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	10/11/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 36221 This citation pertains to Intake #MI00146336. Based on interview, and record review, the facility failed to provide adequate supervision to prevent elopement and respond appropriately to the alarm system in 1 of 3 residents (Resident #103) reviewed for wandering/elopement, resulting in Resident #103 exiting the facility unbeknownst to staff and the potential for injury. Findings include: Review of the policy/procedure Elopement, dated 2/5/20, revealed .It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified will have these issues addressed in their individual plan of care .Residents who have been assessed at risk for elopement/wandering shall be provided at least one of the following safety precautions by the facility .An adult electronic monitoring safety device will be used to notify/alert staff by sounding an alarm when the resident enters the perimeter around an alarmed door .Door alarms placed on facility exits .At no times shall a door alarm be turned off, without the continual supervision of the exit .When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm .The staff person responding to the alarm will check the outside of the building/vicinity of the area to determine if a resident has exited the building . Review of an Admission Record revealed Resident #103 was a male, with pertinent diagnoses which included metabolic encephalopathy (a condition which results in impaired brain function), kidney disease, high blood pressure, heart disease, obstructive lung disease, and altered mental status. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 9/24/24, revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated severe cognitive impairment. Review of a Wandering Risk Scale assessment for Resident #103, with a reference date of 6/25/24, revealed he was considered High Risk for wandering/elopement. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Skld Beltline		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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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 - Few	Review of a Care Plan for Resident #103 revealed the focus .(Resident #103) has a history of and exhibits wandering and exit-seeking behavior in the facility. (Resident #103) will ask when he can exit the facility and return home. His wandering behavior is likely related to recent SNF (Skilled Nursing Facility) placement, desire to return to the community, paired with cognitive impairment (DX (diagnosis): Metabolic Encephalopathy, Altered Mental Status) and labile mood . initiated 6/25/24 and revised 7/18/24, with interventions which included .WANDER ALERT (electronic monitoring safety device) .Check for placement q (every) shift and function per policy . initiated 6/25/24. Review of a General Progress Note for Resident #103, dated 7/16/24 at 7:11 PM, revealed .Resident is wandering and going into resident's rooms. He also attempted to (open) the exit doors . Review of an Incident Report for Resident #103, dated 7/17/24 at 7:45 PM, revealed .A resident (another resident) approached the nurse, stating that the front desk staff let a resident who was not supposed to be outside by themselves out of the front entrance. The nurse proceeded to the entrance and exit from the hall, where she noticed (Resident #103) almost off the facility campus, headed to the main road at the far end of the parking lot. The nurse asked the front desk staff how she let (Resident #103) out of the facility, to which she responded I thought he was a visitor, and he asked to go to the parking lot. The nurse informed the front desk staff that the resident did not have an LOA (Leave of Absence) order to leave independently, so he had the bracelet on his left leg. It was alarming when the nurse helped him back into the facility .Reported by (Witness Y) to (Registered Nurse (RN) DD) - (Resident #103) was let out the front door after he asked the receptionist how to get out to the parking lot. (Resident #103) was not asked to sign out and did not have approved LOA. Resident reporting this to RN (Witness Y) was alarmed something wasn't right because (they) noticed he had a tether on, a white bracelet on his ankle, the receptionist got up and punched in the code to make the alarm stop and then went back to her seat and continued to look at her cell phone. RN was informed by (Witness Y) immediately after incident . Review of a General Progress Note for Resident #103, dated 7/17/24 at 8:30 PM, revealed .(A resident) notified the nurse a resident was outside with (an) alarm on (WANDER ALERT) .The nurse proceeded to the entrance and exit from the hall, where she noticed (Resident #103), walking to the driveway, toward the road. Noted the front desk clerk was at the desk, and the alarm did sound and the (WANDER ALERT) was observed on his left leg. Immediately the nurse went to (Resident #103) to assist him back to the facility . (Resident #103) (was asked) where he was going and responded that he was looking for a cab or bus to get home .(WANDER ALERT) expiration and function (checked) and in good working order .All doors (checked) for function, alarming appropriately. Immediate intervention: placed on 1:1 (direct supervision) and (Care Plan) updated . Review of a Physician Progress Note for Resident #103, dated 7/18/24, revealed .He is seen today after an episode of elopement that occurred yesterday evening. He had a functioning (WANDER ALERT) in place but he was allowed out by front desk staff. He was found in the far end of the parking lot by nursing staff and was redirected back into the building without incident .he was placed on 1:1 supervision . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/10/24 at 3:11 PM, Witness Y, a resident at the facility, reported they observed Resident #103 approach the receptionist at the front desk on 7/17/24, ask how to get out of the building, then exit through the front door. Witness Y reported the receptionist at the desk .didn't try to stop him or nothing. I told the nurse . Witness Y stated .I said that's not a visitor. The front desk girl didn't even care . Witness Y reported a door alarm did sound when Resident #103 exited the facility. Attempted to contact RN DD via phone on 10/10/24 at 3:50 PM for an interview. Phone number provided no longer in service. In an interview on 10/10/24 at 4:24 PM, with Administrator A and Director of Nursing (DON) B, Administrator A and DON B reported Witness Y approached RN DD to report what they had observed. Administrator A and DON B reported RN DD responded immediately, and at that point Resident #103 was outside the building in the parking lot. Administrator A and DON B reported Resident #103 was able to be redirected back inside the facility, his WANDER ALERT bracelet was in place, and the door alarms did sound. Administrator A reported she spoke with Receptionist M about the incident and discovered Receptionist M heard the alarm go off but did not respond appropriately. In an interview on 10/11/24 at 1:47 PM, Licensed Practical Nurse (LPN) X reported Resident #103's elopement on 7/17/24 occurred within an hour of evening shift change. LPN X reported RN DD approached to notify her that Resident #103 had eloped and went out into the parking lot. LPN X reported when she approached Resident #103 after he was brought back into the facility, he was sitting calmly at the desk with a WANDER ALERT bracelet in place. LPN X stated .The receptionist heard the alarm and didn't react . LPN X reported after Resident #103's elopement on 7/17/24, 1:1 supervision was initiated. Review of an Employee Statement from Receptionist M, dated 7/17/24, revealed .Can you tell me what happened? I was at (the) front desk and the resident approached the door I opened it and he walked out. Did you know he was a resident? No, we get new residents all the time how am I supposed to know who is a visitor and who is a resident? Did he sign out as visitor or resident? No. When you heard the alarm going off did you check to see if he was a resident who was not supposed to go (outside)? No that thing makes noise all the time (indicating the alarm system) so I just turned it off . The facility was granted a Past Non-Compliance at the time of exit due to no further like incidents had occurred, the facility re-trained pertinent staff, the Elopement policy was reviewed and deemed appropriate, and the facility had achieved sustained compliance. Therefore, no plan of correction will be required.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation pertains to Intake # MI00146994. Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in 1 of 4 residents (Resident #107) reviewed for accuracy of medical records, resulting in an inaccurate behavior record and the potential for providers to not have an accurate picture of resident status and condition. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing.High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized . Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition. Review of an Admission Record revealed Resident #107 was a male, with pertinent diagnoses which included dementia, high blood pressure, malnutrition, chronic pain, and a history of falls. Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 8/22/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a Wandering Risk Scale assessment for Resident #107, dated 7/18/24, revealed he was At Risk for wandering/elopement. Review of a Care Plan for Resident #107 revealed the focus .Resident is an elopement risk and/or exhibits wandering behavior . initiated 6/16/23 and revised 8/1/24, with interventions which included .WANDER ALERT (electronic monitoring safety device) .Check for placement q (every) shift and function per policy . initiated 6/16/23 and revised 8/1/24. Review of a Care Plan for Resident #107 revealed the focus .Resident is/has potential to be verbally aggressive towards staff due to ineffective coping skills, mental/emotional illness, poor impulse control. (Resident #107) enjoys coloring/drawing and voices enjoying sharing his artwork with others. Some days his artwork is a successful intervention to keep him busy while other days he voices frustration regarding need for facility placement . initiated 9/19/23 and revised 10/10/23, with interventions which included .Monitor behavior and document observation and attempted interventions per facility protocol . initiated 9/19/23. In an observation and interview on 10/4/24 at 12:10 PM, Resident #107 was noted in bed in his room. Resident #107 stated .I would like to get out of here .There is nothing wrong with my legs. I can walk and talk. I just want to get out of here . Observed a WANDER ALERT bracelet on Resident #107's right ankle. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an email sent to Administrator A and Director of Nursing (DON) B on 10/4/24 at 1:06 PM, requested all incident/accident reports for Resident #107 for the past six months. No incident/accident reports were provided. In an interview on 10/10/24 at 9:15 AM, Social Services Director I reported Resident #107 attempted to elope from the facility in July 2024 and stated .staff had to run after him down the street . Social Services Director I reported Resident #107 has a history of wandering/elopement behaviors and wears a WANDER ALERT bracelet. Social Services Director I later clarified that the attempted elopement occurred on 7/28/24. In an interview on 10/10/24 at 1:25 PM, Administrator A reported when Resident #107 attempted to elope from the facility on 7/28/24, he was never out of sight of staff. Administrator A reported Resident #107 exited through the front door and Receptionist K yelled for help and kept eyes on him while nursing staff responded. Administrator A reported Resident #107 often enjoys sitting in the front lobby area, but that day .took off . out the door. In an interview on 10/10/24 at 1:37 PM, Certified Nursing Assistant (CNA) J reported she was charting at the desk when Receptionist K notified her that Resident #107 had exited the facility. CNA J reported when she got outside, Resident #107 was in the driveway, not far from the main entrance. CNA J reported Resident #107 had followed another resident out while the doors were open and stated .he knew what he was doing . CNA J reported Resident #107 continued to walk away from the facility and she followed. CNA J reported Resident #107 was agitated and resistant to redirection. CNA J reported Resident #107 walked out along the main road, and ended up crossing the four-lane, divided street. CNA J stated .I followed him the whole time but didn't get too close because he seemed threatened. I had eyes on him the whole time . CNA J reported she instructed Licensed Practical Nurse (LPN) L, who had also came to assist, to get her car and help bring him back inside. CNA J reported LPN L was able to redirect Resident #107 to get into the vehicle and return to the facility. CNA J reported she did not document the incident in Resident #107's medical record or write a statement about what had occurred. In an interview on 10/10/24 at 1:58 PM, LPN L reported the morning of Resident #107's attempted elopement on 7/28/24, he was in the hallway more than usual. LPN L reported she and CNA J redirected him to his room for breakfast. LPN L reported after breakfast, Resident #107 was sitting in one of the chairs in the main entryway. LPN L reported Receptionist K got CNA J's attention to tell her Resident #107 had exited the facility while the doors were open for another resident. LPN L reported CNA J immediately went after Resident #107 and she (LPN L) followed after them. LPN L reported after Resident #107 left the property, she (LPN L) went to get her vehicle while CNA J continued to follow Resident #107 on foot. LPN L reported she was ultimately able to redirect Resident #107 into the vehicle and bring him back to the facility. LPN L reported she did not document the incident/attempted elopement and stated .I was told if we were in visual sight of the individual that I didn't need to do anything further . LPN L reported documentation for escalation of behaviors is typically completed in the Progress Notes. In an interview on 10/10/24 at 2:45 PM, LPN L reported Resident #107 had removed his WANDER ALERT bracelet prior to his attempted elopement on 7/28/24. LPN L reported she put a new WANDER ALERT bracelet on his right ankle that day and updated the Physician Orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes for Resident #107 revealed no documentation on 7/28/24 related to his escalation of behaviors, including the removal of his WANDER ALERT bracelet and attempted elopement. Review of the Standard Assessments list for Resident #107 revealed no assessments were completed on 7/28/24. Review of the electronic Treatment Administration Record (TAR) for Resident #107, for July 2024, revealed the order .BEHAVIOR TRACKING: Document # of hallucinations/delusions .every shift .Complete based on individual observation of patient and discussion with other care team members . had no documentation (was blank) for 7/28/24 day shift. In an interview on 10/10/24 at 3:55 PM, Receptionist K reported she was at the front desk when Resident #107 attempted to elope on 7/28/24. Receptionist K reported another resident in a wheelchair signed out and was going out the front door when Resident #107 got up from a nearby chair and went out the door. Receptionist K stated .I tried to stop him, telling him he didn't sign out . Receptionist K reported Resident #107 waved her off and continued out the building. Receptionist K reported she notified CNA J and LPN L who went after Resident #107 into the parking lot and brought him back to the building a short time later. Receptionist K reported a door alarm did not sound when Resident #107 exited the building on 7/28/24. In an interview on 10/10/24 at 4:24 PM with Administrator A and Director of Nursing (DON) B, DON B reported she was notified of Resident #107's attempted elopement on 7/28/24, shortly after it occurred. DON B reported the intention was to sit down with the staff involved and document what happened in an Interdisciplinary Team (IDT) note, and complete an incident report. DON B stated .I missed making sure it was done .I got caught up in something else .