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 _____	**6/10/2025**

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 10, 2025, 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 in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		

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

Electronically Signed | 06/23/2025

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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K0000 SS=	INITIAL COMMENTS On June 10, 2025, 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 94. The requirement at 42 CFR, subpart 483.90 (a) is not met as evidenced by:	K0000		

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K0211 SS= E	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. This deficient practice could affect a limited number of occupants of Therapy in the event of obstructed egress during and emergency. Findings Include: On 6/10/25 at 12:04 PM, observation revealed the southwest exit door from Therapy was binding at the frame and threshold which was preventing the door crossbar and latches from opening the door with a horizontal force not greater than 15 pounds and to set in motion for closure a force not greater than 30 pounds as required in LSC 7.2.1.4.5.1. These findings were confirmed during an interview with the Maintenance Director and the Regional Maintenance Director at the time observed.	K0211	Element 1 The southwest exit door in the therapy room was adjust to open and close within the correct amount of force on 6-17-2025. Element 2 A one-time building audit was completed on 6-17-2025 to ensure all facility exit doors opened and closed with the correct amount of force. Element 3 Maintenance staff were re-educated on 6-20-2025 by the Regional Maintenance Director as to the requirements of having all egress doors opening and closing with the correct amount of force. Element 4 A weekly audit x4 and then 1x monthly for 3 months will be completed by the Maintenance director or designee to ensure all egress doors open and close with the correct amount of force. 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. The Administrator is responsible for achieving and sustaining compliance.	6/23/2025
	Egress Doors Egress Doors Doors in a	K0222	Element 1	6/23/2025

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K0222 SS= E	required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING		The correct signage was installed on the three delayed egress doors in the dining room on 6-12-2025. Element 2 A one-time audit was completed on 6-17-2025 to ensure the correct signage is installed on all delayed egress doors in the facility. Element 3 Maintenance staff were re-educated on 6-20-2025 by the Regional Maintenance Director as to the requirements of having the correct signage on exit doors that contain delayed egress locks that read Push for 15 seconds and door will open Element 4 A monthly audit x3 will be completed by the Maintenance director or designee to ensure all delayed egress doors have the correct signage installed on them. 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. The Administrator is responsible for achieving and sustaining compliance.	

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	ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide approved exit access in accordance with the LSC section 19.2.2. This deficient practice could potentially affect all occupants of the Dining room. A delay in exiting the facility could increase occupant exposure to a hazardous condition. Findings Include: On 6/10/25 at 12:50 PM, observation revealed the three newly installed exit doors from the Main Dining room were equipped with 15 second delayed egress magnets yet there was no signage on any of the doors identifying the procedure to open them as required in LSC 7.2.1.6.1.1(4). These findings were confirmed during an interview with the Maintenance Director and the Regional Maintenance Director at the time observed.			
K0321	Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are	K0321	Element 1 The 200 hall soiled linen room door was	6/23/2025

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SS= E	protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide for the protection of hazardous areas in accordance with LSC 19.3.2.1. This deficient practice could potentially affect 25 occupants of the facility in the event of a fire not being contained to the hazardous area. Findings Include: On 6/10/25 at 12:37 PM, observation revealed the 200 Hall Soiled Linen room door did not self-close to a positive latch when		adjusted to come to a positive latch on 6-16-2025. Element 2 A one-time facility audit was completed on 6-16-2025 to ensure all soiled linen room doors came to a positive latch. Element 3 Maintenance staff were re-educated by the Regional Maintenance Director on 6-20-25 to ensure all soiled linen room doors are self-closing and come to a positive latch. Element 4 A weekly audit x4 and then monthly x3 will be completed by the Maintenance Director or designee to ensure all soiled linen room doors come to a positive latch. 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. The Administrator is responsible for achieving and sustaining compliance.	

