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	09/24/2021

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36090 This citation pertains to intake MI00122040 Based on observation, interview, and record review, the facility failed to ensure respectful/dignified care and treatment for three Residents (R 7, R 53, R 104) out of 34 residents reviewed for dignity. This deficient practice resulted in frustration, anxiety, and potential for feelings of helplessness, depression, embarrassment, and loss of self-worth. Findings include: R 7 According to the Minimum Data Set (MDS) assessment, dated 6/12/21, R 7 admitted to the facility with multiple diagnosis including low back pain, difficulty walking, and rheumatoid arthritis. This same assessment indicated R 7 required assistance of staff for moving in bed, transferring, and hygiene needs including using the bathroom. Staff assessed R 7 as cognitively intact, and R 7 made their own health care decisions. Review of an Employee to Resident report dated 7/17/21, R 7 reported to therapy (staff) an altercation with her nurse the evening prior regarding her medications. She stated she felt the interaction was confrontational in nature and resident stating that she had asked for her tramadol (pain medication) twice it is scheduled at 5 am and she did not receive it until 5:40 am. The facility investigation concluded that the allegation of abuse was not substantiated. The facility investigation included R 7's July 2021 Medication Administration Record (MAR) that indicted on 7/15/21, R 7 began taking tramadol four times daily. In the prior two weeks, R 7 used tramadol on average 2. 5 times daily when used as a on needed basis versus scheduled four times daily. (continued on next page)

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

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	09/24/2021

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R 7's progress notes authored by Licensed Practical Nurse (LPN) C on 7/16/21 at 23:55, read, Res (resident) turned her light on at approximately 2250 and CNA (Certified Nursing Assistant) answered her call light and res told CNA that her Tramadol is due at 2300 and will want it then. Res put her light on again and told CNA that she was ready for her 2300 Tramadol and CNA informed res that this nurse was on break. It was 2304. Res turned her light on again at approximately 2330. This nurse was getting her scheduled 2300 Tramadol and her scheduled 0000 Gabapentin. This nurse knocked and walked up to res'(sic) bed. Res asked this nurse why it took 45 mins to get her pain pill that was due at 2300 when she asked for it. This nurse told res that this nurse was on break and then explained to the res that she has until 0000 to administer it. This nurse asked res what the CNA had told her when CNA answered the light the first time and res said I will let the nurse know. This nurse asked res what was told to her the second time CNA answered her call light and res said I don't know. She said the same thing, I will let the nurse know. This nurse told res that this nurse will talk to the CNA about not informing her that his nurse was on lunch. Res got very upset and said well then I will report you tomorrow! You have been a bitch to me ever since I've been here! This nurse asked howand (sic) res said You made me wait 2 hours for a pain pill and that's why I have them scheduled now. You didn't want to hear when I was trying to tell you the times that my pain meds were due. This nurse explained to the res that this nurse doesn't keep track of time when a res will be in pain at the exact time her next PRN pain pill would be available again. Res started yelling get out of my room you f*ck*ng Bitch. I can't believe you're such a bitch! I don't care if they don't have enough nurses here, but we'll see if you're still here after I report you. This nurse left he room and started writing this report. During an interview on 9/23/21 at 10:14 AM, LPN C confirmed she recalled the above interaction with R 7 and stated that Certified Nursing Assistant (CNA) D was also present. LPN C stated that her progress notes accurately reflect the events that occurred and stated, I told her (R 7) when it (medication) is PRN (as needed) we (staff) do not come at the time it is due and ask if she needs it, she needs to call us. She cannot tell us she has pain four hours from now. An interview on 9/23/21 at 12:30 PM, CNA D recalled the situation occurring on the evening of 7/16/21 between R 7 and LPN C. CNA D recalled telling LPN C twice that R 7 wanted pain medications and the third time R 7 called for pain medications, the nurse took them to R 7. CNA D stated the R 7 started taking scheduled pain medication after this event. CNA D was not in the room at the time R 7 and LPN C had the verbal altercation, however, CNA D stated she could hear a loud altercation between both R 7 and LPN C. R 7 was cussing. CNA D stated, Anyone that takes care of her (R 7) knows that she wants her meds (medications) when she requests it. I feel she should have gotten her meds without having to ask for it three times; that's ridiculous, we (evening shift) aren't that busy. CNA D stated that management staff told her that if that situation ever occurs again staff are expected to go into the resident room, tell the nurse to stop, and get another nurse to handle the situation. R 7 was not available during this survey for interviews regarding this situation. R 7 reported on 9/12/21 during initial rounds beginning at 9:40 AM that they were not afraid of anyone within the facility. 29073 Dining Observation (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	09/24/2021

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/22/2021 at 8:48 a.m., Licensed Practical Nurse (LPN) L was observed standing over Resident #53 while she assisted her to eat. After standing over R53 while assisting R53 to eat and drink for several minutes, LPN L asked Registered Nurse (RN) N to assist R53 to eat. RN N did not obtain a chair to sit at eye level with R53 while she assisted the resident to eat. During an observation on 9/22/21 at 8:52 a.m., Certified Nurse Aide (CNA) I was observed leaning over Resident #104 while assisting her with setting up her food. CNA I then offered food to R104 while standing over the resident.

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	09/24/2021

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed to ensure an appropriately activated Power of Attorney (POA) was in place for 1 resident (Resident #83) when two physicians did not carry out a competency evaluation in a timely manner resulting in the potential for inappropriate delegation of resident rights to a person not formally authorized to make decisions on behalf of the resident. Findings: Review of an Admission Record reflected Resident #83 (R83) originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, adult failure to thrive, diabetes, sleep apnea, high blood pressure, weakness, hearing loss and cognitive communication deficit. Review of a Durable Power of Attorney for Healthcare Decisions executed by R83 on 9/13/2017 reflected For medical treatment decisions, the authority conferred hereunder shall be exercisable only when I am unable to give informed consent to medical decisions as determined by my attending physician and another physician or licensed psychologist who after examination of me shall state this determination in writing, shall make the determination part of my medical record, and shall review the determination not less than annually. The document specifies, If a physician or mental health practitioner designated by me is unable or unwilling to conduct the examination and make the determination required herein within a reasonable time, the examination and determination shall be made by another physician or mental health practitioner, as applicable. Pages 10 of the document was titled Certificate of Inability to Participate in Medical Treatment Decisions and was blank, not signed by either a physician or a licensed psychologist. Review of a form ACP (Advanced Care Planning) dated 3/7/2021 reflected a hospital physician initiated the first step in a competency evaluation for R83 with a note titled Advanced Care Planning DPOAH Activation - First sign and wrote the following: I have personally examined the patient and have determined that he is unable to receive and evaluate information effectively, and communicate decisions necessary to manage his health care. I recommend that the provisions contained in his Power of Attorney for Heath Care be activated. Review of a form Annual Review of Determination of Inability to Participate in Complex Decision Making was signed by the facility Medical Director and attending physician for R83 on 9/15/2021, more than six months since the first competency evaluation was completed. The statement did not specify whether R83 was competent or not for making medical decisions as evidenced by the following statement on the form: I have evaluated [R83] and based on my observations, evaluation and professional opinion, he/she IS/IS NOT (circle one) able to make medical treatment and/or financial decisions IS/IS NOT (circle one) able to participate in making medical treatment or financial decisions. The MD did not select a response. The section of the form for a second attending physician or licensed psychologist to indicate a competency evaluation directed the reader to a note from the hospital/outside physician dated 3/7/2021. A check mark next to a statement Continue DPOA was dated 9/15/2021. (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	09/24/2021

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email communication sent to the State Agency by the Director of Nursing (DON) dated 9/21/21 at 12:34 p.m. reflected Social Work will complete a BIMS assessment. If the score is borderline or concerning, additional cognitive assessments are requested from therapy. Two physicians then need to review and make the decision to invoke POA. There is no clear time frame for this process, however we do in good faith attempt to be as prompt as possible. During an interview on 9/21/21 at 12:46, facility Social Worker (SW) E said a competency evaluation should be done in close proximity to the first determination as possible. SW E said that a competency evaluation should not be done 6 months apart from each professional evaluation.

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	09/24/2021

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect, for 1 resident (Resident #52) and all residents residents residing on 300 hall, resulting in poor sleep for R52 and the potential for residents on 300 hall to feel that staff did not want to care for them. Findings: Resident #52 (R52) Review of an Admission Record revealed R52 was a [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnoses of insomnia and pain. According to the medical record, R52 was able to communicate with staff and make concerns known. During an interview on 09/15/21 at 11:45 A.M., R52 reported the following: (a) during the resident council meeting in May 2021, R52 voiced concerns about third shift staff being loud and waking up the resident in the middle of the night, (b) the third shift staff continued to be noisy and wake the resident up in the middle of the night, (c) R52 made another complaint during the resident council meeting in August 2021, about the third shift staff being too loud, (d) staff continue to be very loud during third shift, especially the past two nights, and (e) R52 expressed frustration with this matter because it took the resident two to three hours to get back to sleep after being woke up in the middle of the night, and the resident did not feel very good the next day, after being woke up in the middle of the night by noisy staff. During an observation on 09/15/21 at 8:00 A.M., and while sitting in the small TV room across from room [ROOM NUMBER], this surveyor heard staff person ZZ respond to another unidentified staff person's question about whether or not an agency aide was going to show up for work that day by saying, no she was here but found out her schedule was down here so she left. The other unidentified staff person responded, I don't blame her. This conversation was heard from inside a day room on the 300 hall.

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	09/24/2021

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to MI000122488 Based on observation, interview, and record review, the facility failed to maintain call lights within reach for 4 residents (Resident #2, Resident #111, Resident #105, Resident #4), resulting in the potential for unmet resident needs and falls. Findings: Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year old female, most recently admitted to the facility on [DATE], with a pertinent diagnosis of Multiple Sclerosis. A Minimum Data Set (MDS) assessment, completed 09/03/21, revealed R2 requires extensive assistance from at least one staff person to meet all of the activities of daily living. R2 had impaired mobility of both upper and lower bilateral extremities and was always incontinent of bowel and bladder. During an observation on 09/14/21 at 11:00 A.M., R2 laid in bed resting with eyes closed. The call light cord hung over the left hand rail that was attached to the bed, and the touch pad itself hung below the mattress, almost to the floor, out of reach of the resident. During an observation on 09/14/21 at 12:12 P.M., R2 sat up in bed, lunch tray rested on top of the over the bed table, and the call light cord hung over the left hand rail, and the touch pad hung below the mattress, out of reach of the resident. During an interview at that time, R2 indicated not being able to activate the call light unless it was next to the left shoulder. During an observation on 09/14/21 at 4:00 P.M., R2 laid resting in bed, the call light cord hung over the left hand rail, and the touch pad hung below the mattress out of reach of the resident. R2 stated that staff had been in a couple of times since 11:00 A.M., to feed R2 lunch and then again to get R2 changed and cleaned up. During an observation on 09/15/21 at 7:43 A.M., R2 rested in bed, call light cord remained hung over the left side rail, touch pad out of reach of the resident and almost touching the floor. R2 indicated being changed by staff in the middle of the night, had not been changed since then and was currently wet and needed to be changed again, but cannot call for staff due to the call light placement. During an observation on 09/15/21 at 11:43 A.M., R2 sat awake in bed and the call light hung over the left side rail out of reach of the resident. During an observation on 09/15/21 at 3:24 P.M., R2 sat awake in bed, indicated being wet and needing to be changed but cannot locate the call light. Call light cord remained over the left bed rail and touch pad hung below the mattress, almost to the floor, out of reach of the resident. R2 stated please get staff to come change me. (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	09/24/2021

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/15/21 at 4:11 P.M., R2's call light hung over the left bed rail, the touch pad almost touched the floor, and was out of reach of the resident. At this point, due to ongoing safety concerns for R2, the DON was summoned to R2's room and the above observations from past 24 hours were shared with the DON. Resident #111 (R111) Review of an Admission Record revealed R111 was an [AGE] year old female, originally admitted to the facility with pertinent diagnoses of dementia, cognitive communication deficit, weakness, and history of falls. During observations on 09/21/21 at 07:50 A.M. and 08:34 A.M., R111's call light was out of reach near the foot of the bed. Resident #105 (R105) Review of an Admission Record revealed R105 was a [AGE] year-old male, with pertinent diagnoses of hepatitis, a fractured rib, nose bleeds, low sodium levels, and a stage 2 pressure wound on bilateral buttocks. A Minimum Data Set (MDS) assessment, completed 07/26/21, reflected R105 required extensive assistance from staff for bed mobility, transfers, and going to the bathroom. Eating was listed as supervision and 1-person physical assist. Review of a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated that R105 was cognitively intact. During an observation on 09/15/21 at 7:49 A.M. R105's call light sat on the floor near the foot of the bed, out of reach of the resident. Resident #4 (R4) Review of an Admission Record revealed R4 was a [AGE] year old male with pertinent diagnoses of vascular dementia, history of a nontraumatic intracranial bleed, lack of coordination, retention of urine, and muscle weakness. During an observation on 09/15/21 at 7:55 A.M., R4's call light was clipped to the bed sheet, just above the left shoulder. When asked if R4 could find the call light, R4 shook head no. Review of a Kardex for R4 reflected the following: be sure call light is within reach.

