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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235206 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Skld Whitehall | | STREET ADDRESS, CITY, STATE, ZIP CODE 916 E Lewis St Whitehall, MI 49461 | |

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

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056</p> <p>This citation pertains to intake #: MI00146305 and MI00146949</p> <p>Based on interview and record review, the facility failed to 1.) assess and monitor pressure injuries/wounds, 2.) ensure pressure injury/wound assessments were complete, accurate, and documented in the resident record, 3.) notify the provider and the DPOA (Durable Power of Attorney) of new pressure injuries/wounds, and 4.) provide physician ordered treatments/assessments and ensure treatments were in place for pressure injuries/wounds for 4 of 4 residents (Resident #7, #8, #1, and #9) reviewed for quality of care.</p> <p>Findings:</p> <p>Resident #8 (R8)</p> <p>Review of an Admission Record revealed R8 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Neurocognitive Disorder with Lewy Body Dementia.</p> <p>Review of a Minimum Data Set (MDS) assessment for R8, with a reference date of 7/2/24 revealed a Brief Interview for Mental Status (BIMS) score of 0, out of a total possible score of 15, which indicated R8 was severely cognitively impaired.</p> <p>Review of R8's Nursing Admission Screening/History dated 6/26/24 revealed R8 was dependent upon staff for bed mobility, transferring, eating, toileting, and bathing.</p> <p>During an observation on 09/17/2024 at 8:09 AM, R8 was up in a Broda Chair, in the small dining room at the end of the 400 Hall, the footrest was up/highest position and his bilateral lower extremities extended further than the footrest from approximately his calves down (calves resting on a thin pillow over the metal bar) leaving his feet unsupported. R8 was sitting at approximately a 60-degree angle and did not have offloading boots, an offloading cushion, or padding to the armrests in place. R8 did not have any skin protectors on his bilateral upper extremities.</p> <p>(continued on next page)</p> |

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an observation on 09/17/2024 at 9:09 AM and 09/17/2024 at 10:02 AM, R8 was up in a Broda Chair at the 300/400 Nurses' Station, the footrest was up/highest position and his bilateral lower extremities extended further than the footrest from approximately his calves down leaving his feet unsupported. R8's head was higher than the top of the Broda Chair with nothing in place (headrest/pillow) to support his head/neck. R8 was sitting at a 56-degree angle and did not have offloading boots, an offloading cushion, or padding to the armrests in place. R8 did not have any skin protectors on his bilateral upper extremities.</p> <p>During an observation on 09/17/2024 at 12:19 PM, R8 was up in a Broda Chair in the small dining room at the end of the 400 Hall, the footrest was up/highest position and his bilateral lower extremities extended further than the footrest from approximately his calves down leaving his feet unsupported. R8 was sitting at approximately a 60-degree angle and did not have offloading boots, an offloading cushion, or padding to the armrests in place. R8 did not have any skin protectors on his bilateral upper extremities. R8 had an undated bordered gauze on his left forearm and an undated bordered gauze on his left hand (indicating x2 skin injuries/wounds).</p> <p>During an observation on 09/18/2024 at 7:26 AM, R8 was up in a Broda Chair between room [ROOM NUMBER]-414 against the wall, the footrest was up/highest position and his bilateral lower extremities extended further than the footrest from approximately his calves down leaving his feet unsupported. R8 was sitting at approximately a 45-degree angle and did not have offloading boots, an offloading cushion, or padding to the armrests in place. R8 did not have any skin protectors on his bilateral upper extremities. R8 had an undated bordered gauze on his left forearm and an undated bordered gauze on his left hand (unable to determine if the bordered gauze had been changed from 9/17/24.)</p> <p>During an observation on 09/18/2024 at 8:37 AM, R8 was up in a Broda Chair in the small dining room at the end of the 400 Hall, the footrest was up/highest position and his bilateral lower extremities extended further than the footrest from approximately his calves down leaving his feet unsupported. R8 was sitting at approximately a 45-degree angle and did not have offloading boots, an offloading cushion, or padding to the armrests in place. R8 did not have any skin protectors on his bilateral upper extremities. R8 had an undated bordered gauze on his left forearm and an undated bordered gauze on his left hand.