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 _____	05/14/2020

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 173. Based on interview and record review, the facility failed to report the elopement of a resident from the facility for 1 of 12 sampled residents (Resident #110), reviewed for elopement, resulting in the potential for elopements to continue to be undetected and incidences of elopement to go unreported. Findings include: Review of the Abuse Prevention Program Reporting and Response dated 2/22/18, 5. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility Administrator, Director of Nursing (DON), or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury notify the following persons or agencies of such incident: 1. The State licensing/certification agency responsible for surveying/licensing the facility; . Review of a Admission Record revealed Resident #110 was a 64 -year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 5/16/19 revealed staff conducted the Assessment for Mental Status to determine the cognitive skills for daily decision making indicated Resident #110 were severely impaired. Review of the Interdisciplinary (IDT) Progress Note dated 4/3/2020 at 4:01 PM, revealed .on 4/2/20 resident exited C-hall door. Resident was brought back through doors by staff. No injury. skin and pain assessments were completed with no negative findings. Guardian Notified. Notified Nurse Practitioner (NP) . In an interview on 5/12/2020 at 1:31 PM, Certified Nursing Assistant (CNA) UU reported that on 4/2/2020 on second shift I was in the dining room with a resident and there were 2 other CNA's on the hallway with resident and (Resident #110) was wandering the hall so I thought they were watching him. CNA UU stated I heard the alarm go off and I went and cut alarm off, looked out the window and did not see anyone, there was a resident by the door I suspected had tried to open the door, and the 2 other CNA's were gone so I thought they had (Resident #110), and no one was in the hallway so I thought they were all in their rooms. CNA UU reported that the door she checked opened out to the back of the building by the parking lot. CNA UU reported that then Nursing Home Administrator (NHA) A came to her and told her that (Resident #110) had got out and ask why she had turned the alarm off. CNA UU reported she did not know how long it was between the time she turned the alarm off and when they bought (Resident #110) back in the building. In interviews on 5/8/2020 at 3:37 PM and 5/13/2020 at 4:26 PM, Former Director of Nursing (FDON) SS reported the IDT note written on 4/3/2020 was during a meeting with other managers, she had not been at the facility on 4/2/2020, it was discussed that Resident #110 got into a personal vehicle after getting out of the C-Hall door, and that the alarm did go off, but there was not any response. FDON SS stated I cannot speak to why it was not reported to the State. In an interview on 5/8/2020 at 4:10 PM, Nursing Home Administrator (NHA) A reported that on 4/2/2020 the alarm on C-Hall was sounding, staff responded, (Resident #110) did get into (Former Transportation Drivers (FTD) YY) personal truck that was parked by the C-Hall, and he escorted (Resident #110) into the building. In interviews on 5/11/20 at 8:40 PM and 5/13/2020 at 3:31 PM, Former Transportation Driver (FTD) YY reported that he no longer works at the facility, but had worked in transporting residents to appointments for the facility on 4/2/2020, and had just returned to the facility and parked the transportation vehicle for the day; it was in the afternoon between 3:30 and 4:00 PM. FTD YY reported that before clocking out he went to his personal truck and found a resident of the facility sitting in his passenger seat (Resident #110) so he called NHA A who was not aware (Resident #110) was missing. FTD YY reported that he assisted (Resident #110) out of his personal truck and as he walked with the resident toward the front door of the building, we were met by the NHA (A) and other management nursing staff coming out of the building. Review of the Punch Record dated 4/2/2020, revealed that FTD YY punched in on 4/2/2020 at 9:52 AM and out at 3:46 PM In an interview on 5/12/20 at 12:59 PM, Regional Nurse Consultant (RC) MM stated that it was reported to me by the NHA, that (Resident #110) exited the doors, the alarm sounded, he remained on the premises, staff brought him inside. Review of the documentation revealed no documentation that this incident was reported to the state agency.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI 173. Based on interview and record review, the facility failed to thoroughly investigate a resident elopement from the facility for 1 of 12 sampled resident (Resident #110) reviewed for elopement, resulting in the potential for elopements to continue to be undetected and incidences of elopement to be thoroughly investigated. Findings include: Review of the Accidents and Incidents - Investigating and Reporting Policy dated 12/1/17, revealed Protocols for Conducting an Infestation and Completion of Report of Incident/Accident - 4. Investigative Action on Incident Report: a. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor must conduct an immediate investigation of the accident or incident. The following data, as it may apply, must be included on the Report of Incident/Accident: (1) The date and time of the accident or incident took place; .(3) The circumstances surrounding the accident of incident (fact reporting only, avoid unsupported assumptions, opinions or conclusions); (4) Where the accident or incident took place; (5) The name(s) of witnesses and their accounts of the accident of incident; (6) The injured person's account of the accident of incident; (7) The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; (8) The date/time the injured person's family was notified and by whom; (9) The condition of the injured person, to include his or her vital signs; (10) The disposition of the injured person (i.e., transferred to hospital put to bed, sent home, returned to work, etc.); (11) Any corrective action taken; (12) Follow-up information; (13) Other pertinent data as necessary or required; and (14) The signature and title of the person completing the report as well as the date and time of completion. Review of a Admission Record revealed Resident #110 was a 64 -year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 5/16/19 revealed staff conducted the Assessment for Mental Status to determine the cognitive skills for daily decision making indicated Resident #110 were severely impaired. Requested documentation on 5/8/2020 at 4:45 PM from NHA A for (Resident #110's) elopements and was not provided an Incident and Accident Report (I/A) Report for the incident that occurred 4/2/2020 at approximately 3:00 PM, was not received by exit. Review of the Interdisciplinary (IDT) Progress Note dated 4/3/2020 at 4:01 PM, revealed on 4/2/20 resident exited C-hall door. Resident was brought back through doors by staff. No injury. skin and pain assessments were completed with no negative findings. Guardian Notified. Notified NP. In an interview on 5/12/2020 at 1:31 PM, Certified Nursing Assistant (CNA) UU reported that on 4/2/2020 on second shift I was in the dining room with a resident and there were 2 other CNA's on the hallway with resident and (Resident #110) was wandering the hall so I thought they were watching him. CNA UU stated I heard the alarm go off and I went and cut alarm off, looked out the window and did not see anyone, there was a resident by the door I suspected had tried to open the door, and the 2 other CNA's were gone so I thought they

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