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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to MI000121396 & MI000122658) This citation has two deficient practice statements. Statement A. Based on observation, interview and record review the facility failed to comprehensively assess residents and develop and implement person centered care plans to meet medical and nursing needs for 3 residents (Resident #83, Resident #104 and Resident #113) resulting in (a) harm from avoidable falls, and (b) the potential for serious harm when staff failed to implement interventions based on known risk factors (falls and pressure injuries). Findings: Resident #83 (R83) Review of an Admission Record reflected Resident #83 (R83) originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, adult failure to thrive, diabetes, sleep apnea, high blood pressure, weakness, hearing loss, and cognitive communication deficit. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R83 had short and long-term memory problems and required limited assistance from one person for transfers, walking, toilet use and personal hygiene. The assessment also indicated R83 was not steady moving from a seated to standing position nor moving off the toilet. Section H - Bowel and Bladder reflected R83 did not use a catheter, did not require intermittent catheterization, was not on a toileting program (such as scheduled toileting, prompted voiding or bladder training) and was only occasionally incontinent of urine and never incontinent for bowel movements. Section M-Skin Conditions reflected R83 was at risk for developing pressure ulcers but did not have any pressure sores at the time of the assessment. All policies and procedures pertaining to Falls, Fall Prevention/Fall Program and related protocols, including the Yellow Dot protocol etc. were requested from the Director of Nursing (DON) on 9/22/21 at 9:56 A.M. Review of an email communication sent by the DON on 9/22/21 at 11:21 A.M. reflected an explanation of the Yellow Dot protocol, Yellow Dot - is a tool we use to identify those who are at highest risk for falling when left up in a chair unsupervised. No formal protocol for the facility's Yellow-Dot protocol was provided. Review of incident and accident reports for R83 for the date range 5/13/21-7/23/21 reflected the following: (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	-On 5/13/21 at 10:30 A.M., R83 had an unwitnessed fall in the resident's room without injury. According to the report, R83 had been lying in bed and appeared to be sleeping 30 minutes prior to the fall. The resident told staff he was trying to take himself to the bathroom. A General Progress Note dated 5/17/21 detailed an IDT (interdisciplinary team) Fall review and reflected Resident impulsive and will not ask for assistance. A therapy screen was requested as an intervention to prevent future falls. -On 5/14/21 at 7:29 A.M., R83 had an unwitnessed fall in his room without injury and was found kneeling on the floor, with the rest of his body on his bed. The resident was unable to state what happened. A General Progress Note dated 5/26/21 detailed an IDT Fall review and reflected Had grippys on. Resident will self-transfer. Grippy Strips to be applied to the floor as an intervention to prevent future falls. -On 6/12/21 at 2:50 P.M., R83 had an unwitnessed fall in the doorway of his room without injury. R83 reported he was trying to unplug something. Review of a General Progress Note dated 6/17/21 detailed an IDT fall review and reflected [R83] had been sitting in his chair prior. Floor was dry, resident had grippy socks on . increased confusion this shift . R83 was encouraged to come out into common area, in addition to having STAT (urgent) labs drawn related to R83's increased confusion. -On 7/4/21 at 4:40 P.M., R83 had an unwitnessed fall in his room without injury. R83 was unable to state what happened. Review of a General Progress Note dated 7/13/21 detailed an IDT fall review and reflected R83 had apparently attempted to self-transfer from his bed to his recliner chair. The IDT review indicated R83 Had shoes on. Resident did not use his walker. Self-transferred to his recliner and lost balance. A soft touch call light was to be placed next to R83 to alert staff of attempts to get up unassisted. -On 7/23/21 at 12:51 P.M., R83 had an unwitnessed fall in the bathroom and sustained a right hip fracture. Review of a General Progress Note dated 7/28/21 reflected an IDT fall review that indicated Resident can be confused and impulsive at times .x-ray ordered and showed right hip fracture. Was sent out to hospital. [R83] readmitted under hospice care . The intervention added to the plan of care was for R83 to wear grippy sock at all times. -On 7/29/21 at 5:45 A.M., R83 had an unwitnessed fall in his room. R83 was unable to describe what happened. Review of a General Progress Note dated 8/3/21 detailed an IDT fall review that indicated Resident has a recliner next to his bed. Roommate sitting in recliner. Resident was confused and attempted to get up. Resident is under hospice care. Is impulsive. Has a right hip fracture. All interventions were in place. Intervention was to remove recliner from resident's room. Mat added next to bed. Bed in ultra-low position. (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	Review of a Care Plan Report initiated on 3/9/21 reflected [R83] is at risk for falls r/t failure to thrive, new environment, dementia, DM2, self-transfers/ambulates, hearing loss, OSA (obstructive sleep apnea). Resident is impulsive and will not wait for assistance. Will refuse at times to come out of room, will move call light. The goal of the care plan focus area was for R83 to remain free from fall related injury. Some active interventions were contradictory, as evidenced by the following: (a) Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition, Resident has standard call light, able to use-initiated on 3/9/21; (b) soft-touch call light next to resident (no further instructions provided)-initiated on 7/4/21. Further review of the Care Plan did not reflect any interventions or approaches were in place to address R83's impulsive nature or cognitive impairments. The care plan did not specify R83's assessed high risk for falling nor mention the Yellow Dot protocol described by the DON, despite all falls occurring while in his room/chair and unsupervised. Review of a Care Plan Report reflected [R83] had an ADL self-care performance deficit r/t (related to) dementia, failure to thrive, prostate cancer, DM2 (type 2 diabetes), and hearing loss . initiated on 3/9/21, revised on 9/13/21. The goals of the Care Plan, initiated on 3/9/21 and revised on 8/3/21 were for R83 to maintain his current level of function and participate in ADL tasks with therapy services as ordered to maintain prior level of functioning. Interventions to meet the stated goals included Ambulation with 1 assist RW (rolling walker); Transfers: 1 assist with R/walker needs encouragement and were not initiated until after R83 returned from the hospital with a fractured right hip on 7/25/21 and were Resolved on 7/28/21. There was an intervention added on 5/18/21 PTV (prompt to void) but did not elaborate on how frequently R83 would need prompting. Review of a Care Plan Report reflected that on 3/9/21 R83 was assessed as having Limited physical mobility related to dementia, failure to thrive, prostate cancer, diabetes and hearing loss. The goal of the care plan was for R83 to maintain his current level of mobility with increases as able, with participation in therapy and/or nursing with interventions that included Transfer: 1 assist with 2WW (2-wheeled walker) and gait belt. The intervention was not resolved until 7/28/21 after R83 sustained right hip fracture after a fall at the facility. Review of Braden Scale for Predicting Pressure Sore Risk assessments dated 7/25/21, 8/12/21 and 8/20/21 reflected that R83 had a moderate risk for developing a pressure sore. Review of a Care Plan Report reflected that when R83 admitted to the facility on [DATE], a care plan focus area read Resident has potential to skin integrity r/t dementia, DM2 (type 2 diabetes), PVD (peripheral vascular disease), self-transfers, failure to thrive. The goal of the care plan was Resident will maintain intact skin with no breaks in skin through the next review date. Interventions to reach the goal of maintaining intact skin were: (a) Educate resident/family/caregivers of causative factors and measures to prevent skin injury, (b) Encourage good nutrition and hydration in order to promote healthier skin, (c) Observe skin daily with care activities, report any changes in coloration/integrity etc., to nurse, and (d) Resident needs pressure reduction interventions: (SPECIFY-mattress type, specialty bed, wheelchair cushion, etc.). The care plan did not specify any pressure reducing interventions. (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	Further review of the entire Care Plan Report revealed facility staff had identified focus areas that included: Resident has limited physical mobility r/t (related to) dementia, failure to thrive, prostate cancer, DM2, and hearing loss; None (sic) weight bearing with the goal of keeping R83 comfortable and an intervention to reposition for comfort. The Care Plan Report did not reflect that facility nursing staff had care planned R83's assessed risk for pressure ulcers due to his lack of mobility and being completely bed bound with new bowel incontinence. During a telephone interview on 9/13/21 at 1:54 P.M., R83's Family Member (FM) XX reported that she had just come from the facility after having assisted R83 with his noon meal. FM XX said that she would like to see R83 get out of bed, explaining that he has been bed-bound ever since he broke his hip in a fall at the facility on 7/23/21. FM XX said she had made the suggestion to the hospice staff that see R83 but had not told staff at the facility because they are so busy. FM XX said it was concerning to her because he had a little bedsore on the top of his tailbone, and she would like that treated. During an observation and interview on 9/14/21 at 12:09 P.M., Licensed Practical Nurse (LPN) L said she was not aware of any open areas on R83's coccyx and agreed to assess R83's skin. CNA I assisted in positioning R83 and reported being aware of an open area on R83's coccygeal area and had reported it to another nurse (LPN J) a few weeks ago. Upon entering the room, R83 agreed to the observation and CNA I pointed to individual packets of ointment the CNAs were putting on the open area on R83's coccygeal area. LPN L reported the area was indeed open and measured a 1.0 cm x 0.5 cm area. Additional assessment of R83's skin revealed a small, reddened area on the left second toe, the skin on R83's feet was very dry. Resident #104 (R104) Review of an Admission Record reflected R104 originally admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, delusional disorders, heart failure, adjustment disorder, pain, overactive bladder, and unsteadiness on feet. Review of a quarterly MDS assessment dated [DATE] reflected R104 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 2/15. R104 needed extensive assistance from two people for bed mobility, transfers, walking in a room or in a corridor, toilet use and personal hygiene. Review of a Care Plan Report initiated on 6/22/2019, last revised 6/29/21, reflected R104 had an ADL self-care performance deficit related to weakness, dementia, [R104] can be combative with cares, R104 was 1 assist with bathing and dressing, was independent with transfer and assist as needed and toileting with staff cueing and supervision. Will get combative when staff attempt to assist . The goal of the care plan was for R104 to participate in ADL tasks with interventions that specified AMBULATION: Extensive 2 assist with walking; resident able to ambulate with 2 assists to the dining room. An active care plan intervention conflicted with the Care Plan Focus area statement that the resident was independent with transfers and reflected TRANSFERS: 2 assist tires easily was initiated on 6/23/2019 and revised 4/07/2021. (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	Review of a hospice Care Plan P070: Safety/Fall Prevention reflected the goal was to have R104's safety maintained as evidenced by patient free from injury due to fall through 10/9/2021. An intervention to attain the goal was for Staff to provide 2 person assist with gait belt for ambulation and transfers. During an observation on 9/22/21 at 8:52 A.M., LPN K and CNA I transferred/ambulated R104 from her room to a chair located down the hall several yards away, across from the main dining room. LPN K and CNA I did not use a gait belt, instead, supported/lifted the resident under her arms while the resident did not bear full weight on her legs and feet. Resident #113 (R113) Review of an Admission Record reflected R113 admitted to the facility on [DATE] with diagnoses that included acquired absence of the left leg below the knee, end stage renal disease, dependence on renal dialysis, chronic fatigue, low back pain, lack of coordination, and cognitive communication deficit. Review of a quarterly MDS report dated 8/26/2021 reflected R113 was cognitively intact as evidenced by a BIMS score of 15/15 and needed extensive assistance from two people for bed mobility, transfers, dressing and personal hygiene. During a telephone interview on 9/24/21 at 10:24 A.M., LPN OO reported helping an unknown CNA with transferring R113 from the bed to the commode using a slide board. LPN OO said that at no time did R113 fall but did describe R113 not being any assistance during the transfer and having to literally drag R113 across the slide board to the commode. LPN OO said R113 was care planned to transfer using the slide board as far as LPN OO was aware but did not look at the care plan to confirm R113's transfer status. During a telephone interview on 9/24/21 at 10:36 A.M., CNA D reported that an unknown CNA had come to her asking for assistance with transferring R113, but another call light went off and was unable to help, so the unknown CNA requested the assistance of LPN OO. According to CNA D, LPN OO did assist the unknown CNA in transferring R113 from her bed to the commode and after completing that transfer, LPN OO asked CNA D to complete the transfer of R113 from the commode back to bed because the first transfer did not go well. According to CNA D, a gait belt was used for the second slide board transfer back to bed because without it, (R113) could have fallen. CNA D indicated the transfer status was reflected on the Kardex (care guide), but that the transfers with R113 were very rough because the resident would not help at all, and staff would have to use a lot of muscle. Review of PT-Therapist Progress & Updated Plan of Care, dated 8/29/21 for R113 for review dates 8/01/2021-8/30/2021 and signed by Physical Therapist (PT) RR, reflected R113's prior level of functioning for transfers from bed to chair was minimal assistance (1-25% assist). According to the form, R113's current level of functions as of 8/29/21 was dependent (100% assist). (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	During an interview on 9/24/21 at 10:51 A.M., Occupational Therapist (OT) QQ indicated completing an initial therapy transfer status evaluation for R113 on 7/30/21, the day R113 admitted to the facility. According to OT QQ, R113 was able to complete the slide board transfer with one assist but was under the impression that staff had downgraded R113's transfer status to Hoyer (full mechanical lift) a few months ago due to her refusal to assist with slide board transfers. OT QQ said that in the times that she worked with R113 since the initial assessment, R113 had been using the bed pan for elimination. During an interview on 9/24/21 at 10:55 A.M., PT RR reported not working the day R113 admitted to the facility and that the times she worked with the resident, R113 was using a bed pan for elimination and said it was her understanding that staff had downgraded her from a slide board transfer to a Hoyer transfer, but a communication had not been made about it. PT RR reported that in any case, anytime a staff assists a resident with a transfer or with ambulation a gait belt is to be used. PT RR said that R113 would often refuse to complete slide board transfers with nursing staff but would do it for therapy staff. Review of a Care Plan Report that included resolved/discontinued focus areas and interventions reflected R113 Had an ADL self-care performance deficit r/t BKA (below the knee amputation) of left leg. I will refuse care, treatment, assessments, and therapy at times despite education and encouragement from staff. The goal of the care plan was for R113 to participate in ADL tasks with therapy services as ordered to attain and maintain prior level of function. Interventions included, TOLIET USE: 2 assist with Hoyer, initiated on 5/24/21 and revised on 8/27/21. No evidence R113 was ever a slide board for transfers was found anywhere in the care plan. 31771 Statement B. Based on observation, interview, and record review the facility failed to implement the comprehensive care plan for a deconditioned and medically compromised resident (Resident #9) and implement measures to improve or maintain mobility, resulting in degradation of a sacral skin condition which progressed to a stage 4 pressure sore, further preventing the resident from obtaining the highest practicable level of well-being and the potential for all facility residents dependent on staff for mobility from reaching their highest practicable well-being. Findings: Resident #9 (R9) was originally admitted to the facility 7/24/20 and had diagnoses that included: Diabetes Mellitus, Respiratory Failure, and Stroke. Review of the Minimum Data Set (MDS) Section M titled skin conditions dated 2/19/21 reflected R9 did not have a Stage 1 or greater pressure sore. The Braden Scale assessment (an industry method of predicting pressure sore risk) dated 3/4/21 reflected a score of 13 which indicated R9 was at moderate risk for developing pressure sores. (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record revealed a Progress Note entry dated 2/8/21 at 2:42 P.M. that reflected R9 was readmitted following an extended admission for treatment of covid 19. The documentation reflected R9 was deconditioned and had Moisture Associated Skin Damage (MASD) to the bilateral buttocks. The Progress Note did not reflect measurements. The Progress Notes later reflected R9 was admitted to the hospital on 2/19/21 and returned to the facility on [DATE] with a dressing on the sacrum. On 2/26/21 three Progress Note entries (2:07 PM, 2:09 PM, and 2:11 PM) reflected three wound evaluations on the sacrum and left and right buttocks with measurements. All entries described the wounds as MASD. Review of the hospital documentation dated 2/19/21 reflected R9 arrived at the ED with a large sacral decubitus ulcer that included a photograph of the ulcer and a large area of possible MASD. The hospital documentation reflected that the sacral decubitus ulcer and surrounding cellulitis as a possible source of sepsis. Despite the hospital physician's documentation and photograph on 2/19/21 of the decubitus ulcer, facility documentation after 2/25/21 consistently reflected that R9 wounds are MASD. The EMR (electronic medical record) Progress Notes reflect R9 was transferred to the hospital on 4/29/21 and returned to the facility on [DATE]. The EMR Progress Notes revealed a wound assessment, dated 5/5/21 at 9:20 PM, Wound location is Sacrum. Wound measurements .Length-5.4 centimeters (cm), Width -3.7 cm, Depth - 4.5 cm (approx. 1 1/2 inches in depth). A Progress Note entry on 5/5/21 at 11:16 PM further describes the wound on the sacrum as, sacrum , stage 4, undermining present, slough . hanging off ., Bones and tendons are exposed EMR Medical Provider documentation of 5/12/21 at 1:45 PM reflected that R9 was hospitalized [DATE] for sepsis probably related to a stage IV sacral wound, . prognosis for (R9) is poor. The following Care Plan and EMR Progress Note review was confined to the dates from 2/8/21 to 4/29/21 during which time degradation of the sacral wound is documented. On 2/26/21 total sacral wound area was documented as 2.8 cm2 with a depth of 0.2 cm . On 4/20/21 the total area was documented at 7.8 cm2 and 1. 3 cm in depth. Review of the care plan titled, Resident has limited mobility related to . was reviewed with a goal of Resident will maintain current level of mobility with increase as able with participation in therapy and/or nursing through review date. Initiated on 2/10/21, canceled on 2/22/21, and reinstated on 2/25/21 and canceled again on 4/29/21. The Care Plan reflects interventions that R9 was full weight bearing, with a transfer status of Dependent with Hoyer (lift) and two staff assist, provide mobility assistive devices for mobility; Geri chair implemented on 2/10/21 with cancellations and reinstated as listed above. Review of the EMR Progress Notes from 2/8/21 to 4/29/21 did not reveal R9 was transferred out of the bed or that attempts were made to promote full weight bearing or use of the Geri chair despite Care Planned interventions to do so. The Progress Notes did not reveal efforts were implemented to, maintain current level of mobility with increase as able, nor was documentation found in the Progress Notes that the interventions were attempted or why it had not be implemented. (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	09/24/2021

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 0656 Level of Harm - Actual harm Residents Affected - Some	Review of the Care Plan titled Resident has potential/actual impairment to skin integrity (related to) old (tracheostomy) site to neck . MASD both buttock . initiated 2/10/21, canceled 2/22/21, reinstated on 2/25/21, and canceled on 4/29/21. Interventions included Resident needs pressure reduction interventions: wheelchair cushion and pressure reduction mattress with similar revision and cancellation dates as above. And Blue Dot Protocol: Frequent assisted repositioning, initiated 3/11/21 and canceled 4/29/21. An observation was conducted 9/22/21 at 7:28 AM of a common area room next to the room of R9. The room appeared to be as being used as storage room for several wheelchairs and walkers. One Geri-type chair was observed to be tagged with the name of R9. A Roho- type (pressure reducing) cushion lay in the seat of the chair labeled for R9. The industry Standard of Care for turning and repositioning of all Long-Term Care residents is every two hours. It was observed that R9 has a Blue Dot turning protocol in place, which facility staff reported meant repositioning every two hours (standard of care). Review of an email communication sent by the DON on 9/22/21 at 11:21 AM reflected an explanation of the Blue Dot protocol, Blue Dot - is a tool we use to identify those who are at highest risk and need frequent assisted repositioning. No formal protocol for the facility's Blue-Dot protocol was provided. On 9/23/21 at 10:53 AM an interview was conducted with the DON and Nurse Practitioner (NP) LL to discuss the progression of R9 wounds. NP LL acknowledged that keeping pressure off a compromised area was important. NP LL reported that R9 resists position change. The DON indicated that the Care Plan of R9 had been revised to achieve a goal regarding repositioning. Review of the Care Plan that contained the intervention of the Blue Dot Protocol reflected the revision that R9, Will refuse or decline assistance with repositioning. However, the medical record reflected this was not initiated as part of the Blue Dot Protocol intervention until 5/5/21 which was after the focus area of 2/8/21 to 4/29/21 and after the hospitalization of 4/29/21. Review of the EMR Progress Notes for R9 from 2/8/21 to 4/29/21 reflected one entry on 3/9/21 that R9 was resistive to repositioning. No other documentation was found that indicated R9 was non-compliant with the Blue Dot Protocol of frequent assisted repositioning as described by the DON. Observations documented on 9/21/21 revealed R9 was not turned or repositioned off his back from 9:33 AM to 3:00 PM with observations documented at 9:33 AM, 10:52 AM, 11:45 AM, 1:08 PM, and 3:00 PM. It was observed that the three pillows on the bed of R9 had not moved or had been repositioned during any of these times. While these observations were made outside of the 2/8/21 to 4/29/21 time frame it is reflective of the diligence of the implementation of the Blue Dot Protocol for R9. The focus time frame ended on 4/29/21 followed by the hospital admission that day for sepsis related to the documented stage 4 wound. The wound measurements described in the EMR Progress Note of 5/5/21 on readmission to the facility, reveal the severity of treatment that required hospitalization . The documentation of the medical record did not reflect adherence and diligent implementation of the Care Plan for a dependent and compromised Resident.

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	09/24/2021

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation is related to intake #MI00-122488 and will have 2 deficiency practice statements. DPS #1 Based on observation, interview, and record review, the facility failed to provide coordinated quality care for 1 resident (Resident #69), resulting in, (a) the development of increased swelling and blisters in both legs, when staff were not available to assist R69 back to bed, (b) the need for steroid use and an increased dose of an already prescribed diuretic, to treat the increased swelling and newly formed blisters, (c) administering the increased dose of diuretics outside physician ordered parameters, and (d) lack of monitoring and treatment orders for the blisters acquired Resident #69 (R69) Review of an Admission Record revealed R69 was an [AGE] year old male, admitted to the facility on , d+[DATE], with pertinent diagnoses of quadriplegia, contracture's of both hands, chronic obstructive pulmonary disease, abnormal posture, low blood pressure, and lymphedema. R69 did not have a guardian and was cognitively intact. During an interview on 09/15/21 at 9:20 A.M., R69 reported the following information related to an incident on 08/03/21: (a) was up in the electric wheelchair around 11:00 A.M., while therapy made adjustments, (b) therapy completed the adjustments and evaluation and R69 remained up in the wheelchair until approximately 2:00 P.M., (c) at that time (2 P.M.) R69 asked to be put back into bed because both legs were unsupported, just hanging free with no support, (d) R69 did not receive assistance to get back to bed until approximately 7:00 P.M., and (e) developed several large edema blisters during the time when both legs were hanging down and unsupported. During an interview on 09/15/21 at 9:10 A.M., Occupational Therapist (OT) QQ indicated that on 08/03/21 around 11:00 A.M., the following occurred: (a) OT QQ wanted to get R69 out of bed and into the electric wheelchair to evaluate positioning in the new wheelchair and no staff were available to help with the 2 person hoyer transfer, (b) OT QQ finally got help from another therapy staff person and transferred R69 into the electric wheelchair, (c) OT QQ completed the evaluation, made some needed adjustments and spent approximately 1 hour with R69, (d) R69 remained in the wheelchair (per the request of R69) when OT QQ exited the room, and (e) OT QQ contacted the wheelchair company after the evaluation with R69, because the wheelchair did not provide adequate support for R69 and additional adjustments would need to be made. Review of a Care Plan for R69 reflected the following intervention related to decreased mobility: Encourage and assist resident to change position throughout the day to prevent respiratory complications, dependent edema, flexion deformity and skin pressure areas. Review of a Progress Note for R69, dated 08/04/21 at 9:55 A.M., reflected: Teds (compression stockings worn to help reduce swelling in the lower legs) on at AM and off at HS (bedtime) everyday and evening shift for edema, off today due to fluid filled blister on leg. MD aware. (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	09/24/2021

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 a Progress Note for R69, dated 08/04/21 at 11:51 A.M., revealed Late entry, during care conference resident (R69) expressed delay in receiving assistance back into bed from the wheelchair. Review of a Progress Note for R69, dated 08/04/21 at 1:14 P.M., revealed R69's blisters on right lower leg and left foot are intact at this time. Nurse Practitioner (NP) YY aware and observed the blisters. Review of a Progress Note for R69, dated 08/04/21 at 1:25 P.M. reflected that Prednisone was ordered for the blisters on right lower leg and left foot. Review of a facility Incident Report for R69, dated 08/04/21 at 4:00 P.M. and completed by Licensed Practical Nurse-Unit Manager (LPN-UM) AA, revealed the following: (a) during care conference resident alleged delay in care when requesting to be laid down, (b) no injuries were observed at time of the incident, (c) no injuries were observed post incident, (d) it was determined that the alleged delay in care occurred, and (e) summary- R69 up in chair at 11 A.M., rang at 2 P.M. to get into bed, staff were assisting other residents, and R69 was laid down around 6 P.M. No documentation of the edema or blisters were located in the Incident Report. Review of a Progress Note for R69, dated 08/04/21 at 6:11 P.M. revealed R69 continues to have fluid filled blisters to bilateral lower extremities. RLE (right lower extremity) has 6 blisters in total, one large, 1 medium and 4 small. Right foot has 1 large blister. Left foot has three blisters in total with 2 medium blisters and 1 large blister. Review of an Electronic Treatment Administration Record (Etar) for R69, dated 08/01/21 to 08/31/21, did not reveal an order for staff to monitor or assess the above mentioned multiple fluid filled blisters. A treatment order was put in place for one blister, located on R69's right shin, after it ruptured on 08/17/21. Review of an Electronic Medication Administration Record (Emar) for R69, dated 08/01/21 to 08/31/21, reflected the following changes in medication orders needed to treat R69's increase in bilateral lower extremity edema and the new onset of blisters: (a) discontinue routine dose of Furosemide (diuretic) 20 mg (milligrams) once daily on 08/05/21 at 3:30 P.M., (b) discontinue routine dose of Potassium Chloride (a potassium supplements often administered with Furosemide, a loop diuretic) 10 meq (milliequivalants) daily on 08/05/21 at 3:41 P.M., (c) start Prednisone (a steroid) taper for 12 days, ordered 08/05/21 for blisters, (d) start Furosemide 40 mg twice daily for lower extremity edema (4 x's the previous dose ordered), and (e) on 08/06/21, start Potassium Chloride 10 meq two tabs twice daily (4 x's the previous dose ordered) for lower extremity edema. Review of a Nursing Skin Observation Tool dated 08/08/21, reflected that R69 did not have any new alterations in skin integrity since last review on 08/01/21. The blisters were not mentioned. Review of a Physician Order for R69's Furosemide 40 mg twice daily for lower extremity edema, reflected the following parameters: Hold medication if SP (systolic blood pressure) was less than 110. Review of an Emar, dated 08/01/21 to 08/31/21, reflected that on 08/14/21 in the morning, R69's blood pressure was 99/59 and the Furosemide 40 mg tablet was administered to the resident. Also noted, on 08/27/21 in the morning, R69's blood pressure was 100/48 and the Furosemide 40 mg tablet was administered to the resident. (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	09/24/2021

