STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344020	A. BUILDING _____ B. WING _____	**3/6/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD IONIA	**814 E LINCOLN AVE IONIA, MI 48846**

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F0000 SS=	INITIAL COMMENTS SKLD Ionia was surveyed for a recertification survey from 3/4/24-3/6/24 Intakes: MI00142530 Census: 75	F0000		
F0658 SS= E	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 interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 5 of 8 residents (Resident #17, #23, #43, #46, and #62), reviewed for the provision of nursing services, resulting in lack of vital sign and blood sugar assessments prior to medication administration, medications improperly administered, and management of controlled substances. Finding: Resident #17 (R17) Review of an "Admission Record" revealed R17 was a 79-year-old female, originally admitted to the facility on 12/14/22, with pertinent diagnoses which included: seizure disorder. Review of R17's "Order Summary" revealed, "Lacosamide Oral Tablet 50 MG (Lacosamide) Give 1 tablet by mouth every 12 hours for	F0658		

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

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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	seizures." Review of R17's "Controlled Substance Proof of Use" form revealed on 3/2/24 a dose of lacosamide was administered at 8:20 AM. There was no evening dose documented as pulled/administered. Review of R17's March "Medication Administration Record" revealed on 3/2/24, 2 doses of lacosamide was documented as administered. During an interview on 3/6/24 at 12:32 PM, Director of Nursing (DON) confirmed that there was a medication error and R17 received only received 1 dose of lacosamide on 3/2/24. Resident #23 (R23) Review of an "Admission Record" revealed R23 was a 68-year-old male, originally admitted to the facility on 5/12/23, with pertinent diagnoses which included: hypertension. Review of R23's "Order Summary" revealed, "Lisinopril Tablet 10 MG Give 1 tablet by mouth in the morning for hypertension Hold if SBP <90 (systolic blood pressure/top number is less than 90). Review of R23's February "Medication Administration Record" revealed all 29 doses of lisinopril were administered. Review of R23's March "Medication Administration Record" (reviewed on 3/5/24 at 12:00 PM) revealed all 5 doses of lisinopril were administered. Review of R23's "Blood Pressure Summary" revealed R23's blood pressure was not assessed			

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	on 2/10/24, 2/15/24, 2/17/24-3/1/24, and 3/3/24-3/5/24. Indicating a blood pressure assessment was not completed prior to the administration of the lisinopril to ensure R23's blood pressure was within the provider ordered parameters. Resident #43 (R43) Review of an "Admission Record" revealed R43 was a 67-year-old female, originally admitted to the facility on 3/5/20, with pertinent diagnoses which included: hypertension. Review of R43's "Order Summary" revealed, "Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG-Give 1 tablet by mouth in the morning related to ESSENTIAL (PRIMARY) HYPERTENSION (I10) hold for SBP<100 P<60 (systolic blood pressure less than 100 and pulse less than 60). Review of R43's February "Medication Administration Record" revealed all 29 doses of metoprolol were administered. Review of R43's March "Medication Administration Record" (reviewed on 3/4/24 at 12:00 PM) revealed all 4 doses of metoprolol were administered. Review of R43's "Pulse Summary" revealed R43's pulse was not assessed on 2/15/24, 2/16/24, 2/18/24-2/24/24, 2/26/24, 3/1/24, and 3/3/24. Indicating a pulse assessment was not completed prior to the administration of the metoprolol to ensure R43's pulse was within the provider ordered parameters. Resident #46 (R46) Review of an "Admission Record" revealed R46 was a 76-year-old female, originally admitted to			

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	the facility on 7/7/20, with pertinent diagnoses which included: diabetes. Review of R46's "Order Summary" revealed, "LANTUS SOLOSTAR 100U/ML-Inject 16 unit subcutaneously in the morning for DM hold for BS<100 (for diabetes mellitus. Hold for blood sugar less than 100). Review of R46's February "Medication Administration Record" revealed all 29 doses of Lantus were administered. Review of R46's March "Medication Administration Record" (reviewed on 3/4/24 at 12:00 PM) revealed all 4 doses of Lantus were administered. Review of R46's "Blood Sugar Summary" revealed R46's blood sugar was not assessed from 2/1/24-2/4/24, 2/6/24-2/11/24, 2/13/24-2/18/24, 2/20/24-2/25/24, and from 2/27/24-3/3/24. Indicating a blood sugar assessment was not completed prior to the administration of the Lantus to ensure R46's blood sugar was within the provider ordered parameters. During an interview on 03/06/2024 at 10:26 AM, Director of Nursing (DON) reported that any narcotic administration errors would be immediately reported to her. If there are errors identified randomized audits would be completed to ensure nursing compliance with medication administration. Unit Manager (UM) "B" reported that the facility nurses should be administering medications as ordered by the provider which would include assessing vital signs and blood sugars prior to the administration of medications that had ordered parameters. DON and UM "B" were notified of the medication administration concerns for 8			

