

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 06/27/2025
NAME OF PROVIDER OR SUPPLIER Skld Zeeland		STREET ADDRESS, CITY, STATE, ZIP CODE 285 North State Street 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: MI00153297</p> <p>Based on interview and record review, the facility failed to ensure sufficient supervision and safety measures were in place to prevent an elopement for 1 of 4 residents (Resident #1) reviewed for accidents, safety, and supervision.</p> <p>Findings:</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: Alzheimer's Disease and psychotic disorder with delusions.</p> <p>Review of R1's Facility Reported Incident dated 3/27/25 (from R1's previous facility) revealed R1 had eloped . Resident exited the facility unsupervised at 0510 am. She exited the building through the left exit doors in the main dining room .</p> <p>Review of R1's Nursing admission Screening/History dated 3/27/25 revealed the reason for admission was elopement.</p> <p>Review of R1's baseline care plan section C revealed, MAY WANDER OR ATTEMPT TO LEAVE FACILITY UNATTENDED .</p> <p>Review of R1's Patient admission Information dated 3/27/25 revealed, Transfer from (name omitted) due to increase in elopement risk and need for secured memory care unit. She has had increased attempts to leave the facility .She has been able to be redirected but has been focused on going home leaving the building.</p> <p>Review of a Physician Assessment dated 3/28/25 revealed, .Lately, she has been exit seeking and has eloped .She was transferred from (name omitted) to (facility) to be placed in secure dementia unit .</p> <p>Review of R1's Wandering Scale dated 3/27/25 revealed R1 was at risk to wander and was not high risk to wander.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a maintenance work order dated 5/14/25 revealed an order for R1's room for hole in screen. The work order did not indicate the window lock system had broken.</p> <p>Review of R1's General Progress Note dated 5/14/25 revealed, Reception stated a neighbor saw a woman who looked confused in our courtyard. Upon investigation, we found the window in the residents' room (number omitted) open and the screen torn. Resident was found by staff in the courtyard .</p> <p>Review of the Facility Reported Incident revealed, Incident Summary On 05/14/2025, resident (R1) exited unattended through her bedroom window into the courtyard. The facility staff were notified through nearby neighbors at 6:15 pm and called a Code Yellow immediately. (Licensed Practical Nurse [LPN] C) located (R1) still within the enclosed courtyard fence on the property .</p> <p>Investigative Summary / Timeline: (Certified Nursing Assistant [CNA] D) was interviewed stating, The last time I saw (R1) was around 5 pm 5:30 pm because we had sat and got the residents together for them to eat dinner. She was walking around talking with the staff. I did not notice any exiting seeking, just making comments talking about the military, making comments about the staff and walking up and down the hall. I am not one-hundred percent sure that she ate her meal because she likes to get up and down and doesn't really sit still .During a second interview with (CNA D) she stated that she recalled observing the window open in (R1's) room during her shift on 5/14/2025 around her lunchtime, and she thought in hindsight it may have been fully ajar beyond the 4 inches. She communicated to the Maintenance Assistant that there was a hole in the window screen needing repair, but did not inform the Maintenance Assistant that the window was fully open or also in need of repair .</p> <p>Conclusion: Verified Through witness statements and physical evidence, it can be verified that (R1) exited out of her window unattended into the facility enclosed courtyard. As she exited through the window, there was no alarm to sound to notify of her exit. (R1) was last observed inside the facility around 6:00 pm on 5/14/2025. At 6:15 pm, staff responded to a notification through a nearby neighbor, indicating a woman was in the enclosed courtyard. Staff initiated a Code Yellow and responded immediately. (R1) was located and attended to by staff still inside the enclosed courtyard and was redirected successfully inside the facility at 6:25 pm with no concerns of injury or distress .</p> <p>Review of CNA D's Disciplinary Action Record revealed, On 5/14/25 around 1:45 pm, you discovered a residents window was open & unsecured. A work order was placed regarding the rip in the screen, but it was not indicated to the maintenance team that the window was unsecured/opened in the verbal interaction & work order. This resulted in a residents elopement from the unit .</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:</p> <p>The Quality Assessment and Assurance Committee met on 05/14/2025 and 05/15/2025 to review the incident and determined the following: This serves as the Facility's Plan of Correction in response to the allegation.