STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235347	A. Building B. Wing	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Zeeland	285 N State St Zeeland, MI 49464

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 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** 37573 This citation pertains to intakes M100130137 and M100130026. Based in interview and record review, the facility failed to investigate and prevent injuries of unknown origin for 1 Resident #1) resulting in the potential for abuse to be undetected, unprevented and not corrected. Findings include: Resident #1 (R1) Review of a Face Sheet revealed R1 is an [AGE] year-old female who originally admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's, contractures on all four extremities, dysphagia, and schizophreniform disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed R1 was severely cognitively impaired and required extensive assistance of one staff for cares. She had a feeding tube and no pressure ulcers and had verbal behaviors. Review of the Hospital Records dated [DATE] for R1 revealed she was transferred to the hospital for an evaluation of a newly founded femur fracture. R1 had contractures in all extremities, is nonverbal and bed bound. The hospital determined the fracture appeared to be two weeks old and the facility reported there were no falls or injuries. The hospital noted an 8 centimeter (cm) erythematous and bulge on the medial superior aspect of the right knee that had a central puncture that drained bloody fluid and tender to touch. R1appeared to have dyskinesia movements of the tongue. Bruising of the right medial knee with edema and deformity were noted. R1 was diagnosed with open fracture of distal end of femur, cellulitis of the right knee, and sepsis. The hospital acknowledged R1 had a bruise on the left side of her face about 1.5 weeks ago and the facility denied her falling at that time. Her son reported the facility was not certain how she sustained the bruise. Her feeding tube was replaced, and the notes reported the Resident pulled her feeding tube out, but given her contractures, seems unlikely. R1 expired on [DATE]. Review of a Nursing Progress note dated [DATE] for R1 revealed she had a 2.0 x1.0 maroon discoloration on her forehead. Her bed is up against a wall and combative with cares. A pillow was to be put up against the wall to protect her head when doing care. No signs or symptoms of pain. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident Report dated [DATE] for R1 revealed the resident was combative with medication administration and cares. A small discoloration was noted on her forehead that measured 2.0 x 1.0 and maroon in color. The Administrator was notified on [DATE] at 1:40 PM. The physician was notified on [DATE] at 6:11 PM. Review of several staff statements indicated there were not witnesses who saw her hit her head but said she had been combative with cares all week and jerks her head. This incident was not reported to the State Agency. Review of the Nursing Progress notes for R1 revealed on [DATE], the resident had a reddened/purple area to her right knee that was visualized to be 2 inches in diameter and not clear if it is a bruise or red from an irritant. Reported to the Unit manager on duty and notified the NP (Nurse Practitioner). On [DATE] at 7:20 AM, the reddened area to the right knee was bleeding. It was cleansed and a pressure dressing was applied. The doctor was notified in the book and report was given to the oncoming shift. On [DATE] at 1:40 PM, R1 was sent to the hospital. Review of a Skin assessment dated [DATE] for R1 was documented she had no new alterations in skin integrity but documented she did have a bruise on the outer aspect of her right knee. No further descriptions, measurements or assessments noted. Review of a Physician Progress note dated [DATE] at 10:20 AM for R1 revealed she was seen this day for her 60-day mandatory visit. Today nursing reports the patient has redness and discoloration to her right knee. Nursing denies any recent falls or trauma. On exam, her right knee is beefy red, warm, and swollen to the medial aspect of her knee. A STAT Xray and labs were ordered. Review of a Lab Result report for R1 revealed serum labs were drawn on [DATE] at 5:51 AM, received at 5:09 PM and reported at 6:14 PM. Review of a Nursing Progress note dated [DATE] at 2:35 PM for R1 revealed an Xray was completed on the right knee and showed a transverse supracondylar fracture of the femur. Review of a Nursing Progress note dated [DATE] at 2:35 PM for R1 revealed an Xray was completed on the right knee and showed a transverse supracondylar fracture of the femur. Review of an Incident Report dated [DATE] for R1 revealed there was redness noted on [DATE] and the resident was seen by the Physician Assistant on [DATE] and ordered labs and X-rays of the right knee. On [DATE] the right knee was swollen and draining fluid and the resident was sent to the hospital. R1 was diagnosed with a fracture. On Monday [DATE], the CT (computerized tomography) scan results were received, and the Administrator was notified and reported to the State Agency. The patient was unable to give a description. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Facility investigation for the [DATE] reported incident revealed through staff statements, no witnesses were found to have observed any accidents, abuse, or neglect during care for R1. Two staff statements were not completed and one of those indicated the staff member resigned. Staff witnessed the resident was able to move her right hand and knock things out of their hands. Several reported R1 was verbally abusive. One staff member reported the second shift staff reported redness/bruised knee that she saw on her third shift. No dates/times noted. Another staff member reported she saw and reported the redness/injury on [DATE]. Another staff member reported she saw the redness/injury to R1s right knee, and the nurse was aware of it. She tried to place the knee separator pad between her legs, but the resident was in pain, so she placed a folded pillow case there instead. No dates of her care and observations noted. The facility investigation concluded that physical abuse was not substantiated, and the suspected injury occurred during routine care activities secondary to R1's combative behaviors. In an interview on [DATE] at 11:10 PM, Certified Nursing Assistant (CNA) P reported when she saw R1's reddened knee, she told the nurse who no longer works at the facility now. CNA P reported R1 had mostly verbal behaviors towards staff and occasionally would try to strike out at people. The resident would usually require 2 staff for assistance. R1 was the same towards family and would sometimes argue with herself. CNA P reported she charts resident behaviors in the computer and has not seen staff treat any residents poorly. In an interview on [DATE] at 12:11 PM, the Director of Nursing (DON) reported R1 was combative with everyone and resisted everything people would do, but sometimes she was calm. At this time Behavioral Health Care notes and behavior logs requested. Review of the [DATE]MAR/TAR for R1 revealed an order to monitor behavior tracking and no documented behaviors are noted. Review of the Certified Nursing Assistant (CNA) charting of behaviors in [DATE] for R1 revealed on [DATE] the resident had behaviors of yelling, screaming, and kicking/hitting. Other days were documented with abusive language, yelling/screaming, or no behaviors. In an interview on [DATE] at 12:48 PM, Social Worker 'B reported R1 had verbal behaviors and would reject care. If she were confused or having delusions, she would tell people to get out of her room, but if she were reapproached, she could be receptive to care. She would pinch staff sometimes during care. SW B that the resident did not get Behavioral Health Care Services because she was so severely demented. They addressed her behaviors in the morning meetings with the facility's Physician Assistant. SW B reported that R1's normal baseline for behaviors was a couple times a week. Review of the last Behavioral Health progress note for R1 dated [DATE] revealed she has an allergy to Seroquel. She had no new or worsening concerns at that time but did have a list of several symptoms including but not limited to aggression during care, agitation, and anxiety. She was not considered a danger to herself or others. The follow up included continuing psychiatric services and report any new or worsening behaviors, including medication side effects. This is the last progress note for Behavioral Health Care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:48 PM, Licensed Practical Nurse (LPN) L reported R1 was bedridden and could be combative and verbally abusive to all people no matter who they were and that was her baseline. LPN L reported some of the Certified Nursing Assistants (CNA's) would take it personal until they began to know her. LPN L advised the CNAs to reapproach her if she had behaviors. R1 had a roller coaster of emotions. LPN L reported he did not see R1 hit her head on [DATE] but did see the discoloration on her forehead and notified the Unit Manager that was on call. LPN L does not recall anyone witnessing her hitting her head but is aware that she was combative that morning. The resident cannot reposition herself but thinks it could have happened when she was being repositioned, and then it would have been witnessed. In an interview on [DATE] at 2:38 PM, Unit Manager (UM) J reported R1 had dementia and was nonsensical. She could kick things or knock things out of your hands and was able to pinch people. The resident had behaviors almost every day and would expect the nurses to chart the behaviors. On [DATE] R1 had a discoloration on her forehead but not sure if it was a bruise and concluded it was from her being combative but did not witness it. When she was informed on [DATE] of R1's knee being red, she thought it may be bursitis or gout. When asked if the resident had a history of it, UM J denied it. UM J confirmed the Physician Assistant (PA) was not notified until [DATE] of the residents' knee being red and inflamed. On [DATE] her knee was bleeding. UM J reported she would expect the nursing staff do monitor, assess, and document wounds or any changes regarding a resident's care and did not know why