</p> <p>During an observation on 09/18/2024 at 10:52 AM and 09/18/2024 at 11:34 AM, R8 was up in a Broda Chair at the 300/400 Nurses' Station, the footrest was up/highest position and his left leg extended past the footrest at his calf and his right leg extended past the foot rest near his ankle. R8 was sitting at approximately a 45-degree angle and did not have offloading boots, an offloading cushion, or padding to the armrests in place. R8 did not have any skin protectors on his bilateral upper extremities. R8 had an undated bordered gauze on his left forearm and an undated bordered gauze on his left hand.</p> <p>During an observation on 09/18/2024 at 11:45 AM, Director of Nursing (DON) repositioned the pillow under R8's bilateral lower calves. R8's lower extremities extended further than the footrest from approximately his calves down.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an observation and interview on 09/18/2024 at 11:55 AM, DON brought R8 to his room to complete a skin sweep. DON reported she did not know if R8 was to wear the offloading boots at all times or only while in bed. Registered Nurse (RN) D was also present and reported that she did not know if R8 was to wear the offloading boots at all time or only while in bed and stated might be all the time since R8 developed the DTI (deep tissue injury) to his left lateral foot. At 12:09 PM, DON asked RN D when and why the bordered gauze was applied to R8's left forearm and left hand to which RN D reported that she believed he hit his hand on the wall or his Broda Chair but was unsure the date that the injury occurred only that it was in the last couple days. DON measured/assessed the wound on R8's left hand and reported no injury to R8's left forearm, only bruising.</p> <p>Stage II Pressure Injury to Buttocks</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis (see Fig. 48.4B). The wound bed is viable, pink or red, and moist and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible, and deeper tissues are not visible. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1238). Elsevier Health Sciences. Kindle Edition.</p> <p>Review of R8's Progress Note dated 8/5/2024 revealed, Reported by hospice aide that resident has a dime sized opening to his right buttock. Area measures 1.5cm (length) x 0.5cm (width) x 0.1 (depth) cm (centimeters). Periwound skin is fragile. No drainage. Barrier cream applied. Resident to be repositioned every two hours . Confirming R8 had a Stage II pressure injury (measurable depth and exposed dermis).</p> <p>Review of R8's Order Summary dated 8/9/24-9/2/24 revealed, Wound Care for buttocks : Cleanse with NS (normal saline); apply silicone foam border dressing to open area; Apply house barrier cream ; every shift and PRN (as needed). Indicating a delay in treatment (4 days from the discovery of the pressure injury). The treatment was to be completed at 7:00 AM and 7:00 PM.</p> <p>Review of R8's August Treatment Administration Record revealed that the wound care for R8's buttocks was not completed on the following dates with no rationale documented for the missed treatment:</p> <p>*8/14/24 at 7:00 PM</p> <p>*8/16/24 at 7:00 AM</p> <p>*8/18/24 at 7:00 AM</p> <p>*8/25/24 at 7:00 PM</p> <p>*8/26/24 at 7:00 AM</p> <p>Review of R8's Hospice Note dated 8/13/24 revealed, .Summary of Problems: Pt (patient) at high risk for skin breakdown/has a skin tear and pressure ulcer. Integumentary Interventions-Facility staff responsible for wound care .broda chair cushion .Pt has a worsening PU (pressure ulcer) on coccyx-facility staff unaware . Confirming appropriate pressure injury care was not provided to R8.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of R8's Progress Note dated 9/17/2024 revealed, Hospice resident with expected decline, with poor nutritional status. Res has a pressure ulcer to his left lateral foot. Wound is stable. Treatment orders in place. (There were no other facility progress notes written since 8/5/24.)</p> <p>As of 9/18/24 at 8:30 AM, the only Skin Alteration Evaluation was completed on 8/27/24 and was related to R8's left lateral DTI (not the Stage II pressure injury to his buttocks). The evaluation revealed, Resident has additional skin alterations? No. Confirming the evaluation completed on 8/27/24 did not include an assessment of the right buttock Stage II pressure injury.