times a week to ensure refrigerator temps are within appropriate range, food is stored appropriately, and chemicals are stored within appropriate limits. 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 NHA is responsible for compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 6/11/2024 at 2:15 PM, MD "FF" stated that he put a flame in the reach in refrigerator to get rid of the ice so he said, "Of course the temperature would go up in the reach in refrigerator." On 6/11/2024 at 2:31 PM, it was observed that the reach in refrigerator was cleared out except for one metal container of condiments and two boxes of tomatoes which were on the bottom shelf. The dietary staff said that they would get rid of the condiments and move the tomatoes to another refrigerator. During an interview on 6/11/2024 at 2:35 PM, Nursing Home Administrator (NHA) "A" stated she wasn't aware of the reach in refrigerator temperatures being high since no one told her. NHA "A" said she would follow up and make sure things are cleaned out in the reach in refrigerator. On 6/11/2024 at 3:30 PM, it was observed with DD "Z" that all food in the reach in refrigerator was cleaned out. Review of the Food Receiving and Storage Policy with an implementation date of 7/31/2020 and a reviewed/revised date of 01/01/2022 states, "Foods shall be received and stored in a manner that complies with safe food handling practices, as outlined in the FDA Food Code." Under Policy Explanation and Compliance Guidelines #8, "Refrigerated foods should be stored at or below 41(degrees) F (Fahrenheit) unless otherwise specified by law." According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. "(A) Except during preparation, cooking, or cooling, or when time is			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: ...(2) At 5C (41F) or less." During a follow up tour of the kitchen, at 8:18 AM on 6/12/24, an interview with DD "Z" and Maintenance Director "FF", found that the three-door continental refrigeration unit was having a hard time keeping temperature yesterday. When asked what was going to happen to the unit, MD "FF" stated that they have a vendor coming out to check on the unit, but its looking like it's going to have to get replaced. When asked if they had to discard any food yesterday, DD "Z" stated they did. During a revisit to the kitchen, at 8:42 AM on 6/12/24, it was observed that a spray bottle was tucked into the bottom left side of the three-compartment sink. Upon grabbing the spray bottle, it was observed it stated "H20" and contained a green solution. MD "FF" removed the bottle from the kitchen. According to the 2017 FDA Food Code section 7-102.11 Common Name. "Working containers used for storing POISONOUS OR TOXICMATERIALS such as cleaners and SANITIZERS taken from bulk supplies shall be clearly and individually identified with the common name of the material." During a revisit to the kitchen, at 11:55 AM on 6/12/24, observation of the three door Hussman refrigeration unit found shredded lettuce stored on the bottom shelf behind a couple cases of raw pork chops. When asked if this was were the lettuce is normally, DD "Z" stated "No".			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. "(A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables,(b) Cooked READY-TO-EAT FOOD ..."			
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic	F0842	Element #1 Resident #15 reviewed and had their wound dressings changed per MD order. No ill effects identified. Element #2 All residents who are receiving wound dressing changes in the facility have the potential to be affected. A one-time audit was completed by the DON/designee to identify residents that receive wound dressing changes. These residents were audited to ensure they have current wound dressings per MD order. Identified concerns will be addressed. Element #3 The administrator and DON reviewed the Clean Dressing Change policy and deemed it appropriate. Policy reviewed at QAPI. Licensed nurses were re-educated on following physician orders, including orders for wound dressing changes. Wound dressing changes will be audited by	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00143208. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the documentation of pressure ulcer care and dressings changes for one (Resident #15) of four residents reviewed for pressure ulcers, resulting in the potential for inappropriate follow up care, lack of continued assessment, and worsening of the skin injury.		Wound Nurse/designee 5 days per week. Element #4 The DON/designee will audit and observe 5 residents per week with wound dressing change orders to ensure treatment is provided per provider order. Audits will be conducted x4 weeks and then monthly until sustained compliance. 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 DON is responsible for sustained compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Resident #15 In an interview on 06/11/24 at 02:33 PM, Family Member (FM) "OO" reported that Resident #15's wound dressings did not get changed as frequently as they should and that she felt like that was why his wounds had not healed. Review of Resident #15's "Progress Note" dated 6/6/24 indicated that the resident had returned from the hospital at 4:45 PM that day. During an observation and interview on 06/12/24 at 12:15 PM in Resident #15's room. Registered Nurse (RN) "S" detached Resident #15's incontinence brief and a large white dressing was observed, dated June 7th with Wound Nurse (WN) "X's" initials on it. RN "S" removed the resident's sock on his left foot and a large white dressing was observed, dated June 7th with WN "X's" initials on it. Resident #15 reported the wound dressings are supposed to be changed every day, but its more like every month. RN "S" reported that WN "X" completes the wound care and dressing changes on Monday, Wednesday and Friday, and then the floor nurses are supposed to do them the other days. Resident #15's wound care had not been completed for the past 5 days. In an interview on 06/12/24 at 01:08 PM, WN "X" reported Resident #15 had the wound on his left hip for a very long time, and a wound on his left heel, and both have orders for daily wound care and dressing changes. WN "X" reported that he had performed wound care for Resident #15 on Friday 6/7/24, but did not see documentation in the record, and could not remember if he had seen Resident #15 on Monday 6/10/24, but must not have since the dressing was dated June 7th.