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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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

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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)

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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.

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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)

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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.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake MI-121966 Based on interview and record review, the facility failed to ensure staff responded to resident needs in a timely manner for 1 resident (Resident #125), resulting in neglect and the potential for ongoing psychosocial harm from feeling anxious, fearful, and angry after waiting two hours in a feces soiled bed without staff responding for calls for assistance. Findings: Review of a facility Resident Rights policy and procedure related to Abuse and Neglect last revised 10/14/2020, reflected definitions, policies, and procedures consistent with CFR 483.12 Freedom from Abuse, Neglect, and Exploitation regulatory groups for Long Term Care Facilities. 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) 7/9/2021-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)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(b) 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. Review of a facility Nursing Daily Attendance Report Saturday, July 10, 2021 reflected that Registered Nurse (RN) H and CNA G were assigned to work on the unit where R125 was living. The schedule showed that Licensed Practical Nurse (LPN) OO was scheduled to come in at 10:00 a.m. that day. During an interview on 9/22/21 at 2:40 p.m., LPN OO said she recalled the incident involving R125 on 7/10/21. According to LPN OO, RN H asked her to assist with cleaning up R125 because she needed a second person to assist but by the time they got into R125's room, two CNA's were already performing the cares. During an interview on 9/22/21 at 2:50 p.m., CNA S reported she was assigned to care for R125 on 7/9/21 when a receptionist called to report R125 had been on a bed pan. According to CNA S, R125 had not been on a bedpan when she went to assist him on 7/9/21 but had been incontinent of bowel in his brief and she recalled smelling BM as soon as she walked into the room. CNA S did not specifically recall the incident on 7/10/21. CNA S was not on the schedule for 7/10/21. Review of a statement signed by CNA S on 7/19/21 reflected I remember this, he wasn't on a bed pan. We were in the room changing him. He has a bowel movement and light had only been on for a few minutes to that (sic). He was on the bed pan prior to this incident. He was on and off the bed pan multiple times throughout the day. The statement did not clearly indicate which staff were involved or what incident or time frame was being referred to. The statement did not identify R125 was the subject of the inquiry. 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 9/23/21 at 10:34 a.m., Registered Nurse (RN) H reported she recalled responding to R125's call light and knowing R125 needed to be changed sometime after breakfast (approximately 8:30 a.m.) and said she was unable to complete the cares for R125 by herself, the CNA was unavailable. RN H said she recalled a receptionist coming to the unit to report that R125 needed assistance and that by the time she went into R125's room to check on the situation, 2 CNA's were in the midst of cleaning up R125. According to RN H she was splitting a hall and it seemed like there were quite a few residents to attend to. A telephone call to CNA G was placed on 9/23/21 at 10:45 a.m. and a voice message was left requesting a return telephone call. As of 9/24/2021 at 4:00 p.m., no return call was received. Review of a statement signed by CNA G, dated 7/19/21 reflected Call light was on. Saw he (R125) had a bowel movement. Went to get help, had to do a complete bed change. He waited about 15 minutes. Offered to move bed by wall to roll him but he refused. Needed a second aide to help for safety. The statement did not reference a specific date or time being described and did not clearly identify that R125 was the subject of the interview.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake MI-121966 Based on interview and record review, the facility failed to implement established abuse and neglect prohibition policies and procedures for 1 resident (Resident #125), resulting in the potential for ongoing abuse, neglect and/or mistreatment due to the inability of staff to recognize abuse and neglect, provide resident protection, report to the State Agency, and thoroughly investigate to prevent the reoccurrence of instances of abuse and neglect. Findings: Review of a facility Resident Rights policy and procedure related to Abuse and Neglect last revised 10/14/2020, reflected definitions, policies, and procedures consistent with CFR 483.12 Freedom from Abuse, Neglect, and Exploitation regulatory groups for Long Term Care Facilities. 