STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF KALAMAZOO	1701 S 11TH ST KALAMAZOO, MI 49009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 137. Based on observation, interview and record review the facility failed to treat residents with respect and dignity, and failed to provide and environment that promoted and enhanced resident quality of life for 16 of 31 sampled residents (#114, #118, #119, #120, #121, #122, #123, #124, #128, #112, #113, #125, #126, #127, #129, and #130) resulting in the potential for feeling of frustration, depression, and loss of self-worth and an overall deterioration of psychological well-being. Findings include: Review of the Shower/Tub Bath Policy dated 1/16/11, revealed The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. 1. Be sure that the bath area is a comfortable temperature for the resident. 3. Stay with the resident throughout the bath. Never leave the resident unattended in the tub or shower. Resident #114 Review of an Admission Record revealed Resident #114 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #114, with a reference date of 3/29/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #114 was cognitively intact. Review of the Care Plan for Activities of Daily Living (ADL's) dated 3/23/20, revealed The resident needs activities of daily living assistance related to: MS and [MEDICAL CONDITION] Interventions:BATHING/SHOWERING: -Monday & Friday 1st shift. - 1 assist Date Initiated: 7/20/202. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/19/20-8/20/20, revealed out of 9 opportunities the resident was given (1) resident refused (5) not applicable (1) shower (2) bed bath. During an interview dated 8/19/20 at 1:10 PM, Resident #114 reported that it pisses me off that I can't get a shower, (name of Administrator) tells me it is up to the aid and if you only have one aid, he does not have the time and if they do something for me, then they are not doing something for someone else. It is not fair for me not to get a shower, but if I want a shower it impacts someone else's care if I want a shower and that is unfair. Can't get haircut, can't get a shower, have to get permission to sit in the sun. I have not had a shower for months due to not having an aid on the hall only one aid on the hall. Since we have had the major shut down at least since June. Resident #114 reported that she does receive her bed baths on first shift only and when she reviewed the ADL shower long she noted that only that the CNA's were not first shift CNA's that were documenting baths. During an interview on 8/21/20 at 10:05 AM, Certified Nursing Assistant (CNA) C reported that there are 4 resident that use hoyers (a type of mechanical lift) on D hall, but that 2 of the hoyer residents do not usually want to get out of bed. CNA C reported that when the 2 want to get up I have to get help and if I do a bed bath on (name of Resident #114) it can take up 1.5 hours and if I did a shower it could take longer with the transfer into the chair then into a shower bed and then I have to get someone to help in the shower with the transfer, I cannot leave the resident, I have to pull the call light, so even if the nurse was working on this hall I can't leave it long enough to give her a shower, because there is no one answering lights. CNA C reported that the nurse was shared with the D hall. During an interview on 8/27/20 at 12:10 PM CNA II reported that she did not give Resident #114 a shower on 8/10/20 that she must have charted that shower in error. Resident #118 Review of an Admission Record revealed Resident #118 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #118, with a reference date of 6/1/20 revealed staff conducted the brief mental status for Resident #118's cognitive skills for daily decision making and determined they were severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 3/19/20, revealed (Name of Resident #118) needs activities of daily living assistance related to her dementia and decline that results from this, Interventions- BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date Initiated: 07/08/2020 o BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Monday and Wednesday's day shift. Date Initiated: 04/15/2020. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed out of 18 opportunities the resident was given (2) showers, (13) bed baths, (2) resident refused and (1) not applicable. Resident #119 Review of an Admission Record revealed Resident #119 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #119, with a reference date of 3/1/20 revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated Resident #119 was severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 2/25/20 (no time), revealed The resident needs activities of daily living assistance related to: Cognitive Deficits, Interventions- * BATHING/SHOWERING: The resident is able to bathe herself with assistance and cueing Thursday/Saturday 2nd shift. Date Initiated: 02/25/2020. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Monday and Friday 1st shift 8/19/20 Not applicable, 8/24/20 resident refused. No other bathing was documented for that timeframe. Resident #120 Review of an Admission Record revealed Resident #120 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #120, with a reference date of 7/31/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #120 was severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 2/25/20 (no time), revealed * The resident needs activities of daily living assistance related to: [MEDICAL CONDITION], Interventions- * BATHING/SHOWERING: limited assistance by 1 staff Date Initiated: 11/14/2017.*BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Tuesday & Friday first shift Date Initiated: 07/17/2020. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Monday and Friday 2nd shift 7/3/20-8/25/20 (15 opportunities) (14) bed baths (1) response not required. Resident #121 Review of an Admission Record revealed Resident #121 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #121, with a reference date of 6/12/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #121 was severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 6/23/20 (no time), revealed (Name of Resident #121) needs activities of daily living assistance related to: Dementia. Resident frequently declines assistance with ADL's yelling to staff, no, no, no get out. Date Initiated: 06/23/2020, Interventions- * BATHING/SHOWERING: The resident refuses bathing at times. He requires limited assistance by 1 staff member. May need increased level of assistance depending on mood. Date Initiated: 06/25/2020. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Tuesday and Thursday 1st shift 7/2/20-8/25/20 (17 opportunities) (11) bed baths (2) response not required, (2) resident refused, and (2) not applicable. Resident #122 Review of an Admission Record revealed Resident #122 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set

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

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) (MDS) assessment for Resident #12, with a reference date of 6/12/20 revealed staff conducted the brief mental status for Resident #122's cognitive skills for daily decision making and determined they were severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 5/9/19 (no time), revealed * The resident needs activities of daily living assistance related to: Dementia; he often times loudly chants and repeats the same phrase continuously, Resident need for assistance varies due to his dementia. Interventions * BATHING: Resident requires total assist by one staff member with bathing. Wed & Saturday 1st shift. Date Initiated: 05/28/2019 Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Wednesday and Saturday 6-2 shift 7/1/20-8/26/20. (16 opportunities) (11) bed baths (1) tub bath, (2), shower and (2) not applicable. Resident #123 Review of an Admission Record revealed Resident #123 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #123, with a reference date of 6/13/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #123 was severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 11/19/19 (no time), revealed * Name of Resident #123) needs activities of daily living assistance related to his declining cognition related to his [MEDICAL CONDITION]. Interventions * BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse Dated Initiated 7/6/20. *BATHING/SHOWERING: The resident is able to bath/shower with assistance x1, on days Wednesday and Saturday second shift. (And as needed) Date Initiated: 11/19/2019. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Wednesday and Saturday 2nd shift 7/1/20-8/26/20. (14 opportunities) (7) bed baths (1) resident refused, (1), shower and (5) not applicable. Resident #124 Review of an Admission Record revealed Resident #124 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 7/8/20 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #124 was severely impaired. Review of the Care Plan for Activities of Daily Living (ADL's) dated 7/2/20 (no time), revealed *The resident needs activities of daily living assistance related to: Confusion, Dementia, Interventions * BATHING/SHOWERING: 1 assist, Thursdays & Sundays 1st shift. Date Initiated: 07/02/2020. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Wednesday and Saturday 2nd shift 7/1/20-8/26/20. (13 opportunities) (10) bed baths, (2), shower, and (1) not applicable. Resident #128 Review of an Admission Record revealed Resident #128 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #128, with a reference date of 8/5/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #125 was cognitively intact. Review of the Care Plan for Activities of Daily Living (ADL's) dated 7/30/20 (no time), revealed Interventions o BATHING/SHOWERING: 1 assist Date Initiated: 07/30/2020. * BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Date Initiated: 07/30/2020. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 8/1/20-8/26/20, revealed Bathing Wednesday and Saturday 1st shift . (6 opportunities) (3) bed baths, (1), shower (documented on 8/15/20), and (2) not applicable. During an interview on 8/19/20 at 1:20 PM, Resident #128 sitting in her room stated that she had a shower at the end of her isolation period, the therapy guy had said it would be a good thing to see how I transferred. I have not had one since been doing my hair washing in the sink. During an interview on 8/27/20 at 2:31 PM, Licensed Practical Nurse (LPN) K reported that there has probably been 20 showers on C-hall since March people need their hair washed, basic needs are not being met 2 people need to be on C-hall at all times, so they cannot do showers, because there are not enough staff. During an interview on 8/27/20 at 11:31 AM, CNA FF stated I am giving a lot of bed baths, have not given a shower to (name of Resident #118) lately was on the C-hall, she refuses because the shower is cold, if you try to give shower you can hear them (the residents) from a mile away they get agitated like (name of Resident#127) for the next couple of days she (Resident #127) was traumatized might be better if shower room was on the C-hall and was not cold in the shower room and you have to be quick. If there was a hoyer resident you have to wait for someone then it is difficult, and you have to be very careful and wait for help. Some of the residents understand showers some don't, some you say pamper day some is only day we can get a good look at their skin. CNA FF reported that normally on C-hall there are 2 CNA's at all times and dedicated nurse, now sometimes it is just me and now I share a nurse with another hall, I try and keep an eye on the main exit doors and make sure no one gets out and watch the residents that wander and when nurse gets back do rounds, its a challenge, has happened a couple of times if I want to take a break can maybe get someone from another hall. CNA FF reported that if the shower room was on C-hall and was warm it would be a lot better for the residents. During an observation on C-hall Director of Nursing was in a room with staff on 8/26/20 at 4:12 PM asking staff who were in room how they decide whether residents get bed bath or shower, (she noticed surveyor at this time) then stated you do what the resident wants right? left the room, closing the door, left C-hall unit, there was no staff on the hall 3 resident were in the dining room alone, 3 residents were wandering in the hallway (one was sitting), and the nurse did not return to the unit until 4:16 PM. During an interview on 8/19/20 at 2:54 PM, the Activity/CNA A/CNA T stated that on the C-hall someday's I do CNA work on the floor they do showers when they can, but due to staffing they cannot, someday's there is only one CNA on the hall and one nurse working C and D hall so they can't leave the hall to do the shower, which is on D hall. A/CNA reported that when she arrived today there was one CNA and an orientee and the scheduler, so she took over for the scheduler and no showers were done today. A/CNA T reported that they have 1st and 2nd shift showers set up and they would try and squeeze the showers in on 2nd shift that they missed on 1st shift. A/CNA T reviewed the shower sheet and noted that the list of showers for today would leave (8) showers for 2nd shift to do. During an interview on 8/19/20 at 3:00 PM, CNA DD stated We did 2 showers on A-hall last night, to busy with call lights and care. CNA DD reported that 5 showers were scheduled. During an interview on 8/19/20 at 3:12 PM, CNA J reported that she did 2 bed bath last night on C-hall, they are the residents that do not transfer so well and there was only 2 CNA's and a nurse. CNA J reported that the residents are a 2 person hoyer on night shift and it was hard for staff to go get them down to the shower. CNA J stated You need to leave a nurse and a CNA on this unit (C hall) if you are in the shower and the nurse has to go to the other hall to do work and help transfer the resident in the shower it does not leave enough staff on the hall. During an interview on 8/26/20 (time omitted) LPN G stated that Resident #118 never wants too go out the door of C-hall, Resident #119 does alright, Resident #120 was hard to get out of bed since they just had hip surgery, Resident #121 may refuse to have care staff have to check when he was in a good mood, Residents #122-#125 like showers, Resident #126 you need to get on a good day, Residents #127-#129 do ok, and Resident #130 staff have to catch at the right time. In an interview on 8/18/20 at 5:24 A.M., Certified Nurse Assistant (CNA) P indicated sometimes only one CNA per hall was scheduled. CNA P indicated staff call in often because they are overworked and need a break. CNA P reported when there are call ins, often there is nobody to bring in or to stay and the CNAs have to work short (meaning there are not enough CNAs in the building) and the resident care suffers because of it. In an interview on 8/18/20 at 11:32 A.M., Certified Nurse Assistant (CNA) M stated we sometimes have to work short staffed. CNA M indicated sometimes residents don't get the care they need because of short staffing. In an interview on 08/20/20 at 10:50 A.M., Certified Nurse Assistant (CNA) L reported most of the time bed baths (instead of showers) are done on A Hall because of being short staffed and not having time to take the resident to the shower room. In an interview on 08/20/20 at 11:00 A.M., Licensed Practical Nurse (LPN) K indicated oftentimes, there was 1 CNA per hall resulting in resident basic needs are not being met - showers are not being given, people are not able to get out of bed most of the time, and residents are not being fed in a timely fashion In an interview on 8/26/20 at 4:05 P.M., Certified Nurse Assistant (CNA) J was asked about Bath/Shower charting. CNA J reported when checks N/A (Not Applicable) on the documentation, thought that meant not adequate - meaning did the best they could in the time they had to get the resident cleaned up but knew it was not adequate. Resident #112 Review of a Face Sheet revealed Resident #112 was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #112, with a reference date of 06/30/20 revealed a Brief Interview for Mental Status (BIMS) score of 03 out of a total possible score of 15, which indicated Resident #112 was severely cognitively impaired. Review of a current Care Plan for Resident #112 revealed focus of This resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Disease Process, weakness with interventions which included . BATHING/SHOWERING: Resident prefers showers Wednesday & Sunday 2nd shift, total dependent . with a start date of 07/03/17 and revised on 07/17/20. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/29/20 through 08/26/20 revealed, out of 8 opportunities, the resident was given (1) shower, (4) bed baths, (1) response not required, and (2) not applicable. Note