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #15's "Physician Orders" revealed, "Left trochanter wound: cleanse with wound wash, pat dry, apply collagen (aids in healing) in undermined area, then apply thin coat of triad cream (skin protectant) on base of wound, cover with bordered dressing daily and PRN (as needed) if soiled or missing. Order/Start date 6/9/24." There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's "Treatment Administration Record (TAR)" for the dressing noted above on the left trochanter indicated the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. That was inaccurate documentation, considering the dressing on 6/12/24 was dated 6/7/24. Review of Resident #15's "Physician Orders" revealed, "Left heel: cleanse with wound wash, pat dry, apply Santyl (removes damaged tissue and aids in healing) to slough (dead skin cells), cover with collagen pad, secure with ABD (thick cotton) pad, foam and stretchy kerlix (wrap), daily PRN application along with floating heel while in bed all times as tolerated. Every evening shift for left heel wound. Order/Start date 6/9/24." There was no order to complete the wound care on 6/7/24 or 6/8/24. Review of Resident #15's "TAR" for the dressing noted above on the left heel indicated the wound care was completed on 6/9/24, 6/10/24 and 6/11/24. That was inaccurate documentation, considering the dressing on 6/12/24 was dated 6/7/24. Review of Resident #15's "Pressure Ulcer Care Plan" revealed, "...Chronic surgical ulcer stage 4 to left trochanter (hip), unstageable left heel...Date initiated 9/15/23, Revised on 6/8/24.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Interventions: ...administer treatments per orders. Date initiated: 9/15/23..."			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The	F0880	Element #1 Deficient Practice #1 Resident #46 has EBP sign posted outside of his door and now has PPE available. Resident #57 has EBP sign posted outside of his door and now has PPE available. Resident # 57 CPAP mask is now stored in a plastic bag. CPAP and tubing has been cleaned. PPE is available for use. EBP signage has been placed outside their door. Resident #48 CPAP mask and tubing is now in a plastic bag. EBP signage has been placed outside their door. Resident #49 wound dressing was changed per order, EBP guidelines and policy. No ill effects noted. Resident #65 Nebulizer machine was cleaned and mask and tubing was cleaned and placed in a bag. Name plaque highlighted to identify EBP. Residents IV pole and T/F pump has been cleaned. T/F tubing replaced to ensure cap is in place and no longer on the floor. Resident bed side table floor has been cleaned. Resident tube feeding tubing was changed wearing PPE per EBP guidelines. Resident #141 IV pump and pole have been cleaned. IV tubing has been changed. Resident #141 w/c was cleaned and kerlex was removed. Name plaque highlighted to identify EBP and EBP signage outside of the door.	7/9/2024

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has two deficient practice statements. Deficient Practice Number 1. Based on observation, interview, and record review, the facility failed to ensure proper infection control protocols and practices in seven of 20 residents reviewed for infection control (Resident #46, Resident #57, Resident #48, Resident #49, Resident #65, Resident #15, Resident #83) including 1. Enhanced Barrier Precautions (EBP) per national standards of practice, 2. Routine cleaning and proper storage of continuous positive airway pressure (CPAP) machines and tubing 3. Proper use of PPE (Personal Protective Equipment) during catheter care and dressing changes, 4. Keeping an intravenous therapy (IV) pole clean, 5. Tube feeding practices and 6. Proper wheelchair cleaning resulting in the potential for the spread of infection, cross-contamination, and disease		Resident #43 wheelchair was removed and resident received a brand new wheelchair. Resident #15 physician order added for EBP per MD. Resident observed to ensure transferred with appropriate PPE per EBP guidelines. Resident wound care observed to ensure appropriate PPE used and following EBP guidelines. Resident #65 was observed to ensure treatment to peg tube completed with PPE worn per EBP guidelines. Resident #83 was observed to ensure staff changed drainage bag with appropriate PPE per EBP and infection control guidelines. D hall spa room underside of shower bed mat and mesh netting was cleaned. Deficient #2 Hopper on A and B hall was flushed to ensure stagnate water was removed. C hall hopper handle was repaired. New Chlorine strips will be ordered to ensure within the tenth degree. Water Management plan will be reviewed and revised as needed to ensure within regulatory guidelines. Element #2 Residents who reside in the facility have the potential to be affected One time audit was conducted by Nursing Managers to ensure EBP residents were identified per policy and signage, orders in place, highlighting of door sign completed and	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transmission for residents residing in the facility. Findings include: During an observation on 6/11/2024 at 10:14 AM down D-Hall, one cart with PPE was noted to not have any hand sanitizer on it. Another cart with PPE down the hall had a push sanitizer device on the cart but it was empty. Enhanced Barrier Precautions Review of Centers for Disease Control and Prevention (CDC) dated March 20, 2024, revealed, "...Enhanced Barrier Precautions" (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities...EBP are used in conjunction with standard precautions and expand the use of PPE (personal protective equipment) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing...EBP are indicated for residents with any of the following: *Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO...Effective Date: April 1, 2024..." Resident #46 (R46) Review of the Face Sheet and Minimum Data Set (MDS) dated 4/7/2024 revealed R46's admission date was on 8/17/2022 with diagnoses of benign prostatic hypertrophy (BPH, enlarged prostate gland that causes urination difficulty) and urinary retention. Brief Interview for Mental Status		PPE available Residents with G tubes and Indwelling