STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235347	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Zeeland	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)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 This citation pertains to intake MI00148411 Based on observation, interview, and record review, the facility failed to assess timely, monitor, treat and adequately control pain for 1 Resident (R1) of 3 Residents reviewed for pain. Review of R1's face sheet dated 2/6/25 revealed she was a [AGE] year old female admitted to the facility on [DATE] and had diagnoses that included: 11/28/24 encounter for other orthopedic, polyneuropathy (peripheral nerve disorder that affects multiple nerves throughout the body simultaneously), pain in right shoulder, generalized anxiety disorder, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), Pseudobulbar affect (inappropriate involuntary laughing or crying due to nervous system disorder) and mild cognitive impairment. R1 was listed as her own responsible party. Review of R1's progress note dated 1/20/25 at 12:44 PM revealed R1 had a mental evaluation, and she score 15 out of 15 on her Brief Interview of Mental Status (BIMS). Normal cognitive function. Review of the facility reported incident for R1 dated incident occurred 12/3/24 at 4:30 AM, revealed R1's Family Member (FM) K called the Administrator on 12/3/24 at 7:57 PM accusing Licensed Practical Nurse (LPN) C of not giving her pain medications timely or transferring her to the hospital when she requested to go to the hospital. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility reported incident for R1 dated incident occurred 12/3/24 at 4:30 AM, revealed LPN C provided the following statement in the investigation, This issue started around 4 am this morning (12/3/24). I had every med (medication) written out in advance of what was due for R1 and when because of her behaviors surrounding her pain meds (medication). She asks way ahead of time every night and does not sleep at all at night, this is a battle every night with her. Around 4-4:15 am was the Flexeril (medication for muscle spasms), I said you have couple minutes left before I can give you this. She was laughing, we were talking have a good conversation, ands she said Im [sic] kind of achy in my chest. I took her vitals they were stable; she had no tingling or numbness. I asked her if she would be OK with giving her Flexeril a try and seeing if that makes a difference for her. She agreed to taking the Flexeril and giving that a try before we take other measures. She never rang her call light again between 4:15 and 4:30 am and did not request to see me or to go to the hospital. Around 4:30 am, I was getting ready to check blood sugars, I could hear R1 on the phone with 911 from the hall, so I came over to her room. I could hear the operator asking her if it was an emergency and she said multiple times that this is not an emergency. She said it is not any emergency, I want to go to the hospital because I want more pain meds. (Record review revealed Flexeril was given at 2:58 AM not 4:00 AM as indicated in this interview and R1's pain medication was due again at 4:11 AM, R1 had been taking her as needed pain medication every 4 hours and her was 10/10 (indicating severe pain) since 12/2/24 at 7:24 PM, record review did not reveal any physician notification of increased pain or any timely reassessment of her pain after she reported severe pain on 12/2/24 at 7:24 PM). Review of the facility reported incident for R1 indicated incident occurred 12/3/24 at 4:30 AM and revealed Certified Nurse Aide (CNA) I made the following statement, R1 is frequently turning her call light on to ask for medication, on 12/3/24 I know that she was given her cup of pills after she rang her call light. One of the times R1 turned on her light she said she was going to call 911 because she hasn't had her pills yet. I told this to the nurse. She did not have any physical signs of pain, she was just expressing that she needed her pain meds even though everything that was available had already been administered to her by the nurse, and her Flexeril (not pain medication, used for muscle spasms) was up next, but it was not time to be given. (Record review revealed R1 reported severe pain on 12/2/24 at 7:24 PM and continued to report pain. Flexeril was given on 12/3/24 at 2:58 AM R1's next dose of pain medication was due prior to her calling 911). Review of R1's progress noted dated 12/2/24 at 12:36 PM revealed, Writer spoke with resident regarding pain management and skin concerns. Writer educated resident on PRN (as needed) pain medications. Resident stated being aware of the schedule, but that she [is] still in pain. She was reminded of her follow up appointment with the surgeon today. She stated that she will tall [sic] to the surgeon for more pain meds. Review of R1's progress noted dated 12/3/24 at 4:30 AM revealed, At the time of resident's c/o (complaint of) chest pain resident denies any numbness or tingling to either arm or hand and continued to have a conversation without any s/s (signs or symptoms) of pain or discomfort. Also stated, I just want to go to the Hospital because I know they will give me more pain meds. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's progress note dated 12/3/24 at 5:29 AM revealed, At 4:30 am staff entered resident's room and resident was on the phone with the 911 operator telling him that she was having chest pain but that it was not an emergency. 