STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235365	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Livonia	29270 Morlock Livonia, MI 48152

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34208 Based on observation, interview, and record review the facility failed to ensure treatment and services were provided in a dignified manner for eight residents, (R#'s 20, 70, 10, 76, 17, 13, 5, and 405) of eight residents reviewed for dignity. Findings include: R20 On 1/13/25 at 1:19 PM, R20 was observed in the Rainbow dining room in their geri-chair (reclining lounge chair). R20 was being fed their lunch meal by CNA (Certified Nurse Aide) 'B'. At the conclusion of the meal, CNA 'B' was observed to transport R20 down the hall in their geri-chair by pulling the chair in a forward motion with the chair and R20 facing rearward. On 1/13/25 at 1:22 PM, CNA 'B' was asked about pulling R20 backward in the geri-chair and said sometimes the wheels on the chair drift from side to side. They were asked if they were instructed to pull the chair with the resident facing rearward and they said no, the resident should face forward and the chair should be pushed from behind. On 1/14/25 at 4:10 PM, an interview was conducted with the Director of Nursing (DON) regarding the proper way to transport a resident in a wheelchair or geri-chair and they said the resident should be facing forward and pushed in a forward motion. R70, R10, R17, R13, R5, R405, R76 On 1/13/25 from 12:50 PM to 1:31 PM, an observation of the Rainbow dining room was conducted and eight residents were seated at six tables in the room. Certified Nurse Aide 'D' was overheard requesting bibs (clothing protectors) be brought to the dining room to be placed on residents prior to the lunch meal being served. Further observations included: At 12:59 PM, R70 was sleeping in their wheelchair at the table with their lunch meal in front of them. R10 was seated across from R70 but did not have a meal tray. At 1:05 PM, one-to-one feeding assistance was being provided to R76. R17 was seated across from R76 but was not served a meal. CNA 'E' was observed providing one-to-one feeding assistance to R13, but was observed to leave R13 in the middle of the meal to set up R5's meal tray. (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 - Some	At 1:23 PM, R70 remained asleep in their wheelchair with their meal in front of them, R10 was seated across the table and was provided a meal tray more than twenty minutes after R70. At 1:28 PM CNA 'E' attempted to provide one-to-one assistance to R70 a half an hour after their meal had been served but R70 refused. On 1/14/25 from 12:35 PM until 1:03 PM, a second dining observation was conducted in the Rainbow dining room. Nine residents were observed seated at six tables and two CNA's were present passing the trays, setting up the meals and providing one-to-one feeding assistance. At 12:46 PM, R70 was provided a meal tray and R405 seated across the table. They had fallen asleep in their wheelchair and was not provided their meal until 12:55 PM. R70 was fidgeting with their meal ticket making no attempts to feed themselves. R17 had also been served a meal tray but was making no attempts at feeding themselves. At 12:50 PM, CNA 'F' was providing one-to-one feeding assistance to R76 and CNA 'G' was providing one-to-one assistance to R20. R70 had a meal tray in front of them but was making no attempts at feeding themselves and two residents. R405 and R5 were not provided a meal tray while the rest of the diners either received assistance or fed themselves. At 12:55 PM, CNA 'F' was observed to leave R76 in the middle of the meal to serve and set up R405's tray before returning to R76. At 12:56 PM, R5 was the only resident in the dining room who had not received a meal tray. It was overheard the meal had been delivered to the hallway and CNA 'G' left the dining room to retrieve the tray. R70 remains with a tray in front of them fidgeting with their meal ticket and staff were not observed to be available to cue them or provide one-to-one assistance. At 12:59 PM, CNA 'G' began providing one-to-one feeding assistance to R17, more than ten minutes after their meal had been served. At 1:06 PM, CNA 'F' was observed to transport R76 from the dining room. It was observed their meal tray contained an unopened ice cream and an unopened yogurt. At 1:13 PM, CNA 'F' was asked why they did not offer those meal items to R76 and said they should have. They were then asked if they had enough help in the dining room to provide the one-to-one feeding assistance and cueing and said, they did not and that was why they were, all over the place in the dining room On 1/14/24 at 4:10 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the observations in the dining room. The DON acknowledged the concerns and indicated the dining process for individuals requiring more assistance and cueing was an ongoing process. A review of a facility provided document regarding Resident rights, dignity, and respect was conducted and read, It is the policy of this facility that all residents be treated with kindness, dignity, and respect .