STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235032	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Ionia	814 E Lincoln Ave Ionia, MI 48846

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 28101 Based on observation, interview, and record review, the facility failed to investigate, analyze, and implement meaningful interventions to prevent repeated falls for two Residents (R32 and R117) of three residents reviewed for accident hazards. Findings include: R32 Review of R32's face sheet dated 3/5/25 revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included dementia, lack of coordination, falls, restlessness and agitation. She was not her own responsible party. R32 was observed in bed on 03/04/25 at 10:04 AM. R32 had her eyes open, she was holding a hairbrush. R32 did not respond to her name or any questions. R32 had bruises covering a large portion of her face and forehead. R32 was observed on 3/5/25 at 9:12 AM up in her wheelchair in a hall in the facility. She was not near her room and there were no staff in sight of her location. R32 did not have a comb or brush in her hand. R32 did not respond to any questions. Review of R32's care plan, initiated on 11/8/2019, revised 9/30/2024 revealed R32 had the cognitive capacity of a 2-year-old. Review of R32's fall care plan dated 8/31/22 revealed, Potential for injury to falls d/t (due to) developmental delayed (functional age of 2 yo (year old) dementia, no safety awareness, impulsive, little to no ability to communicate needs, needs for assistance for safe transfers, psychotropic medications, seizures, hx (history) of falls, attempts to reach things on the floor, place self on floor to retrieve dropped items and returns unassisted to w/c (wheelchair). There were no interventions to provide supervision or to offer supervised activities when R32 was awake located in R32's medical record. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 3/5/25 at 4:23 PM, the surveyor questioned if all the information related to R32's falls was provided as requested. The only documentation that was received was incident and accident reports. The reports did not include any investigation, interventions, staff statements, analysis or interventions placed after the fall. The incident and accidents were just a summary of what the nurse saw when R32 was found on the floor and any initial injuries noted. There was no indication of R32's care or condition prior to the fall. The DON said she had some statements and a post fall tool for some of the falls, however the Certified Nurse Aides (CNA's) were not consistent at filling out the post fall tool. The DON said the post fall Interdisciplinary (IDT) notes would have more information. The surveyor asked where the IDT was getting the information to implement interventions if they did not have information on the resident's condition prior to the fall and the DON did not have any information. The DON said she would look for all additional information. Review of R32's incident and accident report dated 12/22/24 at 18:00 (6:00 PM) revealed the resident was found on the floor in her room next to her toy box and her toys were scattered throughout the room. No injury noted. Review of R32's Interdisciplinary Team (IDT) Note dated 12/23/24 at 9:25 AM revealed the same information as the incident report dated 12/22/24 at 6:00 PM with the additional information that R32 was sent to the Emergency Department (ED) for treatment of an acute condition. No information on the acute condition was provided. No information on fall prevention was provided. Review of R32's incident and accident report dated 1/3/25 at 19:30 (7:30 PM) revealed. This nurse was standing at med (medication) cart in the hallway when I heard a crash, went to check on it an observed patient on the floor in her room just inside the doorway, I want a coke. Resident had a bruise on her forehead and was sent to the ED (emergency department) for evaluation. Review of R32's incident and accident report dated 2/22/25 at 00:00 (midnight) revealed, CNA (certified nurse aide) yelled out that she needed help in pt's (patients) room. Upon arrival pt (patient) was lying on the floor bleeding from above her left eye. Pt (patient) states that she dropped her combs and was trying to pick them up. Vital signs obtained and abrasion cleaned. No CNA statement found or information on R32's condition prior to the fall was located. Review of a late IDT note dated 2/24/25 at 13:21 (1:21 PM) revealed the same information in this note as the incident and accident report dated 2/22/24 at midnight and additional information of R32 being sent to the emergency department at 18:50 (6:50 PM). 