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 a Physician Progress Note for R69, dated 08/17/21, revealed the following: (a) chief complaint-lower extremity edema and blisters, (b) resident continues to have bilateral lower extremity edema, however much improved, (c) resident does have one big blister ruptured, the rest of them are intact, (d) lower extremity edema is improving, (e) resident just finished a Prednisone taper, and (f) lower extremity edema 3+ to 4+. Review of a Physician Progress Note for R69, dated 08/25/21 at 2:00 P.M., reflected that the resident continued to have 3+ edema to BLE, a blister to the right foot was intact, and scabbing was noted to RLE where a ruptured blister was. Review of a Progress Note dated 08/27/21 at 10:22 A.M., revealed (R69) has blisters on legs that would burst if [NAME] hose were put on. Review of a Skilled Nursing Note, dated 08/28/21 at 3:15 A.M., reflected the following nursing assessment for R69: (a) Does resident have skin condition or impairment- No, and (b) Did resident display any edema this shift- No. Review of an Emar, dated 09/01/21 to 09/30/21, reflected that on 09/01/21 in the morning, R69's blood pressure was 103/59 and the Furosemide 40 mg tablet was administered to the resident. Review of a Physician Progress Note for R69, dated 09/09/21 at 10:50 A.M., reflected that the resident continued to have quite edematous legs and some leg wounds. Review of a Progress Note dated 09/11/21 at 5:00 P.M. revealed (R69) has too much edema in BLE (bilateral lower extremities) for TED hose at this time. 36090 This citation pertains to intake MI00122506 DPS #2 Based on observation, interview and record review, the facility failed to provide the necessary care and services to maintain the highest practical physical level of wellbeing for two residents (R 85 and 107) out of 34 sampled residents. This deficient practice resulted in unmet care needs when; 1. R 85 was left in wet bedding and developed skin impairments, and 2. staff did not prevent and/or treat constipation for R 117. Findings include: R 85 According to the Minimum Data Set (MDS) assessment, dated 8-9-21, R 85 had multiple diagnosis including diabetes, arthritis, and retention of urine. This same assessment indicated R 85 required extensive assistance of two staff members for moving in bed, transferring, and incontinence care. Staff assessed R 85 as severely cognitively impaired. R 85 was enrolled in Hospice services. (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	09/24/2021

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	During a care observation on 9-14-21 at 3:15 PM, with Hospice Aide O, R 85 was rolled onto her side and a reusable bed pad located under the resident had been wet and now had darkened edges indicating the pad was drying. R 85's coccyx and buttocks were varying shades of purple with areas of pink tissue. A border gauze dressing, undated and located on R 85's bottom, was loosened on the bottom edge and it was soiled with stool. On 9-14-21 at 6:15 PM, Confidential Informant (CI) Q stated that they had found R 85 laying on a wet pad with darkened edges in the past. CI Q stated that the darkened edges indicated that the pad had been wet long enough for it to begin drying. On 9-22-21 at 10:45 AM, R 85 was yelling out for help, no staff was observed in the hall. R 85 was laying on the bed and was heard clearly from the hallway. On 9-22-21 at 12:38 PM, R 85 was yelling out, help me, help me and was clearly heard from the hallway. Housekeeper R was in the hallway outside R 85's room and then entered another resident room without answering R 85's call for help nor obtaining assistance for R 85. When this surveyor asked from the doorway what was needed, R 85 stated that she needed to be cleaned up. During an interview on 9-22-21 at 12:42 PM, Certified Nursing Assistant (CNA) S stated that R 85 only refuses care when in pain and that if R 85 gets something for pain prior to cares then R 85 tolerates them better. Following this interview, Licensed Practical Nurse (LPN) P entered R 85's room to perform a dressing change. During this dressing change R 85 was incontinent of a large amount of urine and R 85 stated that she had been that way for four hours. The brief under R 85 was saturated. There were three open areas, one located on each of R 85's buttocks and one on R 85's coccyx, each approximately the size of a quarter. R 85 required multiple attempts to find a comfortable position following cares. Immediately following the observation, LPN P was interviewed. LPN P confirmed this assessment and had agreed R 85 was more alert and orientated today. Review of R 85's Skin Assessments dated 9-11-21 and 9-18-21 indicated R 85 had no new alteration in skin integrity. Review of R 85's September 2021 Treatment Administration Record (TAR) indicated on 9-12-21 afternoon staff began the following treatment: Apply Periguard (a medicated ointment) to buttock every shift for incontinent dermatitis. Review of R 85's progress notes indicated on 9-16-21 R 85 had continued excoriation on buttock and required encouragement from staff to change wet brief. On 9-17-21 staff documented R 85's buttocks are peeling from moisture and dermatitis. R 117 According to the MDS assessment, dated 9-2-21, R 117 was admitted with cardiac arrhythmias (irregular heart rate), heart failure, high blood pressure, end stage renal disease, and diabetes. Staff assessed R 117 as requiring extensive assistance of one staff member for moving in bed, transferring, and using the bathroom. R 117 was assessed as cognitively intact. R 117 was admitted to the facility on Hospice care. (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	09/24/2021

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	According to the Electronic Medical Record (EMR) Task: Bowel continence, R 117 did not have a bowel movement for 11 days, between early morning 9-4-21 until early morning on 9-15-21. Review of R 117's September 2021 Medication Administration Record (MAR) revealed R 117 was taking Morphine (a constipating pain medication) three times daily and then every four hours beginning September 8th. That same day, Miralax and Milk of Magnesia (medications to treat constipation) was discontinued. On September 7th, another medication to treat constipation, Senna-S, was discontinued for R 117. The physician did not order any medications or treatments to replace these discontinued medications. On 9-14-21, R 117 received a suppository and Milk of Magnesia to promote a bowel movement. On 9-15-21 at 11:00 AM and again on 9-21-21 at 8:21 AM, a request was made of the Director of Nursing (DON) for additional documentation related to R 117's bowel routine. No new information was received. Review of R 117's Care plans revealed a Resident at risk for Constipation care plan revised on 9-8-21. R 117's goal was to have a normal bowel movement at least every three days. Listed interventions included, Follow facility bowel protocol for bowel management and Monitor medication for side effects of constipation. Keep physician informed of any problems. In a follow up email on 9-21-21 at 8:24 to the DON, clarification was asked regarding facility protocol for bowel management. The DON replied that same day at 11:00 AM, We do not have a bowel management policy. We watch alerts (messages on the computer), assess (Resident's) for change in condition, and communicate with (the) provider as needed. On 9-21-21 at 3:15 PM, Hospice staff U reported that even though appetite may be poor, Hospice staff encourage patients to have a bowel movement every three days.

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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 This citation has two Deficient Practice Statements (DPS). DPS A Based on observation, interview, and record review, the facility failed to properly care for one dependent resident (Resident #9) known to have compromised skin integrity resulting in an Immediate Jeopardy when on 02/19/21, the facility failed to prevent, identify, and treat a pressure sore resulting in the deterioration of the sore to a stage 4 (bone and tendon exposed) wound with sepsis and Osteomyelitis. This deficient practice resulted in harm to the resident and inhibited the ability of Resident #9 to reach the highest practicable health and well-being, and has the high likelihood to place all dependent residents at risk for deteriorating skin integrity. Findings: Resident #9 (R9) was originally admitted to the facility 7/24/20 and had diagnoses that included: Diabetes Mellitus, Respiratory Failure and Stroke. Review of the Minimum Data Set (MDS) dated [DATE] reflected R9 required extensive assistance with bed mobility. Section M of this MDS titled Skin Conditions reflected R9 had a Stage 4 pressure sore that was present on admission to the facility which indicated the condition was acquired outside the facility. Review of the Electronic Medical Record (EMR) revealed a Progress Note dated 2/8/21 that indicated R9 was readmitted to the facility following extended treatment of COVID 19 at another facility. The Progress Note reflected R9 had Moisture Associated Skin Damage (MASD) to the bilateral buttocks at that time. No further description of the MASD identified in the Progress Notes from 2/8/21-2/19/21. A Progress Note dated 2/19/21 at 10:30 PM reflected R9 was sent to the hospital and diagnosed with Septic Shock. A Progress Note dated 2/25/21 reflected R9 returned to the facility with a dressing on the sacrum. Progress Note entries dated 2/26/21, timed 2:07 PM, 2:09 PM, and 2:11 PM revealed three wound evaluations of the sacrum and the left and right buttocks with measurements. All three wound assessments described R9's wounds as MASD. Review of the hospital documentation dated 2/19/21 reflected R 9 arrived at the Emergency Department (ED) from the facility with a sacral decubitus ulcer that included a photograph taken in the ED on 2/19/21 of a decubitus ulcer and a large area of possible MASD. The hospital documentation reflected that the sacral decubitus ulcer and surrounding cellulitis as a possible source of sepsis. Despite the hospital physician documentation and photograph of 2/19/21 of R 9 having a decubitus ulcer facility documentation after 2/25/21 consistently reflect R 9 wounds are referred to as MASD in the EMR Progress Notes (3/9/21, 3/12/21, 3/19/21, 3/26/21, 3/29/21, 4/7/21, 4/15/21, 4/20/21) The medical record Progress Note dated 4/29/21 at 3:09 PM reflected R9 was admitted to the hospital again for hypoxia and returned to the facility on [DATE]. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The EMR Progress Notes revealed a wound assessment dated [DATE] at 9:20 PM, Wound location is Sacrum. Wound measurements .Length-5.4 centimeters (cm), Width -3.7 cm, Depth - 4.5 cm (approx. 1 1/2 inches in depth). Another EMR Progress Note on that same day, 5/5/21, at 11:16 PM reflected a wound assessment that R9 had: sacrum , stage 4, undermining present, slough . hanging off ., Bones and tendons are exposed. Review of the EMR reflected Medical Provider documentation dated 5/12/21 at 1:45 PM that R 9 was hospitalized [DATE] for sepsis probably related to his stage IV sacral wound, . prognosis for (R 9) is poor. Review of the Wound Clinic documentation dated 5/24/21 reflected R9's sacral wound had deteriorated, Large amount of visible/palpable bone. The documentation reflected the wound measured 6.5 centimeters (cm) long, 4 cm wide, and 4 cm in depth (approx. 1 1/2 inches deep). The documentation reflected the Medical Provider recommended imaging to rule out Osteomyelitis. Review of the Wound Clinic documentation dated 6/14/21 reflected the Medical Provider had reviewed consultation notes and recommended intravenous (IV) antibiotics with a diagnosis of Osteomyelitis and a wound vac dressing. The documentation reflected R9 left the clinic with a PICC line (peripherally inserted central catheter, used for longer term intravenous access) in place and antibiotics were scheduled. The industry Standard of Care for turning and repositioning of all Long-Term Care residents is every two hours. It was observed that R9 has a Blue Dot turning protocol in place which facility staff reported this means repositioning every two hours (standard of care). Review of an email communication sent by the DON on 9/22/21 at 11:21 a.m. reflected an explanation of the Blue Dot protocol, Blue Dot - is a tool we use to identify those who are at highest risk and need frequent assisted repositioning. No formal protocol for the facility's Blue-Dot protocol was provided. Review of a Therapy Status Communication form dated 6/7/21 reflected, [R9] to lay toward L and R (left and right) side (with) 2 wedges under hips and trunk throughout the day to decrease the risk of further skin breakdown. However, review of the Care Plan did not reveal this recommendation had been added to the comprehensive Care Plan as an intervention. Observations made on 9/21/21 at 9:33 AM, 10:52 AM, 11:45 AM, 1:08 PM, and 3:00 PM revealed R 9 was not turned or repositioned off his back. It was noted that during each observation over the course of five and a half hours, three pillows on the bed of R9 had not moved or had been repositioned during any of these times. No positioning wedges were observed in the room of R9. On 9/21/21 at 1:20 PM a request was submitted to the Director of Nursing (DON) for a timeline of the skin condition on the buttock of R9. On 9/22/21 at 8:54 AM the DON provided a timeline of the wounds for R9. The documentation of the timeline reflected, 2/19/21 Transfer out - No wounds. This is inconsistent with the hospital documentation and photograph of 2/19/21. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/22/21 at 1:27 PM the Administrator and Director of Nursing were notified of an Immediate Jeopardy related to F-686, that began on 02/19/21, when the facility failed to prevent, identify, and properly treat a stage IV pressure sore for R9. On 9/22/21 at 8:54 AM the DON provided a timeline asserting a wound on the buttocks of R 9 developed in the hospital between 2/19/21 and 2/25/21. However, hospital documentation and photo dated 2/19/21 reflected R 9 arrived to the ED with a large sacral decubitus ulcer that included a photograph of a large decubitus ulcer and a large area of possible Moisture Associated Skin Damage (MASD). The hospital documentation reflected that the sacral decubitus ulcer and surrounding cellulitis as a possible source of sepsis. Observations during the current survey reveal R 9 is on a Blue Dot turning protocol (every two hours). Observations documented on 9/21/21 revealed R 9 was not turned or repositioned off of his back throughout five observations made by surveyors from 9:33 AM to 3:00 PM. The identified risk of serious injury, serious harm, serious impairment and/or death was evidenced by: Despite hospital documentation of R 9 having a decubitus ulcer facility documentation after 2/25/21 consistently reflect R 9 wounds are referred to as MASD. R 9 was admitted to the hospital again on 4/29/21 and returned to the facility on [DATE]. Facility documentation reflected R 9 was admitted to the hospital on 4/29/21 for hypoxia. On 5/5/21 facility documentation reflected an assessment of the wounds of R 9 had: sacrum , stage 4, undermining present, slough . hanging off ., Bones and tendons are exposed. The Physician documentation of 5/12/21 reflected the Resident was hospitalized [DATE] for sepsis probably related to his stage IV sacral wound, . prognosis for (R 9) is poor. On 9/23/21 at 12:08 PM the facility plan to remove the Immediate Jeopardy was accepted and the State Agency validated the removal plan which included: 1. On 09/22/21 the facility immediately initiated skin assessments of the at risk residents. Skin sweep assessments will be completed by a licensed or registered nurse. 2. On 09/22/21 the facility initiated review of the skin sweep assessments and updated wound type if necessary. 3. On 09/22/21 the facility updated R9's wound type and the care plan was reviewed and updated with the appropriate interventions as necessary. 4. On 09/22/21 the facility initiated review and update of identified at risk residents care plans with appropriate interventions as necessary. 5. On 09/22/21 the facility initiated review of physician orders and updates based on skin sweep assessment results as necessary. 6. On 09/23/21 the facility initiated completion of a new Braden Scale Assessment on all current residents to ensure risk of pressure ulcer development is accurately assessed. 7. On 09/23/21 the facility initiated notification of the primary care physician, responsible party/guardian of residents with newly identified skin concerns, change in treatments, change in wound severity, and/or plan of care. 8. Medical provider will receive and review the skin monitoring and management program to ensure program meets professional standards of practice. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On 09/23/21 education was started with all licensed and registered nurses and certified nursing assistants to be educated in person on the skin monitoring and management program including but not limited to assessment, correct identification, and implementation of interventions to monitor and treat the development or worsening of pressure wounds. Any staff no present during the education started on 09/23/21, will be educated prior to starting the next scheduled shift. Competency will be validated by a written competency test. On 9/23/21 at 10:53 AM an interview was conducted with the DON and Nurse Practitioner (NP) LL. The DON reported the timeline she provided of the wounds on R9 did not accurately explain the wound's history and treatment. The DON reported she had developed the timeline based on the medical record of R9 and an alternative timeline would be provided. Both the DON and NP LL reported they understood how the conclusions were drawn by the survey team of the progression of R9's wounds in reviewing the facility's medical record. NP LL reported medical records that the surveyors were not privy to would be provided and should be considered. NP LL reported every time the wound was seen by a different person each would give a different description. NP LL reported that MASD topical is an appropriate description and that the wound did not start out as pressure related. NP LL reported that wound progression was unavoidable. NP LL reported moisture on the skin from urine and fecal material is only one factor and that R9 is nutritionally and medically compromised. NP LL reported a urinary catheter was put in place (4/17/21) to remove urine from the area and R9 had been treated for loose stools. NP LL reported that R9 had a history of Covid 19 and we don't know all the data on how Covid affects the skin. NP LL was asked if keeping pressure off the area is important. NP LL stated, yes. NP LL reported that R9 resists position change. The DON reported that R9 was on the Blue Dot program which gives a higher priority to frequent assisted position changes. Review of the EMR Progress Notes for R9 from 2/8/21 to 4/29/21 reflected one entry on 3/9/21 that R9 was resistive to repositioning. No other documentation was found that indicated R9 was non-compliant with the Blue Dot Protocol of frequent assisted repositioning as described by the DON or with the staff's described understanding of the Blue Dot Protocol of repositioning every two hours (standard of care). The Care Plan titled Resident has potential/actual impairment to skin integrity (related to) old (tracheostomy) site to neck . MASD both buttock . was reviewed. The Care Plan reflected the intervention of the Blue Dot Protocol that was initially implemented 3/11/21. The Care Plan reflected the revision that R9, Will refuse or decline assistance with repositioning was added to the Blue Dot Protocol intervention on 5/5/21. This revision was not added to the Blue Dot Protocol until after the hospitalization of 4/29/21 when the wound had progressed to a documented Stage 4 wound. Review of the EMR task document titled Bed Mobility dated 8/24/21 to 9/22/21 (30 days) reflect R9 was Total Dependence on staff for bed mobility which was documented as completed two to four times a day (far less than the standard of care). The documentation of 9/21/21 reflected no bed mobility task was completed from 7:52 AM to 9:14 PM consistent with the observations made 9/21/21 of R9 not being repositioned between 9:33 AM to 3:00 PM as previously noted. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/23/21 at 2:27 PM the DON provided a second timeline. This timeline reflected open areas on the right buttocks were first noted on 10/28/20 prior to R9's admission to a facility for treatment of Covid 19. Documentation not previously available was included in this second timeline. The documents appeared to be from the facility where R9 was admitted during the care and treatment for Covid 19. The documentation reflected the buttocks of R9 was described as MASD consistent with the description of this area upon return to the facility on [DATE]. Although the Immediate Jeopardy was removed on 9/23/21, the facility remained out of compliance at a scope of Actual harm that is not immediate jeopardy due to sustained compliance has not been verified by the state agency. 29073 DPS B Based on observation, interview, and record review, the facility failed to provide coordinated monitoring and treatment for 2 residents with skin breakdown (Resident #83 and Resident #105), resulting in the potential for undetected and untreated worsening pressure ulcers. Resident #83 (R83) Review of an Admission Record reflected Resident #83 (R83) originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, adult failure to thrive, diabetes, sleep apnea, high blood pressure, weakness, hearing loss, cognitive communication deficit and malignant neoplasm of the prostate. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R83 had short- and long-term memory problems and required limited assistance from one person for transfers, walking, toilet use and personal hygiene. The assessment also indicated R83 was not steady moving from a seated to standing position and moving off the toilet. Section H - Bowel and Bladder reflected R83 did not use a catheter, did not require intermittent catheterization, was not on a toileting program (such as scheduled toileting, prompted voiding or bladder training) and was only occasionally incontinent of urine and never incontinent for bowel movements. Section M-Skin Conditions reflected R83 was at risk for developing pressure ulcers but did not have any pressure sores. Review of an Incident Report dated 7/23/21 at 12:51 p.m. reflected R83 had an unwitnessed fall in the bathroom and was sent to the hospital after an x-ray revealed a right hip fracture. Review of hospital Discharge Instructions dated 7/24/21 specified R83 was non-weight bearing on the right leg and Foley catheter until no longer painful for bed rolls. Review of Braden Scale for Predicting Pressure Sore Risk assessments dated 7/25/21, 8/12/21 and 8/20/21 reflected that R83 had a moderate risk for developing a pressure sore. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Care Plan Report reflected that when R83 admitted to the facility on [DATE] a care plan focus area read Resident has potential to skin integrity r/t dementia, DM2 (type 2 diabetes), PVD (peripheral vascular disease), self-transfers, failure to thrive. The goal of the care plan was Resident will maintain intact skin with no breaks in skin through the next review date. Interventions to reach the goal of maintaining intact skin were: (a) Educate resident/family/caregivers of causative factors and measures to prevent skin injury, (b) Encourage good nutrition and hydration in order to promote healthier skin, (c) Observe skin daily with care activities, report any changes in coloration/integrity etc., to nurse, (d) Resident needs pressure reduction interventions: (SPECIFY-mattress type, specialty bed, wheelchair cushion, etc.). The care plan did not specify any pressure reducing interventions. Further review of the entire Care Plan Report revealed facility staff had identified focus areas that included: Resident has limited physical mobility r/t (related to) dementia, failure to thrive, prostate cancer, DM2, and hearing loss; None (sic) weight bearing with the goal of keeping R83 comfortable and an intervention to reposition for comfort. The Care Plan Report did not reflect that facility nursing staff had care planned R83's assessed risk for pressure ulcers due to his lack of mobility and being completely bed bound with new bowel incontinence. Review of a document reflecting a task charted on by Certified Nurse Aides (CNA's) BED MOBILITY: SELF-PERFORMANCE-How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture for the dates 8/23/21-9/20/21 reflected staff documented EXTENSIVE ASSISTANCE-Resident involved in activity; staff provide weight bearing support 58% of the time, with staff documenting R83 was TOTAL DEPENDENCE-Full staff performance 6% of the time in the 30 days look back period. Review of a Skin Observation Tool dated 8/1/21 reflected R83 had excoriation on his coccyx. No other skin abnormalities were documented on the form. Review of a General Progress Note dated 8/1/21 at 10:13 p.m. reflected Resident had bed bath this evening. Observed scab to left forearm related to previous fall, purpura to left forearm and excoriation to bilateral buttock. Notified (hospice group) of excoriation, waiting for new orders of zinc oxide treatment to be applied every shift . During a telephone interview on 9/13/21 at 1:54 p.m., R83's wife, Family Member (FM) XX reported that she had just come from the facility after having assisted R83 with his noon meal. FM XX said that she would like to see R83 get out of bed, explaining that he has been bed-bound ever since he broke his hip in a fall at the facility on 7/23/21. FM XX said she had made the suggestion to the hospice staff that see R83 but had not told staff at the facility because they are so busy. FM XX said it was concerning to her because he had a little bedsore on the top of his tailbone, and she would like that treated. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 9/14/21 at 12:09 p.m., Licensed Practical Nurse (LPN) L said she was not aware of any open areas on R83's coccyx and agreed to assess R83's skin. CNA I assisted in positioning R83 and reported she was aware of an open area on R83's coccygeal area and had reported it to another nurse (LPN J) a few weeks ago. Upon entering the room, R83 agreed to the observation and CNA I pointed to individual packets of ointment the CNAs were putting on the open area on R83's coccygeal area. LPN L reported the area was indeed open and measured a 1.0 cm x 0.5 cm area. Additional assessment of R83's skin revealed a small, reddened area on the left second toe, the skin on R83's feet was very dry. Review of General Progress Notes from 9/14/21-9/21/21 did not reflect the nurse had documented the open area measured on R83 during the observation and interview conducted on 9/14/21 at 12:09 p.m. Review of an Order Recap Report for R83 reflected an order for Periguard cream to coccyx area for protection, every shift was not ordered until 9/14/21, the day of the observation of the small open area on R83's coccyx measured by LPN L. Review of a Skin Observation Tool dated 8/23/21 and 8/30/21 reflected R83 had no new skin issues. Skin Observation Tools dated 9/7/21 and 9/12/21 were blank, indicating no new areas or changes in R83's skin condition. No Skin Observation Tool was completed after the assessment of R83's skin by LPN J on 9/14/2021. Review of a Nurse Practitioner (NP) progress note dated 9/15/21 documented by NP LL reflected R83 was seen for a skin check. The note revealed Patient seen at the request of nursing staff for the evaluation of skin regarding concerns of open area over buttock. Pt is alert awake and hard of hearing. He has been bed bound due to the fact that he has a non-surgical fracture of the right femur. He is dependent on staff for all ADL (activities of daily living). He states his pain is well controlled. He has a Foley catheter and draining clear urine with some slight sediments. Pt has a history of prostate cancer and was under the care of the oncology until he went on hospice care. He has dementia, but he is pleasant and cooperative with care. He has no exhibited behavior so far, he is sleeping well, PO (per mouth) intake is good, he is cooperative with care. The note specified that R83 has no strength for bed mobility. The physical exam revealed His skin over the sacral area is clear and no open areas noted. The coccyx is slightly discolored. It is slightly red and blanchable. No open area noted, no pain or discomfort on palpation. He is incontinent on bowel and needed to be cleaned up while being examined, pt did not show any signs of pain while being cleaned. The Assessment/Plan specified that R83 did not have skin breakdown and no change in treatment was indicated. 37577 Resident #105 (R105) Review of an Admission Record revealed R105 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of hepatitis, a fractured rib, nose bleeds, low sodium levels, and a stage 2 pressure wound on bilateral buttocks. A Minimum Data Set (MDS) assessment, completed 07/26/21, reflected R105 required extensive assistance from staff for bed mobility, transfers, and going to the bathroom. Review of a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated that R105 was cognitively intact. (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	09/24/2021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nursing Admission Screen for R105, dated 08/19/21 at 12:10 P.M., reflected that R105 did not have any skin concerns at the time of admission. Also noted was that R105 had bilateral lower extremity edema. Review of a Skilled Charting note for R105, dated 08/20/21 at 7:09 A.M., reflected the following information (a) R105 required substantial/maximal assistance to change positions from sitting to lying, (b) resident did not have any skin conditions or impairments, and (c) the resident did not have any edema. Review of a Skin & Wound Evaluation for R105, dated 08/20/21 at 9:12 A.M., reflected the following information: (a) R105 was admitted with a pressure type wound, (b) stage- deep tissue injury, (c) location- sacrum, (d) wound measurements- length 10.4 cm x width 7.4 cm (centimeters), (e) goal of care- slow to heal: wound healing is slow or stalled but stable, little/no deterioration, and (f) Additional Care- cushion, incontinence management, mattress with pump, repositioning devices, and turning/repositioning program. The evaluation did not indicate that the dietician nor the facility practitioner were notified. The above mentioned skin evaluation did not indicate that R105's yeast infection was evaluated and did not mention a plan of treatment for the yeast infection. Review of a General Progress Note, dated 08/20/21 at 9:19 A.M. and noted as a late entry, revealed the following information regarding R105 .hospital record indicates a sacral wound, allowed care this am .mood calm .pitting edema to bilateral shins and feet .is jaundice, ascites present, yeast areas under bilateral arm pits and under abdominal pannus .deep tissue injury is noted entire sacral area .skin looks as if it will peel. Review of a Skilled Charting note for R105, dated 08/20/21 at 5:48 P.M., reflected the following information (a) R105 required substantial/maximal assistance to change positions from sitting to lying, (b) resident did not have any skin conditions or impairments, and (c) the resident did not have any edema. Review of a Skilled Charting note for R105, dated 08/21/21 at 12:54 A.M., reflected the following information (a) R105 required substantial/maximal assistance to change positions from sitting to lying, (b) resident did not have any skin conditions or impairments, and (c) the resident did not have any edema. Review of a Skilled Charting note for R105, dated 08/21/21 at 2:36 P.M., reflected the following information (a) R105 required substantial/maximal assistance to change positions from sitting to lying, (b) resident did not have any skin conditions or impairments, and (c) the resident did not have any edema. Review of Skin Observation Tool dated 08/22/21 for R105 did not provide a description of the sacral area nor any measurements, and only indicated that the resident had no new areas of skin concern. Review of a Physician Progress Note dated 08/23/21, reflected no mention of a skin breakdown or skin concerns for R105. Review of Skin Observation Tool dated 08/29/21 for R105 did not provide a description of the sacral area nor any measurements, and only indicated that the resident had no new areas of skin concern.

