STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING ____ B. WING ____	6/16/2022

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F0000 SS=	INITIAL COMMENTS SKLD Beltline was surveyed for a re-visit survey on 6/15/22-6/16/22. Census: 124	F0000		
F0689 SS= G	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement fall interventions, complete accurate and thorough post fall follow up, and properly store smoking supplies for 3 of 4 residents (Resident #201, #202, and #103) reviewed for accidents and hazards, from a total sample of 6 residents, resulting in the potential for accidents and serious injury. Findings include: Resident #201 Review of an "Admission Record" revealed Resident #201 admitted to the facility on 4/2/2020 with pertinent diagnoses which included dementia and one-sided weakness following a stroke. Review of a "Minimum Data Set" (MDS) assessment for Resident #201, with a reference	F0689	Element One Resident #201's care plan was revised to reflect two-person assistance with transfers and collaboration with the Hospice team, reflecting the residents' transfer status. Resident #202 plan of care has been reviewed; the resident has had no falls since 6/11/2022. Resident #103 smoking materials have been collected after a leave of absence (LOA) and given to the nurse for safekeeping. No further incidents were reported. Element Two Residents in hospice have the potential to be affected by this practice. Residents on hospice collaboration initiated with entities regarding transfer status to ensure direct care staff follows the facility care plan. Residents with unwitnessed falls have the potential to be affected by this practice. Residents with unwitnessed falls starting 6/11/2022 investigations are audited to ensure that first staff observed residents on the floor are interviewed, neuro checks completed, and interventions are planned for care. Residents that are smokers on LOA have the potential to be affected by this practice. The facility has identified residents that are smokers and re-education for residents to ensure they turn in smoking materials to staff. Element Three The DON/designee re-educated nurses and nursing assistants on care plan intervention, especially for residents at risk for falls, to	6/8/2022

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

Electronically Signed — 06/28/2022

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.

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	date of 5/12/2022 revealed a "Brief Interview for Mental Status" (BIMS) score of 5, which indicated that Resident #201 was severely cognitively impaired. Review of a current activities of daily living "Care Plan" intervention for Resident #201, with a revision date of 3/16/2022, directed staff to use two persons when transferring the resident using a mechanical lift. In an observation and interview on 6/15/2022 at 9:02 A.M., agency hospice Certified Nursing Assistant (CNA) "Q" used the mechanical lift to transfer Resident #201 from her bed in her room to her Broda chair by herself, without the assistance of another person. CNA "Q" reported that she uses the hospice care plan to determine resident transfer status and that Resident #201 requires one person assistance when transferring with the mechanical lift. In an interview on 6/15/2022 at 09:12 A.M., Licensed Practical Nurse (LPN) "P" reported that Resident #201 requires a two person assist with the mechanical lift when transferring according to the care plan. In an interview on 6/16/2022 at 10:00 A.M., Corporate Clinical Support "E" reported that contractual staff are required to follow the facility care plan when providing resident care. Review of the policy/procedure "Fall Prevention" revealed " ...PURPOSE ... To identify residents at risk in a timely manner ... To gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the resident's needs ... To ensure consistency in the implementation of preventative measures to assist with the reduction of falls ... To evaluate outcomes ..."		ensure interviews, assessments, and interventions are implemented after each unwitnessed fall. Secondly, residents identified as smokers to ensure staff collects their smoking materials upon returning after LOA. Licensed nurses and nursing assistants that do not get re-education by 6/28/2022 will receive re-education before the beginning of their shift. The DON/Designee sent out collaboration communication to the hospice teams collaborating with the facility to ensure direct care staff (nurses and nursing assistants) follow the facility care plan as central to maintaining collaboration. Element Four DON/Designee will conduct random reviews of 5 residents who have had falls weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure witness statements, neuro checks, and interventions are in place. Any concerns identified will be resolved. DON/Designee will conduct random reviews of 5 residents who are smokers and have had an LOA weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure smoking materials is not stored on a person upon returning to the facility. Any concerns identified will be resolved. DON/Designee will conduct random reviews of 5 residents who are on hospice services weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the collaborative plan of care is the same for residents regarding transfers. Any concerns identified will be resolved. DON will bring concerns about this regulation to the quality assurance improvement	