</p> <p>Beginning on 9/18/24 around 9:00 AM, Skin Alteration Evaluations were documented for 8/5/24, 8/14/24, 8/27/24 (added information to previous), 9/4/24, and 9/11/24 with the lock date of 9/18/24. Prior to 9:00 AM, R8's Stage II pressure injury had not been tracked/trended.</p> <p>All Weekly Skin Observation Tools reflected no skin concerns until 9/18/24 (with the exception of 7/10/24 old skin tear and red coccyx, barrier cream)</p> <p>Review of R8's Care Plan revealed, The resident has stage II pressure ulcer sacrum and right buttock r/t End of life care, Immobility, Impaired nutritional status related expected decline .Created on: 09/16/2024 A resident focused care plan with meaningful interventions was not implemented following the identification of the pressure injury for 6 weeks. The intervention resident to be repositioned every two hours was not included despite the documentation it would be implemented in the Progress Note dated 8/5/24.</p> <p>Deep Tissue Injury to Left Foot</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Deep-Tissue Pressure Injury: Persistent nonblanchable deep red, maroon, or purple discoloration Intact or nonintact skin with localized area of persistent nonblanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister (see Fig. 48.4E). Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/ or prolonged pressure and shear forces at the bone-muscle interface . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1238). Elsevier Health Sciences. Kindle Edition.</p> <p>Review of R8's Hospice Note dated 8/27/24 revealed, .educated staff about proper use of heel protectors, and protecting his arms .Pt having increased periods of alertness with associated agitation/increased movement and tremors at times, resulting in increased skin tears/friction-related injuries. Has new L (left) outer, lateral foot pressure injury and increased sacral irritation, in addition to numerous bruises and little skin tears on bilat (bilateral) arms. We added heel protectors, but staff does not always put them on. He sits in a broda chair that is too small for him (he's 6'2), and staff needs to be frequently reminded to pad the arm/position him for comfort .</p> <p>As of 9/18/24 at 8:30 AM, there was only one Skin Alteration Evaluation documented for R8's Left Lateral Deep Tissue Injury (DTI) dated 8/27/24. Confirming the facility staff were aware of the DTI, however, there were no additional wound assessments completed until 9/18/24 at approximately 9:00 AM.</p> <p>Beginning on 9/18/24 around 9:00 AM, Skin Alteration Evaluations were documented for 9/4/24, and 9/11/24 with the lock date of 9/18/24. Prior to 9:00 AM, R8's DTI had not been tracked/trended.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of R8's Order Summary dated 8/28/24 revealed, Wound Care for left outer foot: Cleanse with NS ; Apply skin prep and cover with border gauze (sic) for protection; every day shift and PRN. every shift for wound care AND as needed. To be completed at 7:00 AM and 7:00 PM.</p> <p>Review of R8's August Treatment Administration Record revealed that the wound care for R8's left outer foot was not completed on 8/29/24 at 7:00 PM with no rationale documented for the missed treatment:</p> <p>Review of R8's September Treatment Administration Record revealed that the wound care for R8's left outer foot was not completed on the following dates with no rationale documented for the missed treatment:</p> <p>*9/5/24 at 7:00 PM</p> <p>*9/7/24 at 7:00 PM</p> <p>*9/9/24 at 7:00 AM</p> <p>On 09/18/2024 at 8:38 AM the anatomical assessment that determined the appropriate size Broda chair for R8 was requested via email and included this surveyor's observation that R8 was too tall for the chair the facility provided.</p> <p>Review of R8's Progress Note dated 9/18/2024 at 11:47 AM revealed, spoke with hospice to request a larger broda chair for resident, residents hospice team will reach us with an update. Confirming that the facility did not follow up with the recommendation following the Hospice visit/assessment approximately 3 weeks prior.</p> <p>Review of R8's Care Plans revealed, Resident has potential/actual impairment to skin integrity r/t limited mobility d/t neurocognitive with Lewy bodies .blue puffy boots to bilateral feet at all times Date Initiated: 08/30/2024.</p> <p>Review of the entirety of R8's Care Plans revealed no interventions for a cushion in R8's Broda Chair, protection of R8's arms, padding to the Broda Chair, or positioning despite the Hospice recommendations documented on 8/27/24.