18.5 hours after the fall with injury because R32 required treatment for a laceration. No indication of the size or location of the laceration was documented. The only intervention was emergency treatment of the laceration. No future fall prevention interventions were located. Review of a Post incident CNA report for R32 dated 2/22/25 reflected R32 was weak from being sick and the CNA (Certified Nurse Aide) recommended R32 be supervised in her room when she was in her wheelchair. Review of R32's fall care plan revealed no supervision intervention in place when resident is up in her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R32's incident and accident report dated 3/1/25 at 18:00 (6:00 PM) revealed, summons to room by staff pt (patient) was lying near her activity table, toys were scattered, pt (patient) Comb comb Combs were in her hand, pt (patient) was assessed to no apparent injuries, hips palpated symmetrical, no internal or external rotation was noted, no change in LOC (level of consciousness) or Neuro's (neurological), resident was clean and dry, gripper socks on, no environmental factors involved, CNA (Certified Nurse Aide) was with bed 1 and was not witnessed, pt (patient) was assisted to bed by staff, on call provider and DPOA (durable power of attorney) was notified, table to be removed as had previous incidents with her table and toys, staff to ensure she has her combs, toy table to be assessed by therapy for safety concerns. The DON provided one post incident CNA report dated 3/1/25 and revealed resident was last observed on 3/1/25 at 4:55 PM and R32 was in her room at that time. The floor was clean, and no toys were dropped. No recommendations were made for prevention of future falls. Review of R32's IDT note dated 3/3/25 at 9:19 AM revealed the same information that was in the incident report dated 3/1/25 at 6:00 PM with the additional information of limiting combs and attaching the activity table to the wall. No intervention for supervision on increased assistance was located. During an interview with the DON and Nursing Home Administrator (NHA) on 3/6/25 at 9:45 AM. The facility policy and procedure for Falls was reviewed. The policy did not provide any information on investigation, analysis, or care planning of meaningful interventions after a fall. The focus of the policy was with dealing with injuries related to assessing the resident for injuries after a fall. There was no mention of prevention of further falls. The 4 falls R32 had from 12/22/24 to 3/1/25 were reviewed and they said they had provided all information they had related to those falls. They confirmed that R32 was severely cognitively impaired and had no safety awareness. They could not locate any interventions for supervision when she was up in her wheelchair or any supervised activities. They said at one point her toys were placed in the hall but that became a concern for another resident. No other activity or supervision was placed after R32's toy were placed in her room. R117 Review of R117's Minimum Data Set (MDS) dated [DATE] revealed R117 was [AGE] years old and was admitted to the facility on [DATE] with diagnoses that included stroke and dementia. R117 had a Brief Interview of Mental Status (BIMS) score of 15/15 indicating normal cognitive status. R117 was observed sleeping in bed on multiple occasions on 3/4/25 and did not awaken to calling her name. R117 was observed in bed on 3/5/25 at 12:20 PM and confirmed she slept most of the day 3/4/25 stating she has been ill and was still tired. R117 had no recall of falling on 3/1/25. The only fall she could recall was falling in the therapy department but was not sure how long ago. R117 did not have any walking assistive devices in the room and said she cannot walk anymore without help. R117's wheelchair was next to her bed. The wheelchair had standard brakes, and they were in the locked position. R117 could not think of anything the facility could do to keep her safe from falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R117 incident and accident report dated 9/26/24 at 10:45 AM revealed R117 fell in the therapy room. The therapist was in the room and observed R117 walking fast with a walker, R117 sat at the side of the chair. The plan was to have R117 continue to work with Occupational Therapy to improve safety awareness. Review of the IDT note dated 9/27/24 at 9:21 AM revealed the same information as the incident and accident report along with vital sign monitoring and follow-up with Cardiology. No mention of increased assistance or supervision. Review of R117's incident and accident report dated 1/12/25 at 17:00 (5:00 PM) revealed R117 was found lying on the floor in her room. R117 said she was trying to get dressed, and her left leg gave out. No indication of resident's status prior to the fall was located. Review of the IDT meeting note for R117 dated 1/13/25 at 9:34 AM revealed the same information as the incident and accident report dated 1/12/125 at 5:00 PM with the additional information of physical therapy was to evaluate. No increase in supervision or assistance was mentioned. Review of R117's incident and accident report dated 1/27/25 at 6:45 AM revealed, R117 was found on the floor. She reported that she was trying to get into her wheelchair to go to the restroom, but she felt weak and lowered herself to the floor. The room had poor lighting and resident was drowsy. No new interventions were mentioned, no staff statements were located. No additional assistance or supervision were mentioned. Review of R117's IDT noted dated 1/27/25 at 9:29 AM