catheters were observed to ensure care was completed per EBP policy. IP/ designee will complete a one-time audit of cleanliness of I.V. pumps and poles, TF poles and pumps, bedside tables and wheelchairs. Residents with CPAP□s audited to ensure cleaned and stored appropriately. Residents with Wound dressings were audited to ensure changed per order and EBP policy. Residents with Nebulizers audited to ensure cleaned and stored appropriately. Residents with T/F tubing audited to ensure caps on tubing when not in use. Residents with Tube Feeding in place were audited to ensure T/F was changed wearing PPE per EBP guidelines. Resident with G tube bedside tables audited to ensure clean. Residents with W/C were audited to ensure cleaned and no kerlex or black tape in place. Resident with wound care orders were audited to ensure completed per EBP guidelines. Residents with EBP orders were reviewed when transferred to ensure appropriate PPE in place. Resident with indwelling catheter bags were observed when changing to ensure following	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(BIMS) reflected a score of 4 out of 15 which indicated R46 was severely impaired (0-7 severe impairment). During initial screening on 6/11/2024 at 9:40 AM, it was observed that R46 had an indwelling medical device (catheter) and didn't have an enhanced barrier precaution sign posted outside his door or personal protective equipment (PPE) available. Review of R46's chart revealed the following physician order "Monitor foley cath (catheter) 16F (French size) with 10cc (volume) balloon to dependent drainage every shift for urinary retention." And "Foley cath care and check to see cath in secure every shift for urinary retention." Review of R46's care plan revealed, "Resident has a need for an indwelling catheter (16F, inflate balloon 10 ml (milliliters)) related to BPH and urinary retention, bladder calculus (bladder stone in urinary bladder), frequent UTIs (urinary tract infections). Resident requires enhanced barrier precautions related to urinary catheter." Under Interventions, "Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing, bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis)." Resident #57 (R57) Review of the Face Sheet and Minimum Data Set (MDS) dated 3/28/2024 revealed R57's admission		EBP guidelines. Shower beds were audited and cleaned as needed to ensure clean. Hoppers in the facility audited to ensure flushed to remove stagnate water. Hoppers audited to ensure flush appropriately and handles working correctly. Water will be randomly sampled with chlorine strips that test within the tenth degree to ensure within appropriate range. Concerns will be addressed as noted. Water Management plan will be reviewed and revised as needed to ensure within regulatory guidelines. Element #3 The Administrator and DON have reviewed The infection Prevention and control Program, the EBP Guidelines, the C-Pap/Bi-Pap cleaning guidelines, the PPE guidelines and the wheelchair cleaning guidelines and deemed them appropriate. Policies reviewed at QAPI. Staff will be re-educated by the DON/Designee on The infection Prevention and control Program with a focus on EBP, C-Pap cleaning, PPE, during catheter care, tube feeding, and dressing change, cleanliness of TF poles and pumps, IV poles and pumps and wheelchairs and shower beds. Maintenance educated by NHA/designee on Water management which includes chlorine testing and flushing of hoppers. During routine rounds, infection control concerns are addressed as they are identified by department heads. Concerns requiring	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	date was on 11/5/2022 with diagnoses of neurogenic bladder, neuromuscular dysfunction of the bladder and chronic respiratory failure with hypoxia (low oxygen). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R57 was cognitively intact (13-15 cognitively intact). During initial screening on 6/11/2024 at 10:12 AM, it was observed that R57 had an indwelling medical device (catheter) and didn't have an enhanced barrier precaution sign posted outside her door or personal protective equipment (PPE). Review of R57's chart revealed the following physician order "Change indwelling Foley catheter 14 fr (French size); balloon:10cc r/t (related to) neuromuscular dysfunction of bladder PRN (as needed) as clinically indicated: s/s (signs/symptoms) of obstruction (leakage, increased sediment, etc.), infection, or if closed system was compromised. Change catheter drainage bag as needed." And "Use enhanced barriers while performing high-contact activity with the resident every shift for urinary catheter." Another order related to the CPAP, "Wash C-pap straps and hand to dry in the morning every Fri (Friday)." And "Remove C-pap and rinse out mask in the morning due to chronic respiratory failure with hypoxia." Review of R57's care plan revealed, "Resident has a need for an indwelling catheter related to neurogenic bladder and neuromuscular dysfunction of the bladder. Also, "Resident requires enhanced barrier precautions related to urinary catheter." Under Interventions, "Use gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray. Utilize Enhanced Barrier Precautions when providing high contact resident care activities (dressing,		further follow up are reported to the Infection Preventionist for resolution. Element #4 DON /designee will complete a visual random device audit of C-Paps/Bi-Paps, nebulizers, T/F pumps and poles, IV pumps and poles, shower beds and 10 wheelchairs 3 times weekly x 4 weeks and then monthly to ensure equipment is clean and following EBP guidelines. DON/Designee will complete 10 random audit dressing changes, catheter bag changes, and transfers 3 times weekly x 4 weeks and then monthly to ensure Policies are followed including EBP guidelines. DON/Designee will complete 10 random audits of EBP signage and highlighting name plaque weekly x 4 weeks then monthly. DON/Designee will complete 10 random audits of staff use of PPE for residents with EBP weekly x 4 weeks and then monthly to ensure policies were followed. DON/ Designee will audit 10 staff for tube feeding administration weekly x 4 weeks and then monthly to ensure policies were followed. Housekeeping manager/designee will audit 10 rooms 3x per week to ensure bedside tables and floor is clean of debris x 