</p> <p>Review of R8's Progress Note dated 9/18/24 at 2:09 PM revealed, Per interviews with the nurse and Cena (Certified Nursing Assistants) staff, resident kicks off soft puffy boots while sitting in chair, care plan updated, to use while in bed.</p> <p>Review of R8's Electronic Medical Record revealed no documentation supporting the allegation that he was resistive to care and/or kicked off boots. Additionally, staff interviews revealed staff did not know if he was to wear boots only while in bed or at all times (as documented above).</p> <p>Left Hand Skin Tear</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>As of 9/18/24 at 8:30 AM, R8's Electronic Medical Record (EMR) revealed no documentation of the skin tear to R8's left hand or documentation to an injury to R8's left forearm, physician and guardian notification of the injuries, an assessment of injuries (wound description and measurements), or an order for treatment.</p> <p>Review of R8's Progress Note dated 9/18/24 at 12:18 PM revealed, .Physician notified of the left hand skin tear, and wound orders obtained. Confirming a delay in notification and treatment of R8's left hand skin tear.</p> <p>Resident #7 (R7)</p> <p>Review of an Admission Record revealed R7 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: failure to thrive and weakness.</p> <p>Review of R7's Functional Abilities and Goals dated 9/6/24 revealed R7 was dependent on staff for toileting, bathing, bed mobility, and transferring.</p> <p>Stage I Pressure Injury/Non-Blanchable Redness</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Blanchable erythema is visible skin redness that becomes pale or white when pressure is applied and reddens when pressure is relieved .Nonblanchable erythema is visible skin redness that persists with the application of pressure. It indicates structural damage to the capillary bed/ microcirculation. This is an indication for a stage 1 pressure injury. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1247). Elsevier Health Sciences. Kindle Edition.</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Stage 1 Pressure Injury: Nonblanchable erythema of intact skin Intact skin with a localized area of nonblanchable erythema, which may appear differently in darkly pigmented skin (Fig. 48.4A). Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1238). Elsevier Health Sciences. Kindle Edition.</p> <p>Review of Section M-Skin Conditions in a Minimum Data Set (MDS) assessment for R7, with a reference date of 7/9/24 revealed R7 did not have a pressure ulcer/injury, a scar over bony prominence . at the time of the assessment.</p> <p>Review of R7's Skin Observation Tool dated 9/1/24 revealed R7 had no new skin integrity concerns.</p> <p>As of 9/18/24 at 8:30 AM R7's Electronic Medical Record did not reflect any area of skin integrity concerns/pressure injuries on 9/5/24.</p> <p>Review of Section M-Skin Conditions in a Minimum Data Set (MDS) assessment for R7, with a reference date of 9/6/24 revealed R7 had a pressure ulcer/injury, a scar over bony prominence . Confirming facility staff were aware of a pressure injury at the time of the assessment.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of R7's Hospice Nursing Visit Note dated 9/6/24 revealed, Pt has drsg (dressing) mepilex to coccyx for reported stage II pressure ulcer, clean dry, + intact, applied just prior to arrival of visit. New orders left (with) nurse .wound care orders-cleanse (with) wound cleanser apply foam adhesive drsg. (Change) Q (every) 3 days and PRN (as needed) for drsg disruption . Notified pt's guardian (name omitted) of pt condition + new orders .</p> <p>Review of R7's Hospice Physician Verbal Order dated 9/6/24 Cleanse pressure ulcer to coccyx (with) wound cleanser, apply foam adhesive drsg. (Change) Q 3 days and PRN for dressing disruption. (This order was located on the 300/400 Nurses' Station desk on 9/18/24 at 11:50 AM.)</p> <p>Review of R7's Order Summary revealed the Hospice wound treatment was not ordered/implemented.</p> <p>A weekly Skin Observation Tool was not completed on 9/8/24.</p> <p>Review of R7's Progress Note dated 9/9/24 revealed, Wound observed on sacral region inferior to right buttock 0.5 cm (l) x 0.1 cm (w) Non-blanchable to touch. Redness noted. New treatment order in place for daily dressing changes. Indicating a Stage I pressure injury.