

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/16/2024
NAME OF PROVIDER OR SUPPLIER  Skld Zeeland		STREET ADDRESS, CITY, STATE, ZIP CODE 285 N State St Zeeland, MI 49464	

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)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45410</p> <p>This citation pertains to intake #MI00145408.</p> <p>Based on interview and record review, the facility failed to ensure nursing staff were competent and adequately trained to reconcile physician's orders and medications during the admission process, resulting in the potential for compromised resident safety and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #101 admitted to the facility on [DATE] with pertinent diagnoses which included seizures, fibromyalgia, and hypertension.</p> <p>In a telephone interview on 7/16/2024 at 9:05 AM, Hospital Case Manager B reported it was learned while preparing Resident #101 for discharge from the hospital back to the facility on [DATE] that Resident #101 had not been taking all the medications according to discharge orders the last time she was discharged from the hospital back to the facility on [DATE].</p> <p>Review of Resident #101's local hospital Hospitalist Discharge Summary, dated 6/28/2024, revealed .Patient well known with multiple hospitalization s in 2024, last 6/14-6/16 . Review of medication performed by Pharm Technician revealed that majority of patients medications were discontinued per facility RN. Call was placed by this provider as well to verify medications and patient was not on antihypertensives or bowel routine, these medications were noted to be on her list on all of her admits this year .</p> <p>In an interview on 7/15/2024 at 3:19 PM, Licensed Practical Nurse (LPN) G reported he spoke to an employee at the hospital on 6/18/2024 when Resident #101 was discharged back to the facility and reviewed medication lists. LPN G reported he performed the admission assessment and reviewed medication orders upon Resident #101's return from the hospital that evening, and the third shift nurse was to perform the second check of the orders. LPN G reported a second nurse and the unit manager are required to double check admission orders. LPN G reported management later instructed him that he had missed orders and gave him written counseling regarding this.</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN G Disciplinary Action Record, dated 7/10/2024, revealed .issued on 7/10/24 . Written Warning #1 . Date of Infraction 7/1/2024 &amp; 6/16/24 . On 6/16/24 you failed to correctly enter readmission orders for resident . You had errors in the transcription &amp; placement of orders .</p> <p>In an interview on 7/16/2024 at 12:28 PM, Prior Nurse E reported she took over for Licensed Practical Nurse (LPN) G on 6/16/2024 at 10:00 PM and was supposed to perform the 2nd check for Resident #101's admission orders, but she did not remember whether she did the second check. Prior Nurse E reported she did not know whether the admission checklist was completed for Resident #101's 6/16/2024 admission.</p> <p>In an interview on 7/16/2024 at 3:10 PM, the Nursing Home Administrator reported she was unable to find documentation that Prior Nurse E had been trained regarding the admission process and medication reconciliation. The NHA reported there was an admission process checklist that should have been completed by Prior Nurse E at hire.</p> <p>Review of facility policy/procedure New Employee Orientation, revised 10/1/2023, revealed .The New Employee Orientation is designed to provide a general orientation overview for new employees. Employees will also be provided with a departmental orientation by their immediate supervisor or designee .</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45410</p> <p>This citation pertains to intake #MI00145408.</p> <p>Based on interview and record review, the facility failed to ensure Medication Regimen Reviews, which noted irregularities or recommendations, were addressed by the physician in a timely manner for 1 resident (Resident #101) of 3 residents reviewed for medication use, resulting in the potential for unnecessary medications, negative medication side effects, and for residents to not meet their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #101 admitted to the facility on [DATE] with pertinent diagnoses which included seizures, fibromyalgia, and hypertension.</p> <p>Review of Resident 101's electronic medical record on 7/16/2024 at 1:05 PM revealed the pharmacist perform Medication Regimen Reviews for Resident #101 for each re-admission from the local hospital on 6/16/2024 and 6/28/2024.</p> <p>Review of Resident #101's Medication Regimen Review Note to Attending Physician/Prescriber, dated 6/18/2024, revealed .Please review recommendation(s) below: Please add 'do not crush' to the following medication order, to avoid administration problems, since crushing a med that should not be crushed is now considered a medication error:</p> <ul style="list-style-type: none"> <li>-Levetiracetam</li> <li>-Pantoprazole</li> <li>-Ciprofloxacin.</li> </ul> <p>Please consider changing to a different dosage form or changing to medications that can be crushed .</p> <p>Review of Resident #101's Medication Regimen Review Note to Attending Physician/Prescriber, dated 6/30/2024, revealed .This resident is receiving duplicate therapy of Famotidine and Protonix. Please consider discontinuing one of the above .</p> <p>In an interview on 7/16/2024 at 2:45 PM, the Nursing Home Administrator (NHA) reported they could not find documentation that Resident 101's Medication Regimen Review recommendations from 6/18/2024 or 6/30/2024 had been addressed by a medical provider. Regional Consultant A reported she addressed both reports with Nurse Practitioner (NP) D on 7/16/2024.