911 operator then stated that they would be there shortly to pick her up. VS (vital signs) at that time were 136/72, (blood pressure), 97.3 (temperature), 75 (heart rate), 16 (respirations) 100% (oxygen level) on RA (room air). No s/s (signs or symptoms) of pain or discomfort noted. Percocet (narcotic pain medication) offered to resident at that time and resident stated, No I take too many pills right now. Name of emergency medical services arrived and assessed resident and also obtained VS (vital signs) WNL (within normal limits) except for slightly elevated pulse. Resident then stated that she was anxious. Name of emergency medical services left facility with resident and paperwork for [name of hospital]. Review of R1's progress note dated 12/3/24 at 10:02 AM revealed, Hospital called, and resident admitted to the hospital. Dx (diagnoses) of Bronchitis. Review of R1's progress note dated 12/4/24 at 22:30 (10:30 PM) revealed, Resident returned to facility per ambulance on stretcher. Review of R1's emergency room report dated 12/3/24 revealed, Patient started to experience chest pain across the center of her chest around 22:00 (10:00 PM). Symptoms lasted through the night until EMS (emergency medical services) was called. She was given aspirin and nitroglycerin, patient states her chest pain has resolved at this time. She noted a little shortness of breath. Of note, patient recently had orthopedic surgery at (name of hospital) for Achillies tendon lengthening. Surgery was on November 27. She has been bedridden, and leg has been wrapped ever since the procedure. Review of systems: Respiratory: positive for shortness of breath. Cardiovascular positive for chest pain. Gastrointestinal positive for nausea. Negative for vomiting. Review of R1's Percocet (narcotic pain medication) orders revealed on 12/3/24, Percocet 5-325 MG every 4 hours as needed for pain was discontinued after the last dose was given at 12:11 AM. Percocet 10-325 MG every 4 hours as needed for pain was ordered when she returned from the hospital. (increase in pain medication). R1 was observed on 2/6/25 at 12:45 PM receiving care. Certified Nurse Aides (CNA's) E and J, changed R1's brief and dressed her for an outside appointment. R1's buttock and peri area were bright pink. R1 and CNAs said her buttock had been excoriated for a long time. R1 had several creams and lotions in the room and sign on the wall indicating she was allergic to creams with zinc. R1 was hoping the dermatologist she was going to today would start a new treatment. R1 complained that she is incontinent and when she urinates it burns her buttock. R1 said her shoulder was a pain level of 4 out of 10, and her left arm and leg were both a 6 out of 10. R1 said she is always in pain and has never provided a pain score of zero. R1 talked about activities she used to like to do but said she can't sit up that long anymore. The CNA's confirmed R1 used to get out of bed more often and always reports being in pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a private interview with R1 in her room on 2/6/25 at 1:10 PM, R1 could not recall any specific details of the event on 12/3/24 at 4:30 AM when she called 911. R1 said she has called 911 more than one time because she doesn't feel she is getting her care timely and when she complains things only get worse. R1 was very focused on needing to get back into bed after physical therapy. R1 reported she had to stay out of bed for 4 hours or more on Friday January 31, 2025, and Monday February 3, 2025. R1 said she just spoke to the Therapy Director (TD) L, and he assured her next time he will help her get back into bed after therapy. R1 said she just can't sit in a wet diaper that long. R1 said she really wanted to be able to stand again so she would not have to use the mechanical lift to get into her wheelchair. She said she stood for 10 seconds in therapy twice and believed she would get stronger but was considering stopping physical therapy because it was too painful to stay up in her wheelchair that long. Review of R1's Medication Administration Record (MAR) for December 2024, revealed R1's pain was assessed by a nurse on 12/2/24 at 19:24 (7:24 PM) and her pain was recorded at 10 out of 10 (severe pain) that nurse provided R1 with a Fentanyl Transdermal Patch 72 hour/25mcg/hour.(narcotic pain medication). LPN I provided R1 with her Percocet Oral Tablet 5-325 MG on 12/3/24 at 12:11 AM and rated R1's pain at 8 out of 10 (severe pain). LPN I provided R1 with her Flexeril 5 mg table on 12/3/24 at 2:58 AM (not around 4 am as indicated in her facility statement) LPN I rated R1's pain as 8 out of 10 at 1:58 AM one hour prior to giving the Flexeril. LPN I did not confirm in her investigation statement that R1 had any complaints of pain on 12/3/24 prior to R1 calling 911, however LPN I documented twice prior to 4:30 AM that R1 had severe pain. LPN I documentation in R1's medical record did not match her statement she provided for the facility investigation. LPN I did document R1 has severe pain when she provided the Flexeril at 2:58 AM and she did not provide the as needed pain medication at 4:11 AM when she could have. LPN I did not offer additional pain medication until R1 called 911. Review of R1's pain assessments for R1 on 12/3/24 revealed that, LPN I rated R1's pain again on 12/3/24 at 2:33 AM and this time it was 6 out of 10 (moderate pain) This information was not located in the facility