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 _____	**9/8/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Skld Beltline was surveyed for a re-visit survey from 9/7/22 to 9/8/22. Census: 139	F0000		
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration and documentation in 1 of 4 residents (Resident #113) reviewed for medication administration, resulting in the potential for medication errors. Findings include: According to Potter, Patricia A.; Perry, Anne Griffin; Stockert, Patricia; Hall, Amy. Fundamentals of Nursing. "...High-quality documentation is necessary to enhance efficient, individualized patient care. Quality documentation has five important characteristics: it is factual, accurate, complete, current, and organized..." Accessed from: Kindle Locations 24106-24108). Elsevier Health Sciences. Kindle Edition. Review of the policy/procedure "Administration of Drugs", dated 12/19/19, revealed "...It is the policy of this facility that medications shall be	F0658	F 658 =D Element One Resident #113, resident interviewed regarding medication administration and medication refusal. No adverse effects were reported or noted. Element Two All residents have the potential to be affected by this practice. Audited Residents' (electronic medication administration records) E-MAR using a "Supplemental Refusal Audit" to ensure physician notification and a late entry explanatory note documented in the medical record. Element Three The Director of Nursing/Designee completed 1:1 medication administration audit validation test with licensed nurses to ensure residents receive medications following the six rights (Right resident, Right time, Right medication, Right dose, Right route, and Right documentation) of medication administration as ordered and complete assessments when residents do not receive/refuse medications, including notification to the prescribing clinician for further follow-up and an explanatory note documented in the medical record. Licensed nurses will be educated by 9/9/2022 or by the beginning of their next scheduled shift. Element Four The Director of Nursing/Designee will conduct a random complete 1:1 audit with five nurses	9/9/2022

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

Electronically Signed | 09/14/2022

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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	administered as prescribed by the attending physician...All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR)...The nurse administering the medication must record such information on the resident's MAR before administering the next resident's medication...Should a drug be withheld, refused, or given other than the scheduled time, the nurse must enter an explanatory note..." Review of the policy/procedure "Six Rights of Medication Administration", dated 7/11/18, revealed "...It is the policy of this facility to ensure that the six rights of medication administration are followed in order to ensure safety and accuracy of administration...The six rights of medication administration are as follows...Right Resident...Right Time...Right Medication...Right Dose...Right Route...Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns..." Review of an "Admission Record" revealed Resident #113 was a male, with pertinent diagnoses which included psoriasis (a skin condition which results in itchy, dry patches), vitamin D deficiency, iron deficiency anemia, edema (swelling caused by excess fluid in the body's tissues), diabetes, hyperlipidemia (high levels of fat in the blood), itching, pressure ulcer, and pain in the left and right hands. Review of a "Minimum Data Set" (MDS) assessment for Resident #113, with a reference date of 8/18/22, revealed a "Brief Interview for Mental Status" (BIMS) score of 14, out of a total possible score of 15, which indicated he was cognitively intact. In an interview on 9/8/22 at 10:44 a.m., in the		during medication administration weekly, for four weeks, and then monthly after that time for three months or until substantial compliance has been maintained to ensure medications are administered as ordered and resident refusals have an explanatory note documented in the medical record. Any concerns identified will be resolved. Results of the audits will be presented to the QAA Committee for review and consideration of further corrective actions. We will do meetings at least monthly until resolution. Element Five The Director of Nursing will be responsible for compliance with this regulation by September 9, 2022.	

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	resident's room, Resident #113 reported he was still waiting for his morning medications to be administered. Resident #113 reported he requested his scheduled pain medication "...an hour ago..." Review of an "Order Summary Report" for Resident #113, accessed 9/8/22 at 9:14 a.m., revealed active physician orders for "...Tylenol Extra Strength Tablet 500 MG (milligrams) (Acetaminophen) Give 2 tablet by mouth every 8 hours for pain...", "...MetFORMIN HCl ER Tablet Extended Release 24 Hour 500 MG Give 3 tablet by mouth one time a day for DM (diabetes)...", "...Ascorbic Acid (Vitamin C) Tablet 500 MG Give 1 tablet by mouth one time a day for wound care...", "...Cholecalciferol Tablet (Vitamin D3) 2000 UNIT Give 1 tablet by mouth one time a day for Vitamin D deficiency...", "...Cetirizine HCl Tablet 10 MG Give 1 tablet by mouth one time a day for pruritus (itching)...", "...Atorvastatin Calcium Tablet 10 MG Give 1 tablet by mouth one time a day for hyperlipidemia...", "...Farxiga Tablet 10 MG (Dapagliflozin Propanediol) Give 1 tablet by mouth one time a day for DM...", "...Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day for supplement...", "...Thera-M Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for wound care...", "...Furosemide Tablet 40 MG Give 1 tablet by mouth one time a day for lower extremity edema...", "...hydrOXYzine HCl Tablet 25 MG Give 1 tablet by mouth two times a day for Itching...", and "...Meloxicam Tablet 15 MG Give 1 tablet by mouth in the afternoon for psoriatic arthritis..." Review of Resident #113's September 2022 "Medication Administration Record" (MAR), accessed 9/8/22 at 10:57 a.m., revealed the scheduled medications "...Tylenol Extra Strength Tablet 500 MG (Acetaminophen) Give 2 tablet by			

