STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235103	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Beltline	2320 E Beltline SE Grand Rapids, MI 49546

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41982 Based on observation, interview, and record review, the facility failed to assess and ensure the right to safe self-administration of medication in 1 (Resident #105) of 3 residents reviewed for medication administration, resulting in the potential for unsafe self-administration of medication, medication errors, and medications not being stored in a secure manner. Findings include: Resident #105 Review of an Admission Record revealed Resident #105 was a male, with pertinent diagnoses which included: anemia in other chronic diseases; hemiplegia (muscle weakness or partial paralysis on one side of the body), unspecified affect; dysphagia (swallowing difficulty), oropharyngeal phase; and bipolar disorder, unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 4/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #105 was cognitively intact. During an observation and interview on 4/23/24 at 10:54 AM, Resident #105, who granted permission for this surveyor to enter his room, was in his room, seated on his bed. There was a small plastic cup of water and a medication cup with 2 round tablets (one tablet was round and white and the other tablet was round and yellow) on the bedside table next to Resident #105's bed. Resident #105 reported that the tablets were his Vitamin B12 and Folic Acid. Resident #105 explained that he couldn't take the tablets when the nurse brought them to him because he needed to take them with food so they just leave them here for me so I can take them with my food. Resident #105 reported he would have already taken them with his breakfast, but he didn't care for his breakfast that morning and was waiting for lunch to come to take them. Review of a Physician's Order for Resident #105 revealed, Folic Acid Oral Tablet 1 MG (milligram) (Folic Acid) Give 1 tablet by mouth one time a day for supplement .Active Order Date 02/29/24. Review of a Physician's Order for Resident #105 revealed, Thiamine HCl Oral Tablet 50 MG (Thiamine HCl) Give 1 tablet by mouth one time a day for Supplement .Active Order date 02/29/24 (Note that Thiamine is Vitamin B1 and not Vitamin B12; there was no order for Vitamin B12). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/24 at 9:39 AM, Director of Nursing (DON) B reported if a resident desired to self-administer their medications, the facility would evaluate the resident to ensure they were physically able to take the medication and to do so safely, ensure the resident could correctly identify the medications they were taking, and to review any past behaviors that might prevent safe self-administration. DON B reported once the evaluation was completed and the resident was approved to self-administer their medications, the care plan would be updated to reflect the self-administration status. DON B was requested to show this surveyor the evaluation for Resident #105 to self-administer his medications. DON B reviewed Resident #105's medical record and reported Resident #105 had not been assessed to self-administer medications and should not have had the medications at bedside. In an interview on 4/25/24 at 10:37 AM, Registered Nurse Unit Manager (RNUM) K reported if a resident requested to have their medications at bedside, an assessment would have to be completed to make sure the resident was safe to self-administer. RNUM K reported if a resident was able to self-administer their medications, the care plan would reflect the self-administration status. RNUM K reported it was not okay to leave medications at bedside if the resident had not been assessed. A record review of Resident #105's current Care Plan was conducted on 4/25/24 at 10:20 AM. There was no care planned focus, goals, or interventions documented that Resident #105 could self-administer medications.