investigation. During a telephone interview with LPN I on 2/6/25 at 11:03 AM, LPN I recalled the event on 12/3/24 at 4:30 AM when R1 called 911 and complained of severe pain. LPN I recalled being interviewed by the facility and making a statement. The surveyor read her statement and LPN I confirmed that was her statement. LPN I did not recall assessing R1 earlier that evening as having pain scores of 8, and 6. LPN I could not recall which nurse was on when she arrived and denied being aware R1 had a pain score on 12/2/24 at 7:24 PM of 10 out of 10. LPN I was not sure about the timeline of events that evening. LPN I said she was aware R1 could have her Oxycodone every hour and she did not recall offering to provide R1 with another dose of Oxycodone until R1 had called 911 and R1 refused to take the Oxycodone at that time. (Oxycodone could have been given at 4:11 AM. R1 called 911 at 4:30 AM). During an interview with the Therapy Director (TD) L on 2/6/25 at 1:24 PM he confirmed that R1 attended therapy last Friday January 31 and Monday February 3, 2025. He confirmed that she was able to stand, and she seemed motivated to continue therapy. TD L said he just found out today that R1 was upset about not getting back to bed right after therapy and he did assure her next time he would assist staff getting back to bed after therapy. TD L was asked if R1 ever had a day where she was pain free and TD L said, no. he said he treated her shoulder earlier today and she reported it was a score of 7 out of 10 to start and after treatment she reported it was 4 out of 10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with R1's Family Member (FM) K, on 2/6/25 at 2:17 PM she recalled reporting to the Nursing Home on 12/3/24 that R1 was not getting her pain medication timely. FM K expressed frustration because she feels like when they complain things get worse. FM K said R1 has been in the hospital several times since that event. FM K said she has talked with R1 about hospice care because she does not have any quality of life there. FM K said R1 called her one of the days after therapy crying because staff would not put her to bed. She told her to put her call light on and when staff came in, they were very rude to R1, FM K said she knows her mom gets mad and is rude to the staff too. FM K said they talked and if staff will not get her back to bed after therapy she will have to stop because it is just too painful to sit up that long. FM K said she will decide to go into hospice if she can't get better care, she just can't live like this. Review of R1's pain care plan dated 11/11/19 with revision on 12/13/24 revealed, The resident has acute/chronic pain r/t arthritis and muscle spasms, will refuse all other intervention other than pain med (medication). Resident is reporting increased pain due to recent surgical procedure to lengthen Achilles tendon LLE (left lower extremity). Resident will describe horrible: pain to nursing staff and ask for pain medication, when staff returns, she has been asleep in bed, and on occasion has been difficult to arouse. Strained right shoulder ligament. Refused Sling. Goal: The resident will verbalize and/or exhibit that pain is at a tolerable level and not have pain interfere with daily routine through the review dated: target dated 4/15/25. (no indication of what level pain is tolerable). During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 2/7/25 at 10:30 AM, R1's pain assessments for 12/2/24 and 12/3/24 and her Medication Administration Records (MAR) were reviewed. They confirmed that LPN M had assessed R1 to have pain at 10 out 10 on 12/2/24 at 7:19 PM and no follow up pain assessment was completed until LPN I assessed her at 12:11 AM on 12/3/24 and she still was at a pain level of 8 out of 10. The NHA confirmed that she did not interview LPN M for the investigation related to R1's pain complaints and calling 911 on 12/3/24 at 4:30 AM. LPN M was the nurse that rated R1's pain as 10 out of 10 on 12/2/24 at 7:19 PM. They confirmed that LPN I also assessed R1's pain 12/3/24 at 1:59 AM to still be 8 out 10 and 12/3/24 at 2:33 AM to be 6 out of 10. They confirmed that LPN I did not indicate in her statement that R1 was experiencing severe pain the night of 12/3/24 when R1 called 911 at 4:30 AM. They confirmed that staff did not contact R1's provider when her pain was 10/10 and did not reassess her pain in a timely manner. The pain assessments also revealed several pain assessments that rated R1 as having zero pain. When asked to explain this documentation as the resident and multiple staff interviews indicated R1 is never pain free. The DON said if the resident is sleeping, they can use the nonverbal scale and document zero, if she reports she is comfortable they can document zero and the DON said as a nurse she has heard R1. The DON said she is heard R1 say she is comfortable and has reported to her she is not in pain. When asked what is R1's tolerable pain level the DON reviewed the pain care plan from 2019 and said R1 could tolerate pain levels of 8 and 10. The DON was not sure who completed that assessment or where it was located. The Surveyor requested all information related to pain assessments and her pain tolerance. Upon exit no evaluations indicating R1 could tolerate pain at 8 and 10 were provided. During the interview with the DON and NHA on 2/7/25 at 10:30 AM, the NHA said they were educated today on doing a thorough investigation and started educating nurses on pain.