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) 7/9/2021-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)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(b) 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. Review of a facility Nursing Daily Attendance Report Saturday, July 10, 2021 reflected that Registered Nurse (RN) H and CNA G were assigned to work on the unit where R125 was living. The schedule showed that Licensed Practical Nurse (LPN) OO was scheduled to come in at 10:00 a.m. that day. During an interview on 9/22/21 at 2:40 p.m., LPN OO said she recalled the incident involving R125 on 7/10/21. According to LPN OO, RN H asked her to assist with cleaning up R125 because she needed a second person to assist but by the time they got into R125's room, two CNA's were already performing the cares. During an interview on 9/22/21 at 2:50 p.m., CNA S reported she was assigned to care for R125 on 7/9/21 when a receptionist called to report R125 had been on a bed pan. According to CNA S, R125 had not been on a bedpan when she went to assist him on 7/9/21 but had been incontinent of bowel in his brief and she recalled smelling BM as soon as she walked into the room. CNA S did not specifically recall the incident on 7/10/21. CNA S was not on the schedule for 7/10/21. Review of a statement signed by CNA S on 7/19/21 reflected I remember this, he wasn't on a bed pan. We were in the room changing him. He has a bowel movement and light had only been on for a few minutes to that (sic). He was on the bed pan prior to this incident. He was on and off the bed pan multiple times throughout the day. The statement did not clearly indicate which staff were involved or what incident or time frame was being referred to. The statement did not identify R125 was the subject of the inquiry. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. During a telephone interview on 9/23/21 at 10:34 a.m., Registered Nurse (RN) H reported she recalled responding to R125's call light and knowing R125 needed to be changed sometime after breakfast (approximately 8:30 a.m.) and said she was unable to complete the cares for R125 by herself, the CNA was unavailable. RN H said she recalled a receptionist coming to the unit to report that R125 needed assistance and that by the time she went into R125's room to check on the situation, 2 CNA's were in the midst of cleaning up R125. According to RN H she was splitting a hall and it seemed like there were quite a few residents to attend to. RN H said she thought she provided a statement about the incident to the Unit Manager at that time, Licensed Practical Nurse (LPN) B shortly after the incident. Review of the facility investigation file did not reveal a statement had been obtained from RN H. A telephone call to CNA G was placed on 9/23/21 at 10:45 a.m. and a voice message was left requesting a return telephone call. As of 9/24/2021 at 4:00 p.m., no return call was received. Review of a statement signed by CNA G, dated 7/19/21 reflected Call light was on. Saw he (R125) had a bowel movement. Went to get help, had to do a complete bed change. He waited about 15 minutes. Offered to move bed by wall to roll him but he refused. Needed a second aide to help for safety. The statement did not reference a specific date or time being described and did not clearly identify that R125 was the subject of the interview. Review of a 5 Day Investigation of alleged delay in care of [R125] reflected the following: On 7/12/21, Administrator was notified of alleged delay in care made by wife of resident [R125]. Because of this allegation, it was reported as neglect pending full investigation . [R125] was interviewed regarding the alleged incident. He stated that on 2 occasions over the weekend, it took an extended amount of time to receive assistance with bowel needs . Interviews were conducted with the nurse aides on duty for days of the alleged delays in care. For the first occasion, the aide stated that she helped [R125] on and off the bedpan, per his request multiple times throughout the day. In addition, she responded to a call light only a few minutes after it went on to assist with changing him. For the second occasion the aide responded to the light and saw [R125] had a bowel movement. At the time [R125] required 2 assist for safety and turning during cares in bed. The aide left to find a second person which took less than 15 minutes. The Determination of Findings/Conclusion documented by the Administrator reflected that the facility was unable to confirm there was a delay in care for R125 due to conflicting statements; CNA G, CNA S and R125. No statements were taken from the RN H who was on duty the day of the occurrence or from FR/CNA SS regarding the call to the facility from law enforcement. The report did not include a statement from FM F or reference the memorandum sent by FM F to the NHA or BOM CCC. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/21 at 3:41 p.m., the NHA said she first became aware of the allegation of neglect made by FM F on behalf of R125 on 7/12/21 along with other care concerns. According to the NHA, she considered FM F's report of a delay in care an allegation of neglect. The NHA said she would have expected a report from staff immediately after law enforcement called the facility regarding R125 on 7/10/21. The NHA reported that other staff were being trained on completing investigations and did not have additional information to support that a complete investigation had been conducted on behalf of R125.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake MI-121966 Based on interview and record review, the facility failed to ensure allegations of abuse and neglect were made to the facility abuse prevention coordinator and the State Agency in a timely manner for 1 resident (Resident #125) resulting in the potential for ongoing abuse and neglect. Findings: Review of a facility Resident Rights policy and procedure related to Abuse and Neglect last revised 10/14/2020, reflected definitions, policies, and procedures consistent with CFR 483.12 Freedom from Abuse, Neglect, and Exploitation regulatory groups for Long Term Care Facilities. 