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	09/24/2021

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to provide 2 residents (Resident #55 and Resident #105) with safely placed necessary positioning equipment, resulting in (a) bruising and the inability for R55 to move the left arm and (b) R105 sitting in a chair with legs unsupported for several hours. Findings: Resident #55 (R55) Review of an Admission Record revealed R55 was a [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnoses of history of a stroke that resulted in left upper extremity paralysis, blindness in left eye, epilepsy, and muscle weakness. A Brief Interview for Mental Status (BIMS) assessment, dated 07/27/21, reflected a score of 14 out of 15, which indicated R55 was cognitively intact. During an observation on 09/12/21 at 9:00 A.M., R55 sat up in bed, ate breakfast with use of the right arm, and the left arm was pinned under the over bed table, used to hold the breakfast items in front of R55. The over bed table was observed to be pressing down on R55's left forearm. R55 indicated not having a way to get the table off of the left arm, that's just how they put it sometimes and I have to wait for them to come get it off me. A quarter size bruise was observed on R55's left forearm where the table had been pressed against the arm. Review of a Skin Observation Tool dated 09/13/21, reflected the question: Any new alteration in skin integrity? including open areas of any type, tears, bruising, red areas, rashes, Answer: No. Resident #105 Review of an Admission Record revealed R105 was a [AGE] year-old male, with pertinent diagnoses of hepatitis, a fractured rib, nose bleeds, low sodium levels, and a stage 2 pressure wound on bilateral buttocks. A Minimum Data Set (MDS) assessment, completed 07/26/21, reflected R105 required extensive assistance from staff for bed mobility, transfers, and going to the bathroom. Review of a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated that R105 was cognitively intact. During an observation on 09/15/21 at 11:52 A.M., R105 sat up in a broda chair and the resident's feet did not touch the foot rests, rather, R105's legs dangled unsupported. During an observation on 09/15/21 at 12:53 P.M., R105 remained up in the broda chair, had just finished lunch, and both legs remained hanging freely with no support, feet did not reach the foot pedals. (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	09/24/2021

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/15/21 at 12:59 P.M., Occupational Therapist (OT) QQ observed R105's position in the broda chair, attempted to make adjustments to the foot pedals, and indicated that the foot pedals were up as high as they could be on that particular broda chair. OT QQ indicated that many broda chairs have a foot plate instead of pedals and a call will be made to Hospice and the facility maintenance to see what can be done. (R105) can't be sitting there like that. During an observation on 09/15/21 at 3:33 P.M., R105 (a) remained sitting up in the broda chair, (b) both legs dangled with no support or foot rests, and (c) R105's left leg was adducted (the thigh was pressed in beyond midline of the body) and the shin was pressed against an unpadded metal piece of the broda chair. During an interview on 09/15/21 at 3:41 P.M., Licensed Practical Nurse-Unit Manager (LPN-UM) AA went to R105's room and observed the placement and lack of support for the resident's legs and left the room stating, let me go find someone.