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 Based on observation, interview, and record review, the facility failed to maintain the call light within resident reach for one (R22) of six residents reviewed for call light access. Findings include: Review of the facility record for R22 revealed an admitted [DATE] with diagnoses including Anorexia, Cirrhosis of the Liver, and Diabetes Mellitus. The record further indicated R22 was receiving hospice services. On 01/14/25 at 10:25 AM and12:09 PM, R22 was observed laying in bed. They were not responsive to verbal greetings. The resident's call light was observed laying on the floor under the head of the bed out of reach. On 01/14/25 at 02:28 PM and 3:18 PM, R22 was observed laying in bed and the call light remained on the floor under the head of the bed after staff had been observed in the room assisting the resident. On 01/15/25 at 08:50 AM, R22 was observed laying in bed trying to call out for help. They were interviewed at bedside and asked for help stating that their hip was hurting. The call light was observed laying on the floor under the head of the bed out of reach as it was the previous day. R22 was asked if they know how to use the call light to request assistance and they stated yeah I can use it but I don't have it. On 01/15/25 at 10:50 AM, the facility's Director of Nursing (DON) was was made aware of the concern regarding R22's call light not being accessible during multiple observations. The DON reported the expectation is resident's call lights should be kept within reach at all times. Review of the facility policy Call Lights dated 07/11/18 revealed the policy statement It is the policy of this facility to provide the resident a means of communication with nursing staff. The Procedure portion of the policy includes the entry 7. Be sure call lights are placed within reach of residents who are able to use it at all times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review the facility failed to ensure bathing and hair care was completed and facial hair removed timely for six residents (R34, R57, R63, R84, R99) of six residents reviewed for activities of daily living (ADL) care. Findings include: R57 A review of the facility records for R57 revealed R57 was admitted into the facility on [DATE]. Diagnoses included Need for assistance with Personal Care, Above the knee leg amputations, and Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] indicated intact cognition and the need for partial/moderate assistance of one person for personal hygiene, substantial/maximal assistance to roll left and right and dependent to go from sitting to lying. The shower/bath self was documented as not attempted due to medical condition or safety concerns. The care plan revised 01/02/25 documented, Resident has an ADL self care performance deficit . A review of the shower task in the electronic medical record on 01/14/25 documented three showers attempted in 30 days: 01/01/25 was a bed bath; 12/25/24 was a bed bath; and 12/21/24 was documented as refused. Paper shower sheets documented bathing on 01/11/25, 01/08/25 and 12/14/24. Six of eight possible showers were documented or attempted. The task documented showers were to be given Wednesdays and Saturdays in the evenings. R63 On 01/13/25 through 01/15/25, R63 was not observed out of bed. A review of the facility record for R63 revealed R63 was admitted into the facility 10/23/24. Diagnoses included Stroke, and Bone and Muscle Disorders. The MDS dated [DATE] documented impaired cognition and the need for partial/moderate assistance of one person for personal hygiene, substantial/maximal assistance to roll left and right and dependent to go from sitting to lying. The shower/bathe self was documented as not attempted due to medical condition or safety concerns. The care plan revised 11/08/24 documented, Resident has an ADL self care performance deficit . A review of the facility records and tasks on 01/14/25 revealed five of eight showers were documented or attempted in thirty days: 12/18/24 was refused, a bed bath 12/25/24; 01/01/25 was documented not applicable; a bed bath on 01/4/25, and a bed bath on 01/09/25. Shower sheets were provided for 10/30/24, 11/27/24, 11/30/24, 12/07/24, 12/11/24 and 12/14/24. No additional shower sheets were provided to substantiate showers were given. The task documented showers were to be given Wednesdays and Saturdays in the evenings. R84 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/25 at 10:24 AM, R84 was observed to be dressed and seated in a wheelchair at the left side of the bed. R84 reported they had not always received fresh water and the cream for their