STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Wyoming	625 36th St SW Wyoming, MI 49509

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview, and record review, the facility failed to perform a resident assessment, obtain a physician order for the self-administration of a breathing treatment for 1 (R225) of 4 residents reviewed for medication administration, resulting in a resident self-administering a nebulizer treatment without appropriate supervision and assessments. Findings include: Review of a Face Sheet revealed R225 admitted to the facility on [DATE] with pertinent diagnoses of pneumonitis, heart disease, lack of coordination, and blindness in one eye. During an observation on 10/28/24 at 7:49 AM, R225 was in his room starting a breathing treatment when Registered Nurse (RN) Q walked out of his room. RN Q did not assess R225 before his treatment and when she went back to his room when he finished the treatment, she did not do a post assessment. RN Q reported he received Arformoteral (Brovana) which is a nebulizer treatment. Review of the Medication Administration Record (MAR) for R225 revealed an order started on 10/9/24 for Arformoterol Tartrate Inhalation Nebulization Solution 15 MCG/2ML (micrograms/milliliters), inhale orally via nebulizer every 12 hours for COPD (chronic obstructive pulmonary disease), inhale the contents of 1 vial (2mL) via Nebulization BID (twice daily). (sic) In an interview on 10/30/24 at 1:14 PM, Licensed Practical Nurse (LPN) N reported when a resident receives a nebulizer treatment, they are to stay with the residents when they get a breathing treatment. When asked about R225 receiving a breathing treatment with no nurse present, LPN N reported To be honest, we just don't have time. Review of the Electronic Medical Record for R225 revealed there are no orders, assessments, or care plan for self-administration of medications. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled Self-Administration of Medications adopted 7/11/2018 revealed It is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medication choosing to and capable of self-administration. Purpose: To determine the ability of alert residents to participate in self-administration of medications. To maintain the safety and accuracy of medication administration. 2. If a resident, desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change n the resident's status. if the resident is a candidate for self-administration of medications, this will be indicated in the chart. 6. Nursing will be responsible for recording self-administered doses in the resident's medication administration record (MAR). 9. Appropriate notation of these determinations will be placed in the resident's care plan.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to monitor and assess the use of psychotropic medications for 1 (R19) of 5 residents reviewed for psychotropic medications. Findings include: Review of a policy titled Psychoactive Drug Use adopted 7/11/2018 revealed Purpose: . To ensure that no drug is used in excessive dose, for an excessive duration, or without adequate monitoring, or without adequate indications for its use. Review of a Face Sheet revealed R19 admitted to the facility on [DATE] with pertinent diagnoses of schizoaffective disorder, bipolar disorder, and post-traumatic stress disorder (PTSD). During an observation and an interview on 10/27/24 at 2:36 PM, R19 was in her room sitting at the edge of her bed alone. When asked general questions about her stay at the facility, she was very tearful and intermittently crying then laughed when asked about the food at the facility. Review of the Care Plan for R19 revealed the resident has a behavior concern r/t (related to) PTSD. Interventions included: Administer medications as ordered. Monitor/document for side effects and effectiveness. Refer to current physician orders and medication administration records (MAR). Review of a Behavioral Health document dated 10/8/24 for R19 revealed: Plan: 1. D/C (discontinue) Hydrozine (sic) routine and PRN (as needed) orders. 2. Monitor for changes in mood or behaviors for 14 days. Disposition: Behavioral Management Planning; Review of the October 2024 MAR for R19 revealed she is taking the following psychotropic medications: Ambien for insomnia, bupropion for depression, Clozapine for schizophrenia, and hydroxyzine for anxiety. The hydroxyzine was discontinued on 10/8/24. No monitoring for signs and symptoms, side effects, or effectiveness of psychotropic medications is documented. Review of the electronic medical records (EMR) for R19 revealed no monitoring of the psychotropic medications. In an interview on 10/30/24 at 1:26 PM, Licensed Practical Nurse (LPN) N reported R19 does not have documentation in the MAR for monitoring her behaviors or side effects of psychotropic medications and should. LPN N was able to view another resident who is on psychotropic medications and has appropriate monitoring documented to show how R19 should be monitored.