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	tested as required in LSC 8.7.1.3. These findings were confirmed during an interview with the Maintenance Director and the Regional Maintenance Director at the time observed.			
K0324 SS= D	Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to protect cooking facilities in accordance with LSC 19.3.2.5 and NFPA 96. This deficient practice could potentially affect the occupants of the kitchen in the event of failure of the hood suppression system. Findings Include:	K0324	Element 1 The kitchen hood suppression system was inspected by a contractor on 6-17-2025. Element 2 A one-time audit was completed on 6-17-2025 to ensure all kitchen hood inspections and documentation has been completed and on the correct frequency. Element 3 Maintenance staff were re-educated by the Regional Maintenance Director on 6-20-2025 about the requirements of having the contracted kitchen hood inspection completed on a semi-annual basis directly on the 6-month frequency date. Element 4 A monthly audit x3 will be completed by the Maintenance Director or designee to ensure all kitchen hood documentation is completed and documented on the correct frequency. 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. The Administrator is responsible for achieving and sustaining compliance.	6/23/2025

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	On 6/10/25 during the review of facility records between 9:00 AM and 12:00 PM, there was no current documentation provided for the semi-annual Kitchen hood inspection as required in NFPA 96, 11.2.1. The last semi-annual Kitchen hood inspection available for review was dated 12/3/24. These findings were confirmed during an interview with the Maintenance Director and the Regional Maintenance Director at the time the records were reviewed.			
K0374 SS= E	Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide smoke barrier doors that were self-closing or automatic closing in accordance with LSC Section 19.3.7.6. This deficient practice could potentially affect 25 occupants of the facility in the event of a fire not being contained to the smoke compartment.	K0374	Element 1 The 200 hall cross-corridor door coordinators were adjusted on 6-17-2025 to allow the doors to close leaving the correct amount of clearance for proper operation. Element 2 A one-time building audit was completed on 6-17-2025 on all hallway cross-corridor door coordinators to ensure they allow the doors to close leaving the correct amount of clearance for proper operation. Element 3 Maintenance staff were re-educated by the Regional Maintenance Director on 6-20-2025 about the requirements of having all cross corridor door coordinators functioning correctly to ensure proper operation. Element 4 A weekly audit x4 then monthly x3 will be completed by the Maintenance Director or designee to ensure all cross corridor doors are functioning properly. 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.	6/23/2025

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	Findings Include: On 6/10/25 at 12:04 PM, observation revealed the 200 Hall cross-corridor door coordinators were observed not functioning to allow the doors to close leaving only the minimum clearance necessary for proper operation as required in LSC 8.5.4.1. These findings were confirmed during an interview with the Maintenance Director and the Regional Maintenance Director at the time observed.		The Administrator is responsible for achieving and sustaining compliance.	
K0712 SS= F	Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide written documentation regarding fire drills in accordance with LSC Section 19.7.1. This deficient practice could potentially affect all occupants of the facility if staff are not properly trained in approved emergency procedures. Findings Include: 1. On 6/10/25 during the review of facility	K0712	Element 1 An extra 3rd shift fire drill was completed on 6-18-25. A fire drill schedule has been added to the binder. Element 2 A one-time fire drill audit was completed to identify similar issues. An added fire drill schedule will make sure times of drills are being rotated. Element 3 Maintenance staff were re-educated by the Regional Maintenance Director on 6-20-2025 about the requirements of completing fire drills on the correct shift and at varying times. Element 4 A monthly x3 will be completed by the Maintenance Director or designee to ensure all fire drills are being completed on the correct shit and at varying times. 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. The Administrator is responsible for achieving and sustaining compliance.	6/23/2025

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	records between 9:00 AM and 12:00 PM, there was no documentation provided for a fire drill being conducted on the 3rd shift of the 4th quarter in 2024, as required in 19.7.1.6. There was an entry for the 3rd shift at 8:00pm which would have been a 2nd shift drill. 2. On 6/10/25 during the review of facility records between 9:00 AM and 12:00 PM, the fire drills for the previous year were not conducted under varied times or conditions throughout the shifts as required in 19.7.1.6. These findings were confirmed during an interview with the Maintenance Director and the Regional Maintenance Director at the time the records were reviewed.			