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	09/24/2021

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 0689 Level of Harm - 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** 29073 This citation pertains to intakes MI-121396, MI-122506 and MI-122658 Based on observation, interview and record review, the facility failed to ensure staff provided adequate supervision to prevent accidents, identify hazards, and safely transfer and ambulate residents for 4 residents (Resident #83, Resident #104, Resident #113 and Resident #123) resulting in (a) Resident #83 sustaining a fall and an inoperable right hip fracture after being left alone in the bathroom, (b) Resident #104 being ambulated without a gait belt resulting in the potential for a fall and/or serious injury and (c) Resident #113 and #123 being transferred incorrectly by staff resulting in pain and emotional distress. Findings: Resident #83 (R83) Review of an Admission Record reflected Resident #83 (R83) originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, adult failure to thrive, diabetes, sleep apnea, high blood pressure, weakness, hearing loss and cognitive communication deficit. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R83 had short- and long-term memory problems and required limited assistance from one person for transfers, walking, toilet use and personal hygiene. The assessment also indicated R83 was not steady moving from a seated to standing position and moving off the toilet. Section H - Bowel and Bladder reflected R83 did not use a catheter, did not require intermittent catheterization, was not on a toileting program (such as scheduled toileting, prompted voiding or bladder training) and was only occasionally incontinent of urine and never incontinent for bowel movements. Review of fall risk assessments completed for R83 upon his admission on 3/8/21, after falls occurring on 5/13/21, 5/14/21, 6/12/21, 7/4/21, and 7/23/21, upon readmission on 7/25/21 and after another fall on 7/29/21, reflected R83 was a High Risk for Falling. All policies and procedures pertaining to Falls, Fall Prevention/Fall Program and related protocols, including the Yellow Dot protocol etc. were request from the Director of Nursing (DON) on 9/22/21 at 9:56 a.m. Review of an email communication sent by the DON on 9/22/21 at 11:21 a.m. reflected an explanation of the Yellow Dot protocol, Yellow Dot - is a tool we use to identify those who are at highest risk for falling when left up in a chair unsupervised. No formal protocol for the facility's Yellow-Dot protocol was provided. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy Fall adopted 7/11/2018, reflected, It is the policy of this facility to evaluate extent of injury after a fall, prevent complications and to provide emergency care. The policy specified 6. Evaluate for cause of fall, e.g., wet floor, obstructed pathway etc. The policy did not address fall risk assessment, interventions and strategies to reduce a resident's risk for falling or conducting a meaningful evaluation of falls to identify interventions most appropriate to prevent future falls. Review of a facility policy Gait Belt-Transfer Belt dated 7/11/2018, reflected, It is the policy of this facility to: (a) Provide safety for the unsteady and/or confused resident. (b) Aid in the transfer of the dependent resident. (c) Prevent injuries to employees and residents (i.e., back strain or potential for chronic disability, resident falls or fractures). (d) Allow the resident and aide to feel more secure during a transfer. Review of incident and accident reports for R83 for the date range 5/13/21-7/23/21 reflected the following: -On 5/13/21 at 10:30 a.m., R83 had an unwitnessed fall in his room without injury. According to the report, R83 had been lying in bed and appeared to be sleeping 30 minutes prior to the fall. The resident told staff he was trying to take himself to the bathroom. A General Progress Note dated 5/17/21 detailed an IDT Fall review and reflected Resident impulsive and will not ask for assistance. A therapy screen was requested as an intervention to prevent future falls. -On 5/14/21 at 7:29 a.m., R83 had an unwitnessed fall in his room without injury and was found kneeling on the floor, with the rest of his body on his bed. The resident was unable to state what happened. A General Progress Note dated 5/26/21 detailed an IDT Fall review and reflected Had grippys on. Resident will self-transfer. Grippy Strips to be applied to the floor as an intervention to prevent future falls. -On 6/12/21 at 2:50 p.m., R83 had an unwitnessed fall in the doorway of his room without injury. R83 reported he was trying to unplug something. Review of a General Progress Note dated 6/17/21 detailed an IDT fall review and reflected [R83] had been sitting in his chair prior. Floor was dry, resident had grippy socks on . increased confusion this shift . R83 was encouraged to come out into common area, in addition to having STAT (urgent) labs drawn related to R83's apparent increased confusion. -On 7/4/21 at 4:40 p.m., R83 had an unwitnessed fall in his room without injury. R83 was unable to state what happened. Review of a General Progress Note dated 7/13/21 detailed an IDT fall review and reflected R83 had apparently attempted to self-transfer from his bed to his recliner chair. The IDT review indicated R83 Had shoes on. Resident did not use his walker. Self-transferred to his recliner and lost balance. A soft touch call light was to be placed next to R83 to alert staff of attempts to get up unassisted. -On 7/23/21 at 12:51 p.m., R83 had an unwitnessed fall in the bathroom and sustained a right hip fracture. Review of a General Progress Note dated 7/28/21 reflected an IDT fall review that indicated Resident can be confused and impulsive at times . x-ray ordered and showed right hip fracture. Was sent out to hospital. [R83] readmitted under hospice care . The intervention added to the plan of care was for R83 to wear grippy sock at all times. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Care Plan Report initiated on 3/9/21 reflected [R83] is at risk for falls r/t failure to thrive, new environment, dementia, DM2, self-transfers/ambulates, hearing loss, OSA (obstructive sleep apnea). Resident is impulsive and will not wait for assistance. Will refuse at times to come out of room, will move call light. The goal of the care plan focus area was for R83 to remain free from fall related injury. Some active interventions were contradictory, as evidenced by the following: (a) Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition, Resident has standard call light, able to use-initiated on 3/9/21; (b) soft-touch call light next to resident (no further instructions provided)-initiated on 7/4/21. Further review of the Care Plan did not reflect any interventions or approaches were in place to address R83's impulsive nature or cognitive impairments. The care plan did not specify R83's assessed high risk for falling or mention the Yellow Dot protocol described by the DON, despite all falls occurring while in his room/chair and unsupervised. Review of a Care Plan Report reflected [R83] has an ADL self-care performance deficit r/t (related to) dementia, failure to thrive, prostate cancer, DM2 (type 2 diabetes), and hearing loss . initiated on 3/9/21, revised on 9/13/21. The goals of the Care Plan, initiated on 3/9/21 and revised on 8/3/21 was for R83 to maintain his current level of function and participate in ADL tasks with therapy services as ordered to maintain prior level of functioning. Interventions to meet the stated goals included Ambulation with 1 assist RW (rolling walker); Transfers: 1 assist with R/walker needs encouragement and were not initiated until after R83 returned from the hospital with a fractured right hip on 7/25/21 and were Resolved on 7/28/21. There was an intervention added on 5/18/21 PTV (prompt to void) but did not elaborate on how frequently R83 would need prompting. Review of a Care Plan Report reflected that on 3/9/21 R83 was assessed as having Limited physical mobility related to dementia, failure to thrive, prostate cancer, diabetes and hearing loss. The goal of the care plan was for R83 to maintain his current level of mobility with increases as able with participation in therapy and/or nursing with interventions that included Transfer: 1 assist with 2WW (2-wheeled walker) and gait belt. The intervention was not resolved until 7/28/21 after R83 sustained right hip fracture after a fall at the facility. Review of a General Progress Note dated 7/23/21 at 1:00 p.m., documented by Licensed Practical Nurse (LPN) J reflected, Observed resident sitting on floor between toilet and wall. CNA (Certified Nurse Aide) was in the room and resident just slipped off the toilet. Neuro checks and FROM (Full Range of Motion) done. No internal rotation or shortening to either leg. Denied pain or discomfort. Unable to get Hoyer (mechanical lift) into bathroom and resident assisted with three staff members to a standing position. Intervention is to ensure that resident have grippy socks on. Resident returned to chair and resident had breakfast. Review of a General Progress Note dated 7/28/21 at 12:41 p.m., documented by Registered Nurse (RN) N reflected an IDT fall review: Fall huddle was done. Nurse observed resident sitting on floor between toilet and wall. CNA was in the room doing cares with resident. Resident was sitting on the toilet. Had no grippy socks on due to getting washed up and ready. CNA went to get clothes and resident attempted to stand up and slipped off the toilet. Floor was dry. Resident with dx (diagnosis) of dementia, and prostate cancer. Resident can be confused and impulsive at times. Resident did complain of pain to right hip and head. Xray was ordered and showed fractured right hip. Was sent out to hospital. Resident readmitted under Hospice care. Resident remains comfortable. Will continue to anticipate resident's needs and collaborate with Hospice and change POC (plan of care) as needed. Grippy socks on at all times also added to POC. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/21/21 at 11:53 AM, Certified Nurse Aide (CNA) I reported she did not use a gait belt when she walked with R83 into the bathroom while R83 used a walker. CNA I said she left R83 in the bathroom sitting on the toilet, the walker was in the bathroom, with the door ajar as she went to get a brief from his closet. According to CNA I, R83 stood and fell in just a few seconds. CNA I said R83 was pretty confused that day-making comments about poison and aliens. According to CNA I, the day R83 fell and fractured his hip was her first day caring for him. CNA I reported she was told that R83 could transfer himself. When asked if it was alright to leave R83 alone in the bathroom, CNA I said that it was just common sense not to leave a resident in the bathroom alone. Review of hospital Imaging Results dated 7/24/21 at 1:50 a.m. reflected Findings: There is an acute displaced fracture present involving the basicervical right femoral neck with potential intertrochanteric component. The femoral head appears otherwise intact without significant degenerative changes. Left hip is unremarkable. Chronic changes of the right hemi pelvis noted. It is unclear whether not nondisplaced fractures of the right pubic rami are demonstrated, versus old, healed fractures. Impression: Acute displaced fracture involving the basicervical right femoral neck with potential intertrochanteric component. Discharge instructions specified R83 was non-weight bearing on the right leg and Foley catheter until no longer painful for bed rolls. Review of a hospital record dated 7/25/21 reflected Hospital Course: [R83] with a history of dementia and metastatic prostate CA (cancer) who resides in long term care presented to the ER (emergency room) after a fall and right hip pain. His imaging noted a displaced right femoral neck fracture. He met SIRS (Systemic Inflammatory Response Syndrome, can be caused by trauma) criteria but had no source of infection. He was admitted for pain management and orthopedic consultation. His wife met with ortho and opted for a non-surgical management. A foley was placed for comfort and she met with hospice. He will return to his long-term care facility with hospice care for symptom management. Review of an Incident Report dated 7/29/21 at 5:45 a.m. reflected R83 had another unwitnessed fall in his room. The report reflected This nurse was in common area with other residents when heard a noise then resident talking, went to resident's room and observed him sitting on the floor at the bedside. Head resting against mattress and frame of bed. A General Progress Note dated 8/3/21 at 1:44 p.m. reflected IDT review: Fall huddle done. Resident was observed sitting on the floor at bedside. No injuries noted, Resident was last seen after 5:00 a.m. when catheter bag was emptied. He was asleep at that time in bed. Resident had his night clothes on. Floor was dry, Resident has a recliner next to his bed. Roommate was sitting in recliner. Resident was confused and attempted to get up. Resident under hospice care. Is impulsive. Has fx right hip. All interventions were in place. Intervention was to remove recliner from resident's room. Mat added next to bed. Bed in ultra low position. Will continue to anticipate resident's needs and collaborate cares with hospice. Will continue to change poc as needed. Resident #104 (R104) Review of an Admission Record reflected R104 originally admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, delusional disorders, heart failure, adjustment disorder, pain, overactive bladder and unsteadiness on feet. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE] reflected R104 was severely cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 2/15. R104 needed extensive assistance from two people for bed mobility, transfers, walking in a room or in a corridor, toilet use and personal hygiene. Review of a Care Plan Report initiated on 6/22/2019, last revised 6/29/21, reflected R104 had an ADL self-care performance deficit related to weakness, dementia, [R104] can be combative with cares, she is 1 assist with bathing and dressing, is independent with transfer and assist as needed and toileting with staff cueing and supervision. Will get combative when staff attempt to assist her . The goal of the care plan was for R104 to participate in ADL tasks with interventions that specified AMBULATION: Extensive 2 assist with walking; resident able to ambulate with 2 assists to the dining room. An active care plan intervention conflicted with the Care Plan Focus area statement that the resident is independent with transfers and reflected TRANSFERS: 2 assist tires easily was initiated on 6/23/2019 and revised 4/07/2021. Review of a hospice Care Plan P070: Safety/Fall Prevention reflected the goal was to have R104's safety maintained as evidenced by patient free from injury due to fall through 10/9/2021. An intervention to attain the goal was for Staff to provide 2 person assist with gait belt for ambulation and transfers. During an observation on 9/22/21 at 8:52 a.m., LPN K and CNA I transferred/ambulated R104 from her room to a chair located down the hall several yards away, across from the main dining room. LPN K and CNA I did not use a gait belt, instead, supported/lifted the resident under her arms while the resident did not bear full weight on her legs and feet. Resident #113 (R113) Review of an Admission Record reflected R113 admitted to the facility on [DATE] with diagnoses that included acquired absence of the left leg below the knee, end stage renal disease, dependence on renal dialysis, chronic fatigue, low back pain, lack of coordination and cognitive communication deficit. Review of a quarterly MDS report dated 8/26/2021 reflected R113 was cognitively intact as evidenced by a BIMS score of 15/15 and needed extensive assistance from two people for bed mobility, transfers, dressing and personal hygiene. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an incident report dated 8/27/2021, documented by the DON, reflected Resident reported that night shift nurse and CNA dropped resident during a slide board transfer to the floor. Resident stated that the nurse and CNA stood over her laughing for 5 minutes taunting her to get herself up. Resident stated that she was crying and begging them to assist her up. Resident stated that they finally assisted her off the floor but didn't state if it was to her w/c (wheelchair), the bathroom or back to bed. Resident stated she did not incur any new injuries during the episode and no new skin injuries. Further review of the incident report and subsequent investigation revealed that staff assigned to care for R113 on the night of the alleged occurrence denied R113 fell but admitted there had been a difficult transfer. The DON documented According to staff interviews, [R113] was being assisted with a transfer from her bed to the commode using 2 assist with slide board. Staff report [R113] was not cooperating well and provided little to no assistance. About halfway through the transfer, while on the slide board she was fearful she was going to fall. The two staff, assisted by boosting her over from the slide board and onto the commode, avoiding a fall. Review of a facility Nursing Daily Attendance Report dated 8/26/2021 reflected LPN OO, LPN TT, and CNA D were working at the time of the incident reported to the DON by R113 on 8/27/21. During a telephone interview on 9/24/21 at 10:24 a.m., LPN OO reported she was helping an unknown CNA with transferring R113 from the bed to the commode using a slide board. LPN OO said that at no time did R113 fall but did describe R113 not being any assistance during the transfer and having to literally drag R113 across the slide board to the commode. LPN OO said R113 was care planned to transfer using the slide board as far as she was aware but did not look at the care plan to confirm R113's transfer status. LPN OO said she and the unknown CNA did not use a gait belt because the resident would refuse it. LPN OO said CNA D was not the aide involved with the incident. During a telephone interview on 9/24/21 at 10:36 a.m., CNA D reported that an unknown CNA had come to her asking for assistance with transferring R113, but another call light went off and she was unable to help, so the unknown CNA requested the assistance of LPN OO. According to CNA D, LPN OO did assist the unknown CNA in transferring R113 from her bed to the commode and after completing that transfer, LPN OO asked CNA D to complete the transfer of R113 from the commode back to bed because the first transfer did not go well. According to CNA D, she did use a gait belt for the second slide board transfer back to bed that shift because without it, (R113) could have fallen. CNA D said she thought the transfer status was reflected on the Kardex (care guide), but that the transfers with her were very rough because R113 would not help at all, and staff would have to use a lot of muscle. Review of a Care Plan Report that included resolved/discontinued focus areas and interventions reflected R113 Had an ADL self-care performance deficit r/t BKA (below the knee amputation) of left leg. I will refuse care, treatment, assessments, and therapy at times despite education and encouragement from staff. The goal of the care plan was for R113 to participate in ADL tasks with therapy services as ordered to attain and maintain prior level of function. Interventions included, TOLIET USE: 2 assist with Hoyer, initiated on 5/24/21 and revised on 8/27/21. No evidence R113 was ever a slide board for transfers was found anywhere in the care plan. Review of PT-Therapist Progress & Updated Plan of Care, dated 8/29/21 for R113 for review dates 8/01/2021-8/30/2021 and signed by Physical Therapist (PT) RR, reflected R113's prior level of functioning for transfers from bed to chair was minimal assistance (1-25% assist). According to the form, R113's current level of functions as of 8/29/21 was dependent (100% assist). (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/24/21 at 10:51 a.m., Occupational Therapist (OT) QQ said that she completed an initial therapy transfer status evaluation for R113 on 7/30/21, the day she admitted to the facility. According to OT QQ, R113 was able to complete the slide board transfer with one assist but was under the impression that staff had downgraded R113's transfer status to Hoyer (full mechanical lift) a few months ago due to her refusal to assist with slide board transfers. OT QQ said that in the times that she worked with her since the initial assessment, R113 had been using the bed pan for elimination. During an interview on 9/24/21 at 10:55 a.m., PT RR reported she was not working the day R113 admitted to the facility and that the times she worked with her she was using a bed pan for elimination and said it was her understanding that staff had downgraded her from a slide board transfer to a Hoyer transfer, but a communication had not been made about it. PT RR reported that in any case, anytime a staff assists a resident with a transfer or with ambulation a gait belt is to be used. PT RR said that R113 would often refuse to complete slide board transfers with nursing staff but would do it for therapy staff. Review of a facility policy Transfer Board adopted 7/11/2018 reflected It is the policy of this facility to transfer an individual with lower extremity weakness from bed to wheelchair. The policy specified a gait belt was required and detailed the following: 9. Assist resident to edge of bed; apply gait belt. 10. Instruct and/or assist resident to lift buttocks away from wheelchair and slide one end of the board under their buttocks. Put the other end of the board on the wheelchair seat. Roll the resident onto his side away from you and place board under him. Then roll him back onto the board. 11. Standing close to the resident, steady his trunk by holding on to gait belt. 12. Instruct resident to push against bed and board with arms while sliding across to wheelchair. Resident #123 (R123) Review of an Admission Record reflected R123 admitted to the facility on [DATE] with diagnoses that included morbid obesity, acquired absence of the left leg below the knee, end stage renal disease, dependence on renal dialysis, high blood pressure, and lack of coordination. Review of a Therapy Communication dated 6/22/21 reflected R123 required the assistance of 1 person for bed mobility and was totally dependent on a Hoyer lift for transfers. Review of a Therapy to Nursing Communication-Initial form dated 6/23/21 did not reflect a transfer status had been identified. Review of a Therapy to Nursing Communication-Update form dated 7/4/21, reflected R123's transfer status was a 1 Assist; mobility device Wheelchair. Directions on the bottom of the form specified Hold w/c (wheelchair) to have patient perform scoot transfer. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 9/24/21 at 8:27 AM, R123 reported that on 7/4/21, a CNA (R123 did not know her name) was attempting to transfer her from her bed to her wheelchair. According to R123, the CNA did not have a good hold on her, and she slipped out of the chair and was halfway on the floor, halfway on the chair. R123 reported the CNA said she was going to get help, left her alone in the room and returned with a young guy (R123 did not know who the male helper was). R123 said that the young guy was smaller than the CNA and they both struggled to get her up. R123 said nobody bothered to make report about it and ask if she was OK and that made her very upset. R123 said it took 3 days to get a portable x-ray to be sure she didn't get injured in the incident. Review of a facility Nursing Daily Attendance Report July 4, 2021 reflected CNA S and RN UU were assigned to work on the unit where R123 lived. During a telephone interview on 9/24/21 at 8:53 a.m., CNA S recalled assisting R123 to transfer to her wheelchair from the bed using a slide board. According to CNA S, therapy had just okayed transferring R123 via the slide board with 1 assist/supervision. CNA S reported that a cushion was on the seat of R123's wheelchair was higher than R123 was used to and that threw R123 off. CNA S said R123 never fell on to the floor and was between the bed and the wheelchair, hanging onto the bed when she got help from Registered Nurse (RN) UU who helped boost R123 into her chair. When asked, CNA S said she did not use a gait belt during the transfer and that RN UU placed his arms under R123's shoulders to complete the transfer. CNA S said that she heard R123 complained of pain after the transfer and that an x-ray was obtained. According to CNA S, she started the transfer with R123 because she needed to get her weight and offered to use the Hoyer to obtain R123's weight instead of the wheelchair. CNA S said, The cushion in her wheelchair made a huge difference, I just wish that therapy had worked with me and the resident (when assessing her ability to complete the slide board transfer). During a telephone interview on 9/24/21 at 11:59 a.m., RN UU recalled being asked to assist CNA S transfer R123 on 7/4/21. RN UU said he came into the room and found R123 balancing between CNA S, the wheelchair, and the bed. According to RN UU the slide board had not been placed correctly and R123 was not helping due to R123 was holding something in her hand. RN UU confirmed that CNA S had left the room and R123 to get his attention to help with the transfer. Review of a Dialysis Communication Form for R123 dated 7/6/21, reflected Resident complications during dialysis: Back pain-tx (treatment) ended early. Review of Progress Notes for R123 from 6/21/2021-7/8/2021 did not reflect a progress noted had been written for R123 on 7/4/2021 or 7/6/2021. Review of a General Progress Note dated 7/7/21 at 7:24 a.m. reflected Resident (R123) c/o (complained of) rib and back pain, PRN (as needed) Norco (a narcotic pain reliever) given and on call Dr called and ordered STAT (urgent) chest and thoracic spine X-RAY 2 views, (name of mobile x-ray company) was called and everything was set up. Review of a Radiology Results Report dated 7/7/2021 reflected that an XRAY CHEST 2 VIEWS was obtained on R123 for Chest Pain, unspecified. The report revealed Conclusion: No gross fracture in the diagnostic portions of the images provided. Degenerative intervertebral disc space narrowing. Limited exam, Recommend diagnostic images or CT. (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	09/24/2021

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 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/24/21 at 10:00 a.m., incident and accident reports and grievance reports pertaining to R123 were requested from the DON. The DON reported that there were no incident or accident reports for R123 but that she would find any grievances that may have been completed. Review of a Grievance and Satisfaction Form dated 7/8/21 at 3:00 p.m., received by the Nursing Home Administrator (NHA) on behalf of R123 reflected (R123) stated she attempted to self-transfer on 7/4 but was unable to complete transfer and aide came in to help prevent fall. Aide unable to by herself so called nurse. Nurse and aide assisted with transfer. Alleged that her back and ribs hurt afterwards . The form, completed by the NHA also reflected in the section Investigation, a notation per ADON (name of RN UU) was stuck out. The narrative following reflected X-ray showed no injuries. She (R123) was on pain meds and more added. When she complained of rib pain, x-ray ordered. No fracture, showed intervertebral disc space narrowing . stated nurse was (male name, not RN UU) but it was not (male name). The Resolution revealed Resident has been stating she wanted to leave and decided to leave AMA (against medical advice). Reported investigation results to resident but still not ok with this. The Grievance and Satisfaction Form was not accompanied by witness statements or additional information to suggest the alleged incident was thoroughly investigated to prevent future unsafe transfers.

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	09/24/2021

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview and record review, the facility failed to ensure a resident who admitted to the facility with an indwelling catheter was appropriately assessed for the removal of the catheter for 1 resident (Resident #83) resulting in the potential for serious complications. Findings: Review of a facility policy Catheter, Utilization adopted 7/11/2018 reflected, It is the policy of this facility that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates catheterization was necessary. A resident admitted with an indwelling catheter in place shall have documentation demonstrating clinical necessity or shall be evaluated for catheter removal. Rationale for catheter use shall be documented on the resident's care plan. Resident #83 (R83) Review of an Admission Record reflected Resident #83 (R83) originally admitted to the facility on [DATE] with pertinent diagnoses of unspecified dementia, adult failure to thrive, diabetes, sleep apnea, high blood pressure, weakness, hearing loss, cognitive communication deficit and malignant neoplasm of prostate. A diagnosis supporting the long term use of an indwelling catheter was not listed. Review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R83 had short- and long-term memory problems and required limited assistance from one person for transfers, walking, toilet use and personal hygiene. The assessment also indicated R83 was not steady moving from a seated to standing position and moving off the toilet. Section H - Bowel and Bladder, reflected R83 did not use a catheter, did not require intermittent catheterization, was not on a toileting program (such as scheduled toileting, prompted voiding or bladder training) and was only occasionally incontinent of urine and never incontinent for bowel movements. Review of an Incident Report dated 7/23/21 at 12:51 p.m. reflected R83 had an unwitnessed fall in the bathroom and was sent to the hospital after an x-ray revealed a right hip fracture. Review of hospital Discharge Orders dated 7/25/21 specified, Foley catheter until no longer painful for bed rolls. Review of a Care Plan Report reflected a focus area initiated on 7/26/21 Resident with dx (diagnosis) of cancer of the prostate, has foley cath, under hospice care. The goal of the care plan was that R83 would not have any complications (no complications were listed) with interventions to meet the goal of the care plan Foley cath care every shift; privacy bag over foley catheter. (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	09/24/2021

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Medication Administration Record-Treatment Administration Record (MAR-TAR) for the month of July 2021 reflected R83 was assessed for pain three times a day, and staff recorded a pain level of 1/10 (on a scale of 0-10, with zero meaning no pain and 10 being the worst pain imaginable) during the day shift on 7/26/21. All other pain assessments since R83 readmitted to the facility on [DATE] were 0/10. Further review of the MAR reflected R83 had a PRN (as needed) order for Acetaminophen Tablet 500 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for pain which was administered for a pain level of 2/10 on 7/28/21 and again for a pain level of 4/10 on 7/29/21. Review of a MAR-TAR for the month of August 2021 reflected staff documented R83 had no pain at all, consistently documenting pain at a level of 0/10 on a scale of 0-10. Further review of the MAR reflected R83 was never given a dose of a PRN pain reliever. Review of a MAR-TAR for the month of September 2021 reflected staff documented R83 had no pain at all, consistently documenting pain at a level of 0/10 on a scale of 0-10. Further review of the MAR reflected R83 was never given a dose of a PRN pain reliever. During an observation on 9/14/21 at 12:09 p.m., R83 bent his right leg at the knee and pressed down on the bed with his right heel, lifted his buttocks, and reached his right arm across the bed to assist staff with turning onto his side for an assessment of his coccygeal area. R83 was chatting during the motion and did not express any verbal or non-verbal signs or symptoms of pain. During an interview on 9/15/21 at 12:32 PM, R83's wife, Family Member (FM) XX reported that R83 does not have obstructive uropathy, further explaining that the prostate cancer is on outside of prostate and a little on pelvic bone. FM XX said that R83 had been seeing a urologist for the prostate cancer but that since R83 fractured his hip and was now on hospice care, those visits were on hold. Review of a Nurse Practitioner (NP) progress note dated 9/15/21 documented by NP LL reflected R83 was seen for a skin check. The note revealed Patient seen at the request of nursing staff for the evaluation of skin regarding concerns of open area over buttock. Pt is alert awake and hard of hearing. He has been bed bound due to the fact that he has a non-surgical fracture of the right femur. He is dependent on staff for all ADL (activities of daily living). He states his pain is well controlled. He has a foley catheter and draining clear urine with some slight sediments. Pt has a history of prostate cancer and was under the care of the oncology until he went on hospice care. He has dementia, but he is pleasant and cooperative with care. He has no exhibited behavior so far, he is sleeping well, PO (per mouth) intake is good, he is cooperative with care. The note specified that R83 has no strength for bed mobility. The physical exam revealed His skin over the sacral area is clear and no open areas noted. The coccyx is slightly discolored. It is slightly red and blanchable. No open area noted, no pain or discomfort on palpation. He is incontinent on bowel and needed to be cleaned up while being examined, pt did not show any signs of pain while being cleaned. The Assessment/Plan specified that R83 did not have skin breakdown and no change in treatment was indicated. During a telephone interview on 9/15/21 at 3:21 p.m., Hospice Registered Nurse Case Manager (RNCM) WW reported that a foley catheter is generally not advised and had assumed that R83 had a catheter in place for a medical diagnosis. RNCM WW said she was not aware the catheter had been placed in the hospital with directions to remove it when R83 was no longer painful with bed rolls. (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	09/24/2021

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/15/21 at 4:00 pm., the Director of Nursing (DON) reported that she was not aware R83's catheter had been placed in the hospital with instructions to discontinue it when R83 was no longer painful with turns in bed.