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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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 41982 This citation pertains to intake: MI00143463. Based on interview and record review, the facility failed to respond timely to a request for medical records in 1 (Resident #105) of 6 residents reviewed for resident rights, resulting in delayed access to the resident's medical records and resident frustration. Findings include: Resident #105 Review of an Admission Record revealed Resident #105 was a male, with pertinent diagnoses which included: PTSD (post-traumatic stress disorder). Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 4/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #105 was cognitively intact. In an interview on 4/23/24 at 10:54 AM, Resident #105 reported that on 2/12/24, he had asked one of the nurse aides how to get a copy of his medical records. Resident #105 went on to say that the aide explained the process to him, he followed the protocol, but didn't get any response. Resident #105 reported he waited a few days and still didn't get any response, so he called the corporate office to tell them about his medical records request. Resident #105 reported he thought corporate must have said something to the facility because after that, a bunch of people came to talk to me. (Resident #105 was unable to name the people that talked to him.) Resident #105 reported he has an appointment in May to see his previous primary care physician (PCP) and wanted to be able to have the medical records from the facility for the PCP. Resident #105 reported he also wanted to see his medical records for himself because he wanted to know what was going on with his condition. Resident #105 reported he has asked for the social worker to talk to him about getting his medical records but had not heard anything from them either. Resident #105 stated I have been waiting. Resident #105 confirmed that he had not received copies of his medical records, nor has he been provided with access to his medical records as of this date. In an interview on 4/24/24 at 1:58 PM, Social Services Director (SSD) C reported she was not aware that Resident #105 had been asking for his medical records. SSD C reported that the normal process to request medical records would be to talk to the medical records department and fill out a request. SSD C reported she knew there was a process but was not certain of all the steps. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/24 at 8:51 AM, Medical Records Coordinator (MRC) M reported has been the MRC since December. MRC M reported the process for residents to obtain copies of their medical records was to fill out a Medical Records Request form and submit it to Medical Records Office who then got Nursing Home Administrator approval and fulfilled the request. MRC M reported there was a cost to the requestor for the copies. MRC M reported Resident #105 had called her back in February and she went down and spoke to him in person. MRC M reported Resident #105 had wanted her to send his entire medical record to his phone, and MRC M had explained to Resident #105 that cellular phones didn't hold that much data. MRC M reported she had tried to explain to Resident #105 that there was a cost involved in making the copies and that his entire medical record would likely be thousands of pieces of paper. MRC M reported at one point had reached out to SSD C to have her explain to Resident #105 how the process worked. MRC M reported that, after a while, things quieted down and didn't hear anything else about it so nothing more was done with the request. MRC M reported she had assumed that he didn't need them anymore MRC M was queried as to process for the resident to have access to their medical records without having to pay for copies. MRC M stated there would not have been another way without printing the records and then stated, that is a good question. In a follow up interview on 4/25/24 at 9:12 AM, SSD C reported after the conversation with this surveyor on 4/24/24, she had spoken with Resident #105 about his medical records request and had explained to him that there was a cost involved in printing them. SSD C reported was not sure what the option would be if the resident couldn't afford to pay for the medical record copies and would have to defer to MRC M for advice on another option for a situation like that. In an interview on 4/25/24 at 9:39 AM, Nursing Home Administrator (NHA) A reported was not aware that Resident #105 had made a request for his medical records until yesterday. NHA A reported had asked MRC M about it that morning and that MRC M had explained that she had informed Resident #105 that there was a cost involved in making copies of his medical records. NHA A reported it was her understanding that MRC M felt that Resident #105 had not wanted to go that route (meaning paying for the copies) and thought that was the end of it. NHA A reported if she would have known about Resident #105's request, she would have made alternate arrangements for Resident #105 to have access to his medical records. NHA A reported had not been aware until yesterday that Resident #105 had contacted the corporate office about his medical records request when MRC M had shown her a copy of the email exchange from the corporate admissions person.

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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** 41982 This citation pertains to intake: MI00143329. Based on interview and record review the facility failed to implement their Abuse and Neglect policy following an incident of visitor to resident verbal abuse in 1 (Resident #104) of 6 residents reviewed for abuse resulting in a delay in reporting the Facility Reported Incident (FRI) to the State Agency and a delay in the removal of the visitor pending an investigation. Findings include: Resident #104 Review of an Admission Record revealed Resident #104 was a male, with pertinent diagnoses which included: acquired absence of left leg (amputation), acquired absence of right leg (amputation) major depressive disorder, and cognitive communication deficit. Review of a FRI Intake Information report revealed, Date of Alleged Event: 02/29/2024 Time: 3:00 PM . Facility incident report received via online submission on: 3/1/24, 2:58 PM .Investigation Summary .Date of Incident: 2/29/2024 @ (at) 3:00 pm Brief Description of Event: At approximately 3:00 pm on 2/29/2024, (Resident #104) was sitting in the dining room after the activity; a guest visiting a family member wanted to move a table around (Resident #104). Thus, the guest asked (Resident #104) to move, and he did not respond quickly enough based on the guests actions with attempts to move around (Resident #104). At one point, while the activity director was turned around, the resident and guest started arguing, and (Resident #104) was upset that the guest was in his way. The choice of language they used toward each other was a mix of slang and cursing; the activity director separated (Resident #104) and the guest. (Resident #104) had calmed down .Interviews and investigations: Activity Director: (Resident #104) had stopped talking to another resident as a visitor was trying to move a table, and (Resident #104) was in the way. The visitor said excuse me. (Resident #104) didn't move after she repeated Excuse me three times. Eventually it progressed into the raising voice (sic) at each other about respect. (Resident #104) Statement: I was talking to my roommate, and (guest name omitted) started moving tables next to me. I told her, Let me get out of your way. She started moving the tables before I could get out of the way. Then we started shouting at each other. Then (guest name omitted) walked away . In an interview on 4/23/24 at 8:52 AM, Nursing Home Administrator (NHA) A reported the incident had been reported to the State Agency late because the Activity Director had not brought it up until the next day in the morning meeting. NHA A reported they had developed a plan of correction and presented this surveyor with documentation of the steps taken to correct the deficiency. NHA A reported after the Activity Director had reported the incident in the morning meeting, the guest (visitor) had been contacted and was notified not to come to the facility pending the investigation. On 4/23/24 at 2:39 PM, this surveyor attempted to interview Resident #104 about the incident that had occurred on 2/29/24 between himself and a guest. Resident #104 reported he did not remember the details of the incident and declined to answer further questions regarding the matter. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/24/24 at 1:11 PM, Activity Director (AD) I reported she had witnessed the incident that occurred on 2/29/24 between Resident #104 and (guest name omitted). AD I reported the incident occurred in the dining room. AD I reported (Resident #104) was seated next to a table speaking with another resident when, instead of going around the other side of the table, (guest name omitted), who was trying to move a table, tried to walk between the two residents. AD I reported (guest name omitted) said excuse me 4 times. AD I reported her back had been toward the residents and (guest name omitted) when she heard the guest tell Resident #104 that she was a [AGE] year-old woman and deserved respect and then told Resident #104 don't talk to me like that. AD I reported the guest was telling Resident #104 to shut up and that if he had any respect, he wouldn't be in the wheelchair. AD I reported after that, she (AD I) was just trying to get Resident #104 to move on, but he was angry that this lady (guest name omitted) was coming in and telling him to move, so, after it happened, we separated him from the situation. AD I reported the guest did stay with the resident she was visiting in the dining room, talking with other residents, and was not asked to leave following the incident. AD I reported did not report the incident to the abuse coordinator right away but did bring it up in the morning meeting the next day. AD I reported it was a late report because she was still learning but she had received a teachable moment education from the NHA afterward. In