4 weeks then monthly. Housekeeping manager/designee will audit shower beds 3x weekly for 4 weeks then monthly to ensure clean. Hoppers will be audited by Maintenance	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bathing, transferring, personal hygiene, changing linens, changing briefs/assisting with toileting, device care: central lines, urinary catheters, feeding tubes, tracheostomy/ventilators, wound care, dialysis)." During an interview on 6/11/2024 at 10:12 AM, in R57's room, it was observed she had a CPAP machine, mask and tubing without any barrier or stored in a plastic bag on her bedside table. R57 stated her CPAP wasn't cleaned in a "long time". R57 was also observed to have an indwelling catheter. During an interview on 6/12/2024 at 1:52 PM, R57 stated staff don't wear gowns when providing care and she said they only wear gloves sometimes. Resident #48 (R48) Review of the Face Sheet and Minimum Data Set (MDS) dated 3/9/2024 revealed R48's admission date was on 7/19/2023 with diagnoses of obstructive sleep apnea and shortness of breath. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R48 was cognitively intact (13-15 cognitively intact). Review of R48's chart revealed the following physician order, "Wash C-pap straps and hand to dry in the morning every Mon (Monday)." And "Remove C-pap and rinse out mask in the morning due to obstructive sleep apnea." During an interview on 6/11/2024 at 9:43 PM, in R48's room, it was observed that the CPAP machine, mask and tubing were on his bedside table and without a barrier and it wasn't put in a plastic bag. R48 stated that it was always laying on the bedside table during the day.		Director or designee weekly to ensure flushing appropriately and handle in working order weekly x 4 weeks and then monthly to ensure policies were followed. Maintenance Director/designee will randomly test free chlorine weekly x 4 weeks then monthly to ensure water is within range. Maintenance Director/Designee will audit/review the Water Management Plan monthly to ensure following the plan. 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 NHA is responsible for achieving and sustaining compliance.	

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During another observation on 6/12/2024 at1:54 PM, in R48's room, it was observed that the CPAP machine, mask and tubing were on his bedside table and without a barrier and it wasn't put in a plastic bag. During an interview on 6/11/2024 at 12:30 PM, Registered Nurse (RN) "AA" stated EBP is used when a resident has any indwelling device such as a PEG tube (percutaneous endoscopic tube for nutrition) and catheter and the staff should gown up when giving care. RN "AA" stated that R46 and R57 should both have EBP signs outside their room since they have catheters and she didn't know why they didn't have signs. She stated she would get a sign up outside their rooms. RN "AA" also stated that she thought Certified Nursing Assistants (CNAs) were responsible for cleaning CPAP machines and tubing. She also said, "CPAP cleaning uses sterile water". During an interview on 6/12/2024, CNA "F" stated she doesn't do anything with the cleaning of CPAP machines, masks, or tubing. CNA "F" said nurses should be taking care of CPAP machines and tubing not CNAs. During an interview on 6/12/2024 at 1:28 PM, Director of Nursing (DON) "B" stated residents with open sores, central lines and ports should be on EBP, signs should be posted outside the door and the resident's name plate is colored green with a green highlighter. When discussing CPAP machines and tubing, DON 'B" said CPAP masks and tubing should be cleaned by nurses after each use in the morning when it's taken off. During an interview on 6/13/2024, Licensed Practical Nurse (LPN) "BB" stated the CPAP process should be that it should be cleaned and rinsed every morning when it's taken off and that she wasn't sure who was responsible to do it but			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she does it on her shift. During an interview on 6/13/2024 at 10:02 AM, Infection Preventionist (IP) "DD" and DON "B" stated a resident should be on EBP when they have a feeding tube, catheter, IV (intravenous) access and wounds. IP "DD" said that gowns and gloves should be used for direct care. DON "B" stated that the resident name should be highlighted green, a EBP sign should be posted outside the door and a cart with PPE should be outside the room for staff to put on PPE before entering resident's room. IP "DD" and DON "B" were notified of D-Hall residents not having appropriate EBP signs outside of their door. When asked when the last EBP education was done DON "B" stated that it has been about 1-2 months when the last IP was there. DON "B" said that staff needs reeducation on EBP procedures. DON "B" also stated that each cart should have a bottle of sanitizer on it. DON "B" said the last education on CPAP cleaning and care was done about 6 months ago. R49 According to the Minimum Data Set (MDS) dated 2/25/24, R49 scored 15/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), had an impairment on left side of his upper and lower body, was dependent on staff for ADLs (activities of daily living) which included toileting, bathing, and transfers. He was incontinent of bowel and bladder. Diagnoses included cancer, diabetes, stroke, dementia, and partial paralysis. Further review of R49's MDS included Section M-Skin Conditions indicating the resident was at risk for developing a pressure ulcer and had in fact had developed a stage 3 pressure ulcer.