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	Resident #202 Review of an "Admission Record" revealed Resident #202 was originally admitted to the facility on 12/21/21, with pertinent diagnoses which included: repeated falls, unsteadiness on feet, muscle weakness and difficulty walking. Review of a "Minimum Data Set" (MDS) assessment for Resident #202, with a reference date of 3/15/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #202 was cognitively impaired. Review of the "Functional Status" revealed that Resident #202 required extensive assistance of 1 person for transfers. Review of Resident #202's "Fall Care Plan" revealed, "Resident at risk for falls r/t (related to) repeated falls, muscle weakness, generalized weakness *had an actual fall on 3/10/22. Date Initiated: 12/23/2021. INTERVENTIONS: 6/14/22 reviewed started therapy. Date Initiated: 06/14/2022. Anticipate and meet resident's needs. Date Initiated: 03/03/2022. Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition. Date Initiated: 12/22/2021. Ensure that resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Preferred/Recommended footwear: non skid footwear Date Initiated: 03/03/2022. Keep bed in lowest position when not performing mobility and/or care tasks. Date Initiated: 12/22/2021. Minimize risk factors in environment: areas free of spills and clutter; adequate, glare-free light; bed in low position at night; personal items within reach when in bed/chair, etc. Date Initiated: 03/03/2022." Review of Resident #202's "Fall Risk		performance (QAPI) committee for recommendations at least monthly until substantial compliance is determined. Element Five The Director of Nursing will be responsible for compliance with this regulation by June 28, 2022.	

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Assessment" dated 4/23/22 revealed a score of "High Risk for Falling Score: 65". The assessment indicated a score of 45 or higher was considered high risk.

During an observation and intervview on 6/15/22 at 11:28 A.M. Resident #202 was sitting in her wheelchair in the doorway of her room, and her call light was alarming. Resident #202 reported that she pressed her call light because she was tired and wanted to lay down, so that she could go to bingo later and stated, "...I have been up since 8:00 A.M." At 11:32 A.M. "Certified Nursing Assistant" (CNA)" "C" entered the room to answer the call light. Resident #202 informed CNA "C" that she was tired and wanted to lay down. CNA "C" then informed Resident #202 that it was lunch time, to which Resident #202 replied "oh." CNA "C" left Resident #202's room without any further conversation.

During a subsequent interview on 6/15/22 at 11:30 A.M., Resident #202 stated, "I guess I am staying up..." Resident #202 reported that she had fallen recently when she tried to transfer herself to bed, and reported that this was after getting anxious waiting for staff to assist her.

During an interview and observation on 6/15/22 at 2:53 P.M. Resident #202 was lying in her bed and stated, "...I missed bingo...I was too tired after lunch..."

Review of Resident #202's "Incident Report" dated 6/11/22 at 9:45 A.M. revealed, "....Resident along (sic) on side between bed and wheelchair facing window, call light within reach. Patient Description: "I was trying to get in bed"...no apparent injuries...Predisposing Situation Factors: Change in medication...Notes: 6/11/22 Added to therapy services..." The report was completed by "Licensed Practical Nurse" (LPN) "G".

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During an interview on 6/15/22 at 12:23 P.M., LPN "G" reported that she was on break on 6/11/22 when CNA "D" came and reported that Resident #202 had fallen. LPN "G" reported that she observed Resident #202 on the floor next to her bed, assessed her for injuries, and then assisted CNA "D" with transferring Resident #202 to bed. LPN "G" reported that Resident #202 had been very impulsive lately and stated, "...she knows what she wants...if she wants to lay down, you lay her down..." LPN "G" reported that Resident #202 did not have any new interventions put in place after the fall.