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/16/2024 at 2:45 PM, NP D reported she had been gone in June and one of her coworkers was covering for her. NP D reported she expected to be notified urgently for orders needing to be crushed. NP D reported the Director of Nursing usually brought urgent recommendations to her immediately to address, rather than waiting a few weeks.</p> <p>Review of facility policy/procedure Medication Regimen Review, dated 7/11/2018, revealed .When the pharmacist identifies an irregularity, which requires urgent action to protect the resident, the pharmacist will notify the facility as soon as possible to address the urgent issue immediately .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45410</p> <p>This citation pertains to intake #MI00145408.</p> <p>Based on interview and record review, the facility failed to prevent significant medication errors for 1 resident (Resident #101) of 3 residents reviewed for medication use, resulting in the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #101 admitted to the facility on [DATE] with pertinent diagnoses which included seizures, fibromyalgia, and hypertension.</p> <p>In a telephone interview on 7/16/2024 at 9:05 AM, Hospital Case Manager B reported it was learned while preparing Resident #101 for discharge from the hospital back to the facility on [DATE] that Resident #101 had not been taking all the medications according to discharge orders the last time she was discharged from the hospital back to the facility on [DATE].</p> <p>Review of Resident #101's local hospital Hospitalist Discharge Summary, dated 6/28/2024, revealed .Patient well known with multiple hospitalization s in 2024, last 6/14-6/16 . Review of medication performed by Pharm Technician revealed that majority of patients medications were discontinued per facility RN. Call was placed by this provider as well to verify medications and patient was not on antihypertensives or bowel routine, these medications were noted to be on her list on all of her admits this year .</p> <p>In an interview on 7/15/2024 at 3:19 PM, Licensed Practical Nurse (LPN) G reported he spoke to an employee at the hospital on 6/18/2024 when Resident #101 was discharged back to the facility and reviewed medication lists. LPN G reported he performed the admission assessment and reviewed medication orders upon Resident #101's return from the hospital that evening, and the third shift nurse was to perform the second check of the orders. LPN G reported a second nurse and the unit manager are required to double check admission orders. LPN G reported management later instructed him that he missed two medications, Miralax (a laxative) and Senna (a stool softener) and was given written counseling.</p> <p>Review of LPN G Disciplinary Action Record, dated 7/10/2024, revealed .issued on 7/10/24 . Written Warning #1 . Date of Infraction 7/1/2024 &amp; 6/16/24 . On 6/16/24 you failed to correctly enter readmission orders for resident . You had errors in the transcription &amp; placement of orders .</p> <p>Review and comparison of Resident #101's hospital discharge orders dated 6/16/2024 and facility physician's orders and Medications Administration Record revealed LPN G failed to activate several medication orders upon Resident #101's re-admission to the facility on [DATE] including the following .</p> <p>Amlodipine 10mg daily (hypertension medication), not started again until after Resident #101's 6/27/2024 to 6/28/2024 hospitalization on [DATE]-</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Baclofen 15MG three times a day (skeletal muscle relaxant that can cause withdrawals if stopped abruptly), not started gain until after Resident #101's 6/27/2024 to 6/28/2024 hospitalization on [DATE]-</p> <p>Senna S 8.6/50mg, two twice a day (laxative), not started gain until after Resident #101's 6/27/2024 to 6/28/2024 hospitalization on [DATE]-</p> <p>Miralax 17g daily (laxative), not started gain until after Resident #101's 6/27/2024 to 6/28/2024 hospitalization on [DATE]-</p> <p>Metoprolol Succinate 25mg twice a day (hypertension medication), not started gain until after Resident #101's 6/27/2024 to 6/28/2024 hospitalization on [DATE]-</p> <p>Lisinopril 40mg daily (hypertension medication), not started gain until after Resident #101's 6/27/2024 to 6/28/2024 hospitalization on [DATE]-</p> <p>In an interview on 7/16/2024 at 8:30 AM, the Nursing Home Administrator (NHA) reported she was not aware until yesterday afternoon that Resident #101 went without these medications. The NHA reported they originally thought Resident #101 only went without a couple bowel medications. Regional Consultant A reported LPN G failed to accurately reconcile Resident #101's medications during the admission process, the paper admission checklist was not completed as required for the 6/16/2024 or 6/28/2024 admission, Prior Nurse E failed to perform the second check of the admission orders, the unit manager failed to check the admission orders, and the medical provider failed to check the admission orders. Regional Consultant A reported the facility is working on a plan of correction to address this.</p> <p>Review of facility policy/procedure Admissions, dated 7/11/2018, revealed .Licensed Nurse Procedure . Inform physician of admission and verify transfer and admission orders . order medications from pharmacy .</p> <p>Review of a facility Admission Checklist, dated 7/15/2024, revealed the admission nurse is to confirm admission orders with a physician, have a 2nd nurse verify the admission orders, and ensure the pharmacy has the medication orders. This process is then checked by a nurse manager.</p>		