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) that resident prefers showers per care plan. In an interview on 8/19/20 at 3:30 P.M., Resident #112 indicated reported she had gone at least 2 weeks without a shower and has had to get a bed bath instead. Resident #112 indicated this has been happening ever since that Coronavirus came around. Resident #112 stated, I want to get up and get a shower. In an interview on 8/21/20 at 8:46 A.M., Resident #112 indicated she still has not gotten a shower all week. Resident #112 reported staff clean her up any time she goes (urinates or has a bowel movement) in her brief, but they do not give a shower. Resident #112 indicated she would feel cleaner with a shower and would rather have a shower. Resident #113 Review of a Face Sheet revealed Resident #113 was an [AGE] year-old male, originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #113, with a reference date of 05/26/20 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #113 was moderately cognitively impaired. Review of a current Care Plan for Resident #113 revealed focus of The resident needs activities of daily living assistance related to Activity Intolerance, Disease Process with interventions which included . BATHING/SHOWERING: 1 assist . Provide sponge bath when a full bath or shower cannot be tolerated . with a start date of 05/21/20 and revised on 07/20/20. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/20/20 through 08/17/20 revealed, out of 10 opportunities, the resident was given (2) showers, (1) bed bath, (1) response not required, (1) resident not available, and (5) not applicable. In an interview on 08/19/20 at 3:36 P.M., Resident #113 reported he is supposed to get a shower on Tuesdays and Thursdays. Resident #113 indicated he did not get one yet this week. In an interview on 08/20/20 at 10:50 A.M., Certified Nurse Assistant (CNA) L stated I know (Resident #113) asked for a shower today. Most likely he will get one if we have time. Otherwise he will get a bed bath. In an interview on 8/20/20 at 4:23 P.M., this surveyor visited Resident #113 to see if he had gotten a shower. Resident #113 stated, I have asked 4-5 people today for help to get a shower and they all said they would let someone else know. Nobody has come back all day and it's bullshit that I can't get a damn shower - I feel dirty and want to get clean. Resident #125 Review of a Face Sheet revealed Resident #125 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #125, with a reference date of 07/25/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, indicating resident is rarely/never understood, and the assessment could not be completed. Review of a current Care Plan for Resident #125 revealed focus of (Resident #125) needs activities of daily living assistance related to . cognition decline . dementia . with interventions which included . BATHING/SHOWERING: Avoid scrubbing & pat dry sensitive skin . requires the following amount of assistance (total) to bathe . Monday/Friday 1st shift with a start date of 03/29/19 and revised on 08/03/19. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/31/20 through 08/24/20 revealed, out of 9 opportunities, the resident was given (1) shower and (8) bed baths. Resident #126 Review of a Face Sheet revealed Resident #126 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #126, with a reference date of 06/14/20 revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #126 was severely cognitively impaired. Review of a current Care Plan for Resident #126 revealed focus of The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia . with interventions which included . BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Mondays and Friday's . with a start date of 12/03/15 and revised on 07/07/20. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/31/20 through 08/19/20 revealed, out of 7 opportunities, the resident was given (7) bed baths. Resident #127 Review of a Face Sheet revealed Resident #127 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #127, with a reference date of 06/13/20 revealed a Brief Interview for Mental Status (BIMS) score of 03, out of a total possible score of 15, which indicated Resident #127s was severely cognitively impaired. Review of a current Care Plan for Resident #127 revealed focus of Resident has dry scalp with intervention which included . (brand name of shampoo omitted) shampoo with each shower . with a start date of 11/26/18. Review of a current Care Plan for Resident #127 revealed focus of The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, muscle weakness .history of falls, impaired cognition . with interventions which included . BATHING/SHOWERING: 1 assist . Resident prefers Showers Mondays & Fridays . with a start date of 07/15/20. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/03/20 through 08/24/20 revealed, out of 23 opportunities, the resident was given (2) showers, (8) bed baths, (2) response not required, (1) resident refused, and (10) not applicable. Resident #129 Review of a Face Sheet revealed Resident #129 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #129, with a reference date of 06/10/20 revealed a Brief Interview for Mental Status (BIMS) score of 02, out of a total possible score of 15, which indicated Resident #129 was severely cognitively impaired. Review of a current Care Plan for Resident #129 revealed focus of . requires activities of daily living assistance related to: . [DIAGNOSES REDACTED]. with interventions which included . BATHING/SHOWERING: The resident requires total of 1 assistance with bathing/showering for cueing and ADL assistance (ie help with washing back, feet, etc. . with a start date of 05/28/19 and revised on 07/22/20. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/30/20 through 08/25/20 revealed, out of 9 opportunities, the resident was given (1) showers, (7) bed baths, and (1) response not required. Resident #130 Review of a Face Sheet revealed Resident #130 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #130, with a reference date of 07/07/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, indicating resident is rarely/never understood, and the assessment could not be completed. Review of a current Care Plan for Resident #130 revealed focus of . needs activities of daily living assistance related to: Alzheimer's Confusion . Dementia Disease Process, Impaired balance . with interventions which included . BATHING/SHOWERING: 1 assist. Tuesday & Thursday 2nd shift . with a start date of 07/01/20 and revised on 07/20/20. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/30/20 through 08/25/20 revealed, out of 8 opportunities, the resident was given (1) shower, (1) bed bath, (1) response not required, (1) resident refused, and (4) not applicable.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation contains 2 Deficient Practice Statements (DPS): This citation pertains to Intake #: MI 164 Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent elopement for 1 of 4 residents (Resident #115) reviewed for accidents/hazards, resulting in Resident #115 eloping from the facility and the potential for harm. Findings include: Review of a facility policy Unsafe Wandering & Elopement Prevention Protocol/Missing Resident Protocol revealed, Policy Statement Every effort will be made to prevent unsafe wandering and elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement . Policy Interpretation and Implementation 1. All residents who are at risk for harm because of unsafe wanderings will be assessed by the interdisciplinary care planning team. 2. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. Staff will be informed at shift change of the modifications to the resident's care plan. 3. Interventions for unsafe wandering and elopement attempts will be entered onto the resident's care plan and medical record. 4. Should an elopement episode occur, the contributing factors, as well as the interventions' tried, will be documented on the nurses' notes . Resident #115 Review of a Face Sheet revealed Resident #115 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #115, with a reference date of 08/06/20 revealed a Brief Interview for Mental Status (BIMS) score of 03, out of a total possible score of 15, which indicated Resident #115 was severely cognitively impaired. Review of Resident #115's nursing progress notes dated 8/5/2020 at 14:55 revealed, Note Text: Resident was witnessed aggressively jurking (sic) on the exit door. Resident soon turned and walked away as the alarm sounded. CNA (Certified Nurse Assistant) staff secured the door. CNA staff stated that the resident then threw a cup at her. Review of Resident #115's nursing progress notes dated 8/5/2020 at 15:05 revealed, Note Text: Can (sic) was checking on resident in his room and did not see him came (sic) out of room and saw him in the courtyard. The window in his room was open past its blocking latches. Aide pushed on door, admin