</p> <p>The following action plan has been implemented:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Action taken for residents involved: A code yellow was immediate initiated with a head count of residents to ensure no other resident were affected. (R1) was assisted back inside by staff; vital signs were taken, and a head-to-toe assessment completed by the nurse. There were no signs of injury, distress, no skin alterations and vital signs were stable. A new wandering risk assessment was completed, and resident was coded as High Risk to wander. Upon returning to the facility, the window in her room was repaired, and resident was placed on a 1:1 safety attendant until her room was secured and .15-minute checks were initiated thereafter .</p> <p>Areas identified requiring quality improvement: Elopement policy was reviewed by the QAPI Committee, and determined Elopement policy was followed by facility staff. Through investigation and root cause analysis, it was identified that (R1's) window was observed by a CENA to be unsecured and a hole in the window screen prior to the incident. The hole in the window screen was communicated by the CENA to the Maintenance Assistant, however did not communicate the window being unsecured to maintenance. The Maintenance Assistant did not assess the hole in the window screen that was reported earlier in the shift prior to the incident.</p> <p>Area identified requiring quality improvement includes timely and thorough reporting, assessment, and repair of potential damage to windows, window screens, and exit doors.</p> <p>How facility identified resident(s) affected and residents with potential to be affected: An audit was completed by the Director of Nursing/designee on 5/16/2024 to ensure an elopement assessment for all current residents and new admissions. All residents have assessments in place. Like Residents were identified as residents residing in the facility at high risk for wandering. All residents identified as High Risk for wandering were reviewed by the DON/designee on 5/16/2025 to ensure Wandering Risk Assessments are up to date, and care plans and orders reviewed/revised as needed to ensure appropriate interventions and safety precautions were in place by 5/16/2025. Elopement Books were reviewed and updated by the Administrator/designee on 5/16/2025, and ensured books updated at each nurse station & reception.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Quality Improvement measures or systemic changes made: The Maintenance Director/designee completed an audit of all secured dementia unit windows for appropriate locking and security on 5/14/2025. All secured unit windows were properly locked and secured during audit. The Maintenance Director/designee completed an audit of all Main Unit windows for appropriate locking and security on 5/15/2025. All main unit windows properly locked and secured during the audit. The Elopement Policy was reviewed by the Administrator on 5/14/2025 and deemed appropriate. The Maintenance Director/designee completed an audit of all alarmed doors and panels to ensure appropriate labeling and sounding on 5/15/2025. All alarmed doors were properly function with appropriate identification during alarmed door during audit. Education was initiated by the Administrator/designee on 5/15/2025 for all facility staff on the Elopement Policy and Procedure, and on timely and thorough reporting, assessment, and repair of potential damage to windows, window screens, and exit doors. As of 5/21/2025, 129 out of 148 employees have been educated, and post-quiz completed. Any remaining staff will be educated prior to the start of their next shift. An Elopement Drill code yellow was conducted by the Maintenance Director/designee on 05/16/2025 and 05/21/2025. The Administrator/designee issued a disciplinary action to (CNA D) on 5/21/2025 due to failure to report the window being open earlier in the shift when notifying the Maintenance Assistant of the need to repair a hole in the residents window screen. The Maintenance Assistants were issued 1:1 Teachable Moment regarding any potential damage reported to windows, window screens, or exit doors. Maintenance will consider high priority and assess reported damage to any of these areas immediately upon receipt of request and will triage work required after thorough visual inspection.</p> <p>How facility monitors the effectiveness of its quality improvement measures (sustained compliance): Audits will be completed by the DON/designee on at least 5 residents weekly x4 weeks then monthly x2 months as directed by the QAA committee to ensure that the elopement policy remains implemented to assess resident risk for wandering, ensure appropriate interventions in place to reduce risk for elopement. Any concerns will be forwarded to the QAA committee for further review and recommendations as needed. Elopement Drills will be conducted by the Administrator/designee weekly x4 weeks then monthly x2 months as directed by the QAA committee to ensure appropriate staff response to potential elopement/missing resident. Any concerns will be forwarded to the QAA committee for further review and recommendations as needed. Security audits of windows will be conducted by the Maintenance Director/designee weekly x4 weeks then monthly x2 months as directed by the QAA committee to ensure windows are appropriately secured. Any concerns will be forwarded to the QAA committee for further review and recommendations as needed.</p> <p>Date of Completion: 5/19/2025</p> <p>The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		