During an interview on 6/15/22 at 4:19 P.M. CNA "D" reported that on 6/11/22 she had last observed Resident #202 heading to her room, and then an agency aide reported to her that Resident #202 was on the floor. CNA "D" reported that she could not recall the name of the agency aide. CNA "D" reported that she stayed with Resident #202, and the agency aide went and found LPN "G" to assess the resident before helping her back into bed. CNA "D" reported that Resident #202 had not asked CNA "D" to lay down on 6/11/22 prior to the fall, but if she had, CNA "D" would do it right away to avoid her trying to transfer herself to bed. CNA "D" reported that Resident #202 had been having hallucinations and anxiety.

During an interview on 6/16/22 at 10:13 A.M., DON reported that it was her understanding that LPN "G" was the first to find Resident #202 on the floor after Resident #202's fall on 6/11/22. DON reported that Resident #202 was added to physical therapy services following her fall as a new intervention. This was not consistent with interviews with LPN "G", and CNA "D".

This surveyor was unable to identify and interview the staff member that first responded to Resident #202's fall.

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Review of Resident #202's "Post Fall Assessment" from the fall on 6/11/22 was dated 6/14/22 at 3:36 P.M. and indicated there were no injuries related to the fall, last meal was at 5:10 P.M., see care plan for previous and new interventions, alert charting was initiated, and neurological assessment for unwitnessed fall were initiated. This report was completed by "Unit Manager" (UM) "R".

Review of Resident #202's "Interdisciplinary Post Fall Follow-Up" dated 6/14/22 at 9:45 A.M. revealed, "Date and time of fall: 6/11/22 09:45 (9:45 A.M.), Falls in past 90 days and/or since admission: 2, Current fall prevention care plan interventions: see care plan, At time of fall/incident, was resident participating in any of the following services?...part B therapy? YES...Root Cause and Contributing Factors as determined by IDT: Patient observed sitting on bottom on the floor next to wheelchair. Patient states she was trying to use the bathroom. Nursing assessments complete, no apparent injuries. Corrective actions and/or interventions: was this fall preventable? NO. What changes do we need to make when caring for resident to prevent him/her from experiencing the same type of fall? See care plan...Care Plan reviewed to ensure appropriate interventions are in place? YES...What action does leadership need to take to decrease reoccurrence at system level...(blank space)..."

During an interview on 6/16/22 at 10:23 A.M., UM "R" reported that it was her understanding that LPN "G" was the first to find Resident #202 on 6/11/22 after the fall. UM "R" reported that she was not sure of the details surrounding Resident #202's fall. UM "R" reported that Resident #202 has recently had increased anxiety, and the doctor increase her anxiety medication on 6/9/22, and the facility added anxiety monitors to

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her treatment orders on 6/15/22. UM "R" reported that she did not know the root cause of the fall and that Resident #202 had told her she was trying to get out of her chair and into bed when she fell on 6/11/22. UM "R" reported that Resident #202 should have daily alert charting completed following the fall and neurological checks documented. Reveiw of Resident #202's record with UM "R" did not reveal alert charting or neurological checks. This surveyor requested these documents.

Review of Resident #202's "Physical Therapy Evaluation & Plan of Treatment" revealed, "...Start of Care: 6/6/22 (5 days prior to fall)...Reason for referral/current illness: Pt (patient) referred to PT (physical therapy) due to increased assistance needed for transfers and toileting. Pt with decline in ambulation from initial treatment...Medical Factors: Precautions: falls, auditory and visual hallucinations at times...Pt with decline in transfers and toileting ability recently per nursing staff...Fear of Falling: YES..." The resident received subsequent PT services on 6/10/22 and 6/16/22. Noted that PT was not a new intervention for Resident #202 following her fall on 6/11/22.

During an interview on 6/16/22 at 11:53, Medical Records Unit Secretary "DD" reported that she did not have any neurological check documents to scan in for Resident #202, but Unit Secretary "S" may still have them in her office. At 11:55 A.M., Unit Secretary "S" reported that she did not have any neurological check documents for Residents #202. At 11:57 A.M. DON reported that she would look for Resident #202's neurological checks from the fall on 6/11/22. The records were not provided prior to survey exit.

Review of Resident #202's "Physician Assistant (PA) Note" dated 6/9/22 revealed, "...She is seen

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today for BCS (behavior care service) recommendation to increase Buspar (medication for anxiety) for restlessness and anxiety...