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) 7/9/2021-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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(b) 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. Review of a facility Nursing Daily Attendance Report Saturday, July 10, 2021 reflected that Registered Nurse (RN) H and CNA G were assigned to work on the unit where R125 was living. The schedule showed that Licensed Practical Nurse (LPN) OO was scheduled to come in at 10:00 a.m. that day. During an interview on 9/22/21 at 2:40 p.m., LPN OO said she recalled the incident involving R125 on 7/10/21. According to LPN OO, RN H asked her to assist with cleaning up R125 because she needed a second person to assist but by the time they got into R125's room, two CNA's were already performing the cares. During an interview on 9/22/21 at 2:50 p.m., CNA S reported she was assigned to care for R125 on 7/9/21 when a receptionist called to report R125 had been on a bed pan. According to CNA S, R125 had not been on a bedpan when she went to assist him on 7/9/21 but had been incontinent of bowel in his brief and she recalled smelling BM as soon as she walked into the room. CNA S did not specifically recall the incident on 7/10/21. CNA S was not on the schedule for 7/10/21. Review of a statement signed by CNA S on 7/19/21 reflected I remember this, he wasn't on a bed pan. We were in the room changing him. He has a bowel movement and light had only been on for a few minutes to that (sic). He was on the bed pan prior to this incident. He was on and off the bed pan multiple times throughout the day. The statement did not clearly indicate which staff were involved or what incident or time frame was being referred to. The statement did not identify R125 was the subject of the inquiry. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. During a telephone interview on 9/23/21 at 10:34 a.m., Registered Nurse (RN) H reported she recalled responding to R125's call light and knowing R125 needed to be changed sometime after breakfast (approximately 8:30 a.m.) and said she was unable to complete the cares for R125 by herself, the CNA was unavailable. RN H said she recalled a receptionist coming to the unit to report that R125 needed assistance and that by the time she went into R125's room to check on the situation, 2 CNA's were in the midst of cleaning up R125. According to RN H she was splitting a hall and it seemed like there were quite a few residents to attend to. RN H said she thought she provided a statement about the incident to the Unit Manager at that time, Licensed Practical Nurse (LPN) B shortly after the incident. Review of the facility investigation file did not reveal a statement had been obtained from RN H. A telephone call to CNA G was placed on 9/23/21 at 10:45 a.m. and a voice message was left requesting a return telephone call. As of 9/24/2021 at 4:00 p.m., no return call was received. Review of a statement signed by CNA G, dated 7/19/21 reflected Call light was on. Saw he (R125) had a bowel movement. Went to get help, had to do a complete bed change. He waited about 15 minutes. Offered to move bed by wall to roll him but he refused. Needed a second aide to help for safety. The statement did not reference a specific date or time being described and did not clearly identify that R125 was the subject of the interview. Review of a 5 Day Investigation of alleged delay in care of [R125] reflected the following: On 7/12/21, Administrator was notified of alleged delay in care made by wife of resident [R125]. Because of this allegation, it was reported as neglect pending full investigation . [R125] was interviewed regarding the alleged incident. He stated that on 2 occasions over the weekend, it took an extended amount of time to receive assistance with bowel needs . Interviews were conducted with the nurse aides on duty for days of the alleged delays in care. For the first occasion, the aide stated that she helped [R125] on and off the bedpan, per his request multiple times throughout the day. In addition, she responded to a call light only a few minutes after it went on to assist with changing him. For the second occasion the aide responded to the light and saw [R125] had a bowel movement. At the time [R125] required 2 assist for safety and turning during cares in bed. The aide left to find a second person which took less than 15 minutes. The Determination of Findings/Conclusion documented by the Administrator reflected that the facility was unable to confirm there was a delay in care for R125 due to conflicting statements; CNA G, CNA S and R125. No statements were taken from the RN H who was on duty the day of the occurrence or from FR/CNA SS regarding the call to the facility from law enforcement. The report did not include a statement from FM F or reference the memorandum sent by FM F to the NHA or BOM CCC. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/21 at 3:41 p.m., the NHA said she first became aware of the allegation of neglect made by FM F on behalf of R125 on 7/12/21 along with other care concerns. According to the NHA, she considered FM F's report of a delay in care an allegation of neglect. The NHA said she would have expected a report from staff immediately after law enforcement called the facility regarding R125 on 7/10/21. The NHA reported that other staff were being trained on completing investigations and did not have additional information to support that a complete investigation had been conducted on behalf of R125.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 This citation pertains to intake MI-121966 Based on interview and record review, the facility failed to conduct a thorough investigation and prevent the reoccurrence of alleged abuse, neglect and mistreatment for 1 resident (Resident #125) resulting in the potential for ongoing abuse, neglect and mistreatment. Findings: Review of a facility Resident Rights policy and procedure related to Abuse and Neglect last revised 10/14/2020, reflected definitions, policies, and procedures consistent with CFR 483.12 Freedom from Abuse, Neglect, and Exploitation regulatory groups for Long Term Care Facilities. 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) 7/9/2021-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'. (b) 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!. (continued on next page)