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	09/24/2021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to ensure that hydration was available, accessible, and provided to those who needed assistance with oral intake or those receiving nutrition and hydration through tube feeding for 7 residents (Resident # 63, Resident #105, Resident #2, Resident #3, Resident #4, Resident #111, and Resident #107) reviewed for hydration and nutrition status, resulting in the potential for urinary tract infections, confusion, skin breakdown, low blood pressure, dehydration, and the inability to attain the highest practicable level of well-being. Findings: Resident #63 (R63) Review of an Admission Record revealed R63 was a [AGE] year-old female, with pertinent diagnoses of Cerebral Palsy, legally blind with the use of bilateral prosthetic eye balls, diabetes mellitus type 2, and seizure disorder. A Minimum Data Set (MDS) assessment, completed 07/26/21, reflected R63 required extensive assistance from staff for bed mobility, transfers, and going to the bathroom. Eating was listed as supervision and 1-person physical assist. needed. Review of a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated that R63 was cognitively intact. During an observation on 09/12/21 at 12:20 P.M., Registered Nurse (RN) A was in the room and had taken R63's vitals, and the resident had a Styrofoam water cup on the over bed table, no date, and there was paper covering the end of the straw. Two small empty spouted cups from lunch remained on the over bed table which was situated across the bed and in front of R63. During an observation on 09/12/21 at 12:56 P.M., R63 had a Styrofoam water cup on the over bed table and paper covered the end of the straw. The two small empty spouted cups with handles had been removed. When asked if R63 knew where the water cup was, R63 responded, no, I'm blind and reached the right arm out a little and was feeling the top of the over the bed table for the water cup. The water cup was in the upper left corner of the table, out of reach of the resident. During an observation on 09/12/21 at 2:30 P.M., R63 laid in bed and had a styrofoam cup with fluids on the over bed table. The straw was covered with paper and the over bed table was positioned next to the bed on the fall mat, rendering the fluids out of reach for R63. During an observation on 09/13/21 at 1:03 P.M., R63 had just completed lunch, staff removed the meal tray, and the Styrofoam water cup sat on the over the bed table, in the bottom left corner. R63 demonstrated having no mobility on the left arm, I have Cerebral Palsy, and reached out with the right hand, onto the table to try to locate the water cup. The right arm movement was slow and limited. When asked if staff had told her where the water cup was located on the table, R63 indicated they had not. R63 attempted to reach out again to locate the water cup but was unable to due to the location of the cup on the table and the limited mobility in the right arm. Is the water cup on the table? (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	09/24/2021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/14/21 at 11:55 A.M. R63 was up in chair, self-feeding for lunch, and had 2 small, spouted cups with handles on the lunch tray. During an interview at that time, Registered Dietician (RD) JJ indicated that R63 could independently drink fluids if provided cups with handles and spouted tops; otherwise R63 could not independently drink fluids and hold the cups. During an observation on 09/14/21 at 3:33 P.M. the following was noted for R63: (a) staff had just completed ADL care and exited the room, (b) there were no fluids within reach of the resident, (c) a Styrofoam water cup, with no handles or spout, sat near the door on the bedside table, and (d) R63 indicated that staff had not offered fluids when they were in the room. There were no cups with handles, or a spout observed on R63's side of the room. During an observation on 09/15/21 at 3:36 P.M. R63 laid in bed, no fluids with handles or a spout were within reach, and a Styrofoam water cup of water warm to the touch, sat on the bedside table near the door. There was no date or time written on the Styrofoam cup to indicate when it had been placed in R63's room. During an interview on 09/15/21 at 4:29 P.M., RD JJ reiterated that R63 cannot drink fluids independently unless provided cups with a spout and handles. RD JJ and the surveyor entered R63's room and observed a Styrofoam cup, with no handles or spout, on the over the bed table, which was pushed away from the bed, and well out of reach of the resident. No cups with handles of a spout were observed on R63's side of the room. Review of a Dietary Evaluation dated 07/23/21, reflected the following information regarding R63 (a) was prescribed a regular diet, drank thin liquids, did not have any fluid restrictions, and required a spouted cup to drink liquids, (b) accepted most fluids offered, (c) had a functional problem that affected R63's ability for oral intake (blindness and cerebral palsy), (d) had interventions listed as encourage fluids for adequate hydration and adaptive equipment, and (e) had assistance as needed due to blindness, mainly with set up and did well with sprouted cups. Resident #105 (R105) Review of an Admission Record revealed R105 was a [AGE] year-old male, with pertinent diagnoses of hepatitis, a fractured rib, nose bleeds, low sodium levels, and a stage 2 pressure wound on bilateral buttocks. A Minimum Data Set (MDS) assessment, completed 07/26/21, reflected R105 required extensive assistance from staff for bed mobility, transfers, and going to the bathroom. Eating was listed as supervision and 1-person physical assist. Review of a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated that R105 was cognitively intact. During an observation on 09/13/21 at 12:57 P.M., R105 laid in bed, the over bed table reached across the bed in front of R105, and a cup of fluids without a lid, sat on the table. When asked if R105 could reach the cup, R105 slowly reached up and touched the cup and stated I will spill it. During a medication administration observation on 9/13/21 at 5:10 p.m., R105 was lying in bed, the meal tray and fluids appeared to be untouched and were out of reach. R105 was dependent for assistance from Licensed Practical Nurse (LPN) B to take an oral medication solution and also required assistance repositioning blankets. During the observation, an unknown Certified Nurse Aide (CNA) entered the room and asked LPN B if R105 was finished with his meal, LPN B said she didn't know and the unknown CNA left the room without offering to assist R105 with eating or drinking. (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	09/24/2021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/14/21 at 11:47 A.M., R105 laid in bed and a styrofoam cup 1/2 full of fluids, without a lid, sat on the over bed table, which was pushed away from the bed and near the window, and out of reach of R105. During an observation on 09/14/21 at 3:24 P.M., R105 laid in bed and a styrofoam cup 1/2 full of fluids, without a lid, still sat on the over bed table, near the window, and out of reach of the resident. During an observation on 09/15/21 at 4:07 P.M., R105 laid in bed, bed in the lowest position, and a styrofoam cup full of fluids and warm, dated 9-14 3rd shift, sat on the over bed table. The table was positioned up high and too high for R105 to reach the top of the table. Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year old female, most recently admitted to the facility on [DATE], with a pertinent diagnosis of Multiple Sclerosis. A Minimum Data Set (MDS) assessment, completed 09/03/21, revealed R2 requires extensive assistance from at least one staff person to meet all of the activities of daily living. R2 had impaired mobility of both upper and lower bilateral extremities and was always incontinent of bowel and bladder. During an observation on 09/12/21 at 9:23 A.M., R2 had a styrofoam cup full of fluids with paper covering the end of the straw and out of reach of the resident. R2 stated that with the exception of breakfast, R2 had not had anything to drink yet today. During an observation on 09/14/21 at 10:33 A.M., R2 rested in bed with eyes closed. A full styrofoam water cup sat on the over bed table, out of reach of the resident. During an interview on 09/15/21 at 7:43 A.M., R2 reported that staff had changed a soiled brief during the night last night and did not offer fluids to the resident at that time. R2 also indicated that staff had not offered fluids to the resident yet this morning. The styrofoam cup of fluids sat on the over bed table, next to and at the head of the bed, out of reach for R2. During an observation on 09/15/21 at 11:43 A.M., a 3/4 full styrofoam cup of fluids sat on the over bed table, and was dated 3rd shift 09/14/21. Resident #3 (R3) Review of an Admission Record revealed R3 was an [AGE] year old female, originally admitted to the facility on [DATE] with a pertinent diagnosis of dementia. R3 was dependent on staff for all oral intake. During an observation on 09/12/2/1 at 9:04 A.M., R3 laid in bed and received assistance from Certified Nurse Aide (CNA) MM to eat breakfast. R3 had a styrofoam cup of fluids on the over bed table, that was full. CNA MM indicated that R3 no longer speaks and could move both arms a little. We (staff) have to anticipate (R3's) needs. During an observation on 09/12/21 at 12:33 P.M., R3s styrofoam cup of fluids sat on the over bed table and was full. (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	09/24/2021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/12/21 at 2:10 P.M., R3's styrofoam cup of fluids sat on the over bed table and was full. During an observation on 09/15/21 at 8:12 A.M., R3 had a styrofoam cup on the over bed table that was marked 3rd shift, 9/14, and was full. During an observation on 09/15/21 at 3:18 P.M., R3 had a styrofoam cup on the over bed table that was marked 3rd shift, 9/14, and was full. Resident #4 (R4) Review of an Admission Record revealed R4 was a [AGE] year old male with pertinent diagnoses of vascular dementia, history of a nontraumatic intracranial bleed, lack of coordination, retention of urine, and muscle weakness. During an observation on 09/12/21 at 10:01 A.M., no cup of fluids was noted at R4's bedside nor on R4's side of the room anywhere. During an observation on 09/13/21 at 8:58 A.M., R4 laid in bed, sitting up and had a styrofoam cup of fluids on the over bed table out of reach of the resident. During an observation on 09/15/21 at 7:55 A.M., R4 laid in bed and had a cup of fluids on the over bed table, out of reach of the resident. Review of a Kardex reflected: keep tray table with tv remote and water within reach of resident. Resident #111 (R111) Review of an Admission Record revealed R111 was an [AGE] year old female, originally admitted to the facility with pertinent diagnoses of dementia, cognitive communication deficit, weakness, and history of falls. During an observation on 09/12/21 at 10:21 A.M., a cup of fluids sat on R111's bedside table, out of reach of the resident, and paper covered the end of the straw. During an observation on 09/13/21 at 9:13 A.M., R111 sat in a wheelchair next to the bed and no cup or container of fluids were located on R111's side of the room. 31771 Resident #107 Resident #107 (R107) was originally admitted to the facility 06/28/19 with diagnoses that included Alzheimer's Disease and Diabetes Mellitus. R107 receives nutrition through a feeding tube and does not consume any foods or liquids orally. Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 7 which indicated R107 was cognitively impaired. (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	09/24/2021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/13/21 at 10:50 A.M., R107 laid in bed receiving a tube feeding at 65 cubic centimeters (cc) per hour. R107 had severely dry and cracked lips. On 09/14/21 at 12:28 PM R107 was again observed to be lying in bed receiving nutrition through a feeding tube. It was observed that the lips of R107 remained severely dried and cracked. Licensed Practical Nurse (LPN) AA entered the room and reported she did not believe that R107 had any current interventions for dry and cracking lips. The last two laboratory test results that included a metabolic panel for R107 were reviewed. Using the accepted formula for serum osmolality (2(sodium [na+]) + (Blood Urea Nitrogen [BUN] / 2.8) + (Glucose/18) with normal limit results of 282 to 296, and a result of a number greater than 296 indicates dehydration, the lab results of R107 were inserted into the formula. The lab results of 11/26/20 revealed an na+ of 143, a BUN of 33, and a glucose of 131. Implementing the formula yielded a result of 305.05 which indicated dehydration. Implementing the formula for the lab results of 7/23/21 (na+=144, BUN =36, glucose 138) the formula revealed a result of 308.51 which indicated dehydration. Furthermore, the lab result of the BUN/Creatinine (B/C) ratio , a lab result with a normal range of 8.0 to 25.0 that can reflect kidney function, but an elevated result is also indicative of dehydration. The B/C results for the two labs reviewed of R107 revealed elevated B/C results of 47.14 and 54.55 respectively. On 9/22/21 at 3:46 PM an interview was conducted with Registered Dietician (RD) JJ in his office. RD JJ reported when determining the nutritional needs of a resident receiving tube feeding, he considers age, weight, and energy expenditure. RD JJ reported he also considers labs and any skin concerns. RD JJ reported when reviewing labs, he is attentive to the glucose and BUN levels but mainly the sodium result. RD JJ was informed that the last two labs reflected R107 was dehydrated. RD JJ reported he was working on gradually decreasing the body weight of R107 and offered no further information on the hydration status of the Resident at this time. On 9/23/21 at 8:04 AM RD JJ initiated an interview that included additional information on R107. RD JJ reported the Medical Provider told him that the BUN of R107 would be elevated because of the protein the Resident is receiving due to her wounds. RD JJ reported that the last he heard R107 has a wound on her heel. RD JJ did not provide any information that an elevated BUN by itself explained the hydration status of R107. RD JJ did not provide any further information on how the other abnormal lab results used to determine hydration status could be dismissed. Review of the Doctor's Orders for R107 revealed an order dated 12/17/21 for R107 to receive nothing by mouth (NPO) which meant that all future nutrition and hydration would be through the feeding tube only. Review of the Electronic Medical Record (EMR) Progress Notes from 11/20/20 to 9/14/21 did not reveal any Nutrition documentation of the abnormal labs of 11/26/20 and 7/23/21. No Nutrition documentation was found noting the Doctor's Order that discontinued oral intake on 12/17/20. Nutrition documentation (12/24/20, 2/26/21, and 6/22/21) reflected water intake of 1557 cubic centimeters (cc) remained unchanged and hydration status of R107 was not commented on despite the two labs with abnormal results. (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	09/24/2021

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plans for R107 did not reveal a Care Plan for Hydration. The Care Plan titled The resident is on diuretic therapy . did not reveal any active interventions to monitor for dehydration. Review of the Care plan titled The resident requires tube feedings (related to) . did not reveal any active interventions for monitoring the hydration status of R107.

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	09/24/2021

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36090 Based on observation, interview, and record review, the facility failed to follow physician orders and best practice guidelines for three residents (Resident #109, #121, and #107) receiving tube feeding, resulting in the potential for aspiration, choking, and pneumonia for all 3 residents and the delay in receiving services relevant to the tube feed for Residentt #121. Findings include: Review of facility policy titled Enteral Nutrition- Resident Care, adopted 2/11/21, revealed General monitoring of nursing care should include: Head of bed should be elevated at a 30 - 45-degree angle during feeding and for at least 30 minutes after feeding is completed to prevent gastric reflux and possible aspiration. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, A serious complication associated with enteral feedings in aspiration of formula into the tracheobronchial tree. Aspiration of enteral formula into the lungs .leads to necrotizing infection and pneumonia .Some of the common conditions that increase the risk of aspiration .lying flat .keep the head of bed elevated a minimum of 30 degrees .Place patient in high Fowler's position or elevate head of bed a minimum of 30 (preferably 45) degrees during feedings and for 2 hours afterwards. [NAME], P. A., [NAME], A. G., Stockert, P. A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby. p. 1018 and 1022. R 109 According to the Minimum Data Set (MDS) assessment, dated 9-1-21, indicated R 109 had multiple diagnosis including stroke, gastroesophageal reflux disease (GERD), and dysphagia (difficulty swallowing). This same assessment indicated R 109 was totally dependent upon staff for tube feeding nutrition and required extensive assistance of staff to move in bed and dressing. Staff assessed R 109 as moderately cognitively impaired. Physician orders read, Elevate HOB (head of bed) 30 - 40 degrees during all feeding and flushes. During an observation on 9/13/21 at 8:30 AM revealed R 109 was receiving Jevity 1.5 calorie (a tube feeding formula) at 50 milliliters per hour per programmed pump. R 109 was in bed, the head was elevated between 30 to 40 degrees however, R 109's abdomen was flat on the bottom half of the bed and R 109's head and shoulders rested in the middle upper half of the bed and not at a 30 to 40-degree angle. Another observation that same day at 9:00 AM, R 109 was resting with eyes closed and remained in the same position in bed as previously described and the tube feeding formula continued to infuse placing R 109 at risk for aspiration. 37577 Resident #121 (R121) (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	09/24/2021

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R121 was a [AGE] year old male, originally admitted to the facility on [DATE] with pertinent diagnoses of chronic kidney disease, adult failure to thrive, cognitive communication deficit and more recently, readmitted back to the facility in July 2021, after being hospitalized for aspiration pneumonia. During an observation on 09/13/21 at 8:28 A.M., R121 laid in bed, flat with tube feed running at 85 ml/hr (milliliters per hour). The head of the bed was not elevated. The bag of flush did not have a date and time written on it, to note when it had been started. Review of an Electronic Treatment Administration Record (Etar) for R121 and dated 09/01/21 to 09/30/21, reflected the following order: Elevate HOB (head of bed) 30-45 degrees during all feedings and flushes every shift to minimize risks. During an interview on 09/21/21 at 10:17 A.M., Speech Language Pathologist (SLP) AAA indicated requesting a VFSS (videoflouroscopic swallow study) for R121 last month, however, the swallow study had just been scheduled. SLP AAA indicated following up with Unit Secretary (UC) BBB twice a week to ensure that the VFSS would get scheduled. Review of a Therapy Status Communication form, for R121, written by SLP AAA, and dated 08/19/21, reflected recommend VFSS to assess swallow function. Please schedule for early September. Review of a General Progress Note for R121, dated 09/17/21, revealed that the video swallow study was scheduled for October 25th, 2021, over two months after the initial request was made. 31771 Resident #107 Resident #107 (R107) was originally admitted to the facility 6/28/19 with diagnoses that included Alzheimer's Disease and Diabetes Mellitus Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 7 which indicated R107 was cognitively impaired. Section G of this MDS reflected R107 required extensive assistance of two staff members with bed mobility. Section K of the MDS reflected R107 receives nutrition by way of a feeding tube. Review of the Doctor's Orders for R107 revealed Elevate HOB 30-45 degrees during all feeding and flushes, dated 3/18/21. This order suggests the Resident is to be in this position to receive the tube feeding. Review of the Care Plan titled the resident requires tube feeding (related to) . reflected the intervention, Keep head of bed (HOB) elevated 30-45 degrees during and thirty minutes after tube feed and was initiated 4/10/20. The Kardex, a summary of a resident's care needs, reflected staff providing care for R107 were to, Keep head of bed (HOB) elevated 30-45 degrees during and thirty minutes after tube feed. (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	09/24/2021

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/21/21 at 11:45 AM an observation and interview were conducted in the room of R107. R107 was observed receiving a tube feeding via pump at 65 cubic centimeters (cc) per hour. The head of the bed was at 35 degrees by the scale attached to the bed rail. However, R107 appeared to have slid down and her shoulders were in the bend of the bed and her head and neck were on the elevated portion of the bed. R107's body was almost flat and perpendicular to the lower portion of the bed. Licensed Practical Nurse (LPN) V was summoned to the room and questioned about the positioning of R107. LPN V reported the resident's body should be at 30 degrees or greater to be receiving a tube feeding. LPN V acknowledged the Resident was not in the proper position for this. On 9/24/21 at 8:03 AM R107 was observed to be in bed receiving a tube feeding at 65cc per hour. The head of the bed was observed to be at 30 degrees. However, R107 appears to have slid down and only the Resident's head and shoulders are on the 30-degree plane. At 8:22 AM LPN P was summoned from an adjoining hall to the room of R107. LPN P reported she has split the hall with another nurse who is currently working on another hall. LPN P reported that R107, is a tough one, she slides (down) real easily .we're always repositioning her . We're looking at doing a Broda (chair) for her. LPN P reported staff are in the room as much as they can be but indicated we need more nurses as the medical acuity on the Shore Hall is high. LPN P did not make provisions to reposition R107 before returning to the other hall. On 9/24/21 at 8:41 AM LPN Unit Manager AA reported she did not know which nurse was working on the hall where R107 resided. LPN AA was asked to come to the room of R107. LPN AA acknowledged that R107 was not in the proper position for a tube feeding.

