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 _____	7/3/2024

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 an Abbreviated Survey from 7/2/24 to 7/3/24. Intake: MI00144997 Census: 91	F0000		
F0695 SS= D	Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer oxygen per physician order and professional standards of practice, and store oxygen tubing in a manner to prevent cross-contamination in 1 of 4 residents (Resident #104) reviewed for oxygen administration, resulting in the potential for respiratory distress, worsened respiratory status, and the spread of infection. Findings include: Review of an "Admission Record" revealed Resident #104 was a female, with pertinent diagnoses which included obstructive lung disease, heart failure, anemia, kidney disease, asthma, and dementia.	F0695		

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

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	Review of a "Minimum Data Set" (MDS) assessment for Resident #104, with a reference date of 6/16/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 2, out of a total possible score of 15, which indicated she had severe cognitive impairment. Review of a current "Care Plan" for Resident #104 revealed the focus "...Resident has an impaired pulmonary/respiratory status related to COPD (chronic obstructive pulmonary disease)/Emphysema (oxygen at 2 Liters per minute) via (nasal cannula) continuous..." and interventions which included "...Oxygen as ordered..." both with a start date of 7/1/24. Review of an "Order Summary Report" for Resident #104 revealed the active physician order "...Oxygen: RUN (at) (2 Liters per minute) VIA (nasal cannula) CONTINUOUS every shift..." with a start date of 3/13/24. In an observation on 7/2/24 at 2:42 PM, Resident #104 was noted in bed in her room, with her eyes closed. No oxygen in use at this time. Observed an oxygen concentrator along the wall near the entrance to Resident #104's room. Noted the oxygen concentrator was turned off, and the oxygen tubing was draped over the top of Resident #104's nightstand (not in the designated storage bag). In an observation on 7/2/24 at 4:26 PM, Resident #104 was noted in bed in her room, with her eyes closed. No oxygen in use at this time. Observed an oxygen concentrator along the wall near the entrance to Resident #104's room. Noted the oxygen concentrator was turned off, and the oxygen tubing was draped over the top of Resident #104's nightstand (not in the designated storage bag).			

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	In an interview on 7/2/24 at 4:30 PM, "Licensed Practical Nurse" (LPN) "J" reported (when queried about the oxygen concentrator in Resident #104's room) that Resident #104 does not use the oxygen concentrator and does not have orders for oxygen via nasal cannula. LPN "J" then reviewed Resident #104's active physician orders and stated "...(Resident #104) is on oxygen..." In an observation and interview on 7/2/24 at 4:45 PM, "Certified Nursing Assistant" (CNA) "D" reported Resident #104 receives oxygen via nasal cannula at 2 Liters per minute. Observed CNA "D" enter Resident #104's room and note the oxygen tubing was not in place. CNA "D" placed the oxygen tubing on Resident #104 and turned on the oxygen concentrator. Observed CNA "D" note the oxygen concentrator was not set to the correct flow rate, and adjust the oxygen concentrator to 2 Liters prior to exiting Resident #104's room. In an observation on 7/3/24 at 11:17 AM, noted Resident #104 was not in her room. Observed the oxygen concentrator in Resident #104's room was turned off, with the oxygen tubing draped over the top of Resident #104's nightstand (not in the designated storage bag). In an observation on 7/3/24 at 3:08 PM, noted Resident #104 was not in her room. Observed the oxygen concentrator in Resident #104's room was turned off, with the oxygen tubing coiled on the top of Resident #104's tray table (not in the designated storage bag). In an interview on 7/3/24 at 3:15 PM, CNA "G" reported if an aide were to question the oxygen concentrator settings, they should check with the nurse to verify the orders. CNA "G" reported CNA's should not make adjustments to the			

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	oxygen concentrator settings, as that is the responsibility of the licensed nurse. CNA "G" reported oxygen tubing should be stored in a plastic bag when not in use. Review of the policy/procedure "Oxygen Administration", dated 10/26/23, revealed "...Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences...Oxygen is administered under orders of a physician...Personnel authorized to initiate oxygen therapy include physicians, RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and respiratory therapists...Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include...Keep delivery devices covered in plastic bag when not in use..."			