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37573 Based on observation, interview, and record review, the facility failed to label and date mark opened medications, dispose of expired medications, and secure a medication cart in 2 of 3 medication carts reviewed, in a total of 5 medication carts and stored personal belongings in 1 of 2 medication rooms reviewed. Findings include: Review of a medication cart on the 100 hall on 10/30/24 at 11:00 AM revealed the following: -Flex Touch 1000 insulin pen, not opened in the cart but is supposed to refrigerated until ready for use. -A vial of Lantus long-acting insulin did not have a label on the bottle with the resident's name or the date it was opened. - 2 bottles of Systane eye drops not labeled on the bottle with the names and dates it was opened. -Polymyxin antibiotic eye drops not labeled with the name and dates it was opened. -Dorzolamide/Timol eye drops had no open date. In an interview on 10/30/24 at 11:00 AM, Registered Nurse (RN) S reported the Flex Touch 1000 insulin pen should not be in the cart and should have been refrigerated because it was not opened. She reported the eye drops, and the insulin vial should have been labeled with the resident's name and the date opened. Review of the medication room on the 100 hall had a large black purse in the room inside a cabinet. When queried, Unit Manager (UM) J reported the purse belonged to a nurse and it should not be stored in the room. Review of a policy titled Medication Access and Storage adopted on 7/11/2018 did not address labeling of medications. 31197 The facility provided a copy of the Medication Access and Storage Policy with an Adopted date of 7/11/18 for review. The policy reflected, It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/27/24 at approximately 8:50 AM, a medication cart was observed unlocked and there were no nurses in the hall near the cart. A few moments later Licensed Practical Nurse (LPN) N walked out of a resident room (not in view of the medication cart) and returned to the cart. When asked if LPN N forgot to lock the cart while away, LPN N stated, Yes, I should have locked it. During an observation and interview on 10/27/24 at approximately 8:55 AM, a medication treatment cart was observed in the hall unlocked. This surveyor pulled the top drawer open and observed several topical prescription medications in the drawer. There were no nurses noted within view of the cart. Staff were asked who was assigned to the medication treatment cart and they stated LPN O who was seated at the nurses' desk (not in view of the cart). When asked if the medication treatment cart should be locked when unattended, LPN O stated, Yes. LPN O walked over to the cart and locked it.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observations, interviews, and record review, the facility failed to provide collaborative hospice care for 2 Residents (R16 and R41) of 2 Residents reviewed for hospice care, resulting in a lack of coordinated care and the potential for care needs to be unmet. Findings included: R16 Review of R16's face sheet dated 10/29/24 revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included: multiple sclerosis, encounter for palliative care, and neuromuscular disfunction. R16 was observed in bed on 10/27/24 at 10:10 AM. R16 said she was in hospice care. R16 did not have any schedule in her room that indicated when the hospice staff visited her. R16 was aware the hospice aide came on Wednesdays but said she did not have a set time. R16 did not know when any other hospice staff visited or planned to visit. R16 said the only pain she had was in her left leg. During an interview with facility Social Worker (SW) R on10/29/24 at 9:00 AM, SW R said he does the initial hospice start up and invites hospice to the care conferences. SW R could not locate any documentation that confirmed R16's hospice had participated in her care conferences. R16 did not know when hospice staff visited with R16 or what services they had been providing. Documentation of weekly visits was not located in R16's electronic medical records. An email request for R16's hospice records for the last month was made to the Nursing Home Administrator (NHA) on 10/29/24 at 12:19 PM. Records showing the hospice aide was providing weekly showers was located, however it was not known if the hospice aide was providing other services. Hospice had last provided a copy of their records to the facility on [DATE]. R41 Review of R41's face sheet dated 10/29/24 revealed she was a [AGE] year old female admitted to the facility on [DATE] and had diagnoses that included: hemiplegia and hemiparesis (weakness one side of the body), dysphagia (difficulty swallowing) and chronic kidney disease. R41 was observed in bed on 10/27/24 at 10:19 AM, R41 said her pain in her stomach was a 10 out of 10. R41 said she had a pill for pain but wanted more. R41 put on her call light and Registered Nurse (RN) M said R41 was getting Tylenol for pain and R41 was on hospice. RN M said she would check to see what else could be done for R41's pain. RN M did not know when R41's nurse or hospice providers were scheduled to visit. A request of R41's hospice records was made on 10/29/24 at 12:52 PM. The last hospice records in R41's medical record had been faxed to the facility on [DATE]. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility Social Worker (SW) R on10/29/24 at 9:00 AM, SW R said he does the initial hospice start up and invites hospice to the care conferences. SW R could not locate any documentation that confirmed R41's hospice had participated in her care conferences. SW R did not know when hospice staff visited with R41 or what services they had been providing. Documentation of weekly visits was not located in R41's electronic medical records. On 10/29/24 at 2:41 PM the Nursing Home Administrator (NHA) provided the last hospice RN note she could locate on 10/15/24. All other notes were done weekly in the electronic medical record. There was no explanation provided for a hospice nurse not showing or documenting in R41's medical record for over a week. NHA located documentation that R41 was refusing hospice nurse aide services. Review of R41's progress notes revealed a hospice note dated 10/15/24 at 16:00 (4:00 PM), Patient sleeping and does not awaken for visit today. This nurse checks vitals: BP (blood pressure) 122/72, pulse 62, patient does not awaken. Breathing deep and regular rate at 16, lung sound CTA (clear to auscultation). No nausea or vomiting noted today. Coordinated with nurse proper name. Review of progress note dated 10/27/24 at 10:30 AM revealed, Resident complains of stomach pain with a score of 10/10 and nausea, Zofran 4 mg (nausea medication) and Tylenol 325 mg, 2 tablets given by mouth and resident has an emesis o 100 ml stomach content and mucus, however medications not visualized in emesis. Will follow up on effectiveness of medications. No indication of hospice notification of condition change noted. Review of progress noted dated 10/29/24 at 10:28 AM revealed, PA (physician assistant) into see resident, and reviewed KUB (kidney, ureter and bladder) Xray which she stated was negative, resident not very responsive, did shake her head yes when asked if she was nauseated, took am BP (blood pressure) med (medication) and given prn (as needed) Zofran (nausea medication) at 9 am, 10:30 am resident sleeping at this time, call placed to name of hospice service, message left with nurse regarding recent c/o (complaint] of and test that was order and results.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 This citation has 2 separate Deficient Practice Statements (DPS) #1 and #2. DPS #1 Based on observation, interview and record review the facility failed to ensure Enhanced Barrier Precautions (EBP) and Contact-Based Precautions were implemented for three residents (R23, R68 and R69) of 80 residents reviewed for infection control and follow policies and procedures for IV (intravenous) administration for 1 (R225) of 1 resident reviewed for IV antibiotics. Findings include: R23 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R23 admitted to the facility on [DATE] with diagnosis of (but not limited to) wound infection, pressure ulcer, diabetes and peripheral vascular disease. Brief Interview for Mental Status (BIMS) reflected a score of 12 out of 15 which represented R23 was cognitively intact. R23 required extensive staff assistance of 1-2 with all activities of daily living. The sign on R23's door reflected Enhanced Barrier Precautions and instructed staff and providers to wear gloves and a gown when caring for devices such as central line, urinary catheter, feeding tube, tracheostomy. On 10/27/24 at approximately 3:30 PM, LPN N and RN M were about to enter R23's room when asked about the care R23 would be provided. RN M stated she was going to discontinue the PICC (peripherally inserted central catheter). When asked if this Surveyor could observe the care, RN M stated, Yes. Both nurses entered the room with only gloves on (no gowns as the sign indicated) and walked up next to R23 who was seated in a wheelchair in his room. This Surveyor asked R23 if it would be okay if this Surveyor observed the staff with his care and he stated, No. This Surveyor exited the room and waited just outside the door until the two nurses exited the room. While reviewing the sign on R23's door with RN M the Surveyor