Buspar increased to 5mg TID (three times a day) based on BCS recommendation. Continue to monitor and provide support as indicated..."

Review of Resident #202's "Progress Notes" from 6/9/22-6/16/22 revealed no documentation regarding Resident #202's anxiety and restlessness.

Review of the facility "Plan of Correction (POC)" for F689 with a date of compliance of 6/8/22 revealed, "...Identified resident care plans and kardexes were reviewed for safe transfers methods and bed mobility needs to ensure residents receive adequate supervision and assistance devices to prevent accidents. Care plans and kardexes were updated as needed to reflect resident care needs and preferences. The DON/designee will educate nursing personnel and the Interdisciplinary Team by 06/08/22 on assessing, planning, implementing fall prevention interventions to ensure residents receive adequate supervision and assistance devices to prevent accidents..."

Review of the facilities "Fall Report" indicated 27 resident falls in the past 30 days.

Resident #103

Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 2/12/21, with pertinent diagnoses which included: acquired absence of left toes and right leg below the knee (amputation).

Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference

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date of 3/30/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact.

During an interview on 6/15/22 at 9:04 A.M., Resident #103 reported that she can leave the facility as often as she wants and stated, "..as long as there is a nurse to give me a pass and someone at the front desk to let me out..." Resident #103 reported that she keeps her cigarettes and lighter in her bag and stated, "...initially they wanted them kept in the nurses cart...but they don't ask for them anymore..."

During an interview and observation on 6/15/22 at 3:00 P.M., Resident #103 was sitting near the front entrance of the facility and reported that she was cooling off and resting after being outside, and then would bring her pass to the nurse. At 3:08 P.M. Resident #103 was observed to walk to her room. There were no nursing staff on the hall or at the desk at that time.

During a subsequent observation and interview on 6/15/22 at 3:40 P.M., Resident #103 was sitting on her bed and reported that she had to go back out to the desk and find a nurse to return her pass to and stated, "...my cigarettes are right here in my bag...my lighter is in my pocket..." Resident #103 then walked out to the nurses station and handed her paper pass to LPN "G". LPN "G" said thank you, but was not observed to ask Resident #103 for her smoking supplies. At 3:41 P.M. LPN "G" reported that she was supposed to collect all smoking supplies from residents when they turn in their paper pass, but the nurses have stopped asking because the residents always say that they don't have them. LPN "G" reported that Resident #103 is a known smoker, and her cigarettes and lighter used to be kept in the nurses cart.

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	During an interview on 6/16/22 at 12:57 P.M., NHA reported that the nurses are expected to request all smoking supplies from residents that are known smokers when they return to the facility after a leave of absence. NHA reported that Resident #103 had a history of not complying with the facility no-smoking policy, and just last week Resident #103 had been caught providing smoking materials to another resident. NHA excused himself from the interview for 3 minutes and returned to report that the facility did not have a "regular practice" for collecting smoking materials, due to the facility being completely non-smoking.			
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR	F0842	Element One Residents #103 and #204 showed no change of condition observed, and vital signs are monitored based on physicians' orders and remain at baseline. Element Two All residents have the potential to be affected by this practice. Resident vital signs have been audited since 6/11/2022 based on physician orders. Concerns identified regarding missing or duplicate vital signs have been reported to the physician with further recommendations. No adverse effects reported Element Three DON/designee re-educated licensed nurses and nursing assistants to follow doctor orders, document vital signs as ordered, and accurately input data without duplication. Licensed nurses and nursing assistants that do not get re-education by 6/28/2022 will receive re-education before the beginning of their shift. Element Four DON/designee will conduct random reviews on 5 residents weekly times 4 weeks and then	6/8/2022

