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	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Whitehall	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake # MI00150877 Based on interview and record review, the facility failed to 1.) ensure residents received care and services following provider orders, 2.) identify and notify the physician a change in condition, and 3.) ensure complete and accurate medical records, for 1 resident (Resident #302) out of 3 residents reviewed for quality of care. Findings: Resident #302 (R302) Review of an Admission Record revealed R302 was a [AGE] year-old female, admitted to the facility from [DATE]-[DATE]. Pertinent diagnoses included: congestive heart failure, irritable bowel syndrome, dysphagia (difficulty swallowing), and non-celiac gluten sensitivity. During an interview on [DATE] at 2:10 PM, Family Member (FM) H reported R302's discharge orders from the hospital and the orders from the facility provider were not followed by the facility which resulted in R302's receiving poor care. FM H reported that R302's bottom becoming raw from excessive diarrhea from being given food that had gluten in it, which the resident couldn't tolerate. Additionally, staff had been told about the resident's intolerance for gluten since her admission and no changes were made over the weekend. Review of R302's After Visit Summary from R302's inpatient hospital stay from [DATE]-[DATE] revealed, Wound care instructions .Apply Zinc oxide to buttock 3 x (times) daily and as needed due to irritation in buttock region . Review of R302's hospital Discharge Summary dated [DATE] revealed .Sacral excoriation - Apply moisture barrier ointment (z-guard) to buttock 3x daily and as needed . Review of R302's Order Summary dated [DATE] revealed, Apply zinc oxide to buttocks 3x daily and as needed for excoriation every day and night shift for skin integrity. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R302's January Treatment Administration Record revealed the application of zinc oxide to buttocks was ordered to be completed at 7:00 AM and 7:00 PM. Indicating it was not administered three times a day despite documentation of increased loose stools which increases risk of skin breakdown. Additionally, zinc oxide was not ordered to be administered as needed. During an interview on [DATE] at 2:20 PM, Nursing Home Administrator (NHA) and Regional Director of Clinical (RDC) M confirmed the Zinc transcription error. Further review of the January Treatment Administration Record revealed that on [DATE] at 7:00 AM the application of zinc oxide was not completed. Review of R302's After Visit Summary from R302's inpatient hospital stay from [DATE]-[DATE] revealed, . Diet: Gluten free (patient has reported gluten intolerance) . Review of R302's hospital Discharge Summary dated [DATE] revealed .Gluten intolerance with history of Irritable bowel syndrome - Gluten free diet . Review of R302's Allergies revealed an allergy to gluten was documented. Review of R302's Order Summary from [DATE]-[DATE] revealed no diet ordered. On [DATE] an order was placed for a gluten free diet for celiac disease. Review of R302's Progress Note dated [DATE] revealed, resident not feeling well w/diarrhea. Daughter came and said all of her symptoms were like she had ate gluten. Has a gluten allergy, kitchen aware (in red on kitchen ticket) but her meals have not been gluten free. Her lunch tray was all gluten. I did ask kitchen to make sure she gets no gluten on trays.(resident will eat what is given). During an interview on [DATE] at 11:48 AM, Certified Nursing Assistant (CNA) L reported that after R302 was admitted (Friday [DATE]) and through the weekend ([DATE]-[DATE]) R302 received the wrong diet and would have huge blowouts (excessive diarrhea) from receiving foods that contained gluten. During an interview on [DATE] at 12:17 PM, CNA J reported that R302's daughter (FM H) would visit R302 frequently and was concerned that R302's diet was not being followed. CNA J reported that when R302 first arrived to the facility her diet wasn't wrote down that she couldn't have gluten and R302 was having a lot of diarrhea from the gluten. During an interview via email on [DATE] at 1:23 PM, NHA reported that the hospital discharge dietary order would have been given directly to the kitchen. I cannot attest to why it was not placed in the actual orders until the 13th ([DATE]). Review of R302's After Visit Summary from R302's inpatient hospital stay from [DATE]-[DATE] revealed, . Follow-up labs: Recommend BMP (basic metabolic panel-electrolyte levels), CBC (complete blood count), and Mag (magnesium) within a week of discharge . Review of R302's hospital Discharge Summary dated [DATE] revealed .Hypokalemia- Resolved. S/p (status post) supplementation . (R302's potassium was low during her hospital stay and potassium supplements were administered in order to restore normal potassium levels.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R302's Physician assessment dated [DATE] revealed, .Chronic diastolic CHF (congestive heart failure), HTN (hypertension), PSVT (abnormal heart rhythm), severe aortic stenosis .spironolactone (diuretic medication) 25mg/d (daily) .furosemide (diuretic medication) 40mg/d (daily) .(History of) Hypokalemia (low potassium level) . Diuretics may cause electrolyte levels (potassium) to become depleted/abnormal. Review of R302's Order Summary and Electronic Medical Record revealed no pending and/or complete orders for follow-up laboratory testing from [DATE]-[DATE] despite a diagnosis of hypokalemia which required supplementation prior to admission to the facility. During an interview via email on [DATE] at 2:00 PM, NHA was asked to provide documentation that the recommended laboratory tests were ordered (pending) or completed during her stay at the facility. No documentation was provided prior to survey exit. Review of R302's After Visit Summary from R302's inpatient hospital stay from [DATE]-[DATE] revealed, . Other follow up and instructions: Monitor blood pressure closely. Losartan (lowers blood pressure) was increased the day of discharge and Hydralazine (lowers blood pressure) may be able to be discontinued pending blood pressure .Weigh patient daily . Review of R302's hospital Discharge Summary dated [DATE] revealed, Suspect (weight) around 160 lbs. Weight ,d+[DATE]lbs (most weighs ,d+[DATE]lbs) .Recommend daily weights . with a discharge weight of 150 pounds 9.2 ounces. Review of R302's Physician assessment dated [DATE] revealed, .Continue to monitor weight . Review of R302's Order Summary revealed no order for daily weights. Review of R302's Task Summary revealed, WEIGHT .Q (every) Day Shift and WEIGHT .PRN (as needed). The summary revealed a weight of 150.2 pounds on [DATE], a weight of 127.8 pounds on [DATE], and a weight of 127.6 on [DATE]. (R302's weight obtained upon admission to the facility on [DATE] of 150.2 pounds was accurate based on the discharge weight obtained at the hospital.) Confirming daily weights were not obtained. Review of R302's Electronic Medical Record revealed no documentation that R302's provider was notified of R302's significant weight loss of approximately 23 pounds in 6 days. During an interview on [DATE] at 2:20 PM, NHA and RDC M confirmed the facility staff did not obtain daily weights or identify R302's significant weight change. There was no documentation that facility staff notified R302's provider of the significant weight change. RDC M reported R302's lack of daily weights was identified following her transfer to the hospital and an action plan was implemented regarding resident changes in condition. Review of R302's hospital Discharge Summary dated [DATE] revealed, .After discussion with daughter, (FM H), whom patient states she would like to make her medical decisions, code status update to No CPR/Intubation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Do Not Resuscitate (DNR) Order was signed and dated on [DATE] by R302, a physician, and a Licensed Master Social Worker with documentation that R302 was of sound mind at the time the form was completed. Review of R302's Physician assessment dated [DATE] at 11:44 AM revealed R302's DNR status was reviewed with no change to full code noted. Review of R302's Social Services Progress Note dated 2:11 PM revealed, .Resident currently has no DPOA (Durable Power of Attorney-decision maker) paperwork on file. Resident's daughter (FM H) stated she had paperwork but .would have to look for it. At this time due to residents cognition, Advance Directive paperwork is unable to be completed and resident will default as a FULL CODE until paperwork is provided or residents cognition clears . Review of R302's Order Summary dated [DATE] revealed, Full Code. This order was active until [DATE]. During an interview on [DATE] at 2:20 PM, NHA and RDC M revealed a link in the Electronic Medical Record that opened up R302's signed DNR form and confirmed that R302 was a DNR. RDC M and NHA were not aware of the Full Code order in R302's Order Summary. During an interview via email on [DATE] at 1:23 PM, NHA reported that following R302's stay at the facility and the concerns voiced by FM H Every morning we now go through new admissions in morning meeting and go through the assessments, diet orders, etc to ensure we're not missing anything (orders and recommendations) when a resident is admitted to the facility.