STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235206	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Whitehall	916 E Lewis St Whitehall, MI 49461

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00147849 and MI00148347. Based on interview and record review, the facility failed to protect the residents' right to be free from verbal and mental abuse by staff for 5 of 24 residents (R8, R12, R35, R53, and R68), resulting in residents being verbally abused. Findings include: A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing . A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed mental abuse includes but is not limited to humiliation . Examples: statements such as . Take a shower, you stink . attempts to embarrass or tell on the resident . A review of the facility investigation report received by the State Survey Agency (SSA), dated 11/19/24, revealed it was reported to Interim Nursing Home Administrator (NHA) A at 11:50 am on 11/12/2024 by Certified Nursing Assistant (CNA) C that on 11/11/24 CNA B called R35 an a**hole while providing care and was rude, disrespectful, and used inappropriate language to R12. In addition, the facility investigation report also mentioned R53 as a resident who was also included in the investigation, but did not indicate the reason. R12 A review of R12's Admission Record, dated 12/10/24, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R12's Admission Record revealed multiple diagnoses that included depression. A review of R12's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 10/16/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 13 which revealed R12 was cognitively intact. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R12's Social Services note, dated 11/12/24, revealed, This writer along with the administrator met with this resident in regards to a reported incident that had occurred . A review of R12's typed and undated interview located in the facility's investigative file for the incident on 11/11/24 revealed, NHA A followed up with R12 regarding CNA C's allegation that CNA B was degrading towards him. R12 stated he did not know about the incident on 11/11/24 and had no issues with care. A review of CNA C's typed interview, dated 11/14/24, revealed, CNA C reported to NHA A that on 11/11/24 CNA B had called R12 fat and disgusting while she was providing care to him. CNA C indicated that CNA B knew that R12 was hard of hearing and may not have heard her call him fat and disgusting. A review of CNA I's typed interview, dated 11/15/24, revealed when she came to work on 11/14/24 she noticed that R12's call light was on. She stated that she overheard CNA B inform CNA C that she was going to leave R12 on the toilet for five minutes while she completed another task. CNA I stated that when she heard this she proceeded to go assist R12 in the bathroom. CNA I stated CNA B informed her that she (CNA B) would help R12 immediately. CNA I stated she believed that CNA B was going to leave R12 on the toilet and not assist him. R35 A review of R35's Admission Record, dated 12/10/24, revealed they were an [AGE] year-old resident admitted to the facility on [DATE]. R35's Admission Record also revealed multiple diagnoses that included generalized muscle weakness, post-traumatic stress disorder (PTSD), unsteadiness on feet, and syncope (fainting) and collapse. A review of R35's MDS, dated [DATE], revealed a BIMS score of 12 which revealed R12 was moderately cognitively intact. A review of R35's Social Services note, dated 11/12/24, revealed, This writer along with the administrator met with resident to discuss a incident that took place yesterday, resident had no recollection of the incident . A review of R35's Employee to Resident Incident Report, dated 11/14/24, revealed CNA C reported to NHA A that CNA B called R35 an a**hole while she was in the room providing care (date not specified if other than 11/14/24). CNA C also stated CNA B called other residents *ssholes (date(s) not specified if other than 11/14/24). During an interview on 12/08/24 at 08:49 AM, R35 stated about a month or two ago an aide was sitting in his room doing paperwork. He stated he asked her to change his brief because it was wet and soiled. He stated the aide told him to shut up and then left the room. He stated she was with another aide and I guess she reported her because I had the social worker, administrator, and a bunch of other people interviewing me about it. He stated the facility investigated the issue and he has not seen the aide since. A review of CNA B's typed interview, dated 11/15/24, revealed CNA B denied that she called R35 an *sshole and stated she would never speak to residents that way. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA H's typed interview, dated 11/14/24, revealed CNA H stated CNA B often used profanity around residents. A review of CNA N's typed interview, dated 11/14/24, revealed she did not often work closely with CNA B. However, CNA N stated CNA B did use profanity at work. CNA N further stated that CNA B used the words sh*t and f*ck and that it was possible that CNA B used that language in patient care areas. A review of CNA O's typed statement, dated 11/14/24, revealed that she had heard CNA B use profanity around residents, but had never heard her swear at a resident. CNA O further stated CNA B had no filter (tended to say exactly what she thought without considering the consequences). CNA O also indicated that she takes pride in working at the facility and that CNA B's words made her feel uncomfortable. A review of Social Services Coordinator (SSC) E's typed interview, dated 11/14/24, revealed, that while SSC E was talking to R35 about the allegations of being a victim of verbal abuse by CNA B R35 did confirm that he heard CNA B swear but did not recall any words that were directed towards him. A review of Licensed Practical Nurse (LPN) P's typed interview, dated 11/14/24, revealed CNA B often used profanity in the workplace and had to be reminded to watch her language. A review of CNA Q's typed interview, dated 11/14/24, revealed, CNA B had used profanity towards residents in a joking manner. CNA Q stated CNA B's behavior was unprofessional and that sometimes it was difficult to tell whether she was joking or serious. A review of LPN R's typed interview, dated 11/14/24, revealed