an interview on 4/24/24 at 1:34 PM, Activity Assistant (AA) O reported that she was present in the dining room at the time of the incident on 2/29/24 between Resident #104 and (guest name omitted). AA O reported all she remembered was that the guest was telling Resident #104 that she was a grown (profanity omitted) woman and that he (Resident #104) needed to have respect, that his legs were like that because he did not respect women, and then pointed out that he was a double amputee. AA O reported could tell that Resident #104 was upset and surprised that the guest was yelling at him. AA O reported after the incident, the guest stayed with the resident she was visiting and was talking with other residents at the table who had been in the dining room. AA O reported none of the residents seemed upset by the incident. AA O reported did not ask (guest name omitted) to leave following the incident. Review of the State Operations Manual revealed .S483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately; but not later than 2 hours after the allegation is made . Review of the facility policy Abuse and Neglect last revised 6/17/2019 revealed, POLICY: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, neglect or mistreatment. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations of allegations .Abuse includes: 2) Verbal . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: * Visitor-notification to not come to the facility during the investigation. * Re-education to the Activity Director to report allegations of abuse timely. * The administrator reported the abuse allegations to the appropriate state agencies. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* The administrator investigated the allegation of abuse which included interviewing staff who worked the day of the reported allegation of abuse. * A skin and pain assessment was completed on the resident. * The abuse allegation was reported to the attending physician. * The facility called the resident's family/guardian to report the allegation of abuse. 1:1 (one to one) * Residents with a BIMS (brief interview of mental status) of 10 and above were interviewed to rule out abuse. * Residents with BIMS 9 and below pain assessments and skin assessments completed. * Administrator contact information posted in the facility and (public posting) board. * The Administrator and Director of Nursing reviewed the abuse and prevention policy and deemed it met clinical standards. * The Regional Clinical Consultant re-educated the facility administrator on abuse prevention/reporting and investigation. * The administrator/designee re-educated all staff on abuse and reporting to ensure all allegation of abuse/neglect are reported timely, including abuse test for understanding. *The administrator/designee conducted random audits on five residents' weekly times four weeks and then monthly after that times one month to ensure all allegations of abuse/neglect are reported timely . * The administrator/designee completed five staff members' abuse education validations weekly for four weeks and then monthly one a month to verify understanding of abuse P/P (policy and procedure). * The results of the audits will be presented to the QAA (quality) Committee for review and consideration of further corrective actions. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 41982 Based on observation, interview, and record review, the facility failed to implement care planned interventions or document refusals of care planned interventions to prevent further skin breakdown for 1 (Resident #109) of 3 residents reviewed for pressure ulcer prevention, resulting in the potential for further skin breakdown, worsening of existing pressure ulcers, infection, and overall deterioration in health status. Findings include: Resident #109 Review of an Admission Record revealed Resident #109 was a male, with pertinent diagnoses which included: end-stage renal (kidney) disease, type 2 diabetes mellitus (a condition where the body is not able to properly use sugar from the blood), and pressure ulcer of other site, unstageable. Review of a Minimum Data Set (MDS) assessment for Resident #109, with a reference date of 4/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #109 was cognitively intact. Review of Resident #109's current Care Plan revealed a focus of The resident has DTI (deep tissue injury) pressure ulcer L (left) greater toe r/t (related to) Immobility created on 4/17/24 with interventions which included HEEL PROTECTORS: (bilateral/Right/Left) on while in bed with a date initiated of 4/17/24. Review of Resident #109's current Care Plan revealed a focus of The resident has DTI pressure ulcer 2nd L toe inner r/t Immobility/ toes overlay created on 4/17/24 with interventions which included HEEL PROTECTORS: (bilateral/Right/Left) on while in bed with a date initiated of 4/17/24. Review of Resident #109's