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) had (Resident #110), and no one was in the hallway so I thought they were all in their rooms. CNA UU reported that the door she checked opened out to the back of the building by the parking lot. CNA UU reported that then Nursing Home Administrator (NHA) A came to her and told her that (Resident #110) had got out and ask why she had turned the alarm off. CNA UU reported she did not know how long it was between the time she turned the alarm off and when they bought (Resident #110) back in the building. CNA UU reported that she got suspended immediately for turning the alarm off. In interviews on 5/8/2020 at 3:37 PM and 5/13/2020 at 4:26 PM, Former Director of Nursing (FDON) SS reported the IDT note written on 4/3/2020 was during a meeting with other managers, she had not been at the facility on 4/2/2020, it was discussed during the meeting that Resident #110 got into a personal vehicle after getting out of the C-Hall door, and that the alarm did go off, but there was not any response. FDON SS stated I cannot speak to why it was not reported to the State. FDON SS reported that on 4/6/2020 after CNA UU returned from suspension she was educated on Code Yellow elopement and that we do not turn alarms off, walking through it like a simulation with her doing a teach back. FDON SS stated that CNA UU was suspended immediately after (Resident #110) was returned to the building for turning the alarm off, she was off from Thursday 4/2/2020 over the weekend and came back on Monday 4/6/20 when I educated her. In an interview on 5/8/2020 at 4:10 PM, Nursing Home Administrator (NHA) A reported that on 4/2/2020 the alarm on C-Hall was sounding, staff responded, (Resident #110) did get into (Former Transportation Drivers (FTD) YY) personal truck that was parked by the C-Hall, and he escorted (Resident #110) into the building. In interviews on 5/11/20 at 8:40 PM and 5/13/2020 at 3:31 PM, Former Transportation Driver (FTD) YY reported that he no longer works at the facility, but had worked in transporting residents to appointments for the facility on 4/2/2020, and had just returned to the facility and parked the transportation vehicle for the day; it was in the afternoon between 3:30 and 4:00 PM. FTD YY reported that before clocking out he went to his personal truck and found a resident of the facility sitting in his passenger seat (Resident #110) so he called NHA A who was not aware (Resident #110) was missing. FTD YY reported that he assisted (Resident #110) out of his personal truck and as he walked with the resident toward the front door of the building, we were met by the NHA (A) and other management nursing staff. FTD YY reported that he was told that (CNA YY) went to the C-Hall door when she heard the alarm go off and shut it off. FTD YY stated that his personal truck was parked between building C and D Halls about 10 parking spaces from the fence, when a resident leaves the double doors to exit the building from the C-Hall they have to walk out the double doors then through a fenced area and open the fence, which (Resident #110) was very good at doing, and it was another approximately 80 feet to my truck. FTD YY reported that he did not punch out until after he took (Resident #110) back in the facility. FTD YY reported that he did not hear a Code Yellow called or sign the code yellow sheet, but everyone did run out of the building while he was bringing (Resident #110) towards the building, so it could have been called after he called the NHA and told her (Resident #110) was out of the building and in his personal truck. Review of the Punch Record dated 4/2/2020, revealed that FTD YY punched in on 4/2/2020 at 9:52 AM and out at 3:46 PM. In an interview on 5/12/20 at 12:59 PM, Regional Nurse Consultant (RC) MM stated that it was reported to me by the NHA, that (Resident #110) exited the doors, the alarm sounded, he remained on the premises, staff brought him inside. According to the NHA, they immediately followed with an elopement drill, there was an opportunity for education, so it was completed. Education was done on 4/2/20 and was more of a debriefing/opportunity review of the drill. In an interview on 5/12/2020 at 1:40 PM, CNA VV reported that they were working with on the C-Hall on second shift on 4/2/2020 and that (Resident #110) did get out of the building. CNA VV reported that he and another CNA took a resident to the bathroom that required a 2 person assist and they were in the middle of a transfer when they heard the alarm go off and could not stop, but did not hear an all clear sound. CNA VV reported that it was about 5 minutes or more before he could come out of that resident's room and then he heard a Code Yellow, he looked in (Resident #110's) room and he was gone. CNA VV reported that he and another CNA left the hall through the double door at the end of C-Hall to look outside one went right and one went left working towards the main entrance, which took CNA VV about 10 minutes, and (Resident #110) was found by then. CNA VV reported that 2nd shift started at 2:00 PM and at 3:00 PM when we passed water (Resident #110) was in his room. CNA VV reported that he did not recall that (Resident #110) was wandering in the hall that day, did not recall what time he heard the alarm go off. In an interview on 5/14/20 at 8:15 AM, Human Resources (HR) XX reported that there was no suspension paperwork in CNA UU files the managers do the suspensions and just give her the paperwork to put in the files and that the NHA had the CNA's files up until a few minutes ago. In an interview on 5/14/20 at 9:08 AM, CNA WW stated that almost every shift an alarm goes off on C-Hall, (Resident #110) is a smart man and his behavior is that he will go in the dining room and he will sit down and he will play with some building blocks and then he will go back to his room shut the door, then he will come back out and make his way to the back door and you will hear beep beep beep and you have to be on him, he needs a companion someone with him all the time when he is up. CNA WW reported that he and the another CNA were taking a 2 person assist to the bathroom and we heard an alarm going off and the alarm is going off for about 5 seconds and by that time (Resident #110) has already gotten out of the building and then we get the call over the overhead Code Yellow maybe 5 to 10 minutes had passed, we were just finishing with the resident who required 2 person assist. CNA WW stated A lot of people came down the C-Hall checking rooms, management talked to (CNA UU) in the office and we had a re-education on what we were suppose to do, told them we were in a room with a resident who could not be left. CNA WW reported that the administration staff sent (CNA UU) home that day after it happened, and we were short that day; the talk was she (CNA UU) was suspended. Review of the Code Yellow Drill dated 4/2/2020 (no time), revealed Identification of at risk residents, Elopement Book-What is it? Where do you find it? Code Yellow. All participants names were typed in, there were no signatures.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 085 . Based on interview, and record review the facility failed to ensure residents received care and services consistent with professional standards for the prevention of pressure ulcers in 3 of 3 residents (Resident #101, #105, and #102), reviewed for pressure ulcers, from a total sample of 12 residents, resulting in skin impairment and the potential for the worsening or development of new pressure ulcers. Findings include: Review of the facility's Pressure Ulcers/Pressure Injury Prevention and Treatment Clinical Protocol, dated , revealed .Purpose .Based on the comprehensive assessment of a resident, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing .Change of condition/New skin alteration .a. Complete head to toe skin assessment, document in the medical record . a. Complete head to toe skin assessment, document in the medical record; b. Notify Physician; c. Obtain new orders as needed .e. Complete new Norton's Plus scale . g. Update plan of care to reflect any new risks, goals, and interventions .With each dressing change, or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI(s) be documented. At a minimum, documentation should include the date observed, location, staging, size (perpendicular measurements of the greatest extent of length and width of the PU/PI), depth; and the presence, location and extent of any undermining or tunneling/sinus tract; exudate, if present; type (such as purulent/serous), color, odor, and approximate amount; Pain, if present: nature and frequency (e.g., whether episodic or continuous); Wound bed: Color and type of tissue/character including evidence of healing (e.g., granulation tissue), or necrosis (slough or eschar); and description of the wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration) as appropriate . Resident #101 Review of the Face Sheet revealed Resident #101 was a [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of Resident #101's Minimum Data Set ((MDS) dated [DATE] revealed Resident #101 was cognitively intact. In an interview on 5/8/20 at 3:00 PM, Infection Control Preventionist (ICP) K indicated managed the wounds at the facility. ICP K indicated rounded on all wounds once a week and documents wound measurements and descriptions on a wound care third-party website. ICP K indicated Resident #101 has multiple areas of impaired skin on his stomach, coccyx, lower legs, heels and feet. Resident #101's lower leg skin impairment were mostly related to [MEDICAL CONDITION] (blockage of lymphatic vessels that leads to fluid retention), vascular issues (lack of adequate circulation), and chronic bilateral heel pressure wounds. ICP K has had his bilateral legs (mid-foot to knee) wrapped once a week since he admitted (May 2019). ICP K indicated was the only nurse Resident #101 permitted to treat his legs and heel pressure wounds. Review of Resident #101's April Treatment Administration Record (TAR) revealed the order .Cleanse Lower legs and feet with [MEDICATION NAME] solution (antimicrobial skin wash), rinse and pat dry. Apply collagen (non-adhering dressing for wounds with drainage) to both heel ulcers covered with [MEDICATION NAME] ag (cover bandage for wounds with drainage). Apply lachydrin lotion to lower legs and feet. Wrap with cotton underpad wrap, wrap with coban. DO