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	residents on 3/6/24 at 10:44 AM. At the time of survey exit there was no documentation provided reflecting R23, R43, and R46 had had vital signs/blood sugar assessments prior to the medication administration listed above. Review of the facility policy "Medication Administration" subject "Administration of Drugs" last updated 12/19/19 revealed, "POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician. Procedure ...2. Medications must be administered in accordance with the written orders of the ordering/prescribing physician." R62 R62 was originally admitted to the facility 6/6/23. Review of the medical record reflected R62 had current Doctors Orders for two types of insulin and an order for a fentanyl transdermal patch that is to be changed every 72 hours. On 3/6/24 at 8:04 AM an observation was conducted with Registered Nurse (RN) "E" who was preparing medication for R62. In addition to oral medication, this preparation included two types of insulin and a fentanyl patch. After entering the room of R62 the oral medications were administered to the Resident. To administer the insulin RN "E" first exposed the abdomen of R62 and cleansed an administration site. When it was observed that RN "E" was proceeding to the injection of insulin the RN was asked if gloves were available. RN "E" pointed to a glove dispenser mounted on the wall above the nightstand of R62 and stated "Right there. All the rooms have them". RN "E" continued, without gloves, to administer the two types of insulin near one another to the left of the Resident's umbilicus. It was observed that that first site bled. RN "E"			

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	immediately covered both sites by the Resident's clothing after the second injection was administered without observing for bleeding or addressing the bleeding from the first injection. RN "E" then removed a dated fentanyl patch from right upper chest and applied a new fentanyl patch to the area that was prepped on the left upper chest. The discarded patch had been crumpled and placed in a medication cup. Upon returning to the medication cart RN "E" was asked if she wears gloves when administering insulin. RN "E" stated "No". RN "E" was then observed to place the medication cup containing the discarded fentanyl patch into the top drawer of the medication cart which is not equipped to be double locked. RN "E" reported when she completes her morning medication pass, she will discard the old fentanyl patch with another nurse. On 3/6/24 at 10:54 AM an interview was conducted with the Director of Nursing (DON) in her office. The medication administration and post- administration observations of RN "E" were discussed with the DON. The DON reported that gloves are expected to be worn when a administrating injections. The DON reported that the discarded fentanyl patch should immediately destroyed with another nurse and not left in the medication cart. The DON reported that a used/ dirty patch should not be placed in a clean drawer. The DON acknowledged that controlled substances are to be securely stored. The policy provided by the facility titled "Licensed Nursing Procedures", "Subject: Injections Insulin" last updated 4/19/22 was reviewed. The "Procedure" reflected "13. Wash hands. Apply gloves". And "20. Apply firm pressure over the site with alcohol pad or cotton ball". And "#23. Remove gloves, wash hands". The policy provide by the facility titled			

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	Medication Administration", " Subject: Controlled Drugs" last updated 5/14/20 was reviewed. The policy reflected, "Procedure:" Narcotic Box: A separate locked compartment for controlled drugs is provided within a locked cabinet ..."			
F0686 SS= D	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the facility policy for pressure injury/wound management for 1 out of 6 residents (Resident #41) reviewed for pressure injury monitoring and treatment, resulting in incomplete and late wound assessments. Findings: Resident #41 (R41) Review of an "Admission Record" revealed R41 was a 65-year-old male, originally admitted to the facility on 1/4/20, with pertinent diagnoses which	F0686		