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	09/24/2021

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to MI000121966 Based on observation, interview and record review, the facility failed to ensure competent staff were deployed in sufficient numbers to meet the needs of residents at the facility resulting in neglect, staff burnout, an unsafe environment and the potential for serious adverse physical and psychosocial harm. Findings: Resident #125 (R125) Review of an Admission Record reflected R125 admitted to the facility on [DATE] with diagnoses that included a sprain of an unspecified site, abnormalities of gait, right shoulder pain, pain in the right knee, unsteadiness on feet, lack of coordination, obesity, high blood pressure, type 2 diabetes and gout. During a telephone interview on 9/22/21 at 12:32 p.m., R125's wife, Family Member (FM) F reported that R125 admitted to the facility on [DATE] and was on strict orders not to try to get out of bed on his own due to the injuries to his right knee and right shoulder. According to FM F, R125 called her on 7/10/21 and was so angry after attempting to call for a bed pan and was unable to get help. FM F said R125 had an episode of bowel incontinence that he had to lay in for two hours. FM F said after her husband called her, she tried calling the nursing station and the front office at the facility to get help for R125 and there was no answer. FM F said she got so concerned that she called 911 who was finally able to reach staff at the facility who could go and clean up R125. FM F said she sent a detailed email of her concerns to the Business Office Manager (BOM) CCC at 11:15 on 7/12/21. Review of a Memorandum dated 7/12/21, addressed to the facility Nursing Home Administrator (NHA) and BOM CCC reflected FM F sent a detailed list of concerns including the following: (a) 7/8/2021-Thursday [R125] continued to have difficulty getting a staff member to respond to his needs. From my limited observation and what [R125] could overhear, it appears (name of facility) is operating with a very limited staff working under stressful conditions. He hears patients up & down the hall calling out for help off & on all day. (b) 7/9/2021-Friday [R125] was constipated & treatment was started for that. His bowels finally moved in the afternoon. However, he was left on a full bedpan for an hour or more, his calls were not responded to. At this point we became concerned & angry about the lack of compassion & quality of care from an 'approved skilled nursing facility'. (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	09/24/2021

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(c) 7/10/2021 - Saturday [R125] called me about 9 a.m.-he called for a bedpan at 8:15 a.m. & no one responded. He had a bowel movement in the bed. An aide came in & said she would help cleaning him up & the help was on break. I (FM F) called (name of facility) automated phone system 3 times with these replies: The office is closed; Nurses station did not answer; No response at all. At 10:06 a.m. I was so angry & concerned I called 911-dispatcher called me back & said she talked with a nurse & they were checking out the complaint. [R125] called me & said they came & cleaned him up about 10:19 a.m. [R125] had to lay in his bowel movement for 2 hours!. During a follow-up telephone interview on 9/22/21 at 4:36 p.m., R125 reported that on 7/10/21 at around 8:30 a.m., he attempted to summon assistance from staff to get a bedpan by pushing the call light button multiple times. R125 said he was unable to hold it and had a bowel movement in the bed. R125 said he called out for help and could hear and see staff in the hallway and, after 30 minutes of waiting, decided enough was enough and called his wife for help. R125 said his wife called the facility and couldn't get anyone to answer and then she called 911. R125 said he was finally cleaned up at around 10:30 a.m., after sitting in feces for two hours. R125 said the whole ordeal made him angry, like he wasn't getting the care and services Medicare and the insurance company were paying for and feeling afraid that this was going to be the care he could look forward to. R125 said the whole place was short staffed and recalled an incident when he asked a CNA for water and the aide told him the facility was short staffed and that she had 18 patients across 2 wings of the facility that she was responsible for . R125 said that more than one CNA told him they were looking for other jobs and R125 said this upset him because staff should not tell him these things. During a telephone interview on 9/22/21 at 3:04 p.m., Receptionist HHH reported that she had not been on duty the day that FM F called 911 to get help for R125, however she had heard that it happened. Receptionist HHH said sometimes residents call the front office for help when staff aren't answering call lights and recalled a recent incident when not enough staff were available to assist Resident #55 into her power-chair for a window visit. Receptionist HHH said that CNA MM was only able to move R55's bed closer to the window because two people were not able to assist with a transfer and this was upsetting to R55 because she could not see or hear her visitor very well. During an interview on 9/22/21 at 3:55 p.m., Facility Receptionist/Certified Nurse Aide (FR/CNA) SS said she was working on 7/10/21 and recalled getting a call from law enforcement about R125 needing assistance with getting cleaned up and had been waiting for hours. FR/CNA SS said she called the unit where R125 lived and let the nurse know R125 needed to be helped. FR/CNA SS said that lately it is not unusual to get a call from law enforcement about care and services at the facility, explaining that other residents have called 911 too. FR/CNA SS said she had been educated about the abuse and neglect prohibition policy and procedures at the facility and that a resident alleging they were left soiled for hours could be an allegation of neglect that should be reported immediately. FR/CNA SS said that after law enforcement called the facility about R125 needing assistance after having to wait for hours for help, she did not report the allegation to the NHA. FR/CNA SS said she never provided a statement about the occurrence to anyone. (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	09/24/2021

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a medication administration observation beginning on 9/13/21 at 5:15 p.m., Licensed Practical Nurse (LPN) B struggled to calculate the volume of medication required to dose R105 with physician ordered Lorazepam Concentrate 2 MG/ML Give 0.5 mg by mouth two times a day for Chronic anxiety. LPN B was ultimately able to calculate that in order to dispense the dose correctly, a volume of 0.25 ML was required. The observation took 55 minutes from start to finish, LPN B was visibly shaken, emotional, and distracted during the med pass. LPN B reported that she had been working a lot lately and was exhausted. LPN B went on to explain that she had recently voluntarily resigned her position as a unit manager due to the extensive hours and requirement to pick up shifts when there are staffing shortages. During an interview and record review on 9:/15/21 at 2:00 p.m., Daily Attendance Reports for the date range 9/9/21-9/13/21 were reviewed along with LPN B who explained that there would not be punch card details for several shifts she worked because she was still considered salary in her capacity as Unit Manager for several days. The following was revealed: -On 9/9/21, LPN B explained that she worked from 2:00 p.m.-10:00 p.m. as a charge nurse and had also worked in her capacity as Unit Manager prior to starting her shift. (8 hours, not including time as a unit manager) -On 9/10/21, LPN B worked in her capacity as Unit Manager, arriving to work at around 11:00 a.m. and stayed until she had to work as a charge nurse from 6:00 p.m.-6:00 a.m. (19 hours at the facility). LPN B said she knew what time she came into work that day because she brought everyone coffee. -On 9/11/21, LPN B worked as a Unit Manager on-call and came in to work as a charge nurse from 2:00 p.m. -6:00 a.m. (at least 16 hours). -On 9/12/21, LPN B was no longer considered a salaried employee and worked from 1:42 p.m.-3:00 a.m. (13 hours). -On 9/13/21, LPN B was scheduled to work from 2:00 p.m.-10:00 p.m. but clocked out at 9:35 p.m. According to LPN B, after the nerve-wracking medication administration observation on 9/13/21, she recognized she was too exhausted to safely work. In total, LPN B worked at least 64 hours in 5 days, not taking into account time worked as a Unit Manager on 9/9/21 and 9/11/21. During a telephone interview on 9/13/2021 at 3:32 p.m., Licensed Practical Nurse (LPN) TT reported that on 9/8/21 at approximately 3:00 a.m. she discovered LPN K had left her medication cart unlocked and unsupervised. LPN TT said that when she opened the top drawer of LPN K's medication cart, she discovered a number of preset medications as evidenced by plastic med cups with pills, some crushed preparations mixed with pudding or sauce, preset insulin injections, and biologicals needing temperature-controlled storage. According to LPN TT, the medication cups were labeled with resident names torn from plastic medication bags dispensed by the pharmacy and placed into cups. LPN TT said she recognized several of the pills as controlled substances. According to LPN TT in addition to questioning LPN K about the discovery, she reported the incident to the DON, NHA and Unit Manager, RN N. LPN TT said she provided a write up to the DON and RN N about the incident, in addition to creating incident reports for the residents she was able to identify. (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	09/24/2021

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Medication Error incident reports dated 9/8/21 at 3:00 a.m. were provided for R11, R16, R51, R57 and R86. Each report reflected the same narrative This nurse came upon an unlocked med cart in [name of secured unit] at approximately 0300 (3:00 a.m.) looking for residents' eye gtts (drops) that was recently moved to [name of another unit] and after opening the cart I witnessed 13 preset med cups with residents name cut off their medication bags with regular medications as well as narcotics in most of them. Some pills were whole, and some were crushed, while this nurse was still in (resident room) getting vitals on another resident. The nurse on duty stated that she placed the preset medications in the top of the cart because everyone did it and it was real busy on that hall. The section on the report Immediate Action Taken reflected Educated this nurse on rules and regulations of not presetting medications, as well as leaving her med cart unlocked with narcotics in an unlocked med cart. Reminded this nurse that out window for State survey is currently open. Also this nurse wrote up a disciplinary action form about incident and handed a copy to Administrator, DON and Unit Manager. Review of a Medication Error incident report dated 9/8/21 at 3:00 a.m. for R33 reflected This nurse came upon an unlocked med cart in [name of secured unit] at approximately 0300 (3:00 a.m.) looking for residents' eye gtts (drops) that was recently moved to [name of another unit] and after opening the cart I witnessed 13 preset med cups with residents name cut off their medication bags with regular medications as well as narcotics in most of them. Some pills were whole, and some were crushed, while this nurse was still in (resident room) getting vitals on another resident. Also noted this resident's Enbrel prefilled syringe that needs to be refrigerated until use inside the top of med cart drawer with his Breo Inhaler. The nurse on duty stated that she placed the preset medications in the top of the cart because everyone did it and it was real busy on that hall. During an interview on 9/15/21 at 10:35 a.m., the Pharmacist Consultant (PC) GGG reported that presetting medications is not recommended because it creates a situation highly likely to cause medication administration errors. PC GGG said that she has encountered instances of staff presetting medications as a way to compensate for staffing shortages. PC GGG reported that the medication Enbrel is to be refrigerated until just before it is ready for use and that once the medication reaches room temperature it is not to be put back into the refrigerator because it will degrade the medication and can cause proteins in the solution to clump, decreased the efficacy of the medication or other cause other complications. During an interview on 9/15/21 at 12:35 p.m., LPN K admitted she preset medications on 9/8/21 because it was so busy on the unit and due to staffing shortages, but had never done it before and would never do it again. LPN K said she only preset medication for 3 residents and only one of them (R57) had a narcotic. LPN K admitted she preset R33's Enbrel from the fridge and said it had been out of the fridge for 30 minutes (long enough for the medication to reach room temperature) but that she put it back in the fridge when LPN TT discovered preset medications. LPN K said she wrote the anticipated time of administration of the narcotics she preset on the narcotic Controlled Drug/Receipt/Record/Disposition Form, not the time she pulled the medication. LPN K reported she preset the medications because of staffing shortages related to the busy pace on the unit. (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	09/24/2021

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of photographs forwarded to this surveyor by LPN TT on 9/14/21 at 4:23 p.m. showed images of preset medications for more than six residents on the top of and inside an open top drawer of the medication cart. One of the photos showed the hands of LPN K resting on the drawer, other photos showed the preset medications with some resident names visible on the plastic wrappers used to mark the medication cups. The photos were accompanied by a lengthy text message report made to the DON about the discovery. The photos and text messages were dated 9/8/21 and time stamped 3:41 a.m., 3:53 a.m. and 4:19 a.m. LPN TT was asked to share the contact information she had for the DON, and the number she texted was the same number assigned to the DON as evidenced by a posting in the front entryway at the facility. During an interview on 9/14/21 at 4:29 p.m., CNA EE reported the facility is short staffed. According to CNA EE, three residents (Resident #47, Resident #93 and Resident #111) had falls during her shift that began on 9/10/21 because of the staffing shortage saying, We can't be everywhere. Review of fall incidents for the timeframe referenced by CNA EE confirmed that on 9/11/21 at 3:50 a.m., Resident #111 sustained an unwitnessed fall without injury. On 9/11/21 at 2:49 a.m., Resident #93 had an unwitnessed fall without injury. On 9/11/21 at 5:00 a.m., Resident #47 had a witnessed fall in his room without injury. Review of a Daily Attendance Report dated 9/10/21 reflected 1 nurse worked the 100 and 200 halls, 1 nurse worked the 300 and 400 halls at the facility, and 1 nurse worked on the 500 halls at the facility. Three CNAs split responsibility for the 300, 400 and 500 halls. The census on 9/10/21 was 115 residents. 31771 Resident # 9 and Resident # 107 Resident #9 (R9) was admitted to the facility 7/24/20 and had diagnoses that included: Diabetes Mellitus, Respiratory Failure and Stroke. Review of the Minimum Data Set (MDS) dated [DATE] reflected R9 has a stage 4 pressure sore and requires pressure sore care. Review of the medical record for R9 revealed Moisture Associated Skin Damage (MASD) was first identified on R9 on 2/ 8 /21. The medical record reflected this skin damage had progressed to a stage 4 pressure sore. Review of the Care Plan for Resident #9 (R9) reflected Blue Dot Protocol: Routine frequent repositioning On 9/22/21 at 11:21 a.m. The Director of Nursing reported an explanation of the Blue Dot protocol, Blue Dot - is a tool we use to identify those who are at highest risk and need frequent assisted repositioning. No formal protocol for the facility's Blue-Dot protocol was provided. On 9/21/21 at 9:33 AM Resident #9 was observed in his room on the Shore Hall laying in his bed on his back with two pillows positioned next to him on the bed and one pillow under his head. Resident #9 was observed to be in this same position with the three pillows unmoved since this time at 10:52 AM, 11:45 AM, 1:08 PM, and 3:00 PM. (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	09/24/2021

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #107 (R107) was originally admitted to the facility 6/28/19 with diagnoses that included Alzheimer's Disease and Diabetes Mellitus Review of the Minimum Data Set (MDS) dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 7 which indicated R107 was cognitively impaired. Section G of this MDS reflected R107 required extensive assistance of two staff members with bed mobility. Section K of the MDS reflected R107 receives nutrition by way of a feeding tube. Review of the Doctor's Orders for R107 revealed Elevate HOB 30-45 degrees during all feeding and flushes, dated 3/18/21. This order suggests the Resident is to be in this position to receive the tube feeding. In an interview conducted 9/24/21 at 8:22 AM Licensed Practical Nurse (LPN) P was found on the 500 hall and reported she had split the Shore Hall residents with another nurse. It was observed the Shore Hall was beyond a set of closed double doors. LPN P was summoned to the Shore Hall to the room of R107. R 107 was improperly positioned in her bed while receiving a tube feeding and was on the Blue Dot Protocol of frequent repositioning. LPN P reported R107 slides (down) real easily, we're always repositioning her. LPN P reported staff are in the room as much as we can. LPN P reported that the medical acuity of the Shore Hall was high and that the facility needs someone on the hall all of the time. LPN P reported we need more nurses . on a good day we have two CNA's (Certified Nurse Aides) but that's not the norm LPN P gave an account of some residents she considered to be high acuity. We have (R9 who requires frequent repositioning), two tube feeds, a trach (a resident with a tracheostomy), and two dialysis residents. LPN P reported that if the facility is short of staff, the Shore (Hall) gets shafted, the aides and the nurses are taken away, things get missed. LPN P reported this is not the fault of the staff and reported that staff are, stretched too thin. That's the biggest thing, staffing, consistent staffing.

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	09/24/2021

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 36090 Based on interview and record review, the facility failed to act upon recommendations made by the pharmacist during monthly medication regimen reviews and obtain laboratory values for one Resident (R 41) of five residents reviewed for medication regimen reviews resulting in no monitoring of required laboratory values and potential adverse side effects of medications. Findings include: According to the Minimum Data Set (MDS) assessment, dated 7/5/21, R 41 was admitted to the facility with multiple diagnosis including cancer, anemia, and poor nutrition. R 41 was independent with eating after staff set up. Staff assessed R 41 as cognitively intact. The Pharmacist performed a medication review for R 41 on 7/7/21 and recommended a magnesium (Mg) level (laboratory blood test) as R 41 was taking both Protonix and Prilosec (medications that can impair magnesium absorption). In a note to Attending Physician/Prescriber, printed 7/9/21, the provider marked the Agree box, wrote magnesium next lab draw, and signed the form dated 7/12/21. R 41's electronic medical record was reviewed for Mg laboratory results performed after 7/12/21. According to the list of lab results from 7/12/21 to 9/21/21, R 41 had six blood laboratory test and there was no Mg level results posted. Review of R 41's monthly physician order summaries for July, August, and September 2021 did not contain an order for a Mg laboratory test. Per email on 9/21/21 at 2:45 PM, the Director of Nursing (DON) was asked to provide Mg laboratory results for R 41 since 7/12/21. On 9/23/21 after queried again, the DON provided R 41's Mg results dated the day prior on 9/22/21. R 41 was noted to have a Mg level of 1.8 with a normal range of 1.90 to 2.70.

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	09/24/2021

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 29073 Based on observation, interview, and record review the facility failed to ensure medications were administered as ordered for 2 residents (Resident #105 and Resident #84) when (a) nurses failed to read physician orders and calculate the correct volume of a controlled medication resulting in repeated administration of twice the prescribed dose of a controlled substance and (b) when a nurse did not administer doses of prescribed medication correctly resulting in the potential for serious adverse effects from over and underdosing prescribed medications. Findings: Resident #105 (R105) During a medication administration observation beginning on 9/13/21 at 5:15 p.m., Licensed Practical Nurse (LPN) B was observed struggling to calculate the volume of medication required to dose R105 with physician ordered Lorazepam Concentrate 2 MG/ML Give 0.5 mg by mouth two times a day for Chronic anxiety. LPN B was ultimately able to calculate that in order to dispense the dose correctly, a volume of 0.25 ML was required. During the observation, LPN B identified that on numerous occasions, the Controlled Drug Receipt/Record/Disposition Form for the medication reflected nurses had administered twice the ordered dose. LPN B said she would report the identified errors to the Director of Nursing (DON). Review of an Order Recap Report for the date range 8/01/2021-9/30/2021 reflected the following orders: Lorazepam Concentrate 2 MG/ML (milligram per milliliter) Give 0.5 mg by mouth every 4 hours as needed for anxiety. Start Date 8/19/2021, End Date 8/23/2021. (In order to for the nurse to administer the ordered 0.5 mg dose, a quantity of 0.25 ML of the liquid medication would need to be drawn up.) Lorazepam Concentrate 2 MG/ML Give 0.5 mg by mouth every 4 hours as needed for anxiety for 10 days. Start Date 8/23/2021, End Date 8/26/2021 (In order to for the nurse to administer the ordered 0.5 mg dose, a quantity of 0.25 ML of the liquid medication would need to be drawn up.) Lorazepam Concentrate 2 MG/ML Give 0.5 mg by mouth two times a day for Chronic anxiety. Start Date 8/27/2021, End Date 9/13/2021. (In order to for the nurse to administer the ordered 0.5 mg dose, a quantity of 0.25 ML of the liquid medication would need to be drawn up.) Review of a Controlled Drug Receipt/Record/Disposition Form for R105 revealed a pharmacy label that reflected LORazepam INTENSOL 2MG/ML 0.5 ML (1mg) by mouth every four hours as needed for anxiety for 3 days (which was NOT consistent with the original order for the medication started on 8/19/2021). The form also reflected that 30 ML of the medication had been dispensed on 8/19/2021 and received by the facility on 8/20/21 as noted by the signature on the top of the form of Licensed Practical Nurse (LPN) TT. An undated, handwritten notation next to the pharmacy label included a check mark next to the initials MAR (Medication Administration Record), an abbreviation for Check Medication Administration Record, followed by 0.25 ml = 0.5 mg. (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	09/24/2021

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the Controlled Drug Receipt/Record/Disposition Form for the LORazepam INTENSOL 2MG/ML did not reflected doses were drawn up between 8/19/2021-8/22/2021. The first dose recorded as drawn was on 8/23/2021, the amount given was 0.5 ML (equal to a 1 MG dose of the medication) with a remaining volume of medication 29.5 ML, twice the prescribed dose. Out of 36 opportunities for administration, the medication had been poured at twice the dose ordered 19 times, or 52.7% of the time. 31771 Resident #84 (R84) On 9/13/21 at 9:33 am an observation and interview during the Medication Administration Task was conducted with Registered Nurse (RN) Z. RN Z was observed preparing and administering medication to Resident #84 (R84). RN Z was observed administering Insulin Lispro cartridge to the exposed abdomen of R84. After cleansing the area with an alcohol pad RN Z placed the needled tip of the insulin cartridge into the skin of the Resident, pushed the button and held for one second before lifting the needle out of the skin. RN Z reported the cartridge should be held to the site for, 5 to 10 seconds. RN Z then administered the nasal spray Fluticasone Propionate Suspension giving 2 sprays in succussion in each nostril of R84. RN Z did not have R84 blow her nose prior to administration of the nasal spray. RN Z reported she was not aware of any instruction or recommendation to have a resident blow their nose prior to administration of nasal sprays. The Insulin Lispro cartridge Manufacturer's instructions with illustrations for use was reviewed on the Manufacturer's product information sheet. The instructions reflected that, after selecting the correct dose, the needle is pushed into the skin at the selected site. Then, 5C. Place your thumb on the injection button. Then press all the way in and hold. Then , 5D. Keep the injection button held in and when you see 0 in the dose window, slowly count to 10. This will make sure you get your full dose. The illustration in the instructions also displays a clock with 10 seconds highlighted on the face of a clock. Then, 5E After holding and slowly counting to 10, release the injection button. Then remove the needle from your skin. The Fluticasone Propionate Suspension Manufacturer's instructions with illustrations for use was reviewed on the Manufacturer's product information sheet. The instruction for use reflected, Step 1. Blow your nose to clear your nostrils.