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Enhanced Barrier Precautions (EBP)/ Wound Dressing Change Review of R49's Order Summary dated 4/11/2024 revealed, "Use Enhanced Barriers while performing high-contact activity with the resident every shift for pressure ulcer." Review of R49's MAR/TAR dated 6/1/2024-6/30/14 indicated RN "S" documented he had documented in agreement with "Use enhanced barriers while performing high-contact activity with the resident every shift for pressure ulcer (start dated 4/11/2024). Review of R49's Care Plan, dated 4/11/2024, indicated a Focus of Enhanced Barrier Precautions related to pressure ulcer. The goal was for the resident to have reduced risk of acquiring an infection with interventions that included "Utilize Enhanced Barrier Precautions" when providing high contact resident care activities ...wound care ...use gown and gloves when providing direct care ..." During an interview on 6/12/24 at 8:17 AM, Registered Nurse/Wound Nurse (RN) "X" stated, "There is no wound doctor that comes in. Between myself, the doctor and two nurse practitioners, we follow the residents with wounds. (R49) has a stage 3 wound identified on his left lateral knee. The other wound is on the left leg above his ankle. Observed on 6/12/2024 at 1:00 PM, Enhanced Barrier Precautions signage including the direction CDC (Centers for Disease Control) guidance of wearing gown and gloves when performing direct care for residents with wound care. During an observation and interview on 6/12/24			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at 1:00 PM, RN "S" gathered supplies to change wound dressings for R49's left popliteal fossa (behind left knee) and anterior left lower calf and entered the resident's room. -RN laid supplies on top of resident's blankets at the foot of the bed without a barrier. -No garbage can was placed within reach of the RN. - No barrier was placed underneath either wound. -RN used green handled scissors to remove gauze around knee then placed them on the bed sheets and removed a small square dressing directly touching the wound that was seeping serosanguinous drainage. RN laid the soiled dressing directly on the resident's bottom sheet then picked it and held onto it in right hand. -The would appeared to be smaller than a quarter in size with a scab that had sloughed off leaving a red wound that was had serosanguinous drainage. -With a soiled gauze in hand, the RN cleaned the wound with wound cleaner. -RN placed the small gauze and gauze used for cleaning the wound on the bed. Both were soiled with serosanguinous drainage that left a drop of the drainage on resident's sheet. -RN placed clean small gauze over wound then wrapped with kerlix using the unclean scissors to cut it to length. -RN placed contaminated scissors on resident's blanket at foot of bed. -RN then went to the left lower calf and used the contaminated scissors to cut off the kerlix then			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	placed them back on the blanket at the end of bed. -RN removed dressing from lower calf wound that presented draining serosanguinous drainage, then removed the gauze immediately covering the wound which was soiled with the drainage. -Without changing gloves, the RN cleaned the wound, applied ointment, covered it with a square of gauze and then wrapped it with kerlix. The RN used the contaminated scissors to cut to length. -RN gathered soiled dressings and placed in garbage. Then gathered supplies and placed them in the wound treatment cart. -Without changing resident's bottom sheet that had come into contact with soiled dressing, the RN smoothed a sheet over the resident's legs and left the room. During an interview on 6/13/24 at 2:30 PM, RN "S" stated, "I know (R49) is on Enhanced Barrier Precautions. When doing direct care or treatments a gown and gloves need to be worn. I did not wear a gown when doing the dressing change. I have had infection control training at nursing school and here at the facility, but I do not remember when." R65 According to the MDS dated 4/28/24, R65 scored 10/15 (moderately cognitively impaired) on his BIMS. Section K-Swallowing/Nutrition Status indicated the resident had difficulty swallowing and required a feeding tube. His diagnoses included partial paralysis related to stroke. Nebulizer Review of R65's Order Summary dated 2/14/24,			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the resident was receiving nebulizer (breathing treatment machine) treatments two times a day. Review of R65's MAR/TAR dated 6/1/24-6/30/24, indicated the resident received the nebulizer treatment at 6:00 AM 6/12/24 and 6/13/24. Observed on 6/11/24 at 11:45 AM, R65's nebulizer machine and mask that was not attached to tubing were laying on the windowsill. The machine and mask were covered with splatters of clear liquid and dust. Observed on 6/12/24 at 11:15 AM, R65's nebulizer machine and mask were not attached to tubing and were laying on the windowsill. The machine and mask were covered with splatters of clear liquid and dust. Observed on 6/13/24 at 8:50 AM, R65's nebulizer machine and mask were not attached to tubing, were laying on the windowsill. The machine and mask were covered with splatters of clear liquid, fuzz, and dust and completely covered by a fleece blanket. EBP/Enteral (Tube) Feeding Review of R65's Order Summary dated 4/14/2023 indicated the resident was to receive enteral feeding every 6 hours via a G-tube (gastrostomy tube/PEG (feeding tube)). Review of R65's Care Plan, dated Observed on 6/11/24 at 10:20 AM, R65 had an Enhanced Barrier Precautions (EBP) sign outside his room next to his door. His name on the plaque also outside his door was not highlighted in any color. The EBP CDE guidelines (Centers for			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Disease Control) indicated PPE (Personal Protection Equipment) of gown and gloves must be work while performing direct care with a resident in the room. During an interview and record review on 06/11/24 10:22 AM, RN "R" stated, "I have (R65) on my assignment. I saw he was on Enhanced Barrier Precautions, but I do not know why." Reviewed resident's MDS provided by the facility "SHING". RN stated, "I did not know he had shingles." During an observation and interview on 6/11/24 at 11:45 AM, R65 was in his bed with shirt pulled up. There was no dressing at PEG (feeding tube) insertion site. A bottle of enteral feeding was hung on an IV pole to the right of the resident's head. The feeding was not running. A bag of clear liquid flush was hanging next to it. The tubing was wrapped back up on the IV pole with no end cap and a dribble of feeding was dried on the end. The feeding pump was sitting on a bedside table next to the IV pole. The table and pump were covered with splatters of tan substance resembling tube feeding. The IV pole was also covered with splatters of tan substance resembling tube feeding as was base of pole along with dirt, dust, debris on it and the floor. During an observation on 6/12/24 at 9:55 AM, R65 was in bed with an IV pole next to the right side of him along with an enteral feeding pump on a bedside table. A bottle of enteral feeding was hung on the IV pole but not running. The tubing was hung over the top of the bottle with no end cap. During an observation on 6/12/24 at 11:15 AM, R65 was sitting in a high-backed chair in his room. Behind the resident was an IV pole with tube feeding hung. The tubing was running into a			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	feeding pump on a bedside table with the end of the tubing lying on the floor without an end cap. The IV pole, base of the pole, and feeding pump were covered with dried tan substance resembling tube feeding. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. Observed on 6/12/24 at 12:30 PM R65's tube feeding tubing on floor with no end cap. The IV pole and its base had splatters of the same substance. The base had dirt, dust, and debris on it. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. Observed on 6/12/24 at 1:15 PM R65's tube feeding tubing on floor with no end cap. IV pole and pump splattered with tan substance. The IV pole and its base had splatters of the same substance. The base had dirt, dust, and debris on it. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. During an interview on 6/13/24 at 8:41 AM, ICP "DD" stated, "I am the Infection Control Preventionist, scheduler, Unit Manager, and Staff Education. During dressing change a barrier should be put under the wound in case there is drainage which you do not want contaminating bed linens. The same for supplies; they need to be placed on a barrier to. A garbage can should be close to the nurse doing the dressing change to put soiled dressings and not contaminate the clean field. Scissors should be cleaned after each use so they do not contaminate other areas. Infection can spread this way. There have been no audits done on wound care. All staff have been educated on infection control practices in the last 2 months plus they learn this in nursing school. If a soiled dressing touches the bed, staff should change the			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bedding. When a resident is on EBP for any kind of direct care PPE of gown and glove must be worn. IV poles, bases, and pumps should be cleaned each time something is dripped on them to prevent the spread of infection. The end of a tube feeding line should have an end cap so contaminates do not travel in the line to the resident. The end of the line should be kept sterile. If the tubing is on the floor or no end cap is on it the entire system should be changed." Observed on 6/13/24 at 8:50 AM R65's tube feeding pump had splatters of tan substance resembling tube feeding all over it. The IV pole and its base had splatters of the same substance. The base had dirt, dust, and debris on it. The bedside table had splatters of the tan substance as did the floor under the bedside table and floor. The tubing laid on the floor with no end cap. A drop of feeding was dribbling out onto the floor. During an interview on 6/13/24 at 9:35 AM, DON "B" stated, "When staff enter a resident room to perform direct care that has Enhanced Barrier Precautions (EBP) signage and orders for EBP, they should be wearing PPE including gown and gloves. The resident's name on the name plaque should be highlighted in green." Observed R141's name at doorway not highlighted in green. DON "B" indicated it should have been done to alert staff. DON "B" stated, "A PICC (, central line, catheter, and PEG should all be on EBP. All licensed staff have received infection control training/education within the last 2 months." Observed on 6/13/24 at 1:20 PM, R65's tube feeding tubing was connected to the feeding bottle that was hanging on the IV pole. The tubing ran through the pump and was lying on the floor. The tubing was not dated and there was no end cap. A drop of feeding had dribbled out of the			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	end onto the floor. The pump, IV pole, and base had splatters of a tan dried substance on them. The base had dirt, dust, and debris on it. Observed on 6/13/24 at 2:10 PM R65's tube feeding tubing was connected to his PEG. A new dressing at site dated 6/12. No tubing was in any of the three garbage cans. The feeding pump, IV pole and base had splatters of tan substance that resembled tube feeding. The base had dirt, dust, and debris on it. During an interview on 6/13/24 at 2:12 PM, RN "S" stated, "I connected (R65's) feeding tube just a few minutes ago. I used the tubing that was connected to the tube feeding. I guess I picked the tubing up off the floor and did not change it. I did not need to change the tubing because it was done last night. It did not have an end cap on it." During an interview on 6/13/24 at 2:30 PM, RN "S" stated, "I know (R49) is on Enhanced Barrier Precautions. When doing direct care or treatments a gown and gloves need to be worn. I did not wear a gown when doing the dressing change at PEG site or hooking up the tubing. I have had infection control training." R141 According to R141's Admission Record, he had been recently admitted on 6/5/2024 with diagnoses that included cellulitis of right hand and severe sepsis. Further review of R141's medical record revealed a MDS with a BIMS had not been completed. It was noted during observations and interviews with the resident he was focused on conversation and able to communicate verbally with clear and concise verbalization.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident Equipment/PICC (Peripherally Inserted Central Catheter) Review of R141's Care Plan, Peripherally Inserted Central Catheter (PICC) line, related to cellulitis, dated 6/6/24, include the goal of the resident having no signs/symptoms of IV related complications (e.g., (such as) infection, pain, redness, swelling, drainage, fever, etc. Interventions to meet this goal included IV catheter care and maintenance. Review of R141's Progress Note 6/5/24 at 22:11 (11:11 PM), "Nursing Evaluation Summary" indicated the resident had an IV (intravenous line) in his upper right arm. Review of R141's Order Summary indicated he received an antibiotic solution every shift to the right upper limb. Observed on 6/11/24 at 11:35 AM, R141 was in bed with a bandage on his right hand. An IV pole was to his right side. The pole, base, and IV pump had splatters of dried tan, white, and dark brown substances. A PICC line was observed in his upper right arm. During an observation and interview on 6/12/24 at 8:56 AM, R141 stated, "I had an operation on my right hand and had 15 stitches which they removed yesterday. I am on IV antibiotics, and the staff is late today with it." Observed an IV pole with splatters of tan substance resembling tube feeding which the resident does not receive. An empty, undated/unlabeled IV bag of antibiotic was hung on the pole. Tubing hanging from antibiotic bag was not labeled or dated. The end of the tubing was touching the floor without an end cap. The IV pump had splatters of tan substance resembling tube feeding as well.