asked if she had donned a gown before discontinuing the PICC and RN M stated, No but after re-reading this sign, I should have. The facility provided a copy of the MDS Resident Matrix with a print date of 10/28/24 at 7:56 AM for review. The Matrix reflected that R68 and R69 were in transmission-based precautions. On 10/27/24 at approximately 3:00 PM, this Surveyor observed all rooms and infection control signs on the residents' doors. R68 and R69 both had signs on the door indicating the need for Enhanced Barrier Precautions. In a subsequent observation on 10/30/24 at 9:08 AM, the sign was changed to Contact Precautions. The change in precautions reflected that all providers and staff that enter the room must always wear gloves and gowns upon entry to the room. Additionally, the sign reflected, Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another. R68 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R68 admitted to the facility on [DATE] with diagnosis of (but not limited to) wound infection to stage 4 pressure ulcer, (vancomycin-resistant enterococcus) and paraplegia (unable to move lower half of body). Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R68 was cognitively intact. R68 required extensive staff assistance of 1-2 with all activities of daily living. According to the physician order dated 10/29/24 reflected, Contact Precautions for osteomyelitis left hip . Despite R68 being admitted on [DATE] and placed on Enhanced Barrier Precautions, transmission-based precautions of Contact Precautions were not implemented until the physician ordered it on 10/29/24 (over 6 weeks after admission). R69 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R69 admitted to the facility on [DATE] with diagnosis of (but not limited to) sepsis (infection), diabetes, and gangrene. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which represented R69 was cognitively intact. R69 required extensive staff assistance of 1-2 with all activities of daily living. According to a progress note dated 10/7/24 reflected, HOSPITAL COURSE: (Name of R69) is a [AGE] year-old female presented to the acute hospital with septic shock and was found to have MSSA (Methicillin-Sensitive Staphylococcus Aureus) bacteremia involving multiple sites . According to the physician order dated 10/29/24 reflected, Contact Precautions for sepsis. Despite the R69 being admitted on [DATE] and placed on Enhanced Barrier Precautions, transmission-based precautions of Contact Precautions were not implemented until the physician ordered it on 10/29/24 (25 days after admission). 37573 Review of a policy titled Changing IV Administration Set last revised 2/2019 revealed: Purpose: To provide guidance regarding specific intervals administration sets and tubing will be changed in order to prevent infections associated with IV therapy equipment. 6. Label all tubing with start and change date and time. Change and then label accordingly any tubing that is observed not to have a label. 7. Apply a sterile end cap to the end of primary tubing when it is disconnected from the catheter. Discard the sterile end cap when tubing is reconnected to catheter. 8. IV fluid bags shall be changed every 24 hours. 9. Label IV tubing indicating the date and time started and nurse's initials. Review of a policy titled Intermittent Infusion last revised 12/2014 revealed: Administration sets used for intermittent therapy will be changed every 24 hours or per facility policy. 4. Administration sets used for more than one dose in a 24-hour period will have a new sterile end cap placed on the end of the administration set upon completion of each dose. 5. The practice of attaching the exposed end of the administration set to an injection port on the same set (looping) should be avoided. R225 Review of a Face Sheet revealed R225 admitted to the facility on [DATE] with pertinent diagnoses of pneumonitis, heart disease, lack of coordination, and blindness in one eye. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and an interview on 10/28/24 at 7:49 AM, Registered Nurse (RN) Q was observed starting an intravenous antibiotic (IV) for R225 by removing an undated tubing from the previous antibiotic bag that was hanging on the IV pole and spiking the antibiotic (50 milliliters (ml) of 2 grams Cefepime). When queried about the tubing not being dated, RN Q and was told in report the tubing was new from last night. During an observation and an interview on 10/28/24 at 8:24 AM, RN Q disconnected the IV antibiotic tubing from R225 when it was finished infusing from his PICC (peripherally inserted central catheter) and attached the end of the tubing to a port on the IV line that was hanging on the pole without any disinfecting of the port. When queried why the nurse attached the end of the tubing like that to the port and