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) NOT cover the toes with coban (elastic bandage). Cover toes with dry dressing. every day shift every Fri -Start Date-03/27/2020 (6:00 AM)-Hold Date from 04/22/2020 (1:07 PM) . No treatment in the TAR was marked as completed for the entire month of April (0 of 4 treatment days). Review of Resident #101's Wound Assessments revealed no assessment or description of Resident #101's bilateral heel pressure wounds for the month of April (completed weekly, 0 of 4). Review of Resident #101's electronic medical record (EMR) revealed no documented assessment or description of Resident #101's bilateral heel pressure wounds for the month of April. Review of Resident #101's wound assessment (documented on a third party wound care website) on 4/11/20 revealed he had a new .left calf wound .Length/Width/Depth .1.5/1.5/0.1 cm .[MEDICATION NAME] (as wounds heal [MEDICATION NAME] cells grow across the wound surface from edges to close wound, seen in stage II or greater pressure wounds) . The assessment also revealed a new .right calf wound . Length/Width/Depth . 0.5/0.5/0.1 cm .[MEDICATION NAME] . No description or diagram of the approximate location (lateral, upper, lower calf) was documented, and no staging, or wound type was documented for either calf wounds. For each calf wounds the treatment performed was .wash with [MEDICATION NAME], collage to heel and calf, foam AG to open areas, wrap with cotton underwrap . Review of Resident #101's Physician's Orders revealed no dressing order for the newly discovered bilateral calf pressure ulcers on 4/11/20 (the only related order found was for lower leg wraps and heel treatment dated 3/27/20). Review of Resident #101's April and May Treatment Administration Record (TAR) revealed no treatments for Resident #101's bilateral calf pressure wounds (due to no physician order). Review of Resident #101's Care Plan revealed no new skin integrity care plan interventions were added with the discovery of the bilateral calf pressure ulcers. The last updated intervention for the skin integrity care plan was 5/8/19 (admitted). Review of Resident #101's Norton's Plus Scale assessments revealed no new assessment completed after the 4/11/20 discovery of Resident #101's bilateral calf pressure wounds. In an interview on 5/8/20 at 3:30 PM, ICP K indicated in mid-April (4/11/20) new bilateral wounds were discovered on Resident #101's calves. The new wounds began as moisture and shearing (pressure applied to tissues in the body due to forces moving in opposite directions) but later (4/11/20) developed into pressure wounds. ICP K indicated implemented a new dressing for the calf wounds that would be done at the same time as Resident #101's legs and heels were dressed (no physician order). ICP K indicated did not write a progress note alerting other staff that Resident #101 had new wounds or a new dressing treatment. ICP K indicated Resident #101 probably developed the wounds because he sits in a recliner all day and night and his calves are in contact with the recliner and the under sheet that covers the recliner. ICP K indicated that sheet collects moisture from Resident #101 sweating and drainage from his pannus wounds; the sheet transferred moisture to his lower leg dressings. ICP K indicated did not initiate any new care plan interventions to prevent the worsening of the calf wounds or development of new wounds. In an interview on 5/14/20 at 9:30 AM, Former Director of Nursing SS (FDN) indicated was on leave for a month and returned to the facility approximately March 15th. FDN SS indicated prior to the leave wound care was managed well. After returning from leave FDN SS indicated wound care management had slipped. FDN SS indicated had a difficult time balancing day to day operations, supervising wound management, and preparing for the impending COVID-19 outbreak. FDN SS indicated was not notified by ICP K Resident #101 had developed two new pressure wounds on 4/11/20. FDN SS indicated should have been notified and the staff would have met for an interdisciplinary meeting, implemented new care plan interventions, consulted our physicians, and ordered treatment. Review of Resident #101's electronic medical record (EMR) revealed Resident #101 was transferred from the facility April 22nd to the emergency room (ER) for a positive COVID-19 test result. Resident #101 returned to the facility later that evening. Resident #101 was moved from his room on Unit A to a new room on Unit B the COVID positive unit. Resident #101 was sent back to theER on [DATE] morning and was admitted until 5/7/20. Review of Resident #101's assessment Return from Leave and Transfer In (returned from ER) dated 4/22/20, revealed .Are there any new abnormal skin areas? .yes .List site(s) of any new abnormal skin areas .(area to list was blank, no site or areas listed) .Treatment initiated? .yes .Specify treatment initiated .see TAR . No refusals to observe skin was documented. Review of Resident #101's assessment Skilled Daily - Medically Complex - V 4 dated 4/23/20, revealed .Skin abnormal skin conditions (this box was checked yes) .Describe skin condtions . Various areas Bil lower legs, Under Panus Groin with tx (treatment) in place . No refusals to observe skin was documented in EMR. Review of Resident #101's TAR for April revealed Resident #101 had 5 separate skin treatment orders to prevent further skin breakdown for his groin folds, left and right side of his pannus (flap of excess skin, fat and tissue at the bottom of the abdomen), legs, heels, under his pannus, and coccyx. The TAR has hold dates for all the skin treatments as 4/22/20 (date Resident #101 transferred to the ER). These treatments were not restarted on 4/22/20 (when returned from the ER) and were not active from 4/22/20 to 4/30/20 (admit back to the hospital). Skin treatments were not restarted for Resident #101 for 7 days and the facility did not document 24 physician ordered skin treatments. In an interview on 5/14/20 at 2:00 PM, ICP K reviewed Resident #101's TAR for April and indicated did not restart Resident #101's skin and wound treatment orders when he returned from theER on [DATE]. The treatment orders were resumed on 5/8/20 when he returned from his hospital admission. Review of Resident #101's weekly skin assessments revealed the last documented skin assessment was 4/8/20. No refusals of skin assessments found in progress notes for April. Review of Resident #101's wound assessments revealed Resident #101's last wound assessment was done on 4/17/20. The left calf wound had reduced in sized to 1.0 x 1.0 cm and the right calf wound had resolved. Review of Resident #101's Wound Notes from hospital admission, dated 4/30/20, revealed Resident #101 presented to the hospital with .Pressure Injury Stage .DTPI (A deep tissue pressure injury is an intact purple or marron area caused by damage or pressure to soft tissues under the skin) . Wound Site Assessment .Maroon .100% dark maroon .Wound Length . 1.0 cm .Wound Width .1.0 cm . to the posterior left calf. On the right calf . Wound Length . 