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	included: acute cerebrovascular insufficiency (affects blood flow to the brain). Review of R41's "General Progress Note" dated 1/30/24 revealed, "pt (patient) has a 2.5x3 (cm) shearing to left buttock, pt had been previously sitting at side of bed with therapy, triad cream applied." Review of R41's "Skin" Progress Note dated 2/3/24 revealed, "Location: B/L (bilateral) buttocks Type of Skin Change/Impairment: MASD (moisture associated skin damage) Measurement(s): Left outer 3.5x2 (cm) Left inner 2x1.5 Right 1x0.7 Description ...wound beds are red in color, scant bleeding noted, surrounding skin is pink and flaky, blanchable Current Treatment(s):: cleanse with NS/WC (normal saline/wound cleanser), pat dry, apply collagen to wound bed, cover with silicone foam dressing, change daily ..." The measurement did not identify the "shearing" injury identified on 1/30/24. There were no wound measurements completed on 2/6/24 (7 days from the identification/measurements of shearing on 1/30/24) or on 2/10/24 (7 days from the MASD measurements) per the facility policy. Review of R41's "Skin" Progress Note dated 2/14/24 revealed, "Location: Left and right buttock Type of Skin Change/Impairment: (blank) Measurement(s): Left Outer: 3.3 x 2 (cm) Left Inner 2 x 1.4 Right .9 x1 Description ...Red wound beds scaley around Current Treatment(s): cleanse with NS/WC, pat dry, apply collagen to wound bed, cover with silicone foam dressing, change daily ..." The type of impairment (MASD and/or shearing) was not identified in the			

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	assessment. There were no wound measurements completed on 2/21/24, 2/28/24, or 3/6/24 (as of 1:00 PM). During an interview on 3/6/24 at 1:07 PM, Unit Manager/Wound Care Nurse (UM/WCN) "A" reported that shearing wounds and MASD should be measured weekly. UM/WCN "A" reported that R41 moved from the Front Unit to the Back Unit on 2/14/24 and the wound tracking was unintentionally discontinued at that time. UM/WCN "A" reported a wound assessment would be completed and documented immediately. Review of the facility policy "Skin Monitoring and Management-Pressure Ulcer" adopted 7/11/18 revealed, " ...Assessment of wounds on admission, readmission AND discharge: *A licensed nurse (which may be the Wound Nurse) must assess/evaluate a resident's skin on admission. All areas of breakdown, excoriation, or discoloration, or other unusual findings, must be documented in the Admission Assessment. *A licensed nurse (which may be the Wound Nurse) must assess/evaluate each wound that exists on the resident. This assessment/evaluation should include but not be limited to: *Measuring the wound *Staging the wound *Describing the nature of the wound (e.g., pressure, stasis, surgical wound) *Describing the location of the wound *Describing the characteristics of the wound A. Assessment of wounds identified after			

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	admission: *A licensed nurse (which may be the facility Wound Nurse) must assess/evaluate a resident's skin at least weekly. All areas of breakdown, excoriation, or discoloration, or other unusual findings must be documented in the resident's clinical record. B. A licensed nurse (which can be the facility Wound Nurse) must assess/evaluate at least weekly each wound, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to: *Measuring the wound *Staging the wound *Describing the nature of the wound (e.g., pressure, stasis, surgical wound) *Describing the location of the wound *Describing the characteristics of the wound *Describing the progress with healing, and any barriers to healing which may exist *Identifying any possible complications or signs/symptoms consistent with the possibility of infection ..."			
F0759 SS= D	Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by:	F0759		

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	Based on observation, interview, and record review, the facility failed to ensure adherence to proper medication administration guidelines for two Residents (R15 and R62) resulting in a medication administration error rate of greater than five percent. Findings Resident #15 (R15) Review of the medical record reflected R15 originally admitted to the facility 7/28/19 and a pertinent diagnosis of End Stage Renal Disease (ERSD) and is on Hemodialysis. Review of the Doctor's Orders for R15 revealed an order for "Sevelamer Oral Tablets 800 milligram (mg) Give 2 tablet by mouth before meals for high phosphorous levels." On 3/5/24 at 8:10 AM a medication administration observation was conducted with Licensed Practical Nurse (LPN) "F". LPN "F" was observed to administer 2 tabs of Sevelamer 800 milligrams ordered to be given before meals to R15. R15 reported she had eaten her breakfast earlier. Review of the manufacturer's product information sheet reflects sevelamer is to be taken with meals. The section titled "Clinical Pharmacology" reflects that "taken with meals (the medication) has been shown to decrease serum phosphorus concentrations in patients with ESRD who are on hemodialysis." Under the "Patient Counseling" section of the manufacturer's literature it is reinforced to "Inform patients to take (sevelamer) with meals". Resident #62 (R62)			

