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	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Zeeland	285 N State St Zeeland, MI 49464

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to promote resident dignity for 1 (R21) of two residents reviewed for dignity. Findings include: Review of an Admission Record revealed R21 admitted to the facility on [DATE] with pertinent diagnoses which included hemiparesis (muscle weakness or partial paralysis on one side of the body) and psoriasis (a skin condition in which skin cells build up and form scales and itchy, dry patches). Review of a Minimum Data Set (MDS) assessment for R21, with a reference date of 1/22/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R21 was cognitively intact. Further review revealed R21 required staff assistance with toileting. In an interview on 2/27/2025 at 8:22 AM, R21 reported she had a bowel movement the previous morning at 8:10 AM and pushed her call light. R21 reported Certified Nursing Assistant (CNA) J entered her room and she told him that she had soiled herself and needed to be changed. R21 reported CNA J instructed her she would have to wait until 8:30 or 8:45 to be changed because she had been changed at 6:30 and it had not been two hours yet. R21 reported she pressed her call light again and at 9:00 AM two CNAs entered her room to provide care. R21 reported she had been crying all day and the event made her feel like nobody cares. R21 reported being left in a soiled brief caused pain because of her chronic skin condition. In an interview on 2/26/2025 at 3:25 PM, CNA J reported he responded to R21's call light that morning at 8:00 AM and R21 told him that she was soiled and needed to be changed. CNA J reported he instructed R21 that she was on a two-hour schedule and not due to be changed yet and then left her room. CNA J reported that he discussed the incident with a unit manager at approximately 9:00 or 9:30 AM and the unit manager instructed him that residents needed to be changed immediately if they reported being soiled and could not be told to wait until later. In an interview on 2/27/2025 at 8:43 AM, Licensed Practical Nurse (LPN) E reported he had a discussion with CNA J the previous morning and instructed him that staff must check residents if they reported being soiled and could not wait two hours from the last time the resident was changed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/26/2025 at 3:38 PM, the Director of Nursing (DON) reported staff should not tell residents who reported being soiled that they have to wait 2 hours from the last time they were changed. The DON reported residents should be checked and changed at the time they reported being soiled. Review of facility policy/procedure Resident Rights, dated 7/11/2018, revealed .It is the policy of this facility that all residents be treated with kindness, dignity and respect . The staff shall display respect for Residents when speaking with, caring for, or talking about them .

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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** 45410 Based on observation, interview, and record review, the facility failed to implement dermatology recommendations in a timely manner for one resident (R21) of two residents reviewed for skin conditions. Findings include: Review of an Admission Record revealed R21 admitted to the facility on [DATE] with pertinent diagnoses which included hemiparesis (muscle weakness or partial paralysis on one side of the body) and psoriasis (a skin condition in which skin cells build up and form scales and itchy, dry patches). Review of a Minimum Data Set (MDS) assessment for R21, with a reference date of 1/22/2025 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R21 was cognitively intact. In an observation and interview on 2/25/2025 at 11:56 AM in room [ROOM NUMBER], R21 reported she had a rash, itching, and burning under her right breast that staff were not treating. R21 reported this was an ongoing issue and she had recently been to a dermatologist. This surveyor observed a large area of skin under R21's right breast to be bright red. Review of R21's Physician Orders active 2/26/2023 at 11:21 AM revealed no medicated creams, powders, or lotions were ordered to treat the rash under her right breast. Review of R21's offsite dermatology documentation dated 2/6/2025 revealed R21 was evaluated for psoriasis and given the following recommendations .Zinc Oxide Diaper Cream . Apply to groin, buttocks, and thighs . nystatin . topical powder . apply to affected areas under breast crease . Review of R21's Practitioner Short Progress Note, dated 2/14/2025 revealed dermatology recommendations were reviewed by Nurse Practitioner (NP) Q for zinc and nystatin. Further review revealed R21 was noted to have an allergy to zinc and the facility would follow up with dermatology to request alternative recommendations. In an observation and interview on 2/26/2025 at 12:10 PM, NP Q observed R21's skin with this writer and reported her psoriasis was flaring up. NP Q and this writer observed redness and inflammation of R21's skin under her breasts, between her legs, and on her buttocks. In the hallway, NP Q reported the resident saw dermatology a couple weeks ago and reviewed the dermatology documentation. NP Q stated the nystatin order was not placed and that nursing staff usually places these orders. NP Q stated R21 needed the nystatin and that it would be ordered. NP Q reported facility staff should have contacted the dermatology office to request alternative recommendations for the zinc when the recommendations were initially reviewed on 2/14/2025. In an interview on 2/27/2025 at 12:36 PM, the Director of Nursing (DON) reported she could not find documentation that R21's dermatology recommendations from 2/6/2025 had been addressed by the facility prior to this surveyor's conversation with NP Q on 2/26/2025. (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 facility policy/procedure Skin Monitoring and Management-Non-PU, dated 7/11/2018, revealed .It is the policy of this facility that a resident having areas of skin breakdown . receive necessary treatment and services to promote healing, prevent infection, and prevent new non-pressure sores from developing .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on observation, interview, and record review, the facility failed to ensure proper tube feeding precautions were implemented and maintained for one resident (R37) of two residents reviewed for enteral feeding. Findings: Review of the Electronic Medical Record (EMR) reflected R37 originally admitted to the facility on [DATE] with diagnoses that included a history of stroke, dementia, and was receiving nutrition through a feeding tube. Review of the Doctor's Orders dated 2/14/25 for R37 reflected an enteral feed order and the Medication Administration Record (MAR) reflected or Glucerna 1.5 to be delivered at 100 cubic centimeters (cc) per hour. On 2/25/25 at 9:28 AM, a dressing change for R37 was observed in the Resident's room with Licensed Practical Nurse (LPN) R and Unit Clerk (UC) T. It was observed that the head of the bed was elevated approximately ten degrees and R37 was turned onto his left side during the dressing change that lasted approximately fifteen minutes. It was observed that the enteral feeding pump was infusing at the prescribed rate of 100 cc per hour during the wound dressing change. Following the dressing change the head of the bed of R37 was not increased from the lowered position The policy provided by the facility titled Subject: Enteral Nutrition-Resident. Dated 7/11/2018 was reviewed. The review reflected Policy: It is the policy of this facility that the nurse, in cooperation with other health team members, must carefully monitor the resident's response to the feedings and feeding techniques to assure the attainment of therapeutic goals. And Procedure: General monitoring of nursing care should include: 1. Head of bed should be elevated at a 30-45 degree angle during feeding and for at least one (1) hour after feedings completed to prevent gastric reflux and possible aspiration. On 2/26/25 at 11:59 AM an interview was conducted with LPN R in her office. The dressing changed observed 2/25/25 at 9:28 AM was reviewed. LPN R was asked why the tube feeding was not suspended during the dressing change when the head of the bed was lowered, and the Resident was turned on his side. LPN R stated Is that policy? The proper angle of the bed for tube feeding was discussed. LPN R reported that R37 has remotes (bed controls) and the Resident can adjust the angle of his bed on his own. The undated document titled Job Title (job description) Charge nurse-RN/LPN provided by the facility was reviewed. The document reflected Principal Duties and Responsibilities: which included: Provide care to Residents by performing a variety of treatments, including changing dressing, cleansing and/or irrigating wounds and incisions, performing Foley Catheter irrigations, IV therapy, and administering tube feedings, chest tubes and peritoneal dialysis. And Know and support facility philosophy, standards, policies, and procedures

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on observation, interview, and record review, the facility failed to ensure infection control measures were maintained during a dressing change for one resident (R37) of three residents reviewed for infection control. Findings: Review of the Electronic Medical Record (EMR) reflected R37 originally admitted to the facility on [DATE] with diagnoses that included a history of stroke and dementia, Review of the EMR Progress Notes entry dated 1/28/25 at 2:32 AM reflected a three-centimeter (cm) lump was identified at the hairline of the neck of R37 and the medical provider was notified. On 2/5/25 the Progress Note entry at 3:39 PM reveal a change in the lump and R37 was transported to the hospital for evaluation. On 2/13/25, R37 returned from the hospital with a wound vac dressing (also known as vacuum assisted closure (VAC), a medical device sealed over a wound that uses negative pressure to pull fluid and debris out of the wound promoting granulation tissue growth). The entry reflected R37 was referred to a wound care provider for wound management. Review of the Doctor Orders dated 2/24/25 for R37 reflected the wound vac dressing system was ordered to be changed and to cleanse the wound with Dakins solution prior to wound vac placement every Tuesday, Thursday, and Saturday. On 2/25/25 at 9:28 AM a dressing change for R37 was observed in the Resident's room with Licensed Practical Nurse (LPN) R and Unit Clerk (UC) T. It was observed that the head of the bed was elevated approximately ten degrees and R37 was turned onto his left side to expose the wound vac dressing. UC T supported R37 as the Resident lay on his left side. Wound re-dressing supplies were assembled on a small tray on an over- the- bed table. No barrier was on the over-the-bed table and a pair of scissors, and a large piece of wound film lay directly on the table. LPN R was observed preparing the wound for redressing by cleaning the wound and the perimeter with the prescribed solution and wiping with 4 x4 inch gauze then discarding the blood-tinged gauze. LPN R retrieved the large piece of adhesive film from the unprotected table and used the un-sanitized scissors to cut a piece of adhesive film to size to cover the wound. The cut piece was placed on the small tray next to a piece of black foam that was be inserted in the wound bed. At this point UC T prompted a glove change as LPN R had not degloved after cleaning and wiping the wound area. LPN R donned new gloves without hand sanitizing and retrieved the black foam from the small tray and placed it inside the open the wound. LPN R then covered the wound with the cut film and used the un-sanitized scissors to poke a hole in the film for the wound vac device and placed the scissors back on over-the-bed table. The procedure required another piece of film to be cut from the remaining sheet of film that also rested on the undraped table. Without changing gloves, a newly cut piece of adhesive film was placed over the wound site to complete the dressing change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 11:59 AM an interview was conducted with LPN R in her office. In review of the dressing change observed 2/25/25 at 9:28 AM, LPN R acknowledged that UC T had prompted her to change her gloves. LPN R reported this was because one of the gloves had ripped and did not acknowledge degloving was indicated after irrigating and cleansing the wound with wet gauze. LPN R acknowledge the scissors should have been sanitized and placed in a different location during the dressing change. The undated document titled Job Title (job description) Charge nurse-RN/LPN provided by the facility was reviewed. The document reflected Principal Duties and Responsibilities: which included Understands Infection Control and follows the Company's Infection Control guidelines, such as hand washing principles, understanding of isolation and standard precautions, recognizing signs and symptoms of infection, demonstrating and understanding of the process for identifying and handling infectious waste and cross contamination .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting the following areas: Findings include: Rooms 409/411 During an observation on 2/25/25 at 9:52 AM and 12:17 PM, room [ROOM NUMBER] had a shared bathroom with room [ROOM NUMBER]. Inside the bathroom was a dirty exhaust fan and an oxygen concentrator with a nasal canula connected to it stored under the sink. During observations on 2/26/25 at 7:34 AM and 9:22 AM rooms 409/411 still had the oxygen concentrator in the bathroom with the nasal cannula attached to it. During an observation and an interview on 2/27/25 at 9:30 AM, Certified Nursing Assistant (CNA) B accompanied this surveyor to the connected bathroom for rooms 409/411 and saw the oxygen concentrator with the nasal cannula attached, stored under the sink next to the toilet. The toilet was grossly soiled with stool splatters all over the seat and rim. A bedside commode pan was stored on the floor between the toilet and under the sink next to the oxygen concentrator, with a used brief inside. CNA B reported that the oxygen concentrator belonged to the resident in room [ROOM NUMBER] and confirmed the bathroom should not look like that and the concentrator should not be stored there. The CNA also confirmed the bathroom exhaust fan was very dusty. Rooms 404/406 During an observation on 2/25/25 at 12:38 PM, room [ROOM NUMBER] had a shared bathroom with room [ROOM NUMBER] for four residents. Several mixed toiletries and personal items in the bathroom were gathered on the sink and the shelf above the sink. No labels on any of the items observed. During observations on 2/26/25 at 7:34 AM and 9:24 AM rooms 404/406 had several personal mixed toiletries in the shared bathroom on the sink and the shelf above the sink. During an observation and an interview on 2/27/25 at approximately 9:45 AM, CNA B went with this surveyor to the shared bathroom for rooms 404/406. Several toiletries were on the sink and shelf above it, including 3 opened and used packets of ointment, deodorants, lotions, soaps, and various other items. One large bottle of lotion had a resident's name on it. CNAs B and C stated that residents' toiletries should be stored in their designated areas after use. Both CNAs mentioned the bathroom should not appear as it did and that the ointment packets should have been discarded. They also confirmed that the bathroom exhaust fan was very dusty. 38905 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a tour of the Gilead Pantry, at 9:55 AM on 2/25/25, an odor of sewer gas was present upon entering the room. Further evaluation found a floor drain in the back right corner of the room tucked behind the fridge that was allowing sewer gas to flow back into the space due to an evaporated pee-trap. Evaluation of the sink found a residential spray wand on the back. The spray wand has the potential the be pulled out and lay below the overflow rim of the sink creating a cross connection between the potable and wastewater supply. During a tour of the facility, at 1:01 PM on 2/25/25, it was observed that supplies from the activity department were stored underneath the wastewater line of the sink in the cafe. Observation found debris and staining from an old leak as well as a vase fake flowers stored. During a tour of the facility, at 1:22 PM on 2/25/25, observation underneath the dining room sink found stored activity supplies. These items were stored under and around the wastewater line of the sink. vases, fake flowers, sponges. During a tour of the Gilead dining room, at 2:08 PM on 2/25/25, it was observed that numerous items were stored underneath the sink's wastewater line. These items were vases, a bag of cookie cutters, totes of supplies and containers of decorations. 45410 Resident #89 In an observation and interview on 2/25/2025 at 10:35 AM in room [ROOM NUMBER], Resident #89 (R89) reported staff never cleaned his room. R89 stated, I have to clean my own room. During this interview the floor was littered with food crumbs and scattered sticky areas where liquids had dried, including what appeared to be dried drops of blood scattered around the entire room. In an observation and interview on 2/26/2025 at 8:49 AM in room [ROOM NUMBER], the floor was littered with food crumbs and the same dried red areas that were present on 2/25/2025. R89 reported his room had not yet been mopped. In an observation and interview on 2/27/2025 at 9:18 AM in room [ROOM NUMBER], the floor was littered with crumbs and the same dried red substance was on the floor from the previous two days. Housekeeping Aide K observed the floor with this surveyor and confirmed the presence of the dried red substance on the floor. The spots disappeared immediately as Housekeeping Aide K used a wet mop to clean the floors.