

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235032	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Skld Ionia		STREET ADDRESS, CITY, STATE, ZIP CODE 814 East Lincoln Avenue Ionia, MI 48846	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2566577 and #2575897. Based on interview and record review, the facility failed to ensure dignified care was provided for 2 residents (R100 and R101) of 4 residents reviewed for dignity. Findings include: R100 Review of an admission Record revealed R100 admitted to the facility on [DATE] with pertinent diagnoses which included fibromyalgia, difficulty in walking, and left hip contusion. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R100, with a reference date of 7/8/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R100 was cognitively intact. Further review of the same MDS assessment revealed R100 was occasionally incontinent of urine and required staff assistance with toileting. Review of a current activities of daily living (ADL) Care Plan intervention for R100, initiated 7/7/2025, revealed resident required the assistance of 1 staff with ADLs. In a telephone interview on 8/21/2025 at 11:13 AM, R100 reported when Competency Evaluated Nursing Assistant (CENA) A awaked her for a meal she realized that she had been incontinent of urine and requested assistance to be changed. R100 reported CENA A stated maybe you should have gotten up before you wet yourself. CENA A left the room and told R100 she would return after she finished passing meal trays. R100 reported CENA A never returned to the room to assist and she ended up getting up and changing herself an hour later, knowing that she was not supposed to do this without assistance. R100 reported this event made her feel frustrated, helpless, and depressed. R100 stated It seemed like they didn't want to take care of me, I called my mom crying multiple times. In an interview on 8/26/2025 at 2:35 PM, CENA A reported she went into R100's room with a meal tray and R100 reported she was wet. CENA A reported she told R100 that she would return after she finished passing trays but forgot to return. CENA A reported she did this with another resident at a later date and a supervisor told her that she needed to stop passing meal trays to clean up a wet or soiled resident rather than waiting until she was done passing trays. In an interview on 8/29/2025 at 9:10 AM, the Director of Nursing (DON) reported CENAs should stop passing meal trays to assist residents that are wet or soiled to provide care. R101 Review of an admission Record revealed R101 admitted to the facility on [DATE] with pertinent diagnoses which included depression and apraxia (difficulty with skilled movement). Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R101, with a reference date of 7/10/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R101 was cognitively intact. Further review of the same MDS assessment revealed R101 required staff assistance with toileting. Review of a current ADL Care Plan intervention for R101, initiated 2/3/2022, revealed R101 required the assistance of 1 staff for toileting. In an interview on 8/26/2025 at 9:30 AM, R101 reported she waited up to 30 minutes for help after pressing the call light. R101 reported the previous week that she pressed her call light and waited over 20 minutes for staff to respond. R101 reported she wet herself while waiting and this made her feel dehumanized. Review of facility/procedure Resident Rights, issued 11/12/2024, revealed residents have a right to a dignified existence including to .be treated with dignity and respect. reasonable accommodation of needs and preferences.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2575897. Based on interview and record review, the facility failed to provide showers for 2 dependent residents (R101 and R103) of 4 residents reviewed for accommodation of needs. Findings include:R101 Review of an admission Record revealed R101 admitted to the facility on [DATE] with pertinent diagnoses which included depression and apraxia (difficulty with skilled movement). Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R101, with a reference date of 7/10/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R101 was cognitively intact. Further review of same MDS assessment revealed R101 required staff assistance with showering. Review of a current ADL Care Plan intervention for R101, initiated 2/3/2022, revealed R101 required the assistance of 1 staff with showering. Review of the facility Back Unit Shower List revealed R101 was scheduled to receive showers on Sunday and Thursday evenings. In an interview on 8/29/2025 at 9:36 AM, R101 reported she went for a couple weeks in July without receiving her scheduled shower. R101 reported this made her feel dirty. Review of R101's shower documentation revealed she received a bed bath instead of a shower on scheduled shower days on 7/10/2025, 7/17/2025, 7/24/2025, 7/31/2025, 8/7/2025, and 8/17/2025. Further review revealed R101 went without a shower for two weeks from 7/13/2025 until 7/27/2025. Review of R101's Concern Form, dated 7/31/25, revealed .No shower for two weeks July 14th through July 26th. R103 Review of an admission Record revealed R103 admitted to the facility on [DATE] with pertinent diagnoses which included depression, anxiety, and history of falling. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R103, with a reference date of 7/12/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14, out of a total possible score of 15, which indicated R103 was cognitively intact. Further review of the same MDS assessment revealed R103 required staff assistance with showering. Review of a current ADL Care Plan intervention for R103, initiated 1/3/2023, revealed R103 required the assistance of 1 staff with showering. Review of the facility Back Unit Shower List revealed R103 was scheduled to receive showers on Monday and Friday evenings. In an interview on 8/26/2025 at 2:10 PM, R103 reported she preferred to receive showers and not bed baths but about 3 times a month she received bed baths instead of showers. R103 reported receiving bed baths instead of showers made her feel dirty and like her hair wasn't clean. Review of R103's shower documentation revealed she did not receive a shower or bed bath on 8/1/2025. Further review revealed R103 received a bed bath instead of a shower on scheduled shower days on 8/15/2025, 8/18/2025, and 8/25/2025. In a telephone interview on 8/29/2025 at 8:05 AM, Competency Evaluated Nursing Assistant (CENA) G reported staff try to give scheduled showers instead of bed baths but sometimes they have staffing issues or resident care issues that prevent them from being tied up in the shower. CENA G reported staff will give bed baths instead of showers in these circumstances. In an interview on 8/29/2025 at 9:45 AM, CENA J reviewed R103's shower documentation from 8/18/2025 and reported she was working a double that day, staffing was short, and sometimes she will provide a bed bath instead of a shower if there is not enough time to provide a shower. In an interview on 8/29/2025 at 9:10 AM, the Director of Nursing (DON) reported resident preference for showers over bed baths should be met. Review of facility/procedure Resident Rights, issued 11/12/2024, revealed residents have a right to a dignified existence including to .be treated with dignity and respect. reasonable accommodation of needs and preferences.</p>		