revealed the same information along with ruling out any acute condition and continue therapy. No new intervention for increased assistance or supervision were located. Review of R117's incident and accident report dated 3/1/25 at 8:00 AM revealed R117 was found on the floor in her room near the foot of her bed. R117 had oxygen tubing along the bed and under her along with 4 shoes and a pillowcase were found next to the bed. The wheelchair brakes were locked. R117's call light was not in use. Predisposing Physiological Factors included: incontinent, gait imbalance and impaired memory. Review of R117's IDT note dated 3/3/25 at 9:10 AM revealed the same information that was in the incident and accident report dated 3/1/25 at 8:00 AM with the addition of a wheelchair with auto locking brakes. (observation on 3/5/25 at 12:20 PM revealed this intervention was not in place). The reports also documented R117's wheelchair brakes where functioning and locked at the time of the incident. No new interventions for increased assistance or supervision were located. Review of R117's fall care plan dated revision on 12/12/24 revealed auto-locking wheelchair brakes were to be placed on 3/3/25 (observed not in place 3/5/25). No interventions for assistance with any activities of daily living or any supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the facility Social Worker (SW) D on 3/5/25 at 12:28 PM, SW D confirmed R117 was her own responsible party. This surveyor informed her that R117 had no recall of the fall she had on 3/1/25 (4 days ago) and reported that she had dementia. SW D confirmed that R117 did have dementia, and she was aware of fluctuations in R117 mental status. SW D confirmed that she saw R117 on 3/1/25 and confirmed that R117's wheelchair brakes were functional. SW was not aware of any increased supervision or assistance implemented for R117 after her fall on 3/1/25. During an interview with the DON and NHA on 3/6/25 at 9:50 AM they confirmed they had provided me with all R117's fall information for her falls from 9/27/24 to 3/1/25. They were aware of R117's mental status fluctuations. They were not able to locate any information on increased assistance with activities of daily living or of any increased supervision being provided for R117.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 29073 Based on observation, interview, and record review, the facility failed to implement a) Accurate monthly infection surveillance, b) Conduct an outbreak investigation, and c) Properly store oxygen supplies according to the facility Infection Control plan, program and policies for one resident (R25) of six residents reviewed for Infection Control. Findings: During a comprehensive interview pertaining to the facility Infection Control Program, on 3/6/25 beginning at 9:30 AM, Infection Control (IC)/Licensed Practical Nurse (LPN) reported that he organized a monthly infection report and presented the findings during the monthly Quality Assurance Process Improvement (QAPI) meetings. A review of the IC process revealed that when a resident is prescribed an antibiotic, a review of McGeer's criteria (a set of clinical laboratory definitions used to diagnose and monitor infections in long-term care facilities) is conducted and supporting documentation is obtained and/or validated. Once a diagnosed infection is identified, IC/LPN C maps the infections and includes the infections on a line listing. During an interview on 3/6/25 at 9:30 AM, Infection Control (IC)/Licensed Practical Nurse (LPN) C reported that in January 2025 both R1 and R64 had been sent to the hospital for suspected infections. IC/LPN C reported the hospital sent the residents back with orders for antibiotics which were continued in the facility despite laboratory and x-ray analysis that would not indicate either resident had an infection. IC/LPN C reviewed the Electronic Medical Record (EMR) for each resident and did not identify evidence the facility provider documented a rationale for continuing the antibiotic treatment. The facility infection mapping and infection line list reflected that despite neither resident having an infection, the residents were included in the overall rate of infection for the month of January, 2025. During the Infection Control interview on 3/6/25 beginning at 9:30 AM, IC/LPN C reported the facility had a COVID-19 outbreak in December of 2024. IC/LPN C reported they had not conducted an Outbreak Investigation per policy and had not incorporated an investigation into employee illnesses that may have impacted the spread of COVID-19 amongst residents. IC/LPN C said they did not distinguish COVID-19 from other respiratory illness on the mapping tool used to identify trends, cluster and/or outbreaks at the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy Outbreak Investigation reflected C. The Infection Preventionist will gather and compile date related to the infection(s) as follows: 1. Conduct case finding (review ongoing surveillance charts of other patients at risk and microbiology reports) to determine whether there have been other cases of infection. 