7 cm .Wound Width .8 cm . No documentation or assessment of either of these or any otheres areas of impaired skin integrity were found in the facility EMR or in the third party wound care website since 4/17/20. Review of Resident #101's Admission Record revealed Resident #101 returned from his hospital stay on 5/7/20. Resident #101's May TAR revealed Resident #101 had a dressing treatment done to his bilateral heels on 5/8/20 by Registered Nurse NN (RN). No wound assessment or wound description was found documenting the condition of Resident #101's calves or bilateral heel wounds. No treatment was ordered to address Resident #101's bilateral calf wounds. Review of Resident #101's assessment Skilled Daily - Medically Complex - V 4 dated 5/9/20 (2 days after return from hospital admission), revealed .Skin abnormal skin conditions (this box was checked yes) .Describe skin condtions .Multiple diabetic ulcers to BLE . No refusals to observe skin was documented in EMR. Review of Resident #101 Wound Assessment done 6 days after re-admission, dated 5/13/20 revealed .Right Calf . Acquisition: Reoccurring . First Observed: 4/11/20 .Type of Wound: Pressure . Stage: 3 . Length (cm) 9 . Width (CM) .8 . Depth (cm) 0.3 . In an interview on 5/14/20 at 2:00 PM, ICP K indicated the last time Resident #101's legs and heel pressure ulcers were treated and assessed at the facility was on 4/17/20. ICP K indicated did not assess Resident #101's legs after returning from theER on [DATE] and did not assess him 4/24/20 on his next scheduled treatment date. ICP K indicated did not document on the TAR that any of Resident #101's calves or heel treatments were completed. ICP K indicated on 5/13/20 evaluated Resident #101's calves and heels for the 1st time since 4/17/20. ICP K indicated the DTPI identified on Resident #101's left calf in the hospital was resolved and the wound identified in the hospital on Resident #101's right calf has reopened and was now a stage 3 pressure wound. This citation pertains to MI 173. Resident #105 Review of a Admission Record revealed Resident #105 was an [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 #105, with a reference date of 7/4/19 revealed staff conducted the Assessment for Mental Status to determine the cognitive skills for daily decision making indicated Resident #105 were moderately impaired, and on 4/4/20 a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated Resident #105 was cognitively moderately impaired. Review of the General Nursing Note dated 5/3/2020 at 1:32 PM revealed Resident refusing to eat and drink. Checked pulse ox due to cough and appearing to have difficulty breathing. Pulse ox between 79-90. Attempted x3 to reach on call Nurse Practitioner (NP) received an ok to have oxygen available for resident as needed Review of the General Progress Note dated 5/3/2020 at 5:36 PM, revealed Resident transferred to (name of hospital) via (name of ambulance) per families request. Paperwork, med list, (do not resuscitate) DNR, (power of attorney)POA, Facesheet, sent with resident. Resident was on nonrebreather when left facility. Review of the Hospital Wound Ulcer Incision Assessment - Text dated 5/4/2020 at 9:00 AM and revised at 3:38 PM, revealed Registered Nurse documented Wounds. Incision/Wound Care Wound 1: Wound 1 Type: Pressure injury; Wound 1 Present on admission: Yes; Status-Wound: Current; Wound 1 Location: Coccyx; Wound 1 Location Detail: Medial; Pressure Injury Stage-Wound 1: Suspected Deep Tissue Injury; Incision/Wound Care Wound 2: Wound 2 Type: Pressure injury; Wound 2 Present on admission: Yes; Status-Wound 2: Current; Wound 2 Location: Buttock; Wound 2 Location Details: Right; Wound 2 Description: Ecchymotic (a discoloration of the skin resulting from bleeding underneath); Wound 2 Drainage Amount: None; Pressure Injury Stage-Wound 2: Suspected Deep

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	235282	A. BUILDING _____ B. WING _____	05/14/2020

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) Tissue Injury; Incision/Wound Care Wound 3: Wound 3 Type: Pressure Injury; Wound 3 Present on admission: Yes; Status-Wound 3: Current; Wound 3 Location: Hip; Wound 3 Location Detail: Right; Wound 3 Description: Other: Adherent foam is in place; Wound 3 Drainage Amount: None. Incision/Wound Care Wound 4: Wound 4 Type: Pressure Injury; Wound 4 Location: buttock; Wound 4 Location Detail: Left; Wound 3 Description: Ecchymotic; Wound 4 Drainage Amount: None; Pressure Injury Stage-Wound 4: Suspected Deep Tissue Injury. Review of the Hospital Wound Ulcer Incision assessment dated [DATE] at 12:38 PM, revealed Wound Consult documented Incision/Wound Care Wound 1: Wound 1 Type: Pressure injury; Wound 1 Present on admission: Yes; Status-Wound: Current; Wound 1 Location: Coccyx; Wound 1 Purple Percentage: 100%; Wound 1 Location Detail: Medial; Wound 1 Odor: Odor free; Wound 1: Ecchymotic; Pressure Injury Stage-Wound 1: Suspected Deep Tissue Injury; Wound 1 Surrounding Tissue: Denuded (to make naked), Fragile; Dressing Condition/Intervention (Barrier Cream); Incision/Wound Care Wound 2: Wound 2 Type: Pressure injury; Wound 2 Present on admission: Yes; Status-Wound 2: Current; Wound 2 Location: Buttock; Wound 2 Purple Percentage: 100%; Wound 2 Location Details: Right; Wound 2 Odor: Odor free; Wound 2 Description: Ecchymotic; Wound 2 Drainage Amount: None; Pressure Injury Stage-Wound 2: Suspected Deep Tissue Injury; Wound 2 Surrounding Tissue: Denuded, Fragile; Dressing Condition/Intervention Wound 2: (Barrier Cream); Incision/Wound Care Wound 3: Wound 3 Type: Pressure Injury; Wound 3 Present on admission: Yes; Status-Wound 3: Current; Wound 3 Location: Hip; Wound 3 Purple Percentage: 100%; Wound 3 Location Detail: Right; Wound 3 Odor: Odor free; Wound 3 Description: Ecchymotic; Wound 3 Drainage Amount: None; Pressure Injury Stage-Wound 3: Suspected Deep Tissue Injury; Wound 3 Surrounding Tissue: Fragile, Pink; Dressing Condition/Intervention Wound 3 Foam Adherent. Review of the Hospital Wound Ostomy Continence Note dated 5/4/2020 at 12:44 PM, revealed Wound Consult, Patient skin assessed at bedside in Covid-19 unit. Patient is positive for Covid-19. Patient turned and skin assess with (name of Registered Nurse). Patient noted to have deep tissue pressure injury to coccyx, left buttock (SIC) and right hip. The left hip has surrounding blanchable [DIAGNOSES REDACTED] from laying on that side prior to turn. The buttocks and perineal area have mild denuding from IAD (Incontinence Associated [MEDICAL CONDITION]). The patient is malnourished and his skin is very fragile. Recommend adherent foam to right hip for pressure reduction and barrier cream to the buttocks, coccyx and perineal areas. A pressure reduction overlay has also been ordered for the bed to help reduce pressure Review of the Hospital Wound Ostomy Continence Note dated 5/8/2020 at 2:13 PM, revealed Wound assessment, Wound assessed at bedside. Message from (name of Registered Nurse) in regards to possible worsening of deep tissue injury to right buttock. On admission the pressure injury was noted to be a deep tissue pressure injury. This has now evolved into an unstageable pressure injury. An unstageable pressure injury will most likely, evolve into a stage 3 or 4 when the wound base is clean. At this time there is a thin layer of fibrous tissue covering the wound bed. A Waffle cushion has been ordered since the patient is no longer on a critical care bed surface Will follow up early next week. Review of the Nursing Admission Evaluation (Re-Admission) dated 5/9/2020 at 6:20 PM, revealed 1. Skin a. Does the resident have any identified skin conditions/wounds? (Yes) b. 25) (Site) Right trochanter (hip), (Type) Pressure, (Units of measure: Centimeters) 2.5 Length 1.2 Width Stage 1-- 32 (Site) Left Buttock, (Type) Pressure, (Unites of measure: Centimeter) 3.2 L 2.7 W Stage 2. Review of the Skin assessment dated [DATE] at 4:20 AM, revealed Description weekly skin assessment A. Skin Evaluation 1. Are there any new abnormal skin areas? (no) 2. confirmed that a full skin assessment and no new abnormal skin areas were observed. 5. Are there any existing abnormal skin areas? (no). In an interview on 5/14/20 12:57 PM, Licensed Practical Nurse (LPN) ZZ reported that on A hall where there are still skin assessments weekly you would just put on the (personal protective equipment) PPE. LPN ZZ reported that the User Defined Assessment (UDA) board was to remind staff when scheduled assessment are due, so when she logs into the compute it will pop and show what skin assessment are due and will pop up red if past due. LPN ZZ reported that the first shift nurse also let her know what skin assessments she did not do, sometimes, but LPN ZZ reported she will generally look and see what she needs to do. LPN ZZ reported that Resident #105 ended up going to the hospital on the 5/3/2020 and she was new to the A-hall and shifts had been changed and medication pass may have taken extra long. LPN ZZ reported that (Resident #105) was defiant when taking medication, could be aggressive to care with Certified Nursing Assistant's (CNA's) changing his clothing doing incontinent care, but that she did not recall CNA's reporting any concerns with his bottom. LPN ZZ reported that she did not do the skin assessment that was due on 5/1/2020. In an interview on 5/14/20 at 1:42 PM, LPN AB reported that (Resident 105) has a habit of refusing care and