</p> <p>Review of R7's Order Summary dated 9/9/24 revealed, Cleanse sacrum with normal saline. Apply xeroform and comfort border dressing. every day shift. Confirming a delay in the treatment of the pressure injury as well as an order differing from the Hospice Provider. There was no documentation that clarification of the 2 orders was obtained.</p> <p>Review of R7's September Treatment Administration Record revealed there was no wound treatment for R7's sacrum completed until 9/10/24. Additionally, R7's wound treatment was not completed on 9/14/24 with no documentation/rationale for the missed treatment.</p> <p>Review of R7's Care Plan revealed, The resident has pressure ulcer Date Initiated: 9/11/2024 Created on: 09/11/2024.</p> <p>Review of R7's Hospice Nursing Visit Note dated 9/12/24 revealed, .Dressing to coccyx pressure ulcer changed, skin red and non blanchable, intact, no drainage. Indicating a Stage I pressure injury.</p> <p>Review of R7's Hospice Nursing Visit Note dated 9/17/24 revealed, .Coccyx red, nonblanchable skin intact. Please ensure barrier creams are being utilized to prevent skin breakdown. Indicating a Stage I pressure injury.</p> <p>Review of R7's Progress Note dated 9/18/24 at 9:47 AM, written by a floor nurse revealed, general skin assessment completed with focus on sacrum and buttocks. No open areas noted, blanchable scar tissue noted on the sacrum from what appears to be an old injury. Scratches noted on residents legs that resident states are from him scratching my legs when they itch.</p> <p>Review of R7's Progress Note dated 9/18/24 at 11:33 AM, written by DON revealed, Resident has an area on sacrum of non blanchable scar tissue.</p> <p>Review of the wound documentation listed above revealed a lack of consistent evaluations of the pressure injury on R7's coccyx with contradictory evaluations of the wounds (pressure injury vs scar tissue, blanchable vs non-blanchable).</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>As of 9/18/24 at 8:30 AM, R7's Electronic Medical Record revealed no Skin Alteration Evaluations completed (identified in the MDS assessment on 9/6/24 and in a progress note on 9/9/24). There was no documentation that the provider or the guardian were notified as of 09/18/2024 at 8:30 AM.</p> <p>Physician/Guardian Notification</p> <p>09/18/2024 at 8:38 AM a request was made for documentation that the physician and the guardian were notified of R7's newly identified pressure injury via email.</p> <p>Following the request a Late Entry Progress Note written on 9/18/24 at 9:22 AM and back dated to 9/5/24 revealed, Area of concern noted to residents sacrum reported by floor nurse .Upon further assessment area is old scar tissue. Guardian, physician and DON notified of findings. This note contradicts the hospice, MDS, and facility nurse evaluation that the wound was indicative of a Stage I pressure injury and treatment was ordered by both the hospice provider and the facility provider.</p> <p>An additional Late Entry Progress Note written on 9/18/24 at 9:26 AM revealed, Per telephone conversation with the DPOA, It was stated they were notified of the non blanchable redness to the sacrum, on 9/9/24. Per telephone conversation the physician was notified 9/9/24.</p> <p>On 9/18/24 at 1:20 PM, R7's Hospice Progress Notes were located in a binder at the 300/400 Nurses' Station. (They were not scanned into the Electronic Medical Record). Review of the note dated 9/6/24 revealed, Pt has drsg (dressing) mepilex to coccyx for reported stage II pressure ulcer .Notified pt's guardian (name omitted) of pt condition + new orders .</p> <p>Confirming contradictory documentation of the condition of the skin injury and the date/time the physician and guardian were notified.</p> <p>Resident #1 (R1)</p> <p>Review of an Admission Record revealed R1 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: quadriplegia.</p> <p>Review of a Minimum Data Set (MDS) assessment for R1, with a reference date of 9/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R1 was cognitively intact.</p> <p>During an interview on 09/16/2024 10:33 AM, R1 reported she was dependent on staff for toileting, bathing, bed mobility, and transferring. R1 reported her sacral pressure injury worsened since admitting to the facility and she did not feel she was receiving adequate wound treatments.</p> <p>Review of R1's Wound Clinic Note dated 6/4/24 revealed, Mepilex sacral is NOT meant for BID (twice a day) dressing changes.