2. Evaluate previous experience with the infection. 3. Prepare a line listing of cases to include: resident, room number, date of admission, date of infection onset, site culture results, and physician. 4. Plot number of cases by date of onset (epidemic curve). 5. Review charts of cases and interview involved personnel for various factors that conceivably may have played a role in transmission of an infection, e.g., geographic locations of residents, specific personnel having contact with residents, medications and treatments administered. 6. Review various infection prevention techniques (hand hygiene, use of standard precautions, etc.) as actually practiced in the facility. 7. Maintain surveillance for occurrence of any further infections. VII. ANALYSIS OF DATA - The data collected in the preliminary investigation are reviewed by the investigators to determine whether a common source of infection, break in technique, etc., can be implicated as a cause of the epidemic. A preliminary written report will be prepared. A final written report of the investigation, outlining findings and recommendations, is prepared by the investigation coordinator and issued to the infection prevention committee, others participating in the investigation, medical director, attending physician(s), director of nursing, and others as needed. 31771 Resident #25 R25 Review of the medical record reflects R25 admitted to the facility 4/21/21 and has pertinent diagnoses that include heart failure, chronic obstructive pulmonary disease (COPD) and pneumonia. On 3/4/25 at 9:59 AM an observation and interview were conducted with R25 in his room. R25 reported he uses oxygen all of the time and has a tank on his wheelchair to use when he is out of bed. An oxygen tank was observed in a holder on his wheelchair. The tank had nasal cannula tubing attached and was draped over his wheelchair. Next to the bed on a chair a nebulizer machine was noted with a nebulizer mask laid on a paper towel and rested on a depression on the top of the nebulizer machine. An empty clear plastic storage bag was observed tied to the handle of the nebulizer machine. Review of the Medication Administration Record (MAR) for March 2025 for R25 reflected a nebulizer treatment was administered 3/3/25 at 8:54 PM and the mask remained un-stored as of the observation on 3/4/25 at 9:59 AM. On 3/5/25 at 9:28 AM an observation was made in the room of R25 that the nasal canula tubing and the nebulizer mask remained un-stored and open to air as observed on 3/4/24 at 9:59 AM. Review of MAR for March 2025 for R25 reflected the Resident has received a nebulizer treatment by third shift on 3/5/25 at 5:30 AM and the nebulizer mask remained un-stored as of 9:28 AM, as noted. On 3/5/25 at 2:24 PM in an interview was conducted with the Director of Nursing (DON) in her office. The DON reported an expectation that oxygen tubing and devices are to be stored in a plastic bag when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/5/25 at 2:39 PM an interview was conducted with Infection Control Preventionist (ICP) C. ICP C reported that from an infection control perspective oxygen equipment should be stored in the clear plastics storage bags when not in use. ICP C reported nebulizer masks are cleaned following a nebulizer treatment and air dried first but should be stored in the clear storage bags shortly after cleaning. On 3/6/25 at 7:40 AM the nasal cannula tubing attached to the oxygen tank on the wheelchair of R25 was observed to be draped over the chair and not stored in a clear plastic bag. On 3/5/25 at 10:03 AM a request was emailed the Nursing Home Administrator (NHA) for the facility policies for Oxygen, Oxygen Devices - CPAP, tubing, etc. The policy provided by the facility titled Subject: Oxygen Therapy dated 7/11/2018 was reviewed. This policy reflected Precautions and/or possible complications . 5. Bacterial contamination associated with certain nebulizers and humidifiers may occur And All O2 equipment will be checked daily by Respiratory Therapist/Nurse for proper function, prescribed flow rate. However, this policy does not provide direction for safe storage of O2 equipment when not in use. The policies provided by the facility titled CPAP/BIPAP Support (oxygen devices used primarily while sleeping) dated 7/26/2018 and the facility policy titled Infection Prevention and Control .Subject: Oxygen Use revised 9/24/2018 were reviewed and neither policy provided direction on the safe storage of oxygen equipment when not in use. No other oxygen care related policies were provided by the facility. On 3/6/25 at 10:52 AM during an interview Licensed Practical Nurse (LPN) E indicated oxygen tubing and devices must be stored in the plastic bags when not in use and are changed out weekly usually by third shift. LPN E was informed that none of the policies provided by the facility provided instruction on the proper storage of oxygen devices and was asked how she knew to do this? LPN E reported she knows how to properly store oxygen equipment because of years of being a nurse and indicated this is a infection prevention practice.