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	235282	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF KALAMAZOO	1701 S 11TH ST KALAMAZOO, MI 49009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) called a code yellow. Staff was out in the courtyard escortinghim (sic) back into the building . Review of a Care Plan for Resident #115 prior to elopement revealed focus of The resident is an elopement risk/a wanderer/wants to go home r/t (related to) Disoriented to place, Impaired safety awareness, cognitive impairment with interventions which included Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: puzzles, magazines and tv . Maintain consistent daily routine and consistent bedtime routine . WANDER ALERT: wanderguard to left ankle . with a start date of 8/3/20. Interventions added to Care Plan after elopement included Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes . one to one monitoring with a start date of 8/6/20. Review of the facility investigation revealed, At approximately 14:10 (Resident #115) was seen on camera by the Administrator, walking outside of the C hall exit doors. Administrator directed staff to page a code yellow and responded to C hall. Staff responded appropriately and the door alarms were in working order. Resident was safely escorted back into the building. He had some of his belongings in his left hand and stated that he wanted to go home. Upon review of the cameras, the resident was seen inside in the gated courtyard at all times. At no point in the camera footage did the resident exit through the door. Upon inspection of the resident's room, the window was open with the screen intact. Window safety piece was compromised. The grounds outside of the resident's window was inspected by (Maintenance Director) who found a wooden piece of a picture frame buried in the mulch. The rest of the picture frame pieces were found behind the resident's night stand. The exit point was through the window. A skin and pain assessment were completed on the resident with no negative findings. Resident remains safe in the facility. In an interview on 08/26/20 at 11:44 A.M., camera footage of the elopement event was requested. Nursing Home Administrator (NHA) A reported the facility no longer had the camera footage. Maintenance Director (MD) U confirmed the camera footage had already been taped over. In an interview on 08/25/20 at 2:57 P.M., Nursing Home Administrator (NHA) A reported has camera system in office. NHA A reported was walking out of office and saw someone walking outside of the memory care unit exit door. NHA A indicated told staff to call a code yellow (to indicate elopement), went to memory care unit, and saw staff escorting Resident #115 back inside. NHA A indicated review of the camera footage revealed no record of Resident #115 exiting the building from the memory care unit exit door and investigation results determined resident exited the building via his bedroom window. NHA A indicated there are no alarms on the windows. In an interview on 08/25/20 at 1:27 P.M., Maintenance Director (MD) U reported was notified Resident #115 had gotten out of his window and maintenance needed to figure out how to secure the window. MD U reported that the cameras on the memory care unit where Resident #115 resided point to the end of the hall facing the exit door; therefore, since Resident #115 exited from the window, it would not have shown up on a camera. When asked to describe the window in Resident #115's room, MD U reported it is just a normal window with a normal screen that fits on a track. MD U indicated the screen is spring loaded and can be removed by pressing down and tilting it. MD U indicated there is a little tab on the window (considered the window safety piece) that can be engaged to prevent the window from opening fully. MD U reported inspection of Resident #115's window after the elopement revealed that the window safety piece was present but was not in the engaged position to prevent the window from fully opening. In an interview on 08/25/20 at 3:36 P.M., Waiver Care Aide (WCA) DD reported at the time of the incident, was just starting shift and getting report. WCA DD indicated the person giving report looked in Resident #115's room and did not see him. WCA DD indicated coworker was putting on PPE (personal protective equipment) to enter room when they saw Resident #115 outside. WCA DD reported the door alarm never went off and later learned the facility determined resident must have exited from bedroom window. In an interview on 08/26/20 at 10:22 A.M., Certified Nurse Assistant (CNA) M reported the elopement happened at the end of their shift. CNA M indicated was giving report to WCA DD while walking down the hall to check on each resident. CNA M reported thought Resident #115 was in the bathroom because the bathroom door was closed but then saw him outside of the memory care unit exit door. CNA M indicated that approximately 15 minutes before the elopement, Resident #115 was aggressively trying to push the exit door open and staff had redirected him back to his room. In an interview on 08/27/20 at 11:49 A.M., Certified Nurse Assistant (CNA) FF indicated did not know Resident #115 very well, but he appeared very high functioning. CNA FF reported initially thought Resident #115 was a family member visiting another resident because he did not appear to be a dementia resident. CNA FF indicated was not aware Resident #115 was an exit seeker. This citation pertains to: Intake #s: MI 154, MI 156 Based on interview and record review, the facility failed to follow their policy and provide adequate supervision and an environment free from abuse for 2 of 8 sampled residents (#101, and #105) reviewed for abuse, resulting in resident to resident abuse between Resident #106 & #101 and Resident #106 & #105 (2 incidents) and the potential for injury, fear, anxiety, and frustration for residents #101 and #105 as well as any resident in the vicinity of Resident #106. Findings include: Review of a facility policy Abuse Prevention Program with a revision date of 02/22/18 revealed, . Policy Interpretation and Implementation, Preventing Abuse, Our facility is committed to protecting our residents from abuse by anyone including . facility staff, other residents, . Abuse Identification, Training and Education, 3. Our abuse prevention/intervention education program includes . Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues . Involving qualified psychiatrists and other mental health professionals to help the staff manage difficult or aggressive residents; Identifying areas within the facility that may make abuse and/or neglect more likely to occur (e.g., secluded areas) and monitoring these areas regularly; Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met . Resident #101 Review of a Face Sheet revealed Resident #101 was an [AGE] year-old female, originally admitted to the facility on [DATE] with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 06/11/20 revealed a Brief Interview for Mental Status (BIMS) score of 04, out of a total possible score of 15, which indicated Resident #101 was severely cognitively impaired. Resident #105 Review of a Face Sheet revealed Resident #105 was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 03/02/20 revealed a Brief Interview for Mental Status (BIMS) score of 03, out of a total possible score of 15, which indicated Resident #105 was severely cognitively impaired. Resident #106 Review of a Face Sheet revealed Resident #106 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 06/11/20 revealed a Brief Interview for Mental Status (BIMS) score of 02, out of a total possible score of 15, which indicated Resident #106 was severely cognitively impaired. Intake MI 153 (Resident #106, Resident #101) Review of a document Facility investigation report revealed, Investigation: On 2-19-20 at approximately 0800, (Certified Nurse Assistant (CNA) M) witnessed (Resident #101) sitting in her wheelchair on C hall and (Resident #106) standing in front of her. (Resident #106) grabbed the blanket that was on (Resident #101)'s lap and started to pull it. (Resident #101) grabbed the blanket and started to pull it back. (Resident #106) then struck (Resident #101) on the left cheek area with an open hand. (CNA M) was unable to get to the residents before the altercation occurred, but immediately separated the residents . The facility believes it is possible that (Resident #106) thought the blanket was hers, based on her history of hallucinations and delusions and (Resident #101) was just trying to keep her blanket on her lap . Review of a Care Plan for Resident #106 (current at the time of incident) revealed focus of (Resident #106) exhibits inappropriate social behavior of yelling obscenities if she becomes agitated or upset and having verbal conversations with individuals not present r/t (related to) Neurocognitive disorder with inappropriately smearing bowel on the walls and immediate area with interventions which included Document behavior occurrences on tracking form with a start date of 10/25/19; Offer calm reassuring touch Offer food/fluids unless contraindicated Provide activities that resident enjoys such as coloring, crafts with beads, conversation about her daughter and books . Psychiatric evaluation as appropriate with start date of 10/28/19. Review of CNA (Certified Nurse Aide) charting for MONITOR-Behavior Symptoms of Resident #106 for the period 11/21/19 through 02/14/20 revealed, (1) incident of pushing, (2) incidents of kicking/hitting, and (1) incident of yelling/screaming. In an interview on 8/18/20 at 11:32 A.M,. Certified Nurse Assistant (CNA) M reported could not remember what date the incident occurred but remembers it happened and was doing another resident's hair at the time. CNA M indicated prior to that event, (Resident #106) 's behaviors were sporadic, and that most of the time staff would try to know where (Resident #106) was and try to check her and see what she was doing because she used to just go into other resident rooms. CNA M reported was unable to get to the residents before the altercation occurred, but immediately separated the residents. In an interview on 08/20/20 at 11:00 A.M., Licensed Practical Nurse (LPN) K indicated staff knew Resident #106 had some behaviors prior to the 2/19 between Resident #106 and Resident #101. LPN K reported Resident #106 definitely had a history of [REDACTED].#106's behaviors was redirecting her constantly. Review of a Social Services Progress Note dated 2/21/2020, 14:51 for Resident #106 revealed, Note Text: Resident monitored following altercation with peer. Resident noted to have become physically aggressive,

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) striking peer with an open hand. Individuals were separated following the incident. No concerns noted at this time regarding heightened aggression, mood instability or retaliatory behavior as resident was the aggressor. No additional interventions required. MI 154 (Resident #106, Resident #105) Review of a document Facility investigation report revealed, Investigation: At approximately 5:30 pm, (Resident #106) and (Resident #105) were in the C hall dining room getting ready for dinner. The two residents do not sit near each other in the dining room. It was witnessed by (Certified Nurse Assistant (CNA) J) that (Resident #106) was standing up wandering, walked over to (Resident #105), who was sitting in her wheelchair at the table, and with an open or cupped hand, made contact with (Resident #105)'s right cheek/face area. Initially when (Resident #106) was asked why she hit (Resident #105), (Resident #106) responded that (Resident #105) had hit her. No one witnessed (Resident #105) hit (Resident #106). The residents were separated immediately Review of a Care Plan for Resident #106 (updated 7 days after 02/19/20 incident) revealed focus of (Resident #106) exhibits inappropriate social behavior of yelling obscenities if she becomes agitated or upset and having verbal conversations with individuals not present r/t (related to) Neurocognitive disorder with inappropriately smearing bowel on the walls and immediate area with interventions which included Document behavior occurrences on tracking form with a start date of 10/25/19; Offer calm reassuring touch Offer food/fluids unless contraindicated Provide activities that resident enjoys such as coloring, crafts with beads, conversation about her daughter and books . Psychiatric evaluation as appropriate with start date of 10/28/19 Interventions added 7 days after 2/19/20 incident Ensure resident is not cold . Offer robe if resident complains of being cold . Give resident a teddy bear or other comfort item when available to ease resident anxiety with start date of 02/26/20. Review of CNA (Certified Nurse Aide) charting for MONITOR-Behavior Symptoms of Resident #106 for the period 02/19/20 through 02/26/20 revealed, (3) incidents of grabbing, (1) incidents of pushing. Review of a witness statement by Certified Nurse Assistant (CNA) J revealed, . walking into the dining room, I noticed (Resident #106) in front of (Resident #105) who was sitting on her chair sideways next to a table out of the corner of my eye. I observed (Resident #106) swing her hand toward (Resident #105) and then a smacking sound from the contact . went over to the table and . separated the two residents . In an interview on 08/25/20 at 11:26 A.M., Certified Nurse Assistant (CNA) J reported (Resident #106 and Resident #105) were in the dining room and (Resident #105) was pulled up to the table. CNA J indicated staff were getting ready to serve dinner. CNA J indicated was in the hall showing a new trainee (CNA GG) the resident rooms and the layout of the hall. CNA J stated, We walked through the door and by the time I got to them, (Resident #106) had already hit (Resident #105) in the face. CNA J reported could not recall that any other staff were in the dining room at the time of the incident. Review of a witness statement by Certified Nurse Assistant (CNA) GG revealed, . walking into the C Hall dining room . I observed (Resident #106) walk up to (Resident #105) who was sitting in her w/c (wheelchair) by herself next to a table and swing her left hand towards (Resident #105)'s face and made contact. There was a smacking sound. We immediately intervened and separated the two residents. I took (Resident #106) to the room and sat with her providing comfort and assisting with her meal. In an interview on 08/18/20 at 11:57 A.M., Licensed Practical Nurse (LPN) V reported was in a separate room where the nurses cart was located getting ready to pull medications for the residents when the incident happened. LPN V indicated heard a slap noise but didn't witness it. LPN V reported there was an intervention in place to keep (Resident #106) separated from other residents as much as possible. In an interview on 08/25/20 at 2:14 P.M., Certified Nurse Assistant (CNA) E indicated did recall incident between (Resident #106) and (Resident #105). CNA E indicated being in the hall at the time of the incident. CNA E indicated does not recall any staff being in the dining room at the time of the incident. CNA E reported that there is not usually a staff person in the dining room supervising residents already there because all the staff are getting other residents ready and toileted before the meals. CNA E indicated they should have had someone in there (referring to the dining room) keeping an eye on (Resident #106) because her behaviors were random and staff couldn't really anticipate how she was going to be (referring to behaviors) on any