there was limited documentation. In an interview on [DATE] at 12:12 PM, Licensed Practical Nurse (LPN) O reported on [DATE] the CNAs notified her of R1's knee and the CNAs did not know how it could have happened. LPN O reported she notified the physician by writing it down in the 24-hour physician notification book so when the physician made their rounds, they can see it in the book. LPN O reported she then told UM J who said she would look at it. LPN O reported she did palpate her knee, but it did not look abnormal and there was no pain from it. If it were more serious, LPN O reported she would then call the physicians. LPN O reported R1 had mostly verbal behaviors, but the staff worked well with her. LPN O reported she would document it in the Treatment Administration Record (TAR). LPN O did not know how R1 could have fractured her knee unless she hit the wall when the staff were taking care of her. In an interview on [DATE] at approximately 2:00 PM, Nurse Practitioner (NP) K reported she was not aware of R1 having a reddened knee but would expect staff to call the practitioners for an acute or change in condition and not just write it in the communication book. In an interview on [DATE] at 4:36 PM, the Nursing Home Administrator (NHA) reported to the State Agency and started education to staff immediately on Monday [DATE] when she heard about R1 having a fracture. The education provided is a document titled Neglect and Abuse Education and the staff sign in sheet is not dated. The education provided was 2 paragraphs on what is abuse and knowing who to contact. The education was near the employee entrance so staff can sign they received the education. The NHA reported the CNA said she was combative during care. The NHA reported if the resident is combative, they should excuse themselves from the residents' care, let the nurse know, and reapproach the resident with a different staff member. The list of staff educated and provided by the NHA looked more like a staffing signature list with no dates or title of education provided. When questioned about educating staff on how to deal with residents like R1 to prevent further injuries, there was none. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 10:30 AM, CNA N reported R1 had days when she was combative and days when she was not, and the residents' behaviors were more verbal than combative. The resident seemed to be more behavioral towards people of color. CNA N reported she worked with the day of [DATE] and told the nurse about the redness she observed on R1's knee. She did not recall seeing the knee red the day before and is not sure how or what it was from. Review of the Care Plan for R1 revealed on [DATE] a small discoloration to her forehead. Resident jerks head around at times with cares and gets angry with staff (revised [DATE]). Interventions included for maintenance to put a pad on the wall and medications to be reviewed. A pillow by the wall when turning the resident for cares to help protect the residents head due to the resident being combative with cares. On [DATE], if combative with care, stop and re-approach with an alternative care giver. Review of a Policy titled Abuse and Neglect last revised [DATE] revealed: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect, or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intakes M100130137 and M100130026. Based on observation, interview and record review, the facility failed to properly assess, monitor, document, notify the physician timely, have staff provide care within their practice, and best infection control practices for 2 (Resident #1, Resident #2), resulting in worsening/untreated conditions, a fractured knee, hospitalization s, and sepsis. Findings include: Resident #1 (R1) Review of a Face Sheet revealed R1 is an [AGE] year-old female who originally admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's, contractures on all four extremities, dysphagia, and schizophreniform disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed R1 was severely cognitively impaired and required extensive assistance of one staff for cares. She had a feeding tube and no pressure ulcers and had verbal behaviors. Review of a Change in Condition document dated [DATE] for R1 revealed her feeding tube was displaced and had an open area on her coccyx. She was sent to the hospital. Review of Hospital Records dated [DATE] for R1 revealed the facility reported to the hospital that the resident pulled out her feeding tube. The hospital replaced her feeding tube. Review of the Hospital Records dated [DATE] for R1 revealed she was transferred to the hospital for an evaluation of a newly founded femur fracture. R1 had contractures in all extremities, is nonverbal and bed bound. The hospital determined the fracture appeared to be two weeks old and the facility reported there were no falls or injuries. The hospital noted an 8 centimeter (cm) erythematous and bulge on the medial superior aspect of the right knee that had a central puncture that drained bloody fluid and tender to touch. R1 appeared to have dyskinesia movements of the tongue. Bruising of the right medial knee with edema and deformity were noted. R1 was