medication, and has a general decline, due to his refusal of care. LPN AB reported that prior to (Resident #105) going to the hospital on [DATE], we attempted to do skin assessments, but trying to take care of the critically ill patients with high temperatures, keeping those temps down, and other basic needs like hydration's which required extra fluids, became more of a priority and a focus. LPN AB reported we attempted to turn residents timely which would help prevent wounds and skin breakdown and also did check and change the residents. In an interview on 5/14/20 at 3:33 PM, CNA D reported that (Resident #105) has to be rolled, will say that his back hurts, that prior to going to the hospital his right hip was red. CNA D reported that (Resident #105) had been treated by therapy for pain in that right hip and a sore last year, but that the right side was the side (Resident #105) liked to lay on. CNA D reported that the nurses were aware that the right hip was red, the computer charting done gives a spot to document if I see something new to me and if I told the nurse. Review of the Behavior Record from 4/23/20 - 5/7/20, revealed no documented behaviors for Resident #105. Review of the Activity of Daily Living (ADL) Care Plan dated 8/11/19, revealed The resident needs activities of daily living assistance related to: Activity Intolerance, Deconditioning, Impaired balance. Often declines care and will decline therapy as well. He prefers to remain in room in w/c and needs encouraged to leave his room. Often asks for alcohol and has hx of ETOH abuse. Resident with history of declining incontinence care. Revision date 8/11/19 Goal ADL Care needs will be met throughout his stay Revision on: 04/16/2020 Interventions BED MOBILITY: The resident can turn independently in bed, he has a body pillow that he repositions himself for comfort Revision on: 01/09/2020 BED MOBILITY: The resident is able to manage bed mobility by use of enabler bars to assist in bed positioning. Revision on: 04/16/2020 PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist x1 Revision on: 10/17/2018. Review of the History of Pressure Ulcer Development Care Plan dated 4/18/19, revealed, The resident has history of pressure ulcer development. Has thin fragile skin. He has history of low [MEDICATION NAME] levels and is thin in statue secondary to ETOH abuse prior to admission. Revision on: 04/18/2019 Goal The resident skin alterations will resolve without complications Revision on: 04/16/2020, Interventions Identify/document potential causative factors and eliminate/resolve where possible. Date Initiated: 12/29/2017 Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Date Initiated: 12/29/2017. Review of the Norton Plus Pressure Ulcer Scale dated 4/2/20 at 6:00 AM, revealed Resident #105 was a moderate risk for pressure ulcers. Risk Factors 1. Physical Condition (Fair) 2. Mental State (Alert) 3. Activity (chair bound) 4. Mobility (very limited) 5. Incontinence (double incontinence) B. 1. [DIAGNOSES REDACTED]. [DIAGNOSES REDACTED]. 5 or more medication (yes). Review of the Medication Administration Record [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of the Interdisciplinary Nursing Notes dated 1/22/20 through 5/5/20, revealed no documentation that Resident #105 was refusing care. Resident #102 Review of an Admission Record revealed Resident #102 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 #102, with a reference date of 3/13/20, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated the resident was cognitively intact. Further review of Resident #102's MDS assessment, dated 3/13/20, revealed no documented skin conditions, which included pressure ulcers, skin tears, and Moisture Associated Skin Damage (MASD). Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 4/23/20, revealed no documented skin conditions, which included pressure ulcers, skin tears, and MASD. Review of the Care Plan for Resident #102 revealed the focus .has hx (history) of pressure ulcer development to the following areas (left and right buttock), r/t (related to) Immobility (related to left AKA (above knee amputation) and right BKA (below knee amputation)), DM (diabetes) type 2, [MEDICAL CONDITION] and history of declining assistance with repositioning, history of declining assist with care and getting out of bed . initiated 12/14/17, and revised 4/18/19. Review of the interventions for this focus revealed no new interventions were implemented since 12/15/17, and no existing interventions were revised since 8/11/19. Review of the Care Plan for Resident #102 revealed the focus .Resident has a non-pressure wound abrasion(s) to the following areas left gluteal fold. Resident continues to refuse treatment to area. Education has been provided regarding risks of no treatment . initiated 1/3/20, and revised 1/30/20. Interventions included .administer medications/treatments as ordered - see electronic health record for specific instructions. Observe for effectiveness and complications . initiated 1/3/20, and .observe lesion weekly, during treatments and when necessary. Notify physician as needed of worsening . initiated 1/3/20. Review of the interventions for this focus revealed no new interventions were implemented and no existing

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) interventions were revised since 1/3/20. Review of the Wound History for Resident #102, dated 1/3/20, revealed .Right Buttock .Open .Length / Width / Depth: 1.4 / 1.3 / 1.0 cm .Thickness/Stage: N/A .Tissue Type: Granulation .Exudate Type: Color: Sero-sanguinous .Wound Bed: Granulation .Surrounding Skin: Maceration .Acquired: Reoccurring .Type of Wound: MASD (Moisture Associated Skin Damage) .Odor: Yes .Exudate Amount: Heavy .Primary Dressing: Calcium Alginate Ag 12 Rope with Silver Dressing, QD (once a day) .Secondary Dressing: per resident choice, QD .Education provided to resident about risks of not having a covering to wound. Educated on risks of refusing dressing changes and not turning and positioning as recommended. Resident verbalized understanding that failure to follow treatment orders and not turning and repositioning could result in infection which could lead to osteo[DIAGNOSES REDACTED],[MEDICAL CONDITION] and eventually death. No concerns noted from resident. NP (Nurse Practitioner) notified of wound . Review of a Skin Assessment for Resident #102, dated 3/11/20, revealed .Resident did not allow Nurse to view bottom. Treatment is in place to bottom . Review of a Skin Assessment for Resident #102, dated 3/18/20, revealed .Resident has ongoing Right gluteal fold abrasion. Resident is non-compliant with dressing changes . Review of a Skin Assessment for Resident #102, dated 3/27/20, revealed .Abrasion to Left gluteal fold. Non-compliant with dressing changes. TX (treatment) per TAR . Note this area is opposite what was noted on the previous skin assessment. Review of a Skin Assessment for Resident #102, dated 4/3/20, revealed .Ongoing abrasion to Left buttock. TX (treatment) per TAR. Resident is non-compliant with dressing changes . Review of a Skin Assessment for Resident #102, dated 4/10/20, revealed .Open area to Left and right buttocks. TX (treatment) per TAR. Resident non-compliant with dressing changes . Note open area is now noted on both the right and left buttocks. Review of a Skin Assessment for Resident #102, dated 4/17/20, revealed .Resident non-compliant with dressing changes to his buttocks. Two abrasions noted to either side of his buttocks . Review of a Skilled Daily - Medically Complex assessment for Resident #102, dated 4/20/20, revealed .Abnormal skin conditions .ongoing wound to bottom. treatments in place and implemented . Review of a Skilled Daily - Medically Complex assessment for Resident #102, dated 4/22/20, revealed .Abnormal skin conditions .Ongoing wound treatment to buttock. Resident choose not to allow this nurse to assess . Review of the Wound History for Resident #102, dated 4/24/20, revealed .Right Buttock .Open .Length / Width / Depth: 1.4 / 1.3 / 1.0 cm .Thickness/Stage: N/A .Tissue Type: Granulation .Exudate Type: Color: Sero-sanguinous (sic) .Wound Bed: Granulation .Surrounding Skin: Maceration .Acquired: Reoccurring .Type of Wound: MASD (Moisture Associated Skin Damage) .Odor: Yes .Exudate Amount: Heavy .Primary Dressing: Calcium Alginate Ag 12 Rope with Silver Dressing, QD (once a day) .Secondary Dressing: per resident choice, QD .Measurements noted are from 1/3/20. Resident has consistently declined staff to observe or measure buttocks wounds. Will continue to re-approach. NP aware of refusals . Review of an Orders - Administration Note for Resident #102, dated 4/26/20, revealed .Resident on back stated did not want to lay on his side. Buttocks area red, macerated, excoriated .Buttocks to mid thigh red and macerated with no drainage noted, tender to touch. Reviewed with resident staying off his back and originally declined and then agreed to turning on his right side. resident is a 2 assist to turn and reposition .Resident uses turn assist bar however, is extensive assist with turning and re positioning . Review of an Order Summary Report for Resident #102, dated 5/1/20, revealed an active physician order to .Cleanse open areas on bilat buttocks with ns, pat dry - apply thin layer of [MEDICATION NAME]/AG wound gel. every 4 hours for protection . with a start date of 8/12/19. Review of an Order Summary Report for Resident #102, dated 5/1/20, revealed an active physician order to .Right gluteal fold: Cleanse with ns, pat dry, fluff with silver alginate rope. every day shift . with a start date of 1/4/20. In an interview on 5/12/20 at 4:16 p.m., Licensed Practical Nurse (LPN) K stated in regard to Resident #102's wounds .He initially let me assess them (the buttock wounds). Once I told him the treatment, he wouldn't let me assess them again. He wouldn't let the nurses treat the wounds or assess the wounds . LPN K reported there were times when Resident #102 would allow the nursing staff to observe the buttock wounds, and stated in regard to the wounds worsening .it did progress . LPN K reported the wounds .started as moisture and shearing. He did not change positions .wouldn't turn side to side .He was very particular with his care . LPN K reported Resident #102 .was very anti-male . and preferred female caregivers. LPN K reported skin assessments were scheduled weekly, as Resident #102 would allow. LPN K reported the nurses and CNA's would notify him of changes in the condition of Resident #102's wounds. Review of the Care Plan revealed no documentation related to Resident #102's preference for female caregivers. In an interview on 5/12/20 at 4:41 p.m., Regional Nurse Consultant LL reported Resident #102 allowed her to complete wound care to his buttock wounds on 4/26/20. Regional Nurse Consultant LL stated Resident #102 .had quite a bit of excoriation .He didn't like anyone touchi
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 pertains to intake # MI 173. Based on observation, interview, and record review, the facility failed to ensure the safety and prevent the elopement for 1 of 12 sampled residents (Resident #110) reviewed for safety/elopement, resulting in Resident #110 who was a high elopement risk with a wanderguard in place to prevent elopement, eloped on 4/2/20, unbeknownst to facility staff, placing the resident at risk for serious harm, injury, and/or death. Findings include: Review of a Admission Record revealed Resident #110 was a 64 -year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 5/16/19 revealed staff conducted the Assessment for Mental Status to determine the cognitive skills for daily decision making indicated Resident #110 were severely impaired. Review of the Wanderer Care Plan dated 5/9/19, revealed The resident is a wanderer and at risk for elopement r/t Impaired safety awareness secondary to dementia. Resident does frequently bang on the doors at end of hall. Date Initiated: 05/09/19, Goal - The resident will not exit the facility or enter an unsafe area unattended through the review date. Revision on: 05/30/2019, Interventions - Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Revision on: 05/24/2019 Identify pattern of wandering. (e.g. Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise?) Intervene as appropriate. Date Initiated: 05/09/2019 Increased supervision to meet the needs of the resident. Date Initiated: 05/03/2020. Requested documentation on 5/8/2020 at 4:45 PM from NHA A for (Resident #110's) elopements and was not provided an Incident and Accident Report (I/A) Report for the incident that occurred 4/2/2020 at approximately 3:00 PM, was not received by exit. Review of the Interdisciplinary (IDT) Progress Note dated 4/3/2020 at 4:01 PM, revealed on 4/2/20 resident exited C-hall door. Resident was brought back through doors by staff. No injury. skin and pain assessments were completed with no negative findings. Guardian Notified. Notified NP. In an interview on 5/12/2020 at 1:31 PM, Certified Nursing Assistant (CNA) UU reported that on 4/2/2020 on second shift I was in the dining room with a resident and there were 2 other CNA's on the hallway with resident and (Resident #110) was wandering the hall so I thought they were watching him. CNA UU stated I heard the alarm go off and I went and cut alarm off, looked out the window and did not see anyone, there was a resident by the door I suspected had tried to open the door, and the 2 other CNA's were gone so I thought they had (Resident #110), and no one was in the hallway so I thought they were all in their rooms. CNA UU reported that the door she checked opened out to the back of the building by the parking lot. CNA UU reported that then Nursing Home Administrator (NHA) A came to her and told her that (Resident #110) had got out and ask why she had turned the alarm off. CNA UU) reported she did not know how long it was between the time she turned the alarm off and when they bought (Resident #110) back in the building. CNA UU reported that she got suspended immediately for turning the alarm off. In interviews on 5/8/2020 at 3:37 PM and 5/13/2020 at 4:26 PM, Former Director of Nursing (FDON) SS reported the IDT note written on 4/3/2020 was during a meeting with other managers, she had not been at the facility on 4/2/2020, it was discussed during the meeting that Resident #110 got into a personal vehicle after getting out of the C-Hall door, and that the alarm did go off, but there was not any response. FDON SS stated I cannot speak to why it was not reported to the State. FDON SS reported that on 4/6/2020 after CNA UU returned from suspension she was educated on Code Yellow elopement and that we do not turn alarms off, walking through it like a simulation with her doing a teach back. FDON SS stated that (CNA UU) was suspended immediately after (Resident #110) was returned to the building for turning the alarm off, she was off from Thursday 4/2/2020 over the weekend and came back on Monday 4/6/20 when I educated her. In an interview on 5/8/2020 at 4:10 PM, Nursing Home Administrator (NHA) A reported that on 4/2/2020 the alarm on C-Hall was sounding, staff responded, (Resident #110) did get into (Former Transportation Drivers (FTD) YY) personal truck that was parked by the C-Hall, and he escorted (Resident #110) into the building. In interviews on 5/11/20 at 8:40 PM and 5/13/2020 at 3:31 PM, Former Transportation Driver (FTD) YY reported that he no longer works at the facility, but had worked in transporting residents to appointments for the facility on 4/2/2020, and had just returned to the facility and parked the

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) transportation vehicle for the day; it was in the afternoon between 3:30 and 4:00 PM. FTD YY reported that before clocking out he went to his personal truck and found a resident of the facility sitting in his passenger seat (Resident #110) so he called NHA A who was not aware (Resident #110) was missing. FTD YY reported that he assisted (Resident #110) out of his personal truck and as he walked with the resident toward the front door of the building, we were met by the NHA (A) and other management nursing staff. FTD YY reported that he was told that (CNA UU) went to the C-Hall door when she heard the alarm go off and shut it off. FTD YY stated that his personal truck was parked between building C and D Halls about 10 parking spaces from the fence, when a resident leaves the double doors to exit the building from the C-Hall they have to walk out the double doors then through a fenced area and open the fence, which (Resident #110) was very good at doing, and it was another approximately 80 feet to my truck. FTD YY reported that he did not punch out until after he took (Resident #110) back in the facility. FTD YY reported that he did not hear a Code Yellow called or sign the code yellow sheet, but everyone did run out of the building while he was bringing (Resident #110) towards the building, so it could have been called after he called the NHA and told her (Resident #110) was out of the building and in his personal truck. Review of the Punch Record dated 4/2/2020, revealed that FTD YY punched in on 4/2/2020 at 9:52 AM and out at 3:46 PM. In an interview on 5/12/20 at 12:59 PM, Regional Nurse Consultant (RC) MM stated that it was reported to me by the NHA, that (Resident #110) exited the doors, the alarm sounded, he remained on the premises, staff brought him inside. According to the NHA, they immediately followed with an elopement drill, there was an opportunity for education, so it was completed. Education was done on 4/2/20 and was more of a debriefing/opportunity review of the drill. In an interview on 5/12/2020 at 1:40 PM, CNA VV reported that they were working with on the C-Hall on second shift on 4/2/2020 and that (Resident #110) did get out of the building. CNA VV reported that he and another CNA took a resident to the bathroom that required a 2 person assist and they were in the middle of a transfer when they heard the alarm go off and could not stop, but did not hear an all clear sound. CNA VV reported that it was about 5 minutes or more before he could come out of that resident's room and then he heard a Code Yellow, he looked in (Resident #110's) room and he was gone. CNA VV reported that he and another CNA left the hall through the double door at the end of C-Hall to look outside one went right and one went left working towards the main entrance, which took CNA VV about 10 minutes, and (Resident #110) was found by then. CNA VV reported that 2nd shift started at 2:00 PM and at 3:00 PM when we passed water (Resident #110) was in his room. CNA VV reported that he did not recall that (Resident #110) was wandering in the hall that day, did not recall what time he heard the alarm go off. In an interview on 5/14/20 at 8:15 AM, Human Resources (HR) XX reported that there was no suspension paperwork in CNA UU files the managers do the suspensions and just give her the paperwork to put in the files and that the NHA had the CNA's files up until a few minutes ago. In an interview on 5/14/20 at 9:08 AM, CNA WW stated that almost every shift an alarm goes off on C-Hall, (Resident #110) is a smart man and his behavior is that he will go in the dining room and he will sit down and he will play with some building blocks and then he will go back to his room shut the door, then he will come back out and make his way to the back door and you will hear beep beep beep and you have to be on him, he needs a companion; someone with him all the time when he is up. CNA WW reported that he and the another CNA were taking a 2 person assist to the bathroom and we heard an alarm going off and the alarm is going off for about 5 seconds and by that time (Resident #110) has already gotten out of the building and then we get the call over the overhead Code Yellow maybe 5 to 10 minutes had passed, we were just finishing with the resident who required 2 person assist. CNA WW stated A lot of people came down the C-Hall checking rooms, management talked to (CNA UU) in the office and we had a re-education on what we were suppose to do, told them we were in a room with a resident who could not be left. CNA WW reported that the administration staff sent (CNA UU) home that day after it happened, and we were short that day; the talk was she (CNA UU) was suspended. Review of the Code Yellow Drill dated 4/2/2020 (no time), revealed Identification of at risk residents, Elopement Book-What is it? Where do you find it? Code Yellow. All participants names were typed in, there were no signatures. Review of the Pertinent Charting Initial - Skin dated 4/2/2020 at 4:28 PM, revealed, no documentation, the entire form was blank. Review of the Skin assessment dated [DATE] at 4:28 PM, revealed Description weekly skin assessment A. Skin Evaluation 1. Are there any new abnormal skin areas? (no) 2. confirmed that a full skin assessment and no new abnormal skin areas were observed. 5. Are there any existing abnormal skin areas? (no).
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # MI 085, MI 119, MI 210, & MI 212. Based on interview, and record review, the facility failed to maintain complete and accurate medical records in 2 of 12 residents (Resident #102 & #101) reviewed for accuracy of medical records, resulting in incomplete treatment records and the potential for providers to not have an accurate picture of resident status and condition. Findings include: Review of the policy and procedure Charting and Documentation, revised 2/2018, revealed .All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record .All observations, medications administered, services performed, etc., must be documented in the resident's clinical records (including but not limited to nursing notes, assessments, medication administration records, treatment administration orders, skin measurement grids, etc.) In general, document by exception, meaning lack of documentation means not applicable .All incidents, accidents, or changes in the resident's condition must be recorded .Pertinent Charting may be completed for ease of tracking specific events/monitoring. Pertinent Charting categories include but are not limited to .New or change in skin areas . Resident #102 Review of an Admission Record revealed Resident #102 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 #102, with a reference date of 3/13/20, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated the resident was cognitively intact. Further review of Resident #102's MDS assessment, dated 3/13/20, revealed no documented skin conditions, which included pressure ulcers, skin tears, and Moisture Associated Skin Damage (MASD). Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 4/23/20, revealed no documented skin conditions, which included pressure ulcers, skin tears, and MASD. Review of the Care Plan for Resident #102 revealed the focus .has hx (history) of pressure ulcer development to the following areas (left and right buttock), r/t (related to) Immobility (related to left AKA (above knee amputation) and right BKA (below knee amputation)), DM (diabetes) type 2, [MEDICAL CONDITION] and history of declining assistance with repositioning, history of declining assist with care and getting out of bed . initiated 12/14/17, and revised 4/18/19. Review of the interventions for this focus revealed no new interventions were implemented since 12/15/17, and no existing interventions were revised since 8/11/19. Review of the Care Plan for Resident #102 revealed the focus .Resident has a non-pressure wound abrasion(s) to the following areas left gluteal fold. Resident continues to refuse treatment to area. Education has been provided regarding risks of no treatment . initiated 1/3/20, and revised 1/30/20. Interventions included .administer medications/treatments as ordered - see electronic health record for specific instructions. Observe for effectiveness and complications . initiated 1/3/20, and .observe lesion weekly, during treatments and when necessary. Notify physician as needed of worsening . initiated 1/3/20. Review of the interventions for this focus revealed no new interventions were implemented and no existing interventions were revised since 1/3/20. Review of an Order Summary Report for Resident #102, dated 5/1/20, revealed an active physician order [REDACTED]. every 4 hours for protection . with a start date of 8/12/19. Review of an Order Summary Report for Resident #102, dated 5/1/20, revealed an active physician order [REDACTED]. every day shift . with a start date of 1/4/20. Review of the March 2020 Treatment Administration Record (TAR) for Resident #102 revealed missing entries for .Cleanse open areas on bilat buttocks with ns, pat dry - apply thin layer of [MEDICATION NAME]/AG wound gel. every 4 hours for protection . on 3/14/20 at 4:00 a.m. and 3/21/20 at 4:00 a.m. Review of the April 2020 TAR for Resident #102 revealed missing entries for .Right gluteal fold: Cleanse with ns, pat dry, fluff with silver alginate rope. every day shift . on 4/20/20 and 4/29/20. Review of the April 2020 TAR for Resident #102 revealed missing entries for .Cleanse open areas on bilat buttocks with ns, pat dry - apply thin layer of [MEDICATION NAME]/AG wound gel. every 4 hours for protection . on 4/4/20 at 4:00 a.m., 4/5/20 at 4:00 a.m., 4/6/20 at 12:00 a.m. and 4:00 a.m., 4/10/20 at 12:00 a.m. and 4:00 a.m., 4/15/20 at 12:00 a.m. and 4:00 a.m., 4/19/20 at 4:00 a.m., 4/20/20 at 8:00 a.m. and 12:00 p.m., 4/24/20 at 4:00 p.m. and 8:00 p.m., 4/25/20 at 4:00 a.m., 4/26/20 at 4:00 p.m. and 8:00 p.m., and 4/29/20 at 8:00 a.m. and 12:00 p.m. Review of the May 2020 TAR for Resident #102 revealed missing entries for .Cleanse open areas on bilat buttocks with ns, pat dry - apply thin layer of [MEDICATION NAME]/AG wound gel. every 4 hours for protection . on 5/1/20 at 8:00 a.m., 12:00 p.m., and 4:00 p.m. In an

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 _____	05/14/2020