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	Review of the medical record reflects R62 admitted to the facility 6/6/23 with pertinent diagnoses that included Blindness, History of Stroke, and Hemiplegia/Hemiparesis (weakness or paralysis to one side of the body). Review of the Doctor's Orders for R62 reflected an active order for Fluticasone Propionate Nasal Suspension 50 micrograms (mcg) 2 sprays in each nostril in the morning. The manufacturer's product information sheet instructions for use for fluticasone propionate nasal spray was reviewed. The instructions for use reflect "Step 1. Blow your nose to clear your nostrils." Step 2. Close 1 nostril, Tilt your head forward slightly ..." The direction for use included an illustration of one nostril being held closed and the nasal spray applicator inserted into the other nostril. On 3/6/24 at 8:04 AM a medication administration observation was conducted with Registered Nurse (RN) "E" in the room of R62. Upon entry to the room R62 was in bed lying back at approximately a forty-five-degree angle. RN "E" administered oral medication to the resident. RN "E" then placed the nasal applicator in the left nares of the Resident and gave three successive sprays of Fluticasone Nasal Suspension 50 mcg. R62 appeared to flinch with the insertion of nasal applicator and the sudden administration of sprays as if unprepared. Three sprays of the medication were then administrated into the R nares which R62 appeared to tolerate well. RN "E" did not have R62 tip her head forward or ask R62 to blow her nose prior to the administration. RN "E" did not hold closed the opposite nares when the nasal spray was administered. On 3/6/24 at 11:35 AM a follow up interview was			

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	conducted with R62 in her room. R62 indicated she doesn't recall ever being asked to blow her nose prior to the administration of the nasal spray but reported that she often does have "a stuffy nose". R62 reported that staff administer the nasal spray to her because she doesn't have the hand strength to do so. R62 indicated that she is not always prepared for the sudden spray up her nose stating,, "it does catch me by surprise sometimes".			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation	F0880		

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	should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: This citation has 2 Deficient Practice Statements (DPS) DPS 1 Based on interview and record review, the facility failed to implement an effective and current system of surveillance of staff illnesses to identify possible communicable diseases and infections to prevent the spread of an illness/outbreak. Findings: An infection control program interview on 3/6/24 at 10:07 AM with Unit Manager/Infection			

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	344020	A. BUILDING _____ B. WING _____	**3/6/2024**

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	Control Preventionist (UM/ICP) "B" and Director of Nursing (DON) revealed the following: DON reported that she was responsible for the tracking/surveillance of facility employee illnesses. DON reported that employee illnesses were tracked on the "Respiratory Surveillance Line List" only if they tested positive for COVID. No other "Surveillance Line Lists" were utilized. DON reported that employee illnesses were tracked via the "Employee Absence Form." All staff include maintenance, housekeeping, nursing, dietary, management, reception, and activity staff. Review of the "Employee Absence Forms" tracked in the Infection Control Program for employee surveillance from December 2023-present (3/6/24) revealed: 5 "Employee Absence Forms" for December 2023 2 "Employee Absence Forms" for January 2024 1 "Employee Absence Forms" for February 2024 DON reported that when staff called off of work the "Employee Absence Form" was completed by the person who took the call, sent to the scheduler, and then forwarded by the scheduler to the DON. DON reported that if a staff member had 2 symptoms present (elevated temperature, vomiting, cough, sore throat, diarrhea, open wound, swelling, muscle/joint soreness), they were then tested for COVID. If the COVID test was negative, they could return to work when symptoms resolved. DON reported if a staff member reported a fever, they could not return to work until they were 24 hours fever free without the use of an antipyretic. There were no criteria for staff to return to work following nausea, vomiting, and/or diarrhea. DON reported that			

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	employees were tracked for COVID and confirmed no other illnesses were included such as gastrointestinal (norovirus), respiratory (influenza and/or RSV), contagious skin conditions, etc. During an interview on 3/6/24 at 11:30 AM, Scheduler (S) "C" reported that she would receive the "Employee Absence Forms" and forward the form to the DON only if the employee had 2 symptoms present or had called off of work 2 days in a row. If those criteria were met the employee was to report to the facility parking lot for COVID testing. S "C" reported if the employee only exhibited 1 symptom, and/or called in for 1 shift, they were not required to test. S "C" confirmed there was no required "return to work" date/time for employees who exhibited symptoms of other respiratory or gastrointestinal illnesses. S "C" reported employees were aware of the criteria and would often report only 1 symptom in order to avoid COVID testing. A copy of all "Employee Absence Forms" for the month of February 2024 was requested and received. On 2/3/24 a CNA (Certified Nursing Assistant) was sent home for "vomiting." On 2/4/24 that CNA called off of work due to her "children are vomiting" indicating the possible exposure to residents of a contagious