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	164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 (Resident #103 & #204) of 5 residents reviewed for medical records, resulting in inaccurate and incomplete documentation of vital signs and the potential for facility staff and providers not having all of the pertinent information to care for residents.		monthly thereafter times 3 months or until substantial compliance has been maintained to ensure resident's vitals are completed and accurately documented. Any concerns identified will be resolved. DON will bring concerns about this regulation to the quality assurance improvement performance (QAPI) committee for recommendations at least monthly until substantial compliance is determined. Element Five The Director of Nursing will be responsible for compliance with this regulation by June 28, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	414290	A. BUILDING ______ B. WING ______	6/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BELTLINE	2320 E BELTLINE SE GRAND RAPIDS, MI 49546

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Findings include:

During an interview on 6/16/22 at 9:30 A.M., NHA reported that the facility had issues with duplicated physician orders for vital signs and they were fixing the issue. NHA reported that it was his understanding that the facility was currently in-compliance regarding accurate documentation of vital signs. NHA reported that the facility was currently trying to remove the "pull vitals" option from the electronic health record system, so that the staff would not have the option to duplicate the residents last vital signs when they are completing their charting.

Review of the facility "Plan of Correction (POC)" for "Complete and Accurate Medical Records" with a date of compliance of 6/8/22 revealed, "Resident 103 continues to reside in the facility. Resident has been assessed and has had no adverse effects related to inaccurate vital signs. All residents with orders to obtain vital signs have the potential to be affected. An audit of resident orders for obtaining vital signs was conducted. Identified residents vital signs were reviewed for omitted or duplicated vital signs data. Residents with omitted or duplicated vital signs were assessed for adverse effects and provider/responsible party notifications were made...The DON/designee will educate nursing personnel by 06/08/22 on following physicians orders and appropriate documentation, including obtaining and documenting resident vital signs, to ensure the medical record is complete and accurate in accordance with professional standards and practices. Staff who have not received education by 06/08/2022 will be removed from the schedule until education has been received..."

Resident #103

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Review of an "Admission Record" revealed Resident #103 was originally admitted to the facility on 2/12/21, with pertinent diagnoses which included: acquired absence of left toes and right leg below the knee (amputation).

Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 3/30/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact.

Review of Resident #103's "Vital Signs Record" indicated that on 6/9/22 at 12:09 A.M., 6/9/22 at 2:07 P.M., 6/10/22 at 8:42 P.M. and 6/13/22 at 9:24 P.M., Resident #103 had the following identical findings: Blood Pressure (BP) of 141/76, Pulse of 76, Respirations of 17 and Temperature of 97.5 degrees. During a 4 day period, Resident #103 had vital signs falsely duplicated.

During an interview on 6/15/22 at 11:44 A.M. "Certified Nursing Assistant" (CNA) "H" reported that she had entered duplicate vitals signs for Resident #103 and did not have an explanation as to why it was done. CNA "H" reported that she had recently received re-education about the importance of complete and accurate vital signs.

Review of the facility "POC education materials" revealed "...When you document in the residents record it must be information that is accurate. You cannot copy and paste information forward..."

Resident #204

Review of an "Admission Record" revealed Resident #204 was originally admitted to the facility on 5/19/22, with pertinent diagnoses which included: essential hypertension (high

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	414290	A. BUILDING ______ B. WING ______	6/16/2022

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SKLD BELTLINE	**2320 E BELTLINE SE** **GRAND RAPIDS, MI 49546**

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	blood pressure). Review of a "Minimum Data Set" (MDS) assessment for Resident #204, with a reference date of 5/25/22 revealed a "Brief Interview for Mental Status" (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #204 was cognitively impaired. During an interview on 6/15/22 at 11:11 A.M., Resident #204 reported that she currently takes 2 blood pressure medications and stated, "...they (facility staff) check my blood pressure once in a while...not every day..." Review of Resident #204's "Physician Orders" revealed, "Daily vital signs...every day shift daily...start date 6/11/22 at 7:15 A.M." Review of Resident #204's "Vital Signs Record" on 6/15/22 at 11:51 A.M. indicated no records from 6/11/22, on 6/12/22 at 8:41 P.M. BP of 132/77, on 6/12/22 at 1:26 P.M. BP of 136/81, no records on 6/13/22, 6/14/22 & 6/15/22. This indicated that 3/6 opportunities for BP monitoring had been missed.			