current Care Plan revealed a focus of The resident has DTI pressure ulcer L heel r/t Immobility created on 4/17/24 with interventions which included HEEL PROTECTORS: (bilateral/Right/Left) on while in bed with a date initiated of 4/17/24. During an observation/interview on 4/23/24 at 11:59 AM, Resident #109 was lying in his bed watching television. This surveyor noted that the heel protectors (also referred to as blue boots) were not on the resident; rather, they were located on the windowsill in the room. Resident #109's heels were directly on the mattress of the bed and were not offloaded in any way. Resident #109 reported he did not know when the blue boots were supposed to be on. During an observation on 4/24/24 at 10:19 AM, Resident #109 was lying in his bed watching television. Resident was not wearing the heel protectors (which remained on the windowsill) and his heels were not offloaded. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation/interview on 4/25/24 at 10:32 AM, Resident #109 was lying in his bed watching television. His feet were offloaded and propped under a pillow. Resident #109 was not wearing the heel protectors (which remained on the windowsill). This surveyor commented that his feet were propped up and Resident #109 reported this had just happened today and he confirmed that his feet were usually directly on the mattress. In an interview on 4/25/24 at 11:02 AM, Licensed Practical Nurse Unit Manager (LPNUM) F reported Resident #109 was immobile and would sit with the heel of his right foot on top of the toes of the left foot which caused the tissue injury and skin breakdown on his feet. LPNUM F reported Resident #109 should have the blue boots on both feet while he was in bed. LPNUM F reported Resident #109 refuses a lot of stuff and often refused to be repositioned. LPNUM F reported when a resident refused treatments/interventions, it should be documented in their medical record in the nursing notes or by the CNAs. LPNUM F reviewed Resident #109's nursing notes with this surveyor present and reported there is nothing there about refusals. LPNUM F did not indicate what alternative methods to prevent skin breakdown had been discussed to use for Resident #109 if he did often refuse to wear the blue boots. In an interview on 4/25/24 at 11:31 AM, Certified Nurse Aide (CNA) N reported she worked with Resident #109 sometimes. CNA N stated his foot is messed up. CNA N reported Resident #109 had blue boots that he had to wear but he refused to wear them a lot of the time. In an interview on 4/25/24 at 2:13 PM, CNA J reported Resident #109 had blue boots that he was supposed to wear when he was in bed or in the chair and then the boots were to come off at night. CNA J reported when Resident #109 refused to wear the boots, there was no place for CNA's to document that in the chart so she would just tell the nurse that he refused. In an interview on 4/25/24 at 2:19 PM, Registered Nurse (RN) L reported she worked on all of the units and just met Resident #109 last week. RN L reported if a nurse was supposed to check to see an intervention was done for a resident or to check if the resident refused, it would show up in the computer for them to document. RN L reported did not remember seeing an order yesterday to document for Resident #109's refusals of his heel protectors but that it did show up today when the order was put in. RN L reported she didn't know Resident #109 needed the boots until the order came in today. Review of Resident #109's Order Summary revealed, Document refusals to wear blue boots every shift . Order Date 4/25/24 . and Toe Seperators (sic) between 1st and 2nd digit every night .Order Date 4/25/24.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 This citation pertains to intake: MI00142037. Based on interview and record review, the facility failed to ensure timely and consistent documented follow-up by a qualified nutrition professional following significant weight loss and skin breakdown in 1 (Resident #101) of 3 residents reviewed for nutritional care resulting in undocumented re-evaluation and assessment of resident nutritional needs and care and the potential for unmet nutritional needs. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 was a male, admitted on [DATE] and discharged on [DATE], with pertinent diagnoses which included: multiple sclerosis. Review of a Mini Nutritional Assessment for Resident #101 dated 12/28/23 and completed by Registered Dietitian (RD) D revealed a risk score of 10 which indicated resident was at risk of malnutrition. Review of a Dietary Evaluation for Resident #101 completed by RD D on 1/8/24 revealed, .II B. Most Recent Weight 191.0 Date 12/27/23 C. Most Recent Height 70.0 Date 1/2/24 .IV. Caloric Evaluation .1798-2125 kcals (calories)/day .87-104 g (grams) protein/day .1798-2125 mL (milliliters)/day .F. Does patient have any skin integrity concern that could effect nutritional needs? 