diagnosed with open fracture of distal end of femur, cellulitis of the right knee, sepsis, dilated rectum due to fecal impaction, urinary tract infection (UTI), stage II pressure injury, obstructive hydrocephalus, protein calorie malnutrition, metabolic acidosis, elevated liver function tests likely related to infection, hyperkalemia, and covid-19 infection. Seroquel was listed as an allergy. The hospital acknowledged R1 had a bruise on the left side of her face about 1.5 weeks ago and the facility denied her falling at that time. Her son reported the facility was not certain how she sustained the bruise. Her feeding tube was replaced, and the notes reported the Resident pulled her feeding tube out, but given her contractures, seems unlikely. R1 expired on [DATE]. Review of a Nursing Progress note dated [DATE] for R1 revealed she had a 2.0 x1.0 maroon discoloration on her forehead. Her bed is up against a wall and combative with cares. A pillow was to be put up against the wall to protect her head when doing care. No signs or symptoms of pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Progress notes for R1 revealed on [DATE] a non-blanchable redness to her bilateral buttocks measuring 1x1 cm was noticed and new treatment orders were initiated and a consent for wound care was obtained. On [DATE] during wound rounds a new order put in place. On [DATE] the guardian was notified of a COVID-19 outbreak in the facility. On [DATE], the resident had a reddened/purple area to her right knee that was visualized to be 2 inches in diameter and not clear if it is a bruise or red from an irritant. Reported to the Unit manager on duty and notified the NP (Nurse Practitioner). On [DATE] at 7:20 AM, the reddened area to the right knee was bleeding. It was cleansed and a pressure dressing was applied. The doctor was notified in the book and report was given to the oncoming shift. On [DATE] at 1:40 PM, R1 was sent to the hospital. Review of a Skin assessment dated [DATE] for R1 was documented she had no new alterations in skin integrity but documented she did have a bruise on the outer aspect of her right knee. No further descriptions, measurements or assessments noted. Review of a Physician Progress note dated [DATE] at 10:20 AM for R1 revealed she was seen this day for her 60-day mandatory visit. Her allergy to Seroquel was noted and listed as a medication she is taking since [DATE]. Her stage II pressure wound is followed by wound care. She has lost 14 pounds in six months while receiving a tube feeding. Today nursing reports the patient has redness and discoloration to her right knee. Nursing denies any recent falls or trauma. On exam, her right knee is beefy red, warm, and swollen to the medial aspect of her knee. A STAT Xray and labs were ordered. Review of the [DATE] MAR/TAR for R1 revealed an order a 2-view right knee Xray STAT (as soon as possible) and a serum laboratory order on [DATE] was documented done on [DATE]. Review of a Lab Result report for R1 revealed serum labs were drawn on [DATE] at 5:51 AM, received at 5:09 PM and reported at 6:14 PM. Review of a Nursing Progress note dated [DATE] at 2:35 PM for R1 revealed an Xray was completed on the right knee and showed a transverse supracondylar fracture of the femur. Review of the [DATE] MAR/TAR for R1 revealed an order to monitor behavior tracking and no documented behaviors are noted. An order to monitor the side effects of psychotropic medications does not list symptoms such as dyskinesia, and 2 days were not documented. She is on Zoloft, Gabapentin, and Seroquel 25 milligrams (mg) twice a day for schizophreniform. Seroquel is not listed as an allergy in the electronic medical records. No COVID screening was documented since [DATE] when the family was notified of a COVID outbreak. Review of the last Behavioral Health progress note for R1 dated [DATE] revealed she has an allergy to Seroquel. She had no new or worsening concerns at that time but did have a list of several symptoms including but not limited to aggression during care, agitation, and anxiety. She was not considered a danger to herself or others. The follow up included continuing psychiatric services and report any new or worsening behaviors, including medication side effects. This is the last progress note for Behavioral Health Care. Review of the overall Care Plan for R1 revealed she had a stage 1 pressure ulcer initiated on [DATE] and revised on [DATE] with no new interventions. The care plan does not address and/or have updated and meaningful interventions including but not limited to pressure ulcers, behaviors, tube feeding, and weight loss. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 12:11 PM, the Director of Nursing (DON) reported R1 was combative with everyone and resisted everything people would do, but sometimes she was calm. At this time Behavioral Health Care notes and behavior logs requested. In an interview on [DATE] at 12:48 PM, Social Worker 'B reported R1 had verbal behaviors and would reject care. If she were confused or having delusions, she would tell people to get out of her room, but if she was reapproached, she could be receptive to care. She would pinch staff sometimes during care. SW B that the resident did not get Behavioral Health Care Services because she was so severely demented. They addressed her behaviors in the morning meetings with the facility's Physician Assistant. SW B reported that R1's normal baseline for behaviors was a couple times a week. In an interview on [DATE] at 1:48 PM, Licensed Practical Nurse (LPN) L reported R1 was bedridden and could be combative and verbally abusive to all people no matter who they were and that was her baseline. LPN L reported some of the Certified Nursing Assistants (CNA's) would take it personal until they began to know her. LPN L advised the CNAs to reapproach her if she had behaviors. R1 had a roller coaster of emotions. LPN L reported he did not see R1 hit her head on [DATE] but did see the discoloration on her forehead and notified the Unit Manager that was on call. LPN L does not recall anyone witnessing her hitting her head but is aware that she was combative that morning. The resident cannot reposition herself but thinks it could have happened when she was being repositioned, and then it would have been witnessed. In an interview on [DATE] at 2:38 PM, Unit Manager (UM) J reported R1 had dementia and was nonsensical. She could kick things or knock things out of your hands and was able to pinch people. The resident had behaviors almost every day and would expect the nurses to chart the behaviors. On [DATE] R1 had a discoloration on her forehead but not sure if it was a bruise and concluded it was from her being combative but did not witness it. When she was informed on [DATE] of R1's knee being red, she thought it may be bursitis or gout. When asked if the resident had a history of it, UM J denied it. UM J confirmed the Physician Assistant (PA) was not notified until [DATE] of the residents' knee being red and inflamed. On [DATE] her knee was bleeding. UM J reported she would expect the nursing staff do monitor, assess, and document wounds or any changes regarding a resident's care and did not know why there was limited documentation. In an interview on [DATE] at 12:12 PM, Licensed Practical Nurse (LPN) O reported on [DATE] the CNAs notified her of R1's knee and the CNAs did not know how it could have happened. LPN O reported she notified the physician by writing down the concern in the 24-hour physician notification book so when the physician made their rounds, they can see it in the book. LPN O reported she then told UM J who said she would look at it. LPN O reported she did palpate her knee, but it did not look abnormal and there was no pain from it. If it were more serious, LPN O reported she would then call the physicians. LPN O reported R1 had mostly verbal behaviors, but the staff worked well with her. LPN O reported she would document it in the Treatment Administration Record (TAR). LPN O did not know how R1 could have fractured her knee unless she hit the wall when the staff were taking care of her. In an interview on [DATE] at approximately 2:00 PM, Nurse Practitioner (NP) K reported she was not aware of R1 having a reddened knee but would expect to call the practitioners for an acute or change in condition and not just write it in the communication book. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on [DATE] at 10:30 AM, CNA N reported R1 had days when she was combative and days when she was not, and the residents' behaviors were more verbal than combative. The resident seemed to be more behavioral towards people of color. CNA N reported she worked with the day of [DATE] and told the nurse about the redness she observed on R1's knee. She did not recall seeing the knee red the day before and is not sure how or what it was from. R2 Review of a Face Sheet revealed R2 is a [AGE] year-old female who admitted to the facility on [DATE] with pertinent diagnoses of contractures on bilateral upper extremities, a persistent vegetative state, and tracheostomy. Review of the MDS for R2 dated [DATE] revealed a cognitive assessment was not done and is totally dependent on one staff for cares. During several observations on [DATE] at 8:25 AM, 10:48 AM, 2:07 PM, and 3:00 PM, R2 was in bed on her back with a pillow under her left arm with the tube feeding infusing with a tracheostomy delivering oxygen. She was in the same position during all observations. During an observation on [DATE] at 3:08 PM, CNA M when queried about the last time R2 was repositioned, she reported it was around 1:00 PM then changed her story when asked if she personally repositioned her. CNA M said she was sure the other CNA who had went home at 2:00 PM repositioned her and changed her because they are supposed to do that every 2 hours. The CNA went to R2's room at this time to reposition and check and change her. CNA M put R2's tube feeding on hold and started to change the residents brief that was soaked with urine. She tucked the brief between the residents' legs and began to turn the resident to her side but the tube feeding line limited how far she could move the resident. With the same gloved hand, she disconnected the feeding tube line from the resident and hung the uncapped tubing over the machine and continued to provide care. She reached inside her pocket