given day. Review of a Social Services Progress Note dated 3/3/2020, 10:02 for Resident #106 revealed, Note Text: Resident monitored following physical aggression shown towards peer. Resident slapped peer with an open hand. Both individuals were separated and assessed . No additional interventions from social services required at this time as resident could not recall the incident or her part in it. MI 156 (Resident #106, Resident #101) Review of a document Facility investigation report revealed, Reported Incident: On 3/4/2020 at approximately 0900 (Certified Nurse Assistant (CNA) M) was assisting residents back to their rooms after breakfast and saw (Resident #106) walking in the hallway. As (CNA M) was walking back to the dining room she heard someone ell (sic) out and entered the dining room to witness (Resident #106)'s open hand on (Resident #101)'s cheek. (CNA M) immediately separated the residents. While (CNA M) was directing (Resident #106) away from (Resident #101), (Resident #106) grabbed (Resident #101)'s left arm. (CNA M) was able to get (Resident #106) to release (Resident #101)'s arm without further incident. (Licensed Practical Nurse (LPN) K) entered the dining room as (CNA M) was separating the residents. (LPN K) assessed (Resident #101) and did not identify any injury or note any complaints of discomfort. (LPN K) directed (CNA M) to remain with (Resident #106). (LPN K) assessed (Resident #106) and did not identify any injury or note any complaints of pain . Aggressive behaviors are new for (Resident #106) . Although the facility substantiates that the event took place it is unable to substantiate abuse for the following reasons: 1. Neither resident recalls the incident 2. Neither resident has displayed a change in mood, behavior or routine. 3. (Resident #106) did not have a history of aggressive behaviors previously that would have lead the facility to anticipate these actions . Review of a Care Plan for Resident #106 revealed focus of The resident has potential to be physically aggressive or agitated r/t (related to) Dementia with interventions which included Administer medications as ordered. Monitor/document for side effects and effectiveness . Analyze times of day, places, circumstances, triggers, and what deescalates behavior and document . Assess and address for contributing sensory deficits . Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Psychiatric/Psychogeriatric consult as indicated . When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later . Other 1 on 1 supervision with start date of 03/04/20. Note that the start date of this care plan focus of potential for aggression is on the date of this 3rd incident involving this resident as the aggressor. Review of a witness statement by Licensed Practical Nurse (LPN) K revealed, I was in the office charting, and I heard a resident yell out, but could not make out what was said. As I entered the dining rm (room) I observed (Resident #106) next to (Resident #101) and she had a hold of her left arm. (Resident 3101) was not displaying any signs of discomfort. (Activities Director/Certified Nurse Assistant (AD/CNA) T)/(Certified Nurse Assistant (CNA) M) separated the residents immediately. I asked (CNA M) to stay with (Resident #106) and I went to assess (Resident #101). Review of a witness statement by Activities Director/Certified Nurse Assistant (AD/CNA) T revealed, I was in the office logging onto my computer when I heard (Resident #101) yell out stop it, you are hurting me. (LPN K) and I ran out of the office. When we got to the C Hall dining room door, I observed (CNA M) standing in between (Resident #106) and (Resident #101) trying to separate the two residents. I immediately helped separate the residents. Review of a witness statement by Certified Nurse Assistant (CNA) M revealed, I saw (Resident #101) sitting in the dining room facing the door. (Resident #106) was walking in the hallway. I was helping residents to their rooms after breakfast. As I was heading back to the dining room, I heard (Resident #101) yell leave me alone. I observed (Resident #106) slapping (Resident #101) with both hands. I attempted to separate the residents. At this point (Resident #106) grabbed on to (Resident #101)'s left arm with both hands. (AD/CNA T) came in to assist and the residents were separated. Review of a witness statement by Certified Nurse Assistant (CNA) L revealed, At time of incident I was returning meal trays to the main dining room. When I left the hall, (Resident #106) was in the hallway . In an interview on 08/26/20 at 10:22 A.M., Certified Nurse Assistant (CNA) M indicated the incident between Resident #106 and Resident #101 would have been right after breakfast. CNA M reported all of the staff would have been out of the dining room at the time helping residents get back to their rooms. CNA M reported there was not always someone in the dining room with the residents. In an interview on 08/27/20 at 11:49 A.M., Certified Nurse Assistant (CNA) FF reported there is times that residents have been left in the dining room unattended when staff are taking other residents back to their rooms to be toileted before or after meals - residents need help with that.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 137. Based on observation, interview and record review the facility failed to provide sufficient staffing on the dementia and other units to ensure resident needs were met per the care plan for 16 sampled

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) residents (#114, #118, #119, #120, #121, #122, #123, #124, #128, #112, #113, #125, #126, #127, #129, and #130) resulting in residents not being supervised, needs not being met, ADL care not met for 16 residents reviewed on the dementia unit and 4 resident on other units. Findings include: During an interview on 8/19/20 at 2:54 PM, the Activity/CNA A/CNA T stated that on the C-hall someday's I do CNA work on the floor they do showers when they can, but due to staffing they cannot, someday's there is only one CNA on the hall and one nurse working C and D hall so they can't leave the hall to do the shower, which is on D hall. A/CNA T reported that when she arrived today there was one CNA, an orientee and the scheduler, so she took over for the scheduler and no showers were done today. A/CNA T reported that they have 1st and 2nd shift showers set up and they would try and squeeze the showers in on 2nd shift that they missed on 1st shift. A/CNA T reviewed the shower sheet and noted that the list of showers for today would leave (8) showers for 2nd shift to do. During an interview on (date and time omitted for confidential) LPN KK reported that the nurses on C-hall are expected to cover the C and D hall and the D hall night nurse works as both the nurse and CNA. LPN KK reported that supervisors are aware of this. LPN KK stated that over some weekends C-hall and A-hall have only 1 CNA at night and it is not safe with the nurse covering 2 halls and no one watching D-hall. LPN KK reported that it was almost impossible to provide care on C-hall with just one CNA and one nurse going between C and D hall. Resident #114 Review of an Admission Record revealed Resident #114 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #114, with a reference date of 3/29/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #114 was cognitively intact. During an interview dated 8/19/20 at 1:10 PM, Resident #114 reported that it pisses me off that I can't get a shower, (name of Administrator) tells me it is up to the aid and if you only have one aid, he does not have the time and if they do something for me, then they are not doing something for someone else. It is not fair for me not to get a shower, but if I want a shower it impacts someone else's care if I want a shower and that is unfair. Can't get haircut, can't get a shower, have to get permission to sit in the sun. I have not had a shower for months due to not having an aid on the hall only one aid on the hall. Since we have had the major shut down at least since June. Resident #114 reported that she does receive her bed baths on first shift only and when she reviewed the ADL shower long she noted that only that the CNA's were not first shift CNA's that were documenting baths. During an interview on 8/21/20 at 10:05 AM, Certified