</p> <p>Review of R1's Order Summary revealed Dakins (1/2 strength) External Solution 0.25 % (Sodium Hypochlorite) Apply to coccyx-sacrageal wound topically every shift for wound care (to be completed twice a day at 7:00 AM and 7:00 PM) was not discontinued until 7/31/24 (twice a day dressing changes administered).</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Skld Whitehall | | STREET ADDRESS, CITY, STATE, ZIP CODE 916 E Lewis St Whitehall, MI 49461 | |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of R1's Wound Clinic Note dated 7/31/24 revealed, Cleanse with dakin's pack wound with aquacel AG cover sacral mepilex-change daily and prn when soiled.</p> <p>Review of R1's Wound Clinic Note dated 8/29/24 revealed, cleanse with dakin's pack wound with aquacel AG cover sacral mepilex-change 3 times a week and prn when soiled.</p> <p>Review of R1's Order Summary revealed the following concurrent active orders:</p> <p>*12/11/23 Dakins (1/2 strength) External Solution 0.25 % (Sodium Hypochlorite) Apply to coccyx topically every day shift for wound care per wound clinic.</p> <p>*8/29/24 Dakins (1/2 strength) External Solution 0.25 % (Sodium Hypochlorite) Apply to coccyx topically 3 times a week and prn every Mon, Wed, Fri for wound care cleanse with dakins pack with aquacel ag cover with mepilex.</p> <p>*7/31/24 sacral wound cleanse with dakin's pack with aquacel AG and cover with sacral mepilex. change daily and as needed per wound rec. every day shift for wound care AND as needed for as needed for soiled dressing</p> <p>*7/31/24 sacral wound cleanse with dakin's pack with aquacel AG and cover with sacral mepilex. change daily and as needed per wound rec. every day shift for wound care</p> <p>Review of R1's September Treatment Administration Record revealed all 4 treatment orders were listed (indicating each treatment was to be completed.) There were multiple blank boxes (indicating the treatment was not completed) with no rationale for why a treatment was not completed.</p> <p>Review of R1's Electronic Medical Record revealed no documentation that nursing staff questioned the multiple concurrent orders and obtained clarification to ensure the appropriate treatment was ordered/implemented.</p> <p>Resident #9 (R9)</p> <p>Review of an Admission Record revealed R9 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure.</p> <p>Review of R9's Order Summary dated 4/25/24 revealed, Weights MWF one time a day every Mon, Wed, Fri for CHF (congestive heart failure).</p> <p>Review of R9's July Treatment Administration Record revealed a weight was not obtained and/or documentation of a rationale for not obtaining a weight on 7/5/24, 7/19/24 or 7/29/24.</p> <p>Review of R9's August Treatment Administration Record revealed a weight was not obtained and/or documentation of a rationale for not obtaining a weight on 8/7/24, 8/19/24, and 8/28/24.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 09/18/2024 at 4:23 PM with Director of Nursing (DON) and Wound Nurse/Licensed Practical Nurse (WN/LPN) C (with Nursing Home Administrator and Regional Director of Clinical Care present) revealed the process for newly identified pressure injuries/wounds is for direct care staff to put in a risk management and notify the DON. The DON then reports the concern to WN/LPN C for her to monitor and evaluate weekly. DON reported that if she is notified of a new pressure injury/wound she ensures the nurse measured the wound, initiated treatment, and called the family and provider and stated, those kind of things. DON was asked how she ensures that new pressure injuries/wounds aren't missed and stated, I try my best. DON was asked if she ran reports daily and reported she reviewed the electronic medical record dashboard and would try to look every day but confirmed that missed wound treatments were not reflected on the dashboard. DON was given example of reports that she is able to run in the electronic medical record program utilized by the facility such as the 24-hour progress note reports, new order reports, missed treatment reports, and/or weekly skin assessment reports and stated, I try and reported she would try to review resident UDAs (resident assessments) daily and provided no further explanation.</p> <p>DON was asked if pressure injuries/ wounds were discussed in the Interdisciplinary Team (IDT) daily morning meets and she stated, no. When asked how often the IDT met to review pressure injuries/wounds she reported there were no scheduled meetings regarding wounds with the IDT. DON was asked how the facility pressure injuries/wounds were tracked/trended, and she reported that she and WN/LPN C try to meet weekly and reported that they could not meet weekly due to there not being a dietician full time in the building. When asked if the dietician was available full time to consult new wounds DON reported yes and was unable to explain further how a not having a dietician full time in house impacted their ability to meet weekly regarding resident wounds.