buttocks wound was not applied as often as it was supposed to be. A review of the facility record for R84 revealed R84 was admitted into the facility 12/16/24. Diagnoses included Age Related Physical Debility and Myasthenia Gravis. The MDS dated [DATE] documented intact cognition, impaired range of motion of both upper extremities and the need for partial/moderate assistance of one person for personal hygiene, to roll left and right and to go from sitting to lying. The shower/bathe self was documented as not attempted due to medical condition or safety concerns. The care plan revised 01/06/25 documented, Resident has an ADL self care performance deficit . A review of the facility records and tasks on 01/14/25 indicated five of eight showers were documented in the last thirty days: 12/18/24 was a shower, 12/21/24 was refused; 12/25/24 was a bed bath; 01/01/25 was documented refused; 01/11/25 was a shower. Shower sheets were provided for 12/18/24, 12/21/25, and 12/25/24. The task documented showers were to be given Wednesdays and Saturdays in the evenings. R99 On 01/14/24 at 12:36 PM, a visitor for R99 reported concerns with R99 left in the same socks for three days; R99's feet were dependent all day which caused a dusky purple appearance. A review of the facility record for R99 revealed R99 was admitted into the facility 12/06/24. Diagnoses included Stroke with affected right dominant side and Cerebral Palsy. The MDS dated [DATE] documented impaired cognition and the need for partial/moderate assistance of one person for personal hygiene, substantial/maximal assistance to roll left and right and to go from sitting to lying. The shower/bath self section was documented as substantial/maximal assistance. The care plan initiated 01/07/25 documented, Resident has an ADL self care performance deficit . A review of the electronic shower documentation on 01/14/24 for the last thirty days revealed: showers were documented 12/16/24, 12/19/24, 12/23/24, and 12/26/24. 12/30/24, 01/06/25, 01/09/25 were documented as not applicable. Mondays and Thursdays were the indicated shower days which indicated ten opportunities since Friday 12/06/24. Four showers were documented as attempted or completed. On 01/15/25 at 12:11 PM, the Director of Nursing (DON) acknowledged a resident scheduled for a bath two times a week should be provided a bath two times a week and the completion or attempt documented. 34208 R34 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 10:28 AM, R34 was observed in their room sitting on their bed with a one-to-one sitter. R34's long, gray hair was not combed and had a greasy appearance. They were further observed to have long, thick, facial hairs covering their chin. They were asked if they would like the hair removed and said they wanted to get rid of them but nobody would help. On 1/14/25 at approximately 9:30 AM and 1:40 PM, R34 was observed in their room. Their hair remained uncombed, greasy in appearance and their face remained with thick, long facial hair on their chin. On 1/14/25 at 9:16 AM, a review of R34's clinical record revealed they admitted to the facility on [DATE] and most recently readmitted on [DATE]. R34's diagnoses included: toxic encephalopathy, cirrhosis, dementia, and anxiety disorder. The most recently completed Minimum Data Set (MDS) assessment dated [DATE] indicated R34 had severely impaired cognition, exhibited no hallucinations, delusions, behaviors, or rejection of care, and required mostly moderate assistance from staff for ADL's. A review of R34's Certified Nurse Aide (CNA) task for showers for a 30-day look-back revealed they were scheduled for showers on Tuesdays and Fridays but had only received one bed bath for the 30-day look-back period. The documentation reviewed did not indicate R34 had their hair shampooed or was assisted with the removal of facial hair. A review of R34's CNA task for behaviors for a 30-day look-back period was also conducted and did not document any behaviors. Further review of the record included progress notes, however; no progress notes dating back to November 2024 revealed any documentation to indicate R34 had been offered and refused any ADL care. On 1/14/24 at 12:15 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R34's ADL care. The DON indicated R34 frequently refused the care offered and would fight with the staff. They were asked about the lack of documentation to demonstrate the ADL care had been offered, attempted, and refused by R34 and said staff would have to do better documenting attempts at care, rejection of care, and behaviors. A review of the facility policy titled, Charting and Documentation Adopted 07/11/2018, revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting . A review of the policy title, Shaving adopted 07/11/2018 revealed, It is the policy of this facility to improve the resident's appearance. In accordance with the resident's preference.

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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** 32220 Based on observation, interview and record review the facility failed to complete wound care per the physician order for one resident (R84) of one reviewed for wound care. Findings include: On 01/13/25 at 10:24 AM, R84 was observed to be dressed and seated in a wheelchair at the left side of the bed. R84 reported the cream for their buttocks wound was not applied as often as it was supposed to be. A review of the record documented a physician order dated 01/07/25 which revealed, R (right) buttock: Cleanse with NS (normal saline), apply triad, cover with border gauze. BID (two times a day) /PRN (as needed); every day and night shift for treatment. On 01/14/25 at 11:33 AM, a skin and wound observation of R84's right buttock was conducted with the wound care nurse. A dressing was not observed to be in place. A quarter size open area was observed. The wound nurse applied a dressing to the wound area. The dressing was dated for 01/14/25 and had the initals of the wound care nurse. A review of the January 14, 2025 Treatment Administration Record (TAR) revealed the dressing change had been documented as done by the night shift nurse. On 01/15/25 at 9:11 AM, the right buttocks area and dressing for R84 were observed with Registered Nurse (RN) H. The dressing was observed to be the dressing placed by the wound nurse on 01/14/25. A review of the January 15, 2025 Treatment Administration Record (TAR) revealed the dressing change had been documented as done by the night shift nurse. Review of the December 2024 TAR revealed missing documentation for completion of the right buttocks treatment. On 01/15/25 at 12:06 PM, the Director of Nursing (DON) reported the order should not have been written as two times a day and the facility had made attempts to ensure orders were not written that way unless specifically requested by the physician. The DON further noted audits of documentation were being completed. A review of the audits indicated they were checking for missing documentation. R84's wound care was documented as done but not completed and would not have been caught with only a chart review. A review of the facility record for R84 revealed R84 was admitted into the facility 10/23/24. Diagnoses included Age Related Physical Debility and Myasthenia Gravis. The MDS dated [DATE] documented intact cognition, impaired range of motion of both upper extremities and the need for partial/moderated assistance of one person for personal hygiene, to roll left and right and to go from sitting to lying. The care plan revised 01/06/25 documented, Resident has an ADL self care performance deficit . A review of the facility policy titled, Dressings, Non-Sterile adopted 07/11/2018 revealed, It is the policy of this facility to perform treatments and dressing changes per physician orders. A review of the facility policy titled, Charting and Documentation Adopted 07/11/2018, revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care; c. The assessment data and/or any unusual findings obtained during the procedure/treatment; d. How the resident tolerated the procedure/treatment; e. Whether the resident refused the procedure/treatment; f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208 Based on observation, interview, and record review, the facility failed to ensure application of palm protector devices for one resident (R76) of two residents reviewed for restorative services, resulting in unprotected palm of hand from contracted fingers. Findings include: On 1/13/25 at 10:05 AM, R76 was in their room in their wheelchair. An observation of the left hand revealed a contracture (shortening of mucles causing joints to stiffen) of second, third, fourth, and fifth finger. A device to protect the palm or prevent the worsening of the contracture was not observed in use, and a splint was observed on the dresser. On 1/13/25 at 10:54 AM, an interview was conducted with R76's family member and durable power of attorney. They said they were concerned about R76's left hand contracture and the potential for their fingernails to cause a wound in the palm. They said the staff were supposed to use a splint and or some device in the hand to prevent the worsening of the contracture or the development of a wound. On 1/13/25 at 11:20 AM, 12:36 PM, 4:42 PM, and 1/14/25 at 7:53 AM, R76 was observed with no splint or device in their palm. On 1/13/24 at 3:28 PM, R76 was observed in their room seated in their wheelchair. A splint or device to protect the palm was not present. With R76's Durable Power of Attorney's permission and R76's permission, an observation of their palm was conducted. R76 was able to slightly open and unclench their fingers from their palm and a reddened, small open area where the index finger nail met the palm was observed. R76's fingernails were discolored with debris under the nail bed, extended approximately a quarter of an inch beyond the nail bed, and were filed in a square fashion that gave them sharp edges. A foul odor was noted when R76's hand was opened. R76 was asked if they had any pain and made a grunting noise and nodded their head yes. On 1/14/25 at 9:59 AM, R76's fingernails remained long, discolored, with debris under the nail bed and filed with sharp edges. They were asked if their palm still hurt and nodded saying, still hurts. A review of R76's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: rectal cancer, drug induced subacute dyskinesia (uncontrollable involuntary movements), profound intellectual disabilities, autistic disorder and moderate intellectual disabilities. R76's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed they had severely impaired cognition. R76's physician orders were reviewed and an order dated 5/21/24 read, Apply foam roll in between left hand during daytime, remove at night. A review of R76's most recent Occupational Therapy Discharge Summary for service dates of 5/21/24 thru 8/1/24 was conducted and read, Patient Goals .L. digit contraction of digit 3,4,5 .continued hand splinting a must daytime foam roll and night time resting hand splint . On 1/14/25 at 10:10 AM, an observation of R76's hand was conducted with Wound Care Nurse 'I'. Nurse 'I' observed R76's fingernails and palm and confirmed the presence of odor and a new wound to the palm. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note entered into the record on 1/14/25 at 4:07 PM, by Wound Care Nurse 'I' was reviewed and read, .Writer completed skin observation to (L) (left) hand(contracture) with nails causing tear. Odor noted. Writer cleansed applied Bacitracin/4x4 gauze hand roll. Writer to follow with wound care. On 1/14/25 at 12:15 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R76's left hand contracture, splint, palm protector, fingernails, and development of a wound. The DON confirmed R76 was to have a splint at night and a foam roll or other device to protect the palm during the day. When made aware R76 had not been observed with any devices in place on 1/14/25 they had no explanation. They were then asked about the square nails with sharp edges and said family manicured them that way. They were asked if the family had been educated on the hazards of the nail shape and replied they should have been. They were next asked about the length of the nails and the odor in the palm and said staff should have noticed the condition of the hand and nails and addressed it. A review of a facility provided document, Subject: Restorative Care was conducted and read, It is the policy of this facility to ensure that: Restorative care will be provided to each resident according to his/her individual needs and desires as determined by assessment and interdisciplinary care planning. The resident will receive services to attain and maintain the highest possible mental/physical functional status and psychosocial well-being defined by the comprehensive assessment and plan of care .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 Based on observation, interview, and record review, the facility failed to maintain the resident's water cup within reach for one resident (R22) of five residents reviewed for access to water. Findings include: Review of the facility record for R22 revealed an admitted [DATE] with diagnoses including Anorexia, Cirrhosis of Liver, and Diabetes Mellitus. The record further indicated R22 was receiving hospice care services. On 01/14/25 at 10:25 AM, R22 was observed laying in bed. They were not responsive to verbal greetings. A water cup was observed on the nightstand out of the resident's reach. There was a fall mat on the floor between the bed and the nightstand. On 01/14/25 at 12:09 PM, R22 was interviewed as they were laying in bed. It was observed R22's water cup was on the nightstand out of reach. R22 was asked if they would like to be able to reach their water cup without assistance and they stated yes. On 01/14/25 at 02:28 PM, R22 was observed laying in bed. The water cup was on an over-bed table at the foot of the bed out of the resident's reach after staff were observed in the room assisting the resident with their lunch. Further review of R22's record revealed the 12/03/24 care plan Focus area statement The resident has dehydration or potential fluid deficit related to Hepatitis, Diabetes Mellitus, history of Adult Failure to Thrive. This focus area included the Goal statement Resident will be free of symptoms of dehydration and maintain moist mucous membranes. The Interventions portion of the focus area included the entry Encourage the resident to drink fluids of choice. R22's record revealed no indication the resident should not have access to their water cup. On 01/14/25 at 03:18 PM, R22's water cup remained on the over-bed table out of reach near the foot of the bed. On 01/15/25 at 08:50 AM, R22 was observed laying in bed. R22's water cup was observed on the over-bed table at the foot of the bed, out of reach. There was a fall mat on the floor to the right of the bed and there was approximately 20 inches of space between the left side of the bed and the wall that would accommodate the over-bed table in order to have the water within the resident's reach. R22 was asked if they would like to have access to their water cup and they stated yes. On 01/15/25 at 10:55 AM, the facility Director of Nursing (DON) was informed of the concern regarding R22's water not being accessible while having a care plan item specific to dehydration risk and asked if they were aware of any reason that the water was not being kept within the resident's reach. The DON acknowledged that they were not aware of a care-planned or clinical reason for the water to not be accessible but indicated staff may be placing it out of reach due to a history of the resident spilling water. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235365	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Livonia	29270 Morlock Livonia, MI 48152

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Hydration dated 07/11/18 revealed the policy statement It is the policy of this facility to encourage fluid intake to maintain resident's hydration in compliance with physician orders. The Procedure portion of the policy includes the entry 2. Every resident will be provided fresh ice water every shift. and 3. Fluids will offered at a minimum of every two hours for the dependent resident, unless contraindicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34208 Based on observation, interview, and record review, the facility failed to ensure a medication error rate less than five percent when two errors were made, from 27 opportunities resulting in a medication error rate of 7. 41% for one resident, (R39) of four residents reviewed for medication administration. Findings include: On 1/14/25 at 8:20 AM, Nurse 'A' was observed preparing medications for administration to R39. Nurse 'A' prepared multiple medications including an oral folic acid supplement 400 mcg (micrograms). After preparing the medications Nurse 'A' proceeded to the room and administered the medications to R39. After R39 took the medications Nurse 'A' exited the room and signed the medications as given on the eMAR (electronic medication administration record). They were asked to confirm all medications due at that time had been administered and confirmed they were. On 1/14/25 at 8:52 AM, R39's medications observed administered were reconciled (compared) with their physician's orders. It was discovered R39's order for folic acid was for 1 mg (milligram). It was further discovered R39 had an order for cyanocobalamin (Vitamin B12) 1000 mcg due at the 9 AM medication pass, however; it was not observed the medication had been prepared and administered to R39 at that time. A review of a facility provided policy for medication administration updated 12/2019 was reviewed and read, . It is the policy of this facility that medications shall be administered as prescribed by the attending physician .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235365	A. Building B. Wing	01/15/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34208 Based on observation, interview, and record review, the facility failed to ensure proper hand hygiene during care for four residents (R82, R70, R76, and R5) of four residents reviewed for hand hygiene and infection control, resulting in the potential for the spread of infection. Findings include: R82 On 1/13/25 at 9:03 AM, Nurse 'C' was observed preparing medications at the medication cart in the hallway for R82. They were not observed to perform hand hygiene prior to beginning to prepare the medications. Nurse 'C' prepared multiple medications including an ordered 81 milligram aspirin tab. Two aspirin tabs were deposited from the bottle into the cap for transfer to the medication cup. Nurse 'C' was observed to remove the second tab from the bottle cap with their bare hands and placed it back in the aspirin bottle. When the medication preparation at the medication cart was complete, Nurse 'C' entered R82's room, and was not observed to perform hand hygiene upon entry. They administered the medications, and at that time, R82 requested a medication for pain. Nurse 'C' exited the room and returned to the medication cart to prepare the pain medication. They were not observed to perform hand hygiene upon exiting the room prior to preparing the pain medication. Nurse 'C' deposited two of the pain medication pills from the bottle into the lid of the bottle for transfer into the medication cup. R82 was only to receive one pill and Nurse 'C' was observed to grab the second pill from the bottle cap with their bare hands and place it back into the bottle. Nurse 'C' returned to R82's room to administer the medication and again was not observed to perform hand hygiene prior to administering the medication. On 1/13/25 from 12:50 PM until 1:31 PM, an observation of the Rainbow dining room was conducted and the following was observed: Certified Nurse Aide (CNA) 'D' was observed to place clothing protectors on R70, R76, and R5. They were not observed to perform hand hygiene in between contact with the different residents. They were further observed to straighten R70's hair then sit down to provide one-to-one feeding assistance to R76 without performing hand hygiene. CNA 'D' finished assisting R76 and moved to assist R17, they were not observed to perform hand hygiene after touching R76's utensils, plate, and napkins prior to assisting R17. The dining room was observed without a hand washing sink or dispenser for hand sanitizing gel/foam. On 1/14/25 at 4:10 PM, the infection control observations were discussed with the Director of Nursing. They indicated hand hygiene should be conducted in between resident contacts and pills should not be touched with bare hands. A review of a facility provided document, Subject: Hand Hygiene was reviewed and read, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Immediately before touching a resident . Proper hand hygiene should be performed between all services to residents . After touching a resident or the resident's immediate environment .