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	09/24/2021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 29073 Based on observation, interview and record review the facility failed to ensure drugs (including federally controlled substances) and biologics were stored and administered according to professional standards resulting in the potential for significant medication errors and clinically adverse consequences. Findings: Review of a facility Medication Administration policy Administration of Drugs last updated 10/22/2020 specified, 5. When administering the resident's medication, the nurse should follow the six rights of medication administration. 7. Medications should be administered in accordance with the needs of the resident. Facilities that follow standard med pass models, medications may not be set up in advance and must be administered within (1) hour before or after their prescribed time. NOTE: Before and/or after meal orders must be administered as ordered and may cause the time parameters to change. Facilities that follow a resident centered med pass model, refer to specific facility administration times. Review of a facility Medication Administration policy Controlled Medications adopted 7/11/2018 reflected It is the policy of this facility to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. The procedure specified, 1. The Director of Nursing Services and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications. 2. Medications listed in Schedules II, III, IV, and V are stored under double lock in a locked cabinet or safe designated for that purpose, separate from all other medications. Alternatively, in a unit dose system, Schedule III, IV, and V medications may be kept with other medications in the cart or in a separate locked drawer on the cart. The medication nurse on duty maintains possession of the key to controlled medication storage areas. Back-up keys to all medication storage areas, including those for controlled medications, are kept by the Director of Nursing Services .6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration; Amount administered; Signature of the nurse administering the dose, completed after the medication is actually administered. (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	09/24/2021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy Medication Access and Storage adopted 7/11/2018 reflected It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The procedure specified 2. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access .9. Schedule III and IV controlled medications are stored separately from other medications in a locked drawer or compartment designated for that purpose .14. Medication storage areas are kept clean, well lit, and free of clutter. During interviews conducted at the facility during the annual recertification survey started on 9/12/2021 and exited on 9/24/2021, Confidential Informants (CI) DDD, EEE and FFF alleged Licensed Practical Nurse (LPN) K would agree to pick up part of the night shift and was known to preset medications for administration to residents during the morning med pass, including federally controlled substances. According to witness accounts, the Director of Nursing (DON), Unit Manager, Registered Nurse (RN) N and the Nursing Home Administrator were aware of the concern. During a telephone interview on 9/13/2021 at 3:32 p.m., Licensed Practical Nurse (LPN) TT reported that on 9/8/21 at approximately 3:00 a.m. she discovered LPN K had left her medication cart unlocked and unsupervised. LPN TT said that when she opened the top drawer of LPN K's medication cart, she discovered a number of preset medications as evidenced by plastic med cups with pills, some crushed preparations mixed with pudding or sauce, preset insulin injections, and biologicals needing temperature-controlled storage. According to LPN TT, the medication cups were labeled with resident names torn from plastic medication bags dispensed by the pharmacy and placed into cups. LPN TT said she recognized several of the pills as controlled substances. According to LPN TT in addition to questioning LPN K about the discovery, she reported the incident to the DON, NHA and Unit Manager, RN N. LPN TT said she provided a write up to the DON and RN N about the incident, in addition to creating incident reports for the residents she was able to identify. The employee file for LPN K was requested from the Nursing Home Administrator (NHA) on 9/15/21 at 8:45 a.m. The following was discovered during a review of the employee file for LPN K: (1) An Education/Coaching form dated 3/9/18 reflected LPN K was educated to use the six rights of med pass after giving the wrong medication to a resident. (2) An Education/Coaching form dated 12/21/18 reflected LPN K had been educated about minimizing interruptions during med pass resulting in Gave PRN (as needed) Norco to resident and had routine morphine which was not given. (3) A Teachable Moment dated 5/7/2019 reflected LPN K had been reminded to use the six rights of medication administration after missing a dose an unknown resident's Neurontin (a controlled substance). The employee file did not reflect any evidence a formal write-up, education or discipline was present for presetting medications as alleged. (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	09/24/2021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/21 at 11:11 a.m., evidence of a facility investigation into allegations LPN K preset medications was requested from the DON. The DON said she was familiar with the incident and reported that LPN TT had written up LPN K, but that discipline was not issued due to the DON did not want a peer disciplining a peer. No evidence of a discipline or education about LPN K presetting meds was found at this time. The DON explained that LPN TT had created Medication Error Reports for six residents on 9/8/21, however the DON struck them out because the incident did not reflect medication errors had occurred. The incident reports were requested from the DON at this time. Medication Error incident reports dated 9/8/21 at 3:00 a.m. were provided for R11, R16, R51, R57 and R86. Each report reflected the same narrative This nurse came upon an unlocked med cart in [name of secured unit] at approximately 0300 (3:00 a.m.) looking for residents' eye gtts (drops) that was recently moved to [name of another unit] and after opening the cart I witnessed 13 preset med cups with residents name cut off their medication bags with regular medications as well as narcotics in most of them. Some pills were whole, and some were crushed, while this nurse was still in (resident room) getting vitals on another resident. The nurse on duty stated that she placed the preset medications in the top of the cart because everyone did it and it was real busy on that hall. The section on the report Immediate Action Taken reflected Educated this nurse on rules and regulations of not presetting medications, as well as leaving her med cart unlocked with narcotics in an unlocked med cart. Reminded this nurse that out window for State survey is currently open. Also this nurse wrote up a disciplinary action form about incident and handed a copy to Administrator, DON and Unit Manager. Review of a Medication Error incident report dated 9/8/21 at 3:00 a.m. for R33 reflected This nurse came upon an unlocked med cart in [name of secured unit] at approximately 0300 (3:00 a.m.) looking for residents' eye gtts (drops) that was recently moved to [name of another unit] and after opening the cart I witnessed 13 preset med cups with residents name cut off their medication bags with regular medications as well as narcotics in most of them. Some pills were whole and some were crushed, while this nurse was still in (resident room) getting vitals on another resident. Also noted this resident's Enbrel prefilled syringe that needs to be refrigerated until use inside the top of med cart drawer with his Breo Inhaler. The nurse on duty stated that she placed the preset medications in the top of the cart because everyone did it and it was real busy on that hall. During an interview on 9/15/21 at 10:35 a.m., the Pharmacist Consultant (PC) GGG reported that presetting medications is not recommended because it creates a situation highly likely to cause medication administration errors. PC GGG said that she has encountered instances of staff presetting medications as a way to compensate for staffing shortages. PC GGG reported that the medication Enbrel is to be refrigerated until just before it is ready for use and that once the medication reaches room temperature it is not to be put back into the refrigerator because it will degrade the medication and can cause proteins in the solution to clump, decreased the efficacy of the medication or other cause other complications. During a follow-up interview on 9/15/21 at 11:31 a.m., the DON was asked for a copy of the original write up completed by LPN TT regarding LPN K presetting medications. The DON said she had to get a copy of the current Teachable Moment provided to LPN K by RN N. The DON was told by the Unit Manager, RN N that she did not have the original write-up completed by LPN TT because he had put it in the shredder a while ago and it could not be retrieved. (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	09/24/2021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Teachable Moment form signed by LPN K and RN N reflected the issues of presetting medications and leaving a medication cart unlocked were reviewed. The form was signed by both LPN K and RN N on 9/15/21. During an interview on 9/15/21 at 12:35 p.m., LPN K admitted she preset medications on 9/8/21 but had never done it before and would never do it again. LPN K said she only preset medication for 3 residents and only one of them (R57) had a narcotic. LPN K admitted she preset R33's Enbrel from the fridge and said it had been out of the fridge for 30 minutes (long enough for the medication to reach room temperature) but that she put it back in the fridge when LPN TT discovered preset medications. LPN K said she wrote the anticipated time of administration of the narcotics she preset on the narcotic Controlled Drug/Receipt/Record/Disposition Form, not the time she pulled the medication. LPN K said the Unit Manager, RN N talked to her about the incident the night before (9/14/21). Review of photographs forwarded to this surveyor by LPN TT on 9/14/21 at 4:23 p.m. showed images of preset medications for more than six residents on the top of and inside an open top drawer of the medication cart. One of the photos showed the hands of LPN K resting on the drawer, other photos showed the preset medications with some resident names visible on the plastic wrappers used to mark the medication cups. The photos were accompanied by a lengthy text message report made to the DON about the discovery. The photos and text messages were dated 9/8/21 and time stamped 3:41 a.m., 3:53 a.m. and 4:19 a.m. LPN TT was asked to share the contact information she had for the DON, and the number she texted was the same number assigned to the DON as evidenced by a posting in the front entryway at the facility. 31771 On 9/14/21 at 10:04 AM a narcotic reconciliation count was conducted with the DON and Registered Nurse (RN) Z on the 400 hall at cart #1. The review revealed a medication blister card taken from a locked drawer of 25 tabs of Tramadol. However, the proof of use narcotic log reflected 26 tabs. RN Z reported that she did not sign out the medication on the narcotic proof of use log when the dose was administered. The Electronic Medical Record (EMR) Medication Administration Record (MAR) reflected that the dose of Tramadol was administered to Resident #10 at 7:41 AM. The reconciliation review continued with Resident #10 and a medication blister card of Lyrica that held 15 doses. The narcotic proof of use log reflected 16 doses of Lyrica remained. RN Z reported she had not signed out the medication on the scheduled narcotic log. RN Z displayed the EMR MAR that reflected the medication had been administered to Resident #10 at 7:42 AM. The narcotic reconciliation review continued with a review of the medication blister card of Norco for Resident #9. The medication card revealed that a count of 17 doses remained. However, the narcotic proof of use log reflected 18 doses remained. RN Z reported she administered the dose earlier but did not sign it out on the proof of use log for Resident #9. Review of the EMR MAR reflected that the dose of Norco was administered to Resident #9 at 7:52 AM. At the conclusion of the narcotic reconciliation review that began at 10:04 AM the DON acknowledged that removal of narcotics and scheduled medications from the locked narcotic drawer and the medication from its container should be documented on the proof of use log at the time of removal. (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	09/24/2021

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy provided by the facility titled Medication Administration, Controlled Substances, Adopted 7/11/18, reflected, Procedure: 1. The Director of Nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. And 6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: Date and time of administration, Amount administered, Signature of the nurse administering the dose, completed after the medication is actually administered.

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	09/24/2021

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 0880 Level of Harm - Actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36090 Based on observation, interview, and record review, the facility (A) failed to prevent the spread of COVID 19 on the 500 hall for six Residents (Resident #85, Resident #43, Resident #41, Resident #117, Resident #109, and Resident #7) resulting in multiple residents testing positive for COVID 19 and potential for all residents on that unit to become COVID 19 positive, (B) Failed to maintain a clean urinary drainage system for one Resident (Resident #105) resulting in the potential for the transmission of fecal matter to frequently used resident equipment, and (C) Failed to provide sanitary dining services for one Resident (Resident #104), resulting in the potential for contaminated food. Findings include: COVID 19 Outbreak 500 hall According to the facility COVID 19 Contact Tracing Questionnaire Tool-Resident, dated 9/9/21, a resident became positive when staff tested them as part of an outbreak. This resident was moved from room [ROOM NUMBER] to 512. Two days later, on 9/11/21, Resident #7 (R7) tested positive for COVID 19. R7's room (room [ROOM NUMBER]) was located diagonally from room [ROOM NUMBER]. R7 was moved to room [ROOM NUMBER] on 9/11/21. During an observation on 9/12/21 at 10:00 AM, Certified Nursing Assistant (CNA) VV reported that they were just told by management staff that full Personal Protective Equipment (PPE) needed to be worn in every room. CNA VV exited room [ROOM NUMBER] wearing full PPE, including N95 mask, face shield, plastic gown, and gloves. No signage was located near room [ROOM NUMBER] (the room that Resident #117 occupied) that noted what PPE was required to enter the room. The door to room [ROOM NUMBER] was left open, which located across from room [ROOM NUMBER] (a COVID 19 positive room). During an interview on 9/12//21 at 10:05 AM, Licensed Practical Nurse (LPN) V confirmed that staff had received notice from the facility management team that full PPE was required when entering all resident rooms on the 500 hall. During an observation made on 09/12/21 at 11:39 AM, STOP SPECIAL DROPLET/CONTACT PRECAUTIONS signs were noted outside some resident rooms on the 500 hall. The signs instructed the reader to perform hand hygiene, wear a face mask and eye protection and to gown and glove prior to entering the resident room. This sign read, KEEP DOOR CLOSED. There was no sign outside room [ROOM NUMBER] indicating which PPE was required to safely enter the resident room. During an interview on 9/12/21 at 12:09 PM, Licensed Practical Nurse (LPN) P stated that all residents testing negative on 500 hall were moved to Rooms 500 to 507 and those testing positive were placed in Rooms 509 and above, to keep them distanced. Resident #41 in room [ROOM NUMBER], and Resident #109 in room [ROOM NUMBER], had not tested COVID positive. LPN P confirmed this observation. (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	09/24/2021

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 0880 Level of Harm - Actual harm Residents Affected - Some	According to the facility COVID 19 Contact Tracing Questionnaire Tool-Resident, dated 9/13/21, Resident #85 tested positive for COVID 19 and was moved from room [ROOM NUMBER] to 510. room [ROOM NUMBER] was next to and shared a bathroom with the first COVID 19 positive resident from four days earlier. Observations on 9/13/21 at 7:44 AM revealed Resident #7's (COVID 19 positive resident) door (room [ROOM NUMBER]) was open to the hallway, Resident #7 was observed from the hall to be in bed and a deep, dry cough was noted. Doors to rooms [ROOM NUMBERS] and located across the hallway from room [ROOM NUMBER], were also open. A sign was on the doorways to rooms [ROOM NUMBER], that indicated the doors should be kept shut. An observation made on 9/13/21 at 8:02 AM, LPN V entered room [ROOM NUMBER] without donning gown or performing hand hygiene, exited the room, and grabbed the medication cart to move it down the hall. LPN V was then observed to use hand sanitizer. That same day according to a COVID 19 Contact Tracing Questionnaire Tool-Resident, dated 9/13/21, Resident #41 tested positive for COVID 19. Resident #41 resided in room [ROOM NUMBER] and across the hall from COVID 19 positive rooms [ROOM NUMBERS]. Observations on 9/13/21 at 7:53 AM revealed Resident #43 in room [ROOM NUMBER] with a deep, dry cough, the door was open to the hallway. This room was located directly across the hall from the first COVID 19 positive resident from four days earlier. Resident #43 was sent to the emergency roiagnom on [DATE] and returned to the facility the next day with a COVID 19 diagnosis. On 9/13/21 at 1:56 PM a deep, dry cough was noted coming from Resident #7 (R7) in room [ROOM NUMBER]. R7's door was open to the hallway. Staff had posted a sign on the door indicating that it should be shut. Resident #117 resided in room [ROOM NUMBER] on 9/12/21 when a COVID 19 positive resident was moved across the hall, staff later moved Resident #117 to the other end of the unit, to room [ROOM NUMBER]. When Resident #117's COVID 19 test came back positive on 9/16/21, staff moved Resident #117 to room [ROOM NUMBER] (and across from original room). During an interview with the Director of Nursing (DON) on 9/13/21 at 4:45 PM, when asked about open doorways to COVID 19 positive room, the DON reported staff were leaving them open due to residents being a high fall risk and to keep room temperatures lower. During an observation on 9/15/21 at 7:27 AM, staff had left Resident #85's and R7's (both COVID 19 positive) doors open to the hallway. room [ROOM NUMBER] did not have a sign on the door indicating staff were required to wear additional PPE (gown and gloves) when entering the room. rooms [ROOM NUMBERS] had signs on the door indicating they should be shut; however, the doors were open. On 9/21/21 Resident #109 in room [ROOM NUMBER] tested COVID 19 positive. room [ROOM NUMBER] was diagonal from room [ROOM NUMBER] which had COVID 19 positive residents since 9/13/21. (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	09/24/2021

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 0880 Level of Harm - Actual harm Residents Affected - Some	During an interview on 9/23/21 at 3:47 PM, the Infection Control Nurse (also DON), when discussing the above outbreak pattern and concerns with doors left open, the DON stated that the doors were left open when residents are a high fall risk and to keep the rooms cooler when residents complained of room being too warm (R 7). The DON also stated that the curtains should have been pulled and that there was still more than 6 foot physical distancing between residents. The DON also reported that all doors should have signs indicating what PPE was necessary for each room and claimed that one reason for missing signs are that they may fall off doors. R7 According to the Minimum Data Set (MDS) assessment, dated 6/12/21, R7 admitted to the facility with multiple diagnosis including low back pain, difficulty walking, and rheumatoid arthritis. This same assessment indicated R7 required assistance of staff for moving in bed, transferring, and hygiene needs including using the bathroom. Staff assessed R7 as cognitively intact, and R7 made their own health care decisions. R7 admitted to the facility on [DATE]. During an interview on 9/12/21 at 12:01 PM, R7 reported that she was scared. She reported receiving the vaccine for COVID 19 and was fully vaccinated and now as of last Friday, test positive for COVID 19. R7 stated it felt like a head cold but reported she was otherwise asymptomatic. R7 further reported that she was admitted to the facility for physical therapy and was supposed to be going home soon. R7 expressed concerns about how this COVID 19 infection would impact her ability to return home as planned. During a follow up interview on 9/15/21 at 2:35 PM, R7 was teary and anxious. R7 reported the facility was transferring her to a facility in (another city almost 3 hours away) and that she needed to pack her stuff. R7 became short of breath and was encouraged to relax and breath. After several moments R7 remained tearful and stated that facility management staff told her that she was being transferred and R7 stated that she told them she did not want to go. R7 asked this surveyor if she had to go if she did not want to and claimed she had been sick for five days already in this facility. R7 questioned if she would have to start the quarantine over once arriving to the new facility. This surveyor queried the DON and reported back to R7 that she would not have to start quarantine over and that she would return to this facility once her 10 days were over. R7 counted the days and claimed she would return to this facility on 9/20/21. R7 became less tearful but remained anxious regarding the transfer to a different facility. During on observation on 9/21/21 at 7:30 AM, R7 was not located in the building. That same day at 11:00 AM the DON reported that R7 would not be returning to the facility until the following Monday (9/27/21) due to transportation availability. (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	09/24/2021

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 0880 Level of Harm - Actual harm Residents Affected - Some	Social Service progress notes dated 9/14/21 and located in R7's electronic medical record (EMR) read, Late entry from yesterday 9.13.21. This SW (Social Worker) meet with res. (resident) to talk over the plan r/t (related to) COVID positive and needed to transfer to COVID CRC (covid receiving center) unit for quarantine days then return. SW shared when/where this will likely occur Wednesday/(name of facility)). She was upset/sad and tearful. SW stayed with res. And talked through options as she was considering going home ASAP, even AMA alone. SW talked her through why this was a bad idea, another note read that same day from Social Services indicated that R7 would be leaving the facility on 9/15/21 at 4:00 PM. That same afternoon, another note read, SW meet up with res again today to monitor mood and anxiety related to upcoming transfer. She shared she is doing a little better. Then was tearful and anxious, SW documented following up with the Nurse Practitioner following this encounter. Social Services progress notes dated 9/15/21 indicated that R7 was notified of hydroxyzine HCL (a medication for anxiety) was increased because of increased anxiety. Notes read, She was thankful, but still shared she is struggling. She was tearful again. Then she shared she wanted it noted that she does not what(sic) to go, support was provided and resident asked if she could refuse to go. Clarification was provided on quarantine period of 14 days from positive COVID 19 test and that because the facility did not meet criteria to retain own COVID positive residents, R7 wound need to be transferred to another facility for the remainder of the quarantine period. Another progress note dated 9/21/21 indicated R7 would be leaving to return to the facility 9/27/21 at 2:00 PM (12 days). Review of physician orders located in R7's EMR and viewed 9/22/21 at 3:57 PM, revealed hydroxyzine HCL 50 mg every 12 hours was discontinued on 9/14/21. On 9/15/21 hydroxyzine HCL 50 mg was ordered every 8 hours, and per the September 2021 Medication Administration Record, R 7 received the medication for anxiety three times on 9/15/21, the same day as R7 was transported to the other facility. 37577 Resident #105 Review of an Admission Record revealed R105 was a [AGE] year-old male, with pertinent diagnoses of hepatitis, a fractured rib, nose bleeds, low sodium levels, and a stage 2 pressure wound on bilateral buttocks. R105 had a foley urine collection system in place. A Minimum Data Set (MDS) assessment, completed 07/26/21, reflected R105 required extensive assistance from staff for bed mobility, transfers, and going to the bathroom. Review of a Brief Interview for Mental Status (BIMS) revealed a score of 15 out of 15, which indicated that R105 was cognitively intact. During an observation on 09/14/21 at 11:47 A.M., R105 laid in bed, resting with eyes closed. The urine collection bag for the foley catheter laid on the floor. Fecal matter was visible on the white back portion of the urine collection bag. During an observation on 09/14/21 at 3:24 P.M., R105's urine collection bag had smeared fecal matter on the white back portion of the bag. During an observation on 09/15/21 at 4:07 P.M., R105's urine collection bag sat in a privacy cover and upon inspection, fecal matter was smeared on the back white portion of the bag. (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	09/24/2021

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 0880 Level of Harm - Actual harm Residents Affected - Some	29073 During an observation on 9/22/21 at 8:52 A.M., Certified Nurse Aide (CNA) I leaned over R104 while assisting the resident with food set up. CNA I offered unwrapped sandwiches with bare hands to R104 while standing over the resident.