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed to follow it's Antibiotic Stewardship policy for two residents (R1 & R64) out of 16 residents reviewed for antibiotic stewardship. Findings: R1 Review of an Admission Record reflected R1 originally admitted to the facility on [DATE] and readmitted to the facility after a hospitalization on [DATE]. Review of an Infection Report Form completed by LPN/IC C reflected R1's suspected infection was urinary tract as evidenced by confusion, dysuria, increased (up arrow) incont. (incontinence). The report indicated a UA was obtained and the culture showed no bacterial growth, however R1 was prescribed Keflex (antibiotic) 500 mg (milligram)/TID (three times a day)/PO (per os, orally) - Start date: 1/10/25 - Stop Date: 1/18/25. Further review of the documentation revealed Resident (R1) sent to the ED (Emergency Department) per family request r/t confusion. ED dx (diagnosed) PNA (pneumonia) & UTI (Urinary Tract Infection) & ordered antibiotics x (times) 8 days. Following the notes and a review of McGeer Criteria (a set of clinical laboratory definitions used to diagnose and monitor infections in long-term care facilities), were UA culture results from the hospital and a chest x-ray. The urine culture resulted in Mixed flora. No significant pathogens isolated. The chest-ray result indicated R1 had Interstitial as well as hazy opacities in both lungs. The chest x-ray result was followed by a Physical Exam Subjective: (R1) denies SOB (shortness of breath), chest pain, pressure/pleuritis/nausea/vomiting/constipation/diarrhea . The Objective exam revealed R1's lungs were clear to auscultation (listening to internal sounds), no wheezed or crackles. R64 Review of an Admission Record indicated R64 readmitted to the facility from a hospital on 1/26/2025 diagnosed with Infection and Inflammatory Reaction. Review of an Infection Report Form reflected R64 was admitted with a diagnosis of UTI and was prescribed Amoxicillin 500 mg/TID/PO - Start Date: 1/26/25 - Stop Date- 1/30/25. The report indicated the U/A (urinalysis) '-' (negative). Hospital documentation reflected a urinalysis that did not indicate R64 had white blood cells count that would indicate a treatable infection, and few bacteria were identified. No culture was attempted based on the urinalysis. R64's blood was cultured in the hospital and showed No organism isolated. During an interview on 3/6/25 at 9:30 AM, Infection Control (IC)/Licensed Practical Nurse (LPN) C reported that for both R1 and R64, the hospital sent the residents back with orders for antibiotics which were continued in the facility despite laboratory and x-ray analysis that would not indicate either resident had an infection. IC/LPN C reviewed the Electronic Medical Record (EMR) for each resident and did not identify evidence the facility provider documented a rationale for continuing the antibiotic treatment. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Antibiotic Stewardship policy adopted 7/11/18 reflected It is the policy of this facility that antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The policy specifies 10. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed to administer a COVID-19 vaccine after receiving consent for the vaccine for two residents (R12 and R29), out of 5 residents reviewed for immunizations. Findings: R12 Review of an Admission Record reflected R12 admitted to the facility on [DATE] and was their own responsible party. Review of a COVID-19 Vaccine Consent Form reflected CONSENT FOR VACCINATION: I have been educated on and understand the risks, benefits and potential side effects of the updated COVID-19 vaccine and hereby give consent to receive the Spikevax Moderna COVID-19 vaccine. The consent for vaccination was signed by R12 on 1/17/2025. R29 Review of an Admission Record reflected R29 readmitted to the facility on [DATE] and was not their own responsible party. Review of a pharmacy Immunization Consent Form for the Updated (2023-2024 Formula) Covid-19 Vaccine reflected I/responsible party attest that all criteria defined by the CDC (Centers for Disease Control and Prevention) have been net to receive a COVID-19 vaccine on this day, and consent to receiving the COVID-19 vaccine. The consent form was signed by R29's Durable Power of Attorney (DPOA) on 5/24/2024. During an interview on 3/4/25 at 9:30 AM, the Infection Control (IC) Licensed Practical Nurse (LPN) C reported that when an immunization is consented to by a resident/responsible party, the order for the vaccine should be entered into the Electronic Medical Record (EMR) and the vaccine should be administered shortly thereafter. IC/LPN C reviewed the clinical record for both R12 and R29 and could see the COVID-19 vaccine had NOT been administered to either resident, there was no supporting documentation explaining why the vaccine was not given and was an oversight. Review of the facility policy Immunizations-COVID-19 Vaccine updated 11/1/2024 reflected It is the policy of this facility, that in collaboration with the medical director, to have an immunization program against COVID-19 in accordance with national standards of practice.