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Skld Zeeland	285 N State St Zeeland, MI 49464

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Review of a facility Nursing Daily Attendance Report Saturday, July 10, 2021 reflected that Registered Nurse (RN) H and CNA G were assigned to work on the unit where R125 was living. The schedule showed that Licensed Practical Nurse (LPN) OO was scheduled to come in at 10:00 a.m. that day. During an interview on 9/22/21 at 2:40 p.m., LPN OO said she recalled the incident involving R125 on 7/10/21. According to LPN OO, RN H asked her to assist with cleaning up R125 because she needed a second person to assist but by the time they got into R125's room, two CNA's were already performing the cares. During an interview on 9/22/21 at 2:50 p.m., CNA S reported she was assigned to care for R125 on 7/9/21 when a receptionist called to report R125 had been on a bed pan. According to CNA S, R125 had not been on a bedpan when she went to assist him on 7/9/21 but had been incontinent of bowel in his brief and she recalled smelling BM as soon as she walked into the room. CNA S did not specifically recall the incident on 7/10/21. CNA S was not on the schedule for 7/10/21. Review of a statement signed by CNA S on 7/19/21 reflected I remember this, he wasn't on a bed pan. We were in the room changing him. He has a bowel movement and light had only been on for a few minutes to that (sic). He was on the bed pan prior to this incident. He was on and off the bed pan multiple times throughout the day. The statement did not clearly indicate which staff were involved or what incident or time frame was being referred to. The statement did not identify R125 was the subject of the inquiry. 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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 9/23/21 at 10:34 a.m., Registered Nurse (RN) H reported she recalled responding to R125's call light and knowing R125 needed to be changed sometime after breakfast (approximately 8:30 a.m.) and said she was unable to complete the cares for R125 by herself, the CNA was unavailable. RN H said she recalled a receptionist coming to the unit to report that R125 needed assistance and that by the time she went into R125's room to check on the situation, 2 CNA's were in the midst of cleaning up R125. According to RN H she was splitting a hall and it seemed like there were quite a few residents to attend to. RN H said she thought she provided a statement about the incident to the Unit Manager at that time, Licensed Practical Nurse (LPN) B shortly after the incident. Review of the facility investigation file did not reveal a statement had been obtained from RN H. A telephone call to CNA G was placed on 9/23/21 at 10:45 a.m. and a voice message was left requesting a return telephone call. As of 9/24/2021 at 4:00 p.m., no return call was received. Review of a statement signed by CNA G, dated 7/19/21 reflected Call light was on. Saw he (R125) had a bowel movement. Went to get help, had to do a complete bed change. He waited about 15 minutes. Offered to move bed by wall to roll him but he refused. Needed a second aide to help for safety. The statement did not reference a specific date or time being described and did not clearly identify that R125 was the subject of the interview. Review of a 5 Day Investigation of alleged delay in care of [R125] reflected the following: On 7/12/21, Administrator was notified of alleged delay in care made by wife of resident [R125]. Because of this allegation, it was reported as neglect pending full investigation . [R125] was interviewed regarding the alleged incident. He stated that on 2 occasions over the weekend, it took an extended amount of time to receive assistance with bowel needs . Interviews were conducted with the nurse aides on duty for days of the alleged delays in care. For the first occasion, the aide stated that she helped [R125] on and off the bedpan, per his request multiple times throughout the day. In addition, she responded to a call light only a few minutes after it went on to assist with changing him. For the second occasion the aide responded to the light and saw [R125] had a bowel movement. At the time [R125] required 2 assist for safety and turning during cares in bed. The aide left to find a second person which took less than 15 minutes. The Determination of Findings/Conclusion documented by the Administrator reflected that the facility was unable to confirm there was a delay in care for R125 due to conflicting statements; CNA G, CNA S and R125. No statements were taken from the RN H who was on duty the day of the occurrence or from FR/CNA SS regarding the call to the facility from law enforcement. The report did not include a statement from FM F or reference the memorandum sent by FM F to the NHA or BOM CCC. During an interview on 9/23/21 at 3:41 p.m., the NHA said she first became aware of the allegation of neglect made by FM F on behalf of R125 on 7/12/21 along with other care concerns. According to the NHA, she considered FM F's report of a delay in care an allegation of neglect. The NHA said she would have expected a report from staff immediately after law enforcement called the facility regarding R125 on 7/10/21. The NHA reported that other staff were being trained on completing investigations and did not have additional information to support that a complete investigation had been conducted on behalf of R125.

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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.

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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)

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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)

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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)

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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)

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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.

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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)

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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.

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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)

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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)

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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

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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)

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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)

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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.