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake # MI00149091 and MI00150877 Based on observation, interview and record review, the facility failed to follow physician ordered wound care and provide care to prevent the development of skin breakdown/pressure injuries for 6 residents (Resident #302, #303, #311, #316, #317, and #318) out of 9 reviewed for alterations in skin integrity. Findings: Resident #302 (R302) Review of an Admission Record revealed R302 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R302's After Visit Summary from an inpatient hospital stay from 1/1/25-1/10/25 revealed, .Apply Zinc oxide to buttock 3 x (times) daily and as needed due to irritation in buttock region. Review of R302's Order Summary dated 1/10/25 revealed, Apply zinc oxide to buttocks 3x daily and as needed for excoriation every day and night shift for skin integrity. Review of R302's January Treatment Administration Record revealed the application of zinc oxide to buttocks was ordered to be completed at 7:00 AM and 7:00 PM. Indicating it was not administered three times a day despite documentation of increased loose stools which increases risk of skin breakdown. Additionally, zinc oxide was not ordered to be administered as needed. Further review of the January Treatment Administration Record revealed that on 1/15/25 at 7:00 AM the application of zinc oxide was not completed. Resident #303 (R303) Review of an Admission Record revealed R303 was an [AGE] year-old male, admitted to the facility on [DATE]. Review of R303's Order Summary revealed: Wound # 1 Right Ischium Pressure Treatment: 1. Cleanse with wound cleanser. 2. In med cup mix hydrogel and Collagen powder to create a paste. Apply to wound bed and into tunneling at 12 o'clock. 3. Secure with border gauze (white dressing, not brown). 4. Change daily and PRN (as needed). every day shift . To be completed at 7:00 AM. AND (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound care to sacrum 1. Cleanse with normal saline or wound cleanser. 2. Apply Collagen powder to wound bed. 3. Secure with border gauze (white dressing, not brown). 4. Change daily and PRN. every shift for Pressure injury. To be completed at 7:00 AM and 7:00 PM. Review of R303's March Treatment Administration Record revealed: *On 3/10/25 R303's Right ischium and sacral wound treatments were not completed at 7:00 AM. *On 3/13/25 R303's Right ischium and sacral wound treatments were not completed at 7:00 AM and R303's sacral wound treatment was not completed at 7:00 PM. *On 3/17/25 R303's Right ischium and sacral wound treatments were not completed at 7:00 AM. Review of R303's Electronic Medical Record revealed no documentation for the missed treatments. Resident #311 (R311) Review of an Admission Record revealed R311 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R311's Order Summary revealed, Apply barrier cream to wound to right buttock three times per day at breakfast, lunch, and dinner time. Review of R311's March Treatment Administration Record revealed that on 3/8/25, 3/13/25, and 3/14/25 barrier cream was no applied to R311's right buttock at dinner time. Review of R311's Electronic Medical Record revealed no documentation for the missed treatments. Resident #316 (R316) Review of an Admission Record revealed R316 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R316's Order Summary revealed: Wound Care for abrasion to upper left forearm: Cleanse with saline or wound cleanser; Apply Xeroform, cover with border foam dressing M-W-F (Monday, Wednesday, and Friday) and PRN. every day shift every Mon, Wed, Fri for Abrasion/ skin tear. AND Wound Care for abrasion/skin tear to bridge of nose: Monitor for signs of infection daily every day shift for abrasion. AND Wound Care for pressure injury to sacrum : Cleanse with saline or wound cleanser; sacral border foam M-W-F and PRN .for Pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R316's March Treatment Administration Record revealed that on 3/14/25 R316's treatments were not completed. Review of R316's Electronic Medical Record revealed no documentation for the missed treatments. Resident #317 (R317) Review of an Admission Record revealed R317 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R317's Order Summary revealed, Apply skin prep wipes to right lateral heel and left posterior thigh twice per day to impaired areas. every morning and at bedtime for impaired skin. Review of R317's March Treatment Administration Record revealed that on 3/8/25 and 3/14/25 R316's morning treatment was not completed. Review of R317's Electronic Medical Record revealed no documentation for the missed treatments. Resident #318 (R318) Review of an Admission Record revealed R318 was a [AGE] year-old male, admitted to the facility on [DATE]. Review of R318's Order Summary revealed, Wound Care for groin: Cleanse with soap and water, dry ; Apply antifungal house barrier cream; every shift and PRN every shift for redness and irritation. To be completed at 7:00 AM and 7:00 PM. Review of R318's March Treatment Administration Record revealed that on 3/9/25 at 7:00 AM and 3/13/25 at 7:00 PM R318's treatment was not completed. Review of R318's Electronic Medical Record revealed no documentation for the missed treatments. During an interview on 3/19/25 at 2:20 PM, Nursing Home Administrator (NHA) reported that it was identified that treatments were not being completed as ordered on 3/17/25 and a plan of correction was being implemented.