not disinfect it, RN Q reported they did not have much tubing and didn't have an answer as to why she didn't clean the port. 45410 Deficient Practice Statement #2 Based on interview and record review, the facility failed to implement their water management plan for reducing the risk of legionella and opportunistic pathogens, potentially affecting the entire resident population. Findings include: Review of results from a facility water analysis collected 7/17/2024 and reported on 8/5/2024 revealed the following abnormal results: 1- Hot Post Mixing Valve, 1.0 colony forming units per milliliter (CFU/ml), Legionella species (not pneumophila) 2- room [ROOM NUMBER], Hot sink, 23.5 CFU/ml, Legionella species (not pneumophila) 3- room [ROOM NUMBER], Hot sink, 7.0 CFU/ml, Legionella species (not pneumophila) Review of the facility water management program revealed 10 to 99 CFU/ml in a sample to require remedial action #4, Implement action 3. Cleaning and/or biocide treatment of the equipment is indicated. This level of Legionella represents a moderately high level of concern, since it is approaching levels that may cause outbreaks. It is uncommon for samples to contain number of Legionella that fall in this category. A Control Measures & Corrective Action grid revealed the facility should enhance monitoring when water analysis results are not within normal limits. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/2024 at 9:10 AM, Director of Maintenance D reported he discussed the results of the abnormal water analysis with the Nursing Home Administrator (NHA), the Director of Nursing (DON), and Environmental Services Director C but he did not notify Regional Director of Maintenance E of the abnormal results. Director of Maintenance D reported he had not read the entire water management plan and needed to familiarize himself with this. Director of Maintenance D reported resident room sinks were not being flushed prior to the abnormal test results and the facility began having housekeeping staff run water in the sinks every day during routine cleaning as a response to the abnormal testing. Director of Maintenance D reported the facility did not send a repeat analysis or otherwise enhance monitoring as the water management plan indicated. Director of Maintenance D reported the water is analyzed quarterly and is due to be tested again soon. Regional Director of Maintenance E reported he had not been notified that the facility had an abnormal water analysis. In an interview on 10/30/2024 at 10:09 AM, Environment Services Director C reported housekeeping staff began flushing sinks in resident rooms during daily room cleaning when Director of Maintenance D discussed the abnormal water analysis with her, but staff did not document this action. In an interview on 10/30/2024 at 11:35 AM, Housekeeper G reported she had worked at the facility for 2.5 months and had not been taught to flush sinks in resident rooms. Housekeeper G reported she cleaned the sinks with a disinfectant but did not run the water for any amount of time.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to administer the pneumococcal vaccine to one resident (Resident #29) of 5 residents reviewed for immunizations. Findings include: Review of an Admission Record revealed Resident #29 (R29) admitted to the facility on [DATE] with pertinent diagnoses which included heart disease and hypertension. Review of R29's Michigan Care Improvement Registry (a database that consolidates immunization information for individuals in Michigan), dated as reviewed upon admission to the facility on [DATE], revealed R29 was due for the pneumococcal vaccine PCV20 since his admission to the facility. Review of R29's Consent to Administer Pneumococcal Vaccine PCV20 revealed R29 consented to receive PCV20 upon his admission to the facility on [DATE]. Review of R29's Electronic Health Record immunization history, active 10/30/2024, revealed R29's pneumococcal status as pending. In an interview on 10/30/2024 at 10:27 AM, the Director of Nursing (DON) reported R29 was due for the pneumococcal vaccine PCV20 when he admitted to the facility on [DATE]. The DON reported the unit manager should have scheduled this to be completed but for some reason this did not occur. The DON was not sure whether the Infection Preventionist had a process to ensure residents were offered pneumococcal vaccines in a timely manner. Review of facility policy/procedure Immunizations-Pneumococcal, reviewed 11/11/2019, revealed .It is the policy of this facility that all residents will be offered the pneumococcal vaccines to aid in preventing pneumonia . Upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccines and when indicated, will be offered the vaccinations, unless medically contraindicated or the resident has already been vaccinated .