Nursing Assistant (CNA) C reported that there are 4 resident that use hoyers (a type of mechanical lift) on D hall, but that 2 of the hoyer residents do not usually want to get out of bed. CNA C reported that when the 2 want to get up I have to get help and if I do a bed bath on (name of Resident #114) it can take up 1.5 hours and if I did a shower it could take longer with the transfer into the chair then into a shower bed and then I have to get someone to help in the shower with the transfer, I cannot leave the resident, I have to pull the call light, so even if the nurse was working on this hall I can't leave it long enough to give her a shower, because there is no one answering lights. CNA C reported that the nurse was shared with the D hall. During an interview on 8/27/20 at 12:10 PM CNA II reported that she did not give Resident #114 a shower on 8/10/20 that she must have charted that shower in error. During an interview on 8/26/20 (time omitted for confidential) LPN G stated that Resident #118 never wants too go out the door of C-hall, Resident #119 does alright, Resident #120 was hard to get out of bed since they just had hip surgery, Resident #121 may refuse to have care staff have to check when he was in a good mood, Residents #122-#125 like showers, Resident #126 you need to get on a good day, Residents #127-#129 do ok, and Resident #130 staff have to catch at the right time. During an interview on 8/27/20 at 11:31 AM, CNA FF stated I am giving a lot of bed baths, have not given a shower to (name of Resident #118) lately was on the C-hall, she refuses because the shower is cold, if you try to give shower you can hear them (the residents) from a mile away they get agitated like (name of Resident#127) for the next couple of days she (Resident #127) was traumatized might be better if shower room was on the C-hall and was not cold in the shower room and you have to be quick. If there was a hoyer resident you have to wait for someone then it is difficult, and you have to be very careful and wait for help. Some of the residents understand showers some don't, some you say pamper day some is only day we can get a good look at their skin. CNA FF reported that normally on C-hall there are 2 CNA's at all times and dedicated nurse, now sometimes it is just me and now I share a nurse with another hall, I try and keep an eye on the main exit doors and make sure no one gets out and watch the residents that wander and when nurse gets back do rounds, its a challenge, has happened a couple of times if I want to take a break can maybe get someone from another hall. CNA FF reported that if the shower room was on C-hall and was warm it would be a lot better for the residents. During an interview on 8/19/20 at 3:12 PM, CNA J reported that she did 2 bed bath last night on C-hall, they are the residents that do not transfer so well and there was only 2 CNA's and a nurse. CNA J reported that the residents are a 2 person hoyer on night shift and it was hard for staff to go get them down to the shower. CNA J stated You need to leave a nurse and a CNA on this unit (C-hall) if you are in the shower and the nurse has to go to the other hall to do work and help transfer the resident in the shower it does not leave enough staff on the hall. During an interview on 8/26/30 at 2:33 PM, Director of Nursing (DON) B reported that when education on the care of a resident was completed she would completed an (in-service) sheet and place that data in the communication board so that anyone had access to the information. DON B reported that the communication board was on the computer system that they use. During an interview on 8/27/20 at 2:31 PM, Licensed Practical Nurse (LPN) K reported that there were no more staffing for residents with increased supervision on C-hall, we just put them in the dining room and give them something to do, sometimes there was staff in the dining room, but sometimes they pull the activity staff who was also a CNA to the floor. LPN K reported that when there are behaviors on the C-hall we see if there was a reason for the behavior when determining how to put a plan in place to stop the next behavior. LPN K reported that staff can tell management all day long about behaviors and they do not come back to C-hall unless they put residents on 1:1. LPN K reported that if a resident was put on 1:1 and C-hall has 2 CNA's, one stays with the 1:1 and the other does care the nurse works both C and D hall. LPN K reported that she was not aware of a communication board and the 24-hour reports are no longer used. LPN K reported that there has probably been 20 showers on C-hall since March people need their hair washed, basic needs are not being met 2 people need to be on C-hall at all times, so they cannot do showers, because there are not enough staff. During an observation on C-hall DON B was in a room with staff on 8/26/20 at 4:12 PM asking staff who were in room how they decide whether residents get bed bath or shower, (she noticed surveyor at this time) then stated you do what the resident wants right? left the room, closing the door, left C-hall unit, there was no staff on the hall 3 resident were in the dining room alone, 3 residents were wandering in the hallway (one was sitting), and the nurse did not return to the unit until 4:16 PM. Resident #118 Review of an Admission Record revealed Resident #118 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #118, with a reference date of 6/1/20 revealed staff conducted the brief mental status for Resident #118's cognitive skills for daily decision making and determined they were severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed out of 18 opportunities the resident was given (2) showers, (13) bed baths, (2) resident refused and (1) not applicable. Resident #119 Review of an Admission Record revealed Resident #119 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #119, with a reference date of 3/1/20 revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated Resident #119 was severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Monday and Friday 1st shift 8/19/20 Not applicable, 8/24/20 resident refused. No other bathing was documented for that timeframe. Resident #120 Review of an Admission Record revealed Resident #120 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #120, with a reference date of 7/31/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #120 was severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Monday and Friday 2nd shift 7/3/20-8/25/20 (15 opportunities) (14) bed baths (1) response not required. Resident #121 Review of an Admission Record revealed Resident #121 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #121, with a reference date of 6/12/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #121 was severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Tuesday and Thursday 1st shift 7/2/20-8/25/20 (17 opportunities) (11) bed baths (2) response not required, (2) resident refused, and (2) not applicable. Resident #122 Review of an Admission Record revealed Resident #122 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #12, with a reference date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF KALAMAZOO	1701 S 11TH ST KALAMAZOO, MI 49009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) of 6/12/20 revealed staff conducted the brief mental status for Resident #122's cognitive skills for daily decision making and determined they were severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Wednesday and Saturday 6-2 shift 7/1/20-8/26/20. (16 opportunities) (11) bed baths (1) tub bath, (2), shower and (2) not applicable. Resident #123 Review of an Admission Record revealed Resident #123 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #123, with a reference date of 6/13/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated Resident #123 was severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Wednesday and Saturday 2nd shift 7/1/20-8/26/20. (14 opportunities) (7) bed baths (1) resident refused, (1), shower and (5) not applicable. Resident #124 Review of an Admission Record revealed Resident #124 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #124, with a reference date of 7/8/20 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #124 was severely impaired. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 7/1/20-8/27/20, revealed Bathing Wednesday and Saturday 2nd shift 7/1/20-8/26/20. (13 opportunities) (10) bed baths, (2), shower, and (1) not applicable. Resident #128 Review of an Admission Record revealed Resident #128 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #128, with a reference date of 8/5/20 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #125 was cognitively intact. Review of the Certified Nursing Assistant (CNA) Bath ADL charting dated 8/1/20-8/26/20, revealed Bathing Wednesday and Saturday 1st shift . (6 opportunities) (3) bed baths, (1), shower (documented on 8/15/20), and (2) not applicable. During an interview on 8/19/20 at 1:20 PM, Resident #128 sitting in her room stated that she had a shower at the end of her isolation period, the therapy guy had said it would be a good thing to see how I transferred. I have not had one since been doing my hair washing in the sink. During an interview on 8/19/20 at 3:00 PM, CNA DD stated We did 2 showers on A-hall last night, to busy with call lights and care. CNA DD reported that 5 showers were scheduled. Review of the Initialed Schedule for 8/17/20, revealed 6a-2p (2)0 CNA's on A hall, (2) CNA's on C hall, (1) CNA on (D) hall. (1) facility support 6a-6:30p, (1) nurse A hall (1) nurse B hall , 2p-10p (2) CNA's A hall, (2) CNA's C hall (1 till 8pm), (1) CNA D hall (till 6pm), 6p-6:30a (1) nurse A hall (1) nurse B hall, 10p-6a (1) CNA A hall (2) CNA's C hall, (1) CNA D hall. In an interview on 8/18/20 at 5:24 A.M., Certified Nurse Assistant (CNA) P indicated sometimes only one CNA per hall was scheduled. CNA P indicated staff call in often because they are overworked and need a break. CNA P reported when there are call ins, often there was nobody to bring in or to stay and the CNAs have to work short (meaning there are not enough CNAs in the building) and the resident care suffers because of it. In an interview on 8/18/20 at 11:32 A.M., Certified Nurse Assistant (CNA) M stated we sometimes have to work short staffed. CNA M indicated sometimes residents don't get the care they need because of short staffing. In an interview on 08/20/20 at 10:50 A.M., Certified Nurse Assistant (CNA) L reported most of the time bed baths (instead of showers) are done on A Hall because of being short staffed and not having time to take the resident to the shower room. In an interview on 08/20/20 at 11:00 A.M., Licensed Practical Nurse (LPN) K indicated oftentimes, there is 1 CNA per hall resulting in resident basic needs are not being met - showers are not being given, people are not able to get out of bed most of the time, and residents are not being fed in a timely fashion In an interview on 8/26/20 at 4:05 P.M., Certified Nurse Assistant (CNA) J was asked about Bath/Shower charting. CNA J reported when checks N/A (Not Applicable) on the documentation, thought that meant not adequate - meaning did the best they could in the time they had to get the resident cleaned up but knew it was not adequate. Resident #112 Review of a Face Sheet revealed Resident #112 was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #112, with a reference date of 06/30/20 revealed a Brief Interview for Mental Status (BIMS) score of 03 out of a total possible score of 15, which indicated Resident #112 was severely cognitively impaired. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/29/20 through 08/26/20 revealed, out of 8 opportunities, the resident was given (1) shower, (4) bed baths, (1) response not required, and (2) not applicable. Note that resident prefers showers per care plan. In an interview on 8/19/20 at 3:30 P.M., Resident #112 indicated reported she had gone at least 2 weeks without a shower and has had to get a bed bath instead. Resident #112 indicated this has been happening ever since that Coronavirus came around. Resident #112 stated, I want to get up and get a shower. In an interview on 8/21/20 at 8:46 A.M., Resident #112 indicated she still has not gotten a shower all week. Resident #112 reported staff clean her up any time she goes (urinates or has a bowel movement) in her brief, but they do not give a shower. Resident #112 indicated she would feel cleaner with a shower and would rather have a shower. Resident #113 Review of a Face Sheet revealed Resident #113 was an [AGE] year-old male, originally admitted to the facility on [DATE] and readmitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #113, with a reference date of 05/26/20 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #113 was moderately cognitively impaired. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/20/20 through 08/17/20 revealed, out of 10 opportunities, the resident was given (2) showers, (1) bed bath, (1) response not required, (1) resident not available, and (5) not applicable. In an interview on 08/19/20 at 3:36 P.M., Resident #113 reported he is supposed to get a shower on Tuesdays and Thursdays. Resident #113 indicated he did not get one yet this week. In an interview on 08/20/20 at 10:50 A.M., Certified Nurse Assistant (CNA) L stated I know (Resident #113) asked for a shower today. Most likely he will get one if we have time. Otherwise he will get a bed bath. In an interview on 8/20/20 at 4:23 P.M., this surveyor visited Resident #113 to see if he had gotten a shower. Resident #113 stated, I have asked 4-5 people today for help to get a shower and they all said they would let someone else know. Nobody has come back all day and it's bullshit that I can't get a damn shower - I feel dirty and want to get clean. Resident #125 Review of a Face Sheet revealed Resident #125 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #125, with a reference date of 07/25/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, indicating resident is rarely/never understood, and the assessment could not be completed. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/31/20 through 08/24/20 revealed, out of 9 opportunities, the resident was given (1) shower and (8) bed baths. Resident #126 Review of a Face Sheet revealed Resident #126 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #126, with a reference date of 06/14/20 revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #126 was severely cognitively impaired. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/31/20 through 08/19/20 revealed, out of 7 opportunities, the resident was given (7) bed baths. Resident #127 Review of a Face Sheet revealed Resident #127 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #127, with a reference date of 06/13/20 revealed a Brief Interview for Mental Status (BIMS) score of 03, out of a total possible score of 15, which indicated Resident #127s was severely cognitively impaired. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/03/20 through 08/24/20 revealed, out of 23 opportunities, the resident was given (2) showers, (8) bed baths, (2) response not required, (1) resident refused, and (10) not applicable. Resident #129 Review of a Face Sheet revealed Resident #129 was an [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #129, with a reference date of 06/10/20 revealed a Brief Interview for Mental Status (BIMS) score of 02, out of a total possible score of 15, which indicated Resident #129 was severely cognitively impaired. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/30/20 through 08/25/20 revealed, out of 9 opportunities, the resident was given (1) showers, (7) bed baths, and (1) response not required. Resident #130 Review of a Face Sheet revealed Resident #130 was a [AGE] year-old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #130, with a reference date of 07/07/20 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, indicating resident is rarely/never understood, and the assessment could not be completed. Review of the Certified Nurse Assistant (CNA) Bath ADL (Activities of Daily Living) charting for the period 07/30/20 through 08/25/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235282	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF KALAMAZOO	**1701 S 11TH ST KALAMAZOO, MI 49009**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) revealed, out of 8 opportunities, the resident was given (1) shower, (1) bed bath, (1) response not required, (1) resident refused, and (4) not applicable.