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	mouth every 8 hours for pain..." scheduled for 8:00 a.m., "...MetFORMIN HCl ER Tablet Extended Release 24 Hour 500 MG Give 3 tablet by mouth one time a day for DM (diabetes)..." scheduled at breakfast time, "...Ascorbic Acid (Vitamin C) Tablet 500 MG Give 1 tablet by mouth one time a day for wound care..." scheduled at breakfast time, "...Cholecalciferol Tablet (Vitamin D3) 2000 UNIT Give 1 tablet by mouth one time a day for Vitamin D deficiency..." scheduled at breakfast time, "...Cetirizine HCl Tablet 10 MG Give 1 tablet by mouth one time a day for pruritus (itching)..." scheduled at breakfast time, "...Atorvastatin Calcium Tablet 10 MG Give 1 tablet by mouth one time a day for hyperlipidemia..." scheduled at breakfast time, "...Farxiga Tablet 10 MG (Dapagliflozin Propanediol) Give 1 tablet by mouth one time a day for DM..." scheduled at breakfast time, "...Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet by mouth one time a day for supplement..." scheduled at breakfast time, "...Thera-M Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for wound care..." scheduled at breakfast time, "...Furosemide Tablet 40 MG Give 1 tablet by mouth one time a day for lower extremity edema..." scheduled at breakfast time, "...hydrOXYzine HCl Tablet 25 MG Give 1 tablet by mouth two times a day for Itching..." scheduled at breakfast time, and "...Meloxicam Tablet 15 MG Give 1 tablet by mouth in the afternoon for psoriatic arthritis..." scheduled at lunch time, were all documented as administered. In an interview on 9/8/22 at 10:58 a.m., at the medication cart, "Registered Nurse" (RN) "D" stated in regard to Resident #113's morning medications "...Now that I know he is awake I have to give them (the medications) to him..." RN "D" stated in regard to Resident #113's morning medications "...I already documented on those (as administered) but I have to go back and change			

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	the times..." RN "D" reported she attempted to administer Resident #113's morning medications earlier in the shift, but he initially declined to take the scheduled medications. RN "D" reported she did not document the refusal at the time it occurred, and stated "...I have to go back and change that..." RN "D" reported she discarded Resident #113's morning medications when he initially refused, but intended to prepare new medications once Resident #113 was ready to take them. In an observation and interview on 9/8/22 at 11:10 a.m., RN "D" prepared scheduled morning medications for Resident #113 at the medication cart. Observed RN "D" prepare two tablets of "Acetaminophen 500 mg", three tablets of "Metformin HCl ER 500 mg", one "Vitamin C 500 mg" tablet, one "Vitamin D3 2,000 Units" tablet, one "Cetirizine HCl 10 mg" tablet, one "Atorvastatin Calcium 10 mg" tablet, one "Farxiga 10 mg" tablet, one "Ferrous Sulfate 325 mg" tablet, one "Thera-M" tablet, one "Furosemide 40 mg" tablet, one "Hydroxyzine HCl 25 mg" tablet, and one "Meloxicam 15 mg" tablet for Resident #113 and place the medications in a plastic medication cup. Noted all the medications prepared were already documented in the electronic medical record as administered. Observed RN "D" bring the prepared medications to Resident #113 in his room, however, Resident #113 refused to take the medications. RN "D" then returned to the medication cart, and reported she would have to "Strike-Out" the documentation for each medication previously documented as administered. In an interview on 9/8/22 at 1:52 p.m., RN "D" reported she recently completed education in regard to medication administration and documentation. RN "D" reported medications should be documented as given after			

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	administration. In an interview on 9/8/22 at 4:04 p.m., "Licensed Practical Nurse" (LPN) "K" reported medications should be documented after administration. LPN "K" stated "...I don't click save until after the resident takes the medications..." LPN "K" stated medications should not be documented as having been administered "...until after they are given..." In an interview on 9/8/22 at 4:10 p.m., LPN "J" reported medications should be documented as given after administration. LPN "J" stated "...If they refuse then I document the refusal..." In an interview on 9/8/22 at 4:30 p.m., with Administrator "A", Administrator in Training "N", and "Director of Nursing" (DON) "B", DON "B" stated in regard to medication administration "...you don't want to sign it (the medication) out before you actually give it..." DON "B" reported medications should be documented after administration.			