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Observed on 6/13/24 at 9:35 AM, R141 was in bed with antibiotic running via a pump through a tube into a PICC in his upper right arm. The pump was attached to an IV pole. The IV bag of antibiotics was not dated or labeled. The IV pole, base, and pump had splatters of tan, white, and brown substances. The base of the IV pole had accumulation of dust, dirt, and debris. Resident Equipment/Wheelchair Observed on 6/11/24 at 11:35 AM, 6/12/24 at 8:56 AM, and 6/13/24 at 9:35 AM, R141's wheelchair area where the foot pedals attached to the frame of wheelchair, left brake handle, and exposed screws on the seat frame wrapped with a non-cleanable kerlix (stretchable wound wrap). On the frame of the wheelchair, seat, and arm rests were splatters of various dried substances along with dirt, dust, and debris. R43 According to R43's MDS dated 4/5/24, the resident scored 15/15 (cognitivey intact) on his BIMS and required the use of a wheelchair for ambulation related to the amputation of his right leg. During an observation on 6/11/24 at 11:40 AM, R43 was in the hall using his wheelchair, the push ring had black tape wrapped around it that was frayed and falling apart. During an observation on 6/12/24 at 8:47 AM, R43 was in his room sitting in his wheelchair. The push ring had black tape wrapped around it was frayed and falling apart. During an observation and interview on 6/13/24 at 8:55 AM R43 was in his room sitting in his wheelchair. The push ring had black tape			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wrapped around it and was frayed, falling apart with rough edges. R43 stated, "I got this wheelchair from another resident. He had this tape on it. It is sharp sometimes where it is peeling off. Staff are to clean it at least weekly, and they should know that it is falling apart." During an interview on 6/13/24 at 9:35 AM, Director of Nursing (DON) "B" stated, "There should be no bandage wrap on (R141's) wheelchair for infection control because it is a non-cleanable surface." During an interview on 6/13/24 at 1:50 PM, Nursing Home Administrator (NHA) "A" reported during QAPI meeting, "Infection control practices should be monitored with rounding, and they are tracked with rounds and infection rates. The ICP and DON "B" are responsible for monitoring." Resident #15 During an observation on 06/11/24 at 12:32 PM Enhanced Barrier Precautions signage was on the wall outside of Resident #15's room and his name was highlighted on the name plate. There was a cart located a few rooms down the hallway that contained the necessary PPE. Review of Resident #15's "Physician Orders" revealed, no orders for Enhanced Barrier Precautions. Review of Resident #15's "Physician Orders" revealed, "Left trochanter (hip) wound: cleanse with wound wash, pat dry, apply collagen (aids in healing) in undermined area, then apply thin coat of triad cream (skin protectant) on base of wound, cover with bordered dressing daily and PRN (as needed) if soiled or missing. Order/Start date 6/9/24."			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #15's "Physician Orders" revealed, "Left heel: cleanse with wound wash, pat dry, apply Santyl (removes damaged tissue and aids in healing) to slough (dead skin cells), cover with collagen pad, secure with ABD (thick cotton) pad, foam and stretchy kerlix (wrap), daily PRN application along with floating heel while in bed all times as tolerated. Every evening shift for left heel wound. Order/Start date 6/9/24." During an observation and interview on 06/12/24 at 12:15 PM in the hall outside of Resident #15's room and in his room, Registered Nurse (RN) "S", DON "B" and Certified Nursing Assistant (CNA) "PP" were preparing to transfer the resident from his chair to bed, using the mechanical hoyer lift. Staff were wearing gloves, but did not don gowns. All 3 staff were physically involved in the transfer as it was difficult to maneuver Resident #15 out of his chair, through the doorway and then into his bed. RN "S" detached Resident #15's incontinence brief to visualize his wound dressing and also removed the resident's sock. During an observation on 06/12/24 at 02:00 PM in Resident #15's room along with Wound Nurse (WN) "X" to complete wound care and dressing changes. Enhanced Barrier Precautions signage was observed posted outside of Resident #15's room. WN "X" donned gloves, but did not don a gown. WN "X" removed the dressing from Resident #15's left hip that was dated June 7th, which revealed a deep wound with black crusting covering the wound. At 2:17 PM WN "X" removed the dressing dated June 7th from Resident #15's left heel, which revealed multiple small areas of open skin, and a dried piece of collagen. In an interview on 06/12/24 at 02:38 PM, WM "X" reported that he did not know what Enhanced			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Barrier Precautions meant, and/or why there were signs posted outside of several resident's rooms. In an interview on 06/12/24 at 02:40 PM, CNA "PP" reported that a gown was not needed to perform transfers for someone that was on enhanced barrier precautions and stated, "...only when you are working with their catheter or wounds..." Resident #65 During an observation on 06/12/24 at 01:44 PM RN "S" was observed entering Resident #65's room, that had signage indicating Enhanced Barrier Precautions, and was carrying peroxide and gauze. In a subsequent interview on 06/12/24 at 01:48 PM, RN "S" reported that he had cleaned up Resident #65's peg tube (feeding tube in stomach), because there was some drainage around it and stated, "...I was in a hurry, but with enhanced barrier precautions I should have worn a gown..." Resident #83 Review of an "Admission Record" revealed Resident #83 had pertinent diagnoses which included: bladder-neck obstruction (a blockage that does not allow urine to flow from the body), urinary tract infection, cognitive communication deficit. Review of a "Minimum Data Set" (MDS) assessment for Resident #83, with a reference date of 3/5/24 revealed a "Brief Interview for Mental Status" (BIMS) score of 3/15 which indicated Resident #83 was severely cognitively impaired.			