with the same gloved hands she provided pericare with and applied a Periguard cream on her buttocks and applied a new brief. The CNA continued to reposition the resident touching her clothing and sheets with the same gloves. When she was done, she changed her gloves, used hand sanitizer, and reconnected the tube feed line to the resident. CNA M said the resident can take ,d+[DATE] staff to reposition her, but it depended on how many staff were available. The resident was repositioned with pillows on her right side. Review of a Nurse Practitioner Progress note dated [DATE] for R2 revealed the resident has a pressure injury on her coccyx and brown scabbing noted. The resident was soiled with stool, cleaned and the wound was observed. Wound care to address pressure injury and wound on the shin. In an interview on [DATE] at 2:54 PM, UM J reported R2 went to the hospital this day for respiratory distress and thick sputum. UM J reported she had not done a respiratory assessment earlier this day but found the resident to be absent of lung sounds on one side and implemented trach suctioning before she went to the hospital. Confirmed R2 had a stage II pressure ulcer on her coccyx and a wound on her right shin that started as a blister from when her leg boot was caught on a strap. Said the resident is to be repositioned every two hours and not sure if the CNAs are able to put the tube feeding on hold but did say they should not disconnect the line. When queried about pericare and infection control observations, UM J reported it sounded like they needed to reeducate the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235347	A. Building B. Wing	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Zeeland	285 N State St Zeeland, MI 49464

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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the [DATE] MAR/TAR ([DATE] to [DATE]) for R2 revealed an order for daily trach care and was not done for 5 days. Palm protectors not applied as ordered for 4 days. Skin prep to right inner foot/bunion daily not done for 4 days. An order to ensure additional cannulas are at bedside for airway management not documented for 5 opportunities. Pulse oximetry (oxygen saturations) every shift was ordered and not documented as done for 6 entries. Check the function of the oxygen concentrator ordered for every shift is missing 6 entries. Check tube feeding placement every shift is missing 5 days of care. Elevate the head of the bed ,d+[DATE] degrees during feeding and flushed every shift for minimizing risks is not documented as done for 5 opportunities. Oxygen ,d+[DATE] liters per minute via trach mask every shift is documented as not done for 6 entries.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for 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** 37573 This citation pertains to intakes M100130137 and M100130026. Based on observations, interview and record review, the facility failed to implement measures and prevent pressure ulcers for 2 (Resident #1, and Resident #2) resulting in the development of pressure ulcers. Findings include: Resident #1 (R1) Review of a Face Sheet revealed R1 is an [AGE] year-old female who originally admitted to the facility on [DATE] with pertinent diagnoses of Alzheimer's, contractures on all four extremities, dysphagia, and schizophreniform disorder. Review of the Minimum Data Set (MDS) dated [DATE] revealed R1 was severely cognitively impaired and required extensive assistance of one staff for cares. She had a feeding tube and no pressure ulcers and had verbal behaviors. Review of a Skin assessment dated [DATE] for R1 revealed the resident had a new stage I pressure ulcer on the right buttock that measured 1 x 1 and a stage I pressure ulcer on the left buttock that measured 1 x 1. Review of a Late entry Nursing Progress Note dated 7/2/22 and created 7/11/22 for R1 revealed she had 2 open areas by the coccyx area that measured 2.0 x 1.0 each. The physician was notified and treatment in place. The resident has an APM (alternating pressure mattress) mattress. Review of an incident report dated 7/2/22 for R1 revealed she had 2 open areas on her coccyx that measured 2.0 x 1.0 each. She was on an APM mattress already and is a tube feeder. No new interventions or information noted. Review of the Nursing Progress notes for R1 revealed on 7/6/22 a non-blanchable redness to her bilateral buttocks measuring 1x1 cm was noticed and new treatment orders were initiated and a consent for wound care was obtained. On 7/7/22 during wound rounds a new order put in place. Review of a Wound Care Progress note dated 7/7/22 for R1 revealed a stage II pressure ulcer on her left buttock that measured 1 cm x 1.5 cm width with no measurable depth, with an area of 1.5 sq cm. There is scant amount of serous drainage. Another stage II pressure ulcer noted on the right buttock that measured 1 cm x 1 cm with no measurable depth, with an area of 1 sq cm. There is scant amount of serous drainage noted with has no odor. Review of a Wound Care Progress note dated 7/14/22 for R1 revealed the onset of her pressure ulcers on her right and left buttock was reported in July 2022. Nursing