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) interview on 5/12/20 at 4:16 p.m., Licensed Practical Nurse (LPN) K stated in regard to Resident #102's wounds .He initially let me assess them (the buttock wounds). Once I told him the treatment, he wouldn't let me assess them again. He wouldn't let the nurses treat the wounds or assess the wounds . LPN K reported there were times when Resident #102 would allow the nursing staff to observe the buttock wounds, and stated in regard to the wounds worsening .it did progress . LPN K reported the wounds .started as moisture and shearing. He did not change positions .wouldn't turn side to side .He was very particular with his care . LPN K reported Resident #102 .was very anti-male . and preferred female caregivers. LPN K reported skin assessments were scheduled weekly, as Resident #102 would allow. LPN K reported the nurses and CNA's would notify him of changes in the condition of Resident #102's wounds. LPN K reported any refusals of care should be documented in the electronic medical record. Review of the Care Plan revealed no documentation related to Resident #102's preference for female caregivers. In an interview on 5/12/20 at 4:41 p.m., Regional Nurse Consultant LL reported Resident #102 allowed her to complete wound care to his buttock wounds on 4/26/20. Regional Nurse Consultant LL stated Resident #102 .had quite a bit of excoriation .He didn't like anyone touching him .His bottom was definitely red. Some spots were blanchable . Regional Nurse Consultant LL reported all treatments should be documented in the Treatment Administration Record (TAR) and any refusals should be documented in the TAR/Nurses notes. In an interview on 5/13/20 at 10:10 a.m., Registered Nurse (RN) PP stated in regard to Resident #102 .sometimes he makes choices that are not the right choices for good outcomes for his health, particularly when it comes to his wounds . RN PP reported Resident #102 will sometimes not allow the nurses to complete treatments as ordered, and often refuses care. RN PP reported Resident #102 has refused to allow male nurses to complete the treatments. RN PP reported wound care and refusals of wound care should be documented in the TAR. In an interview on 5/13/20 at 12:19 p.m., Certified Nursing Assistant (CNA) NO reported Resident #102 .would only accept care from certain people . CNA NO stated the wounds on Resident #102's buttocks looked .terrible . and stated .He wouldn't really let you do too much with them . In an interview on 5/13/20 at 12:39 p.m., Nurse Practitioner QR reported she worked with Resident #102 for at least the past five years, since he was admitted to the facility. Nurse Practitioner QR stated .he does have chronic wounds. He won't get out of the bed, he won't turn, he won't reposition, he refuses treatment . Nurse Practitioner QR reported Resident #102 is particular with his care, and prefers a topical gel treatment for [REDACTED]. Nurse Practitioner QR reported she assessed the resident during virtual visits on 4/24/20 and 5/1/20, and during an in person visit on 4/14/20. Nurse Practitioner QR reported Resident #102's wounds were not assessed during the visits on 4/14/20, 4/24/20, or 5/1/20. Nurse Practitioner QR stated .I wasn't informed that the wound was any different than it had been . Nurse Practitioner QR stated .it is (the facility's) responsibility to inform me when things are changing so that I can be involved . In an interview on 5/13/20 at 12:53 p.m., RN PQ reported she worked with Resident #102 on 5/1/20 when he was sent to the hospital. RN PQ reported Resident #102 preferred to be in charge and direct his own care. RN PQ reported she did not observe Resident #102's wounds on 5/1/20 but did observe the wounds on previous occasions. RN PQ stated .(Resident #102) would let us apply a barrier cream but not any other dressings . RN PQ stated .He had multiple open areas . RN PQ reported LPN K approached Resident #102 weekly to try and assess the wounds, but .He said he was having a hard time having (Resident #102) allow him to assess the wounds . RN PQ reported treatments and refusals of treatments should be documented in the TAR. In an interview on 5/13/20 at 3:55 p.m., CNA TU reported she worked with Resident #102 on 5/1/20 before he was sent to the hospital. CNA TU reported the wounds on Resident #102's buttocks appeared worsened and reported there was bleeding from the wounds. CNA TU stated .he had creams that were applied that were not effective . CNA TU stated .(Resident #102) was particular about who completes his care . In an interview on 5/14/20 at 9:21 a.m., CNA OP reported Resident #102 would only accept care from a few specific staff members. CNA OP reported on 5/1/20, Resident #102's wounds were bleeding more than normal. CNA OP stated Resident #102's wounds were .always bad . In an interview on 5/14/20 at 11:33 a.m., CNA XY reported Resident #102 preferred to be in control of his care and stated .He only liked certain people to provide care . In an interview on 5/14/20 at 12:39 p.m., Regional Nurse Consultant NN reported any treatments or refusals of treatments should be documented in the TAR. In an interview on 5/14/20 at 12:49 p.m., LPN FF reported all treatments and refusals of treatments should be documented in the TAR. In an interview on 5/14/20 at 2:41 p.m., LPN K reported Resident #102 refused all additional wound measurements after the initial measurements were completed on 1/3/20. LPN K reported the wound identified on 1/3/20 were related to moisture and shearing. LPN K reported Resident #102 had a history of [REDACTED]. LPN K reported in the weeks prior to Resident #102's discharge to the hospital he was notified that the wounds had worsened but .the resident would not allow changes (to treatments or care) or assessment (of the wounds) . LPN K reported refusals of wound treatments should be documented in the TAR with an explanation in the progress notes. LPN K reported there should not be any blank entries in the TAR. LPN K stated in regard to Resident #102's refusals of wound treatments .He was his own person and able to make his own decisions .(He is) allowed to make bad decisions . In an interview on 5/14/20 at 4:06 p.m., Director of Nursing (DON) B reported Resident #102's wounds .are pressure with a combination of moisture . Resident #101 Review of the Face Sheet revealed Resident #101 was a [AGE] year-old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of Resident #101's Minimum Data Set ((MDS) dated [DATE] revealed Resident #101 was cognitively intact. Review of Resident #101's April Treatment Administration Record (TAR) revealed the order .Cleanse Lower legs and feet with [MEDICATION NAME] solution (antimicrobial skin wash), rinse and pat dry. Apply collagen (non-adhering dressing for wounds with drainage) to both heel ulcers covered with [MEDICATION NAME] ag (cover bandage for wounds with drainage). Apply lachydrin lotion to lower legs and feet. Wrap with cotton underpad wrap, wrap with coban. DO NOT cover the toes with coban (elastic bandage). Cover toes with dry dressing. every day shift every Fri . No treatment were documented as completed for the month of April. No resident refusals of bilateral heel pressure ulcers dressing treatment were documented in Resident #101's electronic medical record (EMR) during the month of April. Review of Resident #101's wound assessment (documented on a third party wound care website) on 4/11/20 revealed he had a new .left calf .Length/Width/Depth .1.5/1.5/0.1 cm .[MEDICATION NAME] . wound. The assessment also revealed a new .right calf . Length/Width/Depth . 0.5/0.5/0.1 cm .[MEDICATION NAME] . wound. No description or diagram of the approximate location (lateral, upper, lower calf) was documented, and no staging, or wound type was documented for either calf wounds. For each calf wounds the treatment performed was .wash with [MEDICATION NAME], collage to heel and calf, foam AG to open areas, wrap with cotton underwrap . No wound treatment for [REDACTED]. No refusals of bilateral calf pressure ulcers dressing treatment were documented Resident #101's EMR during the month of April. In an interview on 5/8/20 at 3:30 PM, ICP K indicated in mid-April (4/11/20) new bilateral wounds were discovered on Resident #101's calves. ICP K indicated implemented a new dressing for the calf wounds that would be done at the same time as Resident #101's legs and heels were dressed. ICP K indicated did not document in the EMR alerting other staff that Resident #101 had new wounds or a new dressing treatment. ICP K indicated dressed and treated Resident #101's calves on heels on 4/11/20 and 4/17/20 but did not document on the TAR or in a progress notes that these treatments were done.