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36221 Based on observation, interview, and record review, the facility failed to implement posted transmission-based precautions and don required Personal Protective Equipment (PPE) prior to entering COVID-19 positive resident rooms in 2 of 2 rooms reviewed for transmission-based precautions, resulting in the potential for cross-contamination and the development and spread of infection to a vulnerable population. Findings include: Review of the policy/procedure COVID-19 Core Practices, dated 5/11/23, revealed .The facility will follow recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic . Resident placement for suspected or confirmed SARS-CoV-2 (COVID-19) .It is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2 .Staff members entering a resident room with suspected or confirmed SARS-CoV-2 should use all recommended PPE, which includes use of a NIOSH approved N95 or equivalent or higher-level respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face), gloves, and gown . In an observation on 10/4/24 at 11:23 AM, noted a resident room with an open door and an activated call light on the 600 Hall. Observed signage on the door which indicated Special Droplet/Contact Precautions were in place. Per the signage, staff were to wear a N-95 mask, eye protection (face shield or goggles), and don a gown and gloves prior to entering the room. Noted the sign stated KEEP DOOR CLOSED. Observed Certified Nursing Assistant (CNA) H respond to the activated call light wearing a surgical mask. Noted CNA H did not change to a N-95 mask, or don any additional PPE prior to entering the room. Noted the PPE bin in the hallway outside the room only contained disposable gowns. No N-95 masks, gloves, or eye protection available. In an interview on 10/4/24 at 11:30 AM, CNA H reported she was not aware that any additional transmission-based precautions were in place for the room with the posted Special Droplet/Contact Precautions sign on the 600 Hall. CNA H reported she did not see the sign because the door to the room was open. CNA H reported for a room with Special Droplet/Contact Precautions in place, PPE should be worn into the room for the care of either resident (regardless of infection status). In an observation on 10/4/24 at 11:33 AM, Licensed Practical Nurse (LPN) V donned a gown, in addition to a surgical mask already worn, prior to entering a resident room with signage on the door that indicated Special Droplet/Contact Precautions were in place on the 600 Hall. Note this was the same room previously entered by CNA H. Per the signage, staff were to wear a N-95 mask, eye protection (face shield or goggles), and don a gown and gloves prior to entering the room. No N-95 mask, gloves, or eye protection utilized by LPN V while in the Special Droplet/Contact Precautions room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/4/24 at 11:37 AM, LPN V reported the room on the 600 Hall with the Special Droplet/Contact Precautions in place had two residents, one who had a current COVID-19 infection and the other who had tested negative for COVID-19. LPN V reported the policy is to shelter COVID-19 positive residents in place to reduce the risk of contaminating someone else. LPN V reported staff try and keep the door to the room closed .as much as possible . LPN V reported PPE required in the Special Droplet/Contact Precautions room was a N-95 mask and gown. LPN V reported gloves were worn if they came in contact with the resident. LPN V reported she only wore a surgical mask into the Special Droplet/Contact Precautions room because she went to speak with the COVID-19 negative resident, and did not provide any care to the resident who was COVID-19 positive. LPN V reported when she entered the room, N-95 masks were not available in the PPE bin. LPN V acknowledged the required PPE should be worn when entering the Special Droplet/Contact Precautions room, not just specifically for the care of the COVID-19 positive resident. In an interview on 10/10/24 at 11:49 AM, CNA P reported residents who test positive for COVID-19 are placed on Special Droplet/Contact Precautions which require the use of PPE, which included a gown, gloves, eye protection, and N-95 mask. In an observation on 10/11/24 at 1:33 PM, noted a resident room with an open door on the 400 Hall. Observed signage on the door which indicated Special Droplet/Contact Precautions were in place. Per the signage, staff were to wear a N-95 mask, eye protection (face shield or goggles), and don a gown and gloves prior to entering the room. Noted the sign stated KEEP DOOR CLOSED. Observed Activity Director W talking with a resident in the room, while wearing only a surgical mask for PPE. Noted the resident she was speaking with was currently COVID-19 positive. In an observation and interview on 10/11/24 at 1:38 PM, Activity Director W exited the COVID-19 positive resident room. Noted Activity Director W continued to wear the surgical mask previously worn within the COVID-19 positive resident room. Activity Director W indicated the signage on the door listing PPE was only for direct care or when there was the chance to come into contact with body fluids. Noted after exiting the room, Activity Director W left the door to the room open. In an interview on 10/11/24 at 3:02 PM, Director of Nursing (DON)/Infection Preventionist B reported residents who test positive for COVID-19 are placed on Special Droplet/Contact Precautions, which require the use of a N-95 mask, gown, gloves, and goggles or a face shield. DON/Infection Preventionist B reported if one resident tests positive for COVID-19, and the other negative in the same room, the facility shelters the residents in place and places both residents on Special Droplet/Contact Precautions. DON/Infection Preventionist B reported the PPE required for both the COVID-19 positive and COVID-19 negative resident in the Special Droplet/Contact Precautions room was the same.