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
E0000 SS=	Initial Comments On June 13, 2024, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Medilodge of Westwood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness. The facility has 97 certified beds. At the time of the survey the census was 87.	E0000		
E0015 SS= F	Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste	E0015		

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

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

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	disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide enough safe emergency food to fulfill the needs of the emergency menu. This results in the potential for staff confusion, delayed mealtimes, and a lack of preparedness in the event of an emergency, potentially affecting all residents as well as any staff and visitors. Findings include: During a tour of the emergency food product, at 1:28 PM on 6/12/24, an interview with Certified Dietary Manager (CDM) "Z" and Regional Dietitian "QQ" found that canned goods should get rotated through every six to twelve months. Observation of the emergency food product found labels and delivery dates were facing the wall and could not be seen without re organizing heavy cases of canned goods. Once the cases were picked up and turned around, the following delivery dates were found: One case of Chicken and Dumplings delivered on 10/23/2018, One			

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	case of Beef Stew delivered on 1/7/2019, One case of Chili Con Carne delivered on 2/5/2019, and one case of Vegetable Green Bean Mix delivered on 9/20/2020. An interview with CDM "Z" and RD "QQ" found that they will need to go through the items and make sure it properly stocked and rotated through. A review of the facilities emergency menu found Beef Stew for day one dinner, Chicken and Dumplings and canned green beans for day 2 lunch, and Chili Con Carne for day 3 lunch.			
K0000 SS=	INITIAL COMMENTS On June 13, 2024, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Medilodge of Westwood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a single-story building of Type II (111) construction originally built in 1973. A Therapy Wing addition was built in 2011 and was determined to be Type II(000) construction. The entire facility is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility also has single station battery-operated smoke detectors installed in all resident rooms. The facility has 97 certified beds. At the time of the survey the census was 87.	K0000		

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K0211 SS= F	Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and continuously maintained free of all obstructions to full use in case of an emergency as required by 19.2.1 and 7.1.10.1. This deficient practice could affect all occupants in the event of obstructed egress during and emergency. Findings Include: On 6/13/24 at 9:09 AM, observation revealed the North Main Dining room exit door frame and threshold were rusted which was preventing the door releasing mechanism to operate the 15 second delay countdown to open the door. The deteriorating door frame and threshold also prevented the door crossbar and latches from opening the door with a horizontal force not greater than 15 lbf (66 N) as required in LSC 7.2.1.7.1(3). These findings were confirmed during an interview with the Maintenance #1 and Maintenance #2 at the time observed.	K0211		