</p> <p>DON was asked who was responsible for reviewing Hospice recommendations/visit notes/new orders and reported the Social Services Director usually keeps track of hospice recommendations. DON stated she had been relying on the Social Services Director to notify her of any hospice recommendations. When asked if her expectation was for Social Services to ensure new orders, new treatments, and nursing interventions were in place she stated, yes. DON was asked specifically about R7 and the hospice order written on 9/6/24 and stated she had never had hospice make treatment changes and stated the Facility was responsible for wounds and it was up to the facilities to make changes in the treatments.</p> <p>When asked who was responsible for ensuring meaningful interventions are implemented in resident skin care plans DON reported WN/LPN C was responsible and reported she would try to double check and make sure things are in there.</p> <p>DON was asked how she ensured all ordered treatments, vital signs, weights, and labs were completed and reported she would try to follow up with the licensed floor nurses and again referenced the dashboard.</p> <p>When asked who was responsible for ensuring all recommendation and/or new orders were reviewed and received following an appointment outside of the facility, specifically a wound clinic appointment, WN/LPN C reported she would occasionally have to track down the recommendations. WN/LPN C reported the floor nurse caring for the resident during the shift should be implementing new orders. DON was asked if she provided oversight and assistance with the Wound Management Program and ensured that recommendations and/or new orders from outside agencies/clinics were reflected in the resident medical records and she stated, (WN/LPN C) is responsible for the program.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of the facility policy, Skin Monitoring and Management-Pressure Ulcer dated 7/11/18 revealed, POLICY: It is the policy of this facility that:</p> <p>A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable; and</p> <p>A resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing.</p> <p>D. Develop comprehensive care plan if indicated following the evaluation/assessment. Care plans must be individualized and designed to meet the needs of the resident for whom they are being developed .F. Assessment of wounds identified after admission:</p> <p>A licensed nurse (which may be the facility Wound Nurse) must assess/evaluate a resident's skin at least weekly. All areas of breakdown, excoriation, or discoloration, or other unusual findings must be documented in the resident's clinical record.</p> <p>G. A licensed nurse (which can be the facility Wound Nurse) must assess/evaluate at least weekly each wound, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to:</p> <p>Measuring the wound</p> <p>Staging the wound</p> <p>Describing the nature of the wound (e.g., pressure, stasis, surgical wound)</p> <p>Describing the location of the wound</p> <p>Describing the characteristics of the wound</p> <p>Describing the progress with healing, and any barriers to healing which may exist</p> <p>Identifying any possible complications or signs/symptoms consistent with the possibility of infection</p> <p>H. It is understood that a resident may experience pain associated with the presence of a wound and/or any form of skin compromise. Therefore, the nursing staff shall be responsible to assess the resident for complaints of pain on assessment, prior to treatment, and as appropriate.</p> <p>Complaints of pain shall be documented in the resident's clinical record.</p> <p>Clinical interventions designed to alleviate the complaints of pain shall be administered by the nursing staff.</p> <p>The resident's response to the intervention shall promptly be assessed following its administration to validate its effectiveness and confirm that the resident's pain has been adequately alleviated.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Both the intervention and the response to the intervention shall be documented in the resident's clinical record.</p> <p>I. Once a wound has been identified, assessed, and documented, nursing shall administer treatment to e [TRUNCATED]</p> | | |