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 6/12/24 at 11:35 AM., an observation of signage posted outside of Resident #83's room indicated enhanced barrier precautions, per Centers for Disease Control and Prevention (CDC), should be used by staff when providing care. The signage revealed "...everyone must clean their hands including before entering and when leaving the room... provider and staff must also wear gloves and gowns for the following high-contact resident care activities...device care or use: ... urinary catheter..." During an observation on 6/12/24 at 11:37 AM., "Registered Nurse" (RN) "S" entered Resident #83's room to change Resident #83's catheter drainage bag (a bag that collects urine from a catheter) due to leakage. RN "S" entered Resident #83's room carrying an unopened packaged urinary drainage bag. RN "S" closed the door to the room and applied gloves. Resident #83 placed drainage bag into the garbage can. RN "S" opened the packaging of the new catheter drainage bag, removed the end cap, pinched the catheter that was inserted into Resident #83's body, disconnected the leaking drainage bag and dropped the tubing into the garbage can. RN "S" then connected the new catheter drainage bag to the catheter inserted into Resident #83's body. RN "S" then removed his gloves, gathered the garbage bag containing the discard urinary drainage bag and exited the room. At no time did RN "S" perform hand hygiene, nor did RN "S" apply personal protective equipment (to include gown and gloves) per enhanced barrier precautions guidelines as indicated by the signage posted outside of Resident #83's room. Review of "Physician Orders" for Resident #83 revealed "...use enhanced barrier while performing high-contact activity with the resident. every shift for chronic suprapubic catheter... ordered on 4/11/24."			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of "Care Plan" for Resident #83 revealed "... Goal... resident requires enhanced barrier precautions related to urinary catheter date initiated 4/11/24...interventions... use gown and gloves when providing direct care face protection may be needed if performing activity with risk of splash...Utilize enhanced barrier precautions when providing high contact resident care activity...urinary catheters..." An observation of the D hall spa room, at 1:42 PM on 6/12/24, with District Housekeeping Manager "GG", found the underside of the shower bed mat and mesh netting, were found with increased amounts of dirt and debris remnants from previous resident showers. Further observation found multiple quarter size brown stains on the mesh with stuck on brown debris on the underside of the mat. Review of Enhanced barrier Precautions (EBP) Policy with an implementation date of 5/10/2023 and review/revision date of 3/26/2024 under Policy Explanation and Compliance Guidelines revealed, "2. Initiation of Enhanced Barrier Precautions b. If the resident is not known to be infected or colonized with a MDRO, an order for enhanced barrier precautions will be obtained for residents with the following: II. Indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes)." Review of the CPAP/BiPAP Cleaning Policy with an implementation date of 7/1/2020 and a review/revision date of 12/13/2023 under Policy Explanation and Compliance Guidelines #5, "clean mass frame daily after use with cpap cleaning wipe or soap and water. Dry well, ensuring no visible moisture or water droplets remain on the equipment prior to storing. Cover with plastic bag or completely enclosed in			

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 _____	6/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	machine storage when not in use." And #6, "weekly cleaning activities: a. wash headgear/slash straps in warm soapy water and air dry, b. wash tubing with warm soapy water and air dry." Deficient Practice Number 2. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing. Findings include: During a tour of the facility, starting at 9:33 AM on 6/12/24, it was observed that brown water, momentarily, came out of the faucet fixtures located on the hoppers of A and B hall. Observation of the hopper and on C hall found that it would not flush when the handle was pulled. An interview with Maintenance (M) "O" at 3:00 PM on 6/12/24, found that he does regular flushing of the hoppers, but only flushes the commode portion, and had not been flushing out the stagnant water that had been sitting in the pipes of the faucet over the hopper. When asked if there were other areas of the facility where regular flushing of water fixtures was occurring due to minimal use or inactivity, M "O" was unsure. When asked if there was a team that oversaw the Water Management Plan, M "O" was unsure. When asked if any samples are routinely taken of the facilities water supply, Maintenance Director "FF" and M "O" stated that Legionella and free chlorine is monitored. A review of the free chlorine samples found all the 2024 monthly samples were logged as .4 parts per million (ppm) of free chlorine. A review of the test strips indicate the level of free chlorine would be between 0 - 20 ppm, with no way to accurately			

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 _____	**6/13/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assess samples to the tenth degree. A review of the facilities "Water Management Program", not dated, found that: "1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing." and "5. Based on the risk assessment, control points will be identified. The list of identified points shall be keptin the water management program binder.6. Control measures will be applied to address potential hazards at each control point A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan." No observation of documented control points or active control measures were found to have been established or monitored.			