staff report patient developed wounds to bilateral buttocks. Both wounds are a stage II pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physician Progress note dated 7/21/22 at 10:20 AM for R1 revealed she was seen this day for her 60-day mandatory visit. She has a stage II pressure wound on her coccyx and is followed by wound care. She is bed bound and dependent on staff for ADL's (activities of daily living). She has lost 14 pounds in six months and currently on a tube feeding. Review of the July 2022MAR/TAR for R1 revealed an order to monitor behavior tracking and no documented behaviors are noted. Review of the overall Care Plan for R1 revealed she had a stage 1 pressure ulcer initiated on 3/22/22 and revised on 7/6/22 with no new interventions. The care plan does not address and/or have updated and meaningful interventions including but not limited to pressure ulcers, behaviors, tube feeding, and weight loss. Resident #2 (R2) Review of a Face Sheet revealed R2 is a [AGE] year-old female who admitted to the facility on [DATE] with pertinent diagnoses of contractures on bilateral upper extremities, a persistent vegetative state, and tracheostomy. Review of the MDS for R2 dated 6/22/22 revealed a cognitive assessment was not done and is dependent on one staff for cares. During several observations on 8/17/22 at 8:25 AM, 10:48 AM, 2:07 PM, and 3:00 PM, R2 was in bed on her back with a pillow under her left arm with the tube feeding infusing with a tracheostomy delivering oxygen. She was in the same position during all observations. During an observation and an interview on 8/17/22 at 3:08 PM, CNA M when queried about the last time R2 was repositioned, she reported it was around 1:00 PM then changed her story when asked if she personally repositioned her. CNA M said she was sure the other CNA who had went home at 2:00 PM repositioned her and changed her because they are supposed to do that every 2 hours. The CNA went to R2's room at this time to reposition and check and change her. CNA M put R2's tube feeding on hold and started to change the residents brief that was soaked with urine. CNA M said the resident can take 1-2 staff to reposition her, but it depended on how many staff were available. The resident was cleaned and repositioned with pillows on her right side. Review of an incident report dated 7/22/22 for R2 revealed the resident had an open area on her coccyx. Review of a Nursing Progress note dated 7/22/22 for R2 revealed an open area on her coccyx that measured 1 x 1 x 0.01 cm. Wound care was notified. The resident is on an APM mattress and uses repositioning pillows for offloading. The head of the bed is elevated related to her tube feeding for nutrition. Review of a Wound Care Progress note dated 7/28/22 for R2 revealed she had a stage II pressure ulcer that measured 2.1 cm x 1.5 cm width with no measurable depth, with an area of 3.15 sq cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Wound Care Progress note dated 8/5/22 for R2 revealed she had stage II sacral pressure ulcer that measured 0.7 cm x 0.7 cm width with no measurable depth with an area of 0.49 sq cm. There is scan amount of sero-sanguineous drainage noted. Review of a Nurse Practitioner Progress note dated 8/10/22 for R2 revealed the resident has a pressure injury on her coccyx and brown scabbing noted. The resident was soiled with stool, cleaned and the wound was observed. Wound care to address pressure injury and wound on the shin. Review of a Nursing Progress note dated 8/10/22 for R2 revealed a protective boot strap was pinching the skin, blister was noted when the boots were removed. Geri-legs were placed on the resident and the protective boots reapplied. Mepilex every 3 days and as needed. Review of a Wound Care Progress noted dated 8/11/22 for R2 revealed a stage II sacral pressure ulcer that measured 0.9 cm x 0.7 cm width with no measurable depth, with an area of 0.63 sq cm. The wound continues to evolve. Increased surface area but wound clinically unchanged. The right medial shin is a stage II pressure ulcer that measured 2 cm x 1.7 cm width with no measurable depth, with an area of 3.4 sq cm. Review of the July 2022 Medication Administration and Treatment Administration Record (MAR/TAR) for R2 revealed orders for a palm protector and a blue carrot splint every morning documented not done 7 days. Skin prep to the right inner foot/bunion for wound care not done for 7 days. Review of the August 2022 MAR/TAR (8/1/22 to 8/17/22) for R2 revealed 2 different orders for treatment to her right shin to start 8/10/22 and again on 8/12/22, treatment was not documented done until 8/15/22. Wound care for the right side of her neck (unclear what type of wound) was not done for 5 days. Geri leg sleeves on bilateral legs for protection every shift not documented done for 5 opportunities. Right inner foot/bunion to have skin prep daily for wound care not documented for 4 days. In an interview on 8/18/22 at 2:54 PM, UM J confirmed R2 had a stage II pressure ulcer on her coccyx and a wound on her right shin that started as a blister from when her leg boot was caught on a strap. She reported the resident is to be repositioned every two hours.