2. No .Additional Information, Summary of needs, goal and plan of care: (Resident #101) is a 70 y/o year old male who was admitted on ,d+[DATE] d/t (due to) inability to care for himself. The patient is w/c (wheelchair) bound .Braden Score -14.0 (indicating moderate risk for pressure ulcer development) .Appetite: (Resident #101) reports that his appetite has diminished over the last few years. Intake: fair to good .UBW (usual body weight) unknown per resident, he feels he may have lost some wt (weight) recently but is unsure. Reports he would like to maintain his wt at this time CBW (current body weight): 191.0# (pounds), weekly wts (weights) in place for monitoring .Goal is for wt stabilization at this time . Review of a Care Plan for Resident #101 revealed a focus of (Resident #101) has nutritional problem or potential nutrition problem r/t (related to) dx (diagnosis) of multiple sclerosis, HLD (hyperlipidemia - high levels of fat in the blood), and HTN (hypertension - high blood pressure). Date Initiated 1/2/24. Care planned interventions initiated on 1/2/24 included: DIET: regular, regular texture, thin liquids. ALTERNATIVES: Offer resident alternatives at mealtime if dislike or intolerance of served items. Provide, serve diet as ordered. Monitor intake and record q (every) meal. Report changes in consumption to nurse and/or dietician. RD to evaluate and make diet change recommendations PRN (as needed). Weigh resident per facility protocol, maintaining consistency in type of scale, time of day, etc. as able. Review of a Weight Summary report for Resident #101 revealed the following complete list of entries: 12/27/2023 .191.0 Lbs (pounds) Mechanical Lift (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235103	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Beltline	2320 E Beltline SE Grand Rapids, MI 49546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/17/2024 .187.0 Lbs Mechanical Lift 1/17/2024 .175.5 Lbs Mechanical Lift 1/24/2024 .175.5 Lbs Wheelchair 1/24/2024 .175.5 Lbs Wheelchair (8% Weight Loss since admission = significant) Review of a Skin Timeline for Resident #101 provided by facility at this surveyor's request revealed, 12/27/23 Skin intact Pressure relieving mattress .1/4/24 Left hip unstageable L (length) 6.5 cm (centimeters) W (width) 4 cm D (depth) 0 .1/16/24 Sacrum Stage 1 L-3cm W-1cm D-0 .1/23/24 Sacrum (Stage 3) L-5cm W-3cm D-0. 1 .2/3/24 Left ankle stage 1 L-1.8 W-1.6cm D-0 .2/3/24 Right ankle stage 1 L-1.6cmW-0.5cm D-0 .2/3/24 Left heel stage 1 L-1.8 W-1.4 D-0 2/3/24 Right heel stage 1 L1.8 W-1.6 D-0 . A review of Resident #101's complete medical record was conducted on 4/24/24 at 3:12 PM for evidence of Registered Dietitian follow-up, monitoring, or reassessment of nutritional needs following Resident #101's significant weight loss and development of skin breakdown. It was noted that Resident #101's Care Plan focus (Resident #101) has nutritional problem or potential nutrition problem r/t (related to) dx (diagnosis) of multiple sclerosis, HLD (hyperlipidemia - high levels of fat in the blood), and HTN (hypertension - high blood pressure) was revised on 1/16/24 to include Altered skin integrity. A care planned intervention of Provide and serve supplements as ordered. Refer to physician orders for specifics. Notify nurse and/or RD (Registered Dietitian) of changes in consumption, adherence with intakes, etc. was initiated on 1/16/24. There was no further documentation from the Registered Dietitian beyond the Dietary Evaluation for Resident #101 completed by RD D on 1/8/24 found. In an interview on 4/24/24 at 2:20 PM, RD D reported Resident #101 was admitted on [DATE] and a mini nutritional assessment was completed to determine Nutrition Risk. RD D reported the actual dietary assessment was completed to assess the resident's nutritional status and to determine the nutritional needs at that point. RD D reported tried to do a 2-week follow-up on everybody but was unable to provide evidence of follow-up on Resident #101. RD D reported weight monitoring was done on all newly admitted residents such that they were weighed the day they were admitted , and then weekly for 4 weeks, and then, if weight stabilized, once per month thereafter. RD reported thought Resident #101 had refused his weekly weight between 12/27/23 and 1/17/24, but there was no documentation to that effect. RD D reported resident nutritional status was reassessed quarterly but if a resident lost weight, was not eating, or had skin breakdown, they would need to be reassessed as soon as that occurred, and the nutritional reassessment would need to be documented in the medical record. RD D reported that she had followed up with Resident #101 after his skin breakdown and had added a nutrition supplement for extra calories and protein but did not document any follow-up or nutritional reassessments in the chart.