CNA B was very outspoken and blunt. LPN R stated he knew CNA B used profanity often but had never witnessed her using profanity around the residents. However, LPN R did state that CNA B did sometimes use profanity at the front desk. A review of CNA I's typed interview, dated 11/15/24, revealed CNA B used a lot of profanity at work. CNA I stated she had never heard CNA B swear at a resident. R53 A review of R53's Admission Record, dated 12/10/24, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R53's Admission Record revealed multiple diagnoses that included gangrene (dead tissue caused by an infection of lack of blood flow which can cause pus and foul-smelling discharge), generalized muscle weakness, and paranoid schizophrenia. A review of R53's MDS, dated [DATE], revealed a BIMS score of 15 which revealed R53 was cognitively intact. A review of R53's Social Services note, dated 11/12/24, revealed, This writer along with the administrator met with resident to discuss an issue that had been reported. He stated that the only complaint he had was when he has his call light on, it takes 40 minutes to an hour for a response. No further concerns . A review of R53's Employee to Resident Incident Report, dated 11/11/24, revealed that it was reported to NHA A that CNA B made derogatory statements to R53 regarding his hygiene. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/08/24 at 11:10 AM, R53 denied anyone had used inappropriate/derogatory language toward him. A review of R53's undated typed interview revealed NHA A spoke with R53. R53 indicated that he had no issues with CNA B and did not recall her making derogatory comments to him. A review of CNA C's typed statement, dated 11/12/24, revealed, CNA C stated R53 was just waking up when they (CNA B and CNA C) went into the room to perform care. CNA C stated that while CNA B was in the room, she verbalized loudly that R53's room always smells like urine, that he has poor hygiene, and that he is just gross in general. CNA C stated that she believed R53 was sleeping and may not have heard CNA B make the statement. A review of SSC E's typed statement, dated 11/14/24, revealed, that when he interviewed R53 about the allegations against CNA B R53 denied knowing anything about the incident. A review of NHA A's typed statement, dated 11/15/24, revealed I spoke with [name of CNA B] regarding a report that I received about her degrading regarding [name of R53]'s hygiene. [Name of CNA B] indicated that the allegation was not true. I informed [name of CNA B] that it was reported that she informed a new hire of this while she was training them. She began to get upset and defensive. I informed [name of CNA B] of the importance of professionalism and that we must be mindful of what we say at work . A review of CNA O's typed statement, dated 11/14/24, revealed she felt that CNA B had no filter (tended to say exactly what she thought without considering the consequences). CNA O also indicated that she takes pride in working at the facility and that CNA B's words (or statements) made her feel uncomfortable. A review of CNA Q's typed interview, dated 11/14/24, revealed, CNA B's behavior was unprofessional and that sometimes it was difficult to tell whether she was joking or serious. A review of the facility's investigative documentation for the incident on 11/11/24, undated, revealed the following they concluded the following: - The facility verified, based on witness statements, CNA B did use profanity at work, including in resident care areas and around residents, and creates an uncomfortable work environment. - The facility verified that based on witness account, CNA B called R35 an *sshole and was degrading as it pertains to R12's and R53's hygiene. During an interview on 12/09/24 at 03:15 PM, the NHA stated all the allegations that CNA B had used degrading/derogatory language toward R12 and R53 and had called R35 an *sshole were substantiated. The NHA further stated she could not believe that they all occurred, but they did. She also stated she was shocked when she heard about them initially. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of CNA B's Disciplinary Action Record Work Rules form, dated 11/18/24, revealed it was reported to NHA A that on 11/11/24 CNA B called residents *ssholes and was degrading to residents due to their hygiene. In addition, CNA B had a prior history of degrading residents and using profanity. CNA B s Disciplinary Action Record Work Rules form further revealed they were terminated from their employment at the facility effective 11/18/24. A review of CNA B's Employee Termination Form, dated 11/18/24, revealed CNA B was terminated from employment at the facility for calling residents names.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation is related to intake # MI00148049 Based on interview and record review, the facility failed to prevent the misappropriation of controlled substances for three (Resident #35, Resident #5, and Resident #174) of three residents reviewed. Findings: Resident#35 (R35) Review of an Admission Record revealed R35 was an [AGE] year old male, last admitted to the facility on [DATE] with pertinent diagnoses of diabetes mellitus, post traumatic stress disorder, chronic obstructive pulmonary disease, and left lower extremity below the knee amputation. Resident #5 (R5) Review of an Admission Record revealed R5 was an [AGE] year old female, last admitted to the facility with pertinent diagnoses of dementia, anxiety disorder, claustrophobia, and chronic obstructive pulmonary disease. Resident #174 (R174) Review of an Admission Record revealed R174 was a [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of rheumatoid arthritis, chronic pain, and diabetes mellitus. Review of an Incident Report dated 10/31/24 reflected the following information: (a) the night of 10/30/24 at approximately 11:45 PM, certified nurse aide (CNA) CC observed Registered Nurse DD place a pill (later discovered to be the narcotic Oxycodone) prescribed to R35 in her pocket, (b) CNA CC asked R35 if he had received his pain medications and R35 stated he had not, (c) CNA CC then advised Unit Manager (UM) EE of the observation, (d) UM EE called Interim Nursing Home Administrator (I-NHA) A and reported the incident, (e) I-NHA A did not immediately report the incident to the State Agency and did not immediately suspend RN DD pending an investigation, (f) RN DD had picked up an additional over time shift and was still at the facility working when I-NHA A arrived to the facility at 7:30 AM on 10/31/24, (g) RN DD was then removed from the floor, (h) the Director of Nursing and Licensed Practical Nurse (LPN) P completed an audit of the medication cart RN DD had been using and discovered two additional narcotics were unaccounted for, (i) further investigation revealed that the two missing narcotics belonged to R5 and R174, and (j) the two missing narcotics prescribed to R5 and R174 were located in a medication cup in the bathroom of room [ROOM NUMBER]. During an interview on 12/10/24 at 12:30 PM, the current Administrator and the Regional Director of Clinical Operations X reviewed the details of the incident. There was no additional information provided beyond what had previously been stated in the initial report. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility submitted a packet of information requesting that past non-compliance be considered. However, the facility failed to show substantial compliance with narcotic documentation and storage at the time of the survey and remained out of compliance with professional standards of practice for controlled drug administration and documentation. Review of the facility policy Abuse and Neglect reflected: It is the policy of this facility to provide professional care and services in an environment that is free from .misappropriation of property.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30120 This citation refers to MI00147849 and MI00148347. Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act and report within a timely manner to facility management and the State Survey Agency allegations of verbal and/or mental abuse by staff for three of 24 residents (R12, R35, and R53), resulting in a delay in investigating allegations of abuse and the potential for residents to not be protected from abusive individuals Findings include: A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing . A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed mental abuse includes but is not limited to humiliation . Examples: statements such as . Take a shower, you stink . attempts to embarrass or tell on the resident . A review of the facility's Abuse and Neglect Policy and Procedure, dated 3/24/23, revealed, All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to the appropriate State Agencies (e.g. State Survey Agency) immediately after the initial report is received . The Administrator is the Abuse Coordinator . The abuse coordinator must submit a preliminary investigation report to the appropriate State agencies immediately once assurances for the resident's or other resident's safety have been established . A review of the facility investigation report received by the State Survey Agency (SSA), dated 11/19/24, revealed it was reported to Interim Nursing Home Administrator (NHA) A at 11:50 a.m. on 11/12/2024 by Certified Nursing Assistant (CNA) C that on 11/11/24 CNA B called R35 an *sshole while providing care and was rude, disrespectful, and used inappropriate language to R12. In addition, the facility investigation report also mentioned R53 as a resident who was also included in the investigation, but did not indicate the reason. The facility investigation report further revealed the incident was not reported to the State Survey Agency until 11/12/24 at 1:40 p.m. During a review of CNA C's personnel file on 12/10/24 at 9:35 a.m., Human Capital Partner (HCP) Z stated she was not aware if CNA C had received any education and/or discipline regarding her failure to report allegations of abuse in a timely manner to facility management when it was discovered that CNA C's personnel file did not have any educational opportunities or disciplines in it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/24 at 10:46 AM, the Nursing Home Administrator (NHA) stated CNA C had received a Teachable Moment for failing to report allegations of abuse timely to the interim Nursing Home Administrator (NHA A). A review of CNA C's Teachable Moment form, dated 11/12/24, revealed she had failed to report an allegation of abuse to the administrator immediately on 11/11/24. CNA C was educated that she needed to report all allegations of abuse to the NHA upon discovery.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37577 Based on observation, interview, and record review, the facility failed to secure unattended medication carts for three of five carts reviewed and failed to label opened medications according to industry standards. Findings: During an observation on 12/09/24 at 7:19 AM, (a) the medication cart labeled 409-416 was unlocked and unattended by licensed nursing staff, (b) the medication cart contained 5 loose pills at the bottom of the second drawer, (c) a Lantus insulin kwik pen prescribed to the resident in bed 416-2 did not have a date written on it identifying when the medication was opened, (d) a bottle of Lantus insulin prescribed to the resident in bed 407-1 did not have a date written on it to indicate when the medication had been opened, and (e) contained the eye drops brimonidone 0.15% for the resident in bed 415-1 and did not have a date written on it to identify when it had been opened. During an observation on 12/9/24 at 7:31 AM, the medication cart labeled 309-316 contained eight loose pills at the bottom of the second drawer. During an interview at the same time, Licensed Practical Nurse (LPN) R indicated that lose pills should not be in the medication carts and that the carts must be locked at all times when unattended by a nurse. During an observation on 12/10/24 at 7:30 AM, both medications carts on the 400 hall sat side by side unlocked and unattended by nursing personnel. A staff person identified as Registered Nurse L exited a room and approached the medication cart I was just in a room for a quick second. Review of the facility policy Medication Access and Storage reflected: It is the policy of this facility to store all drugs and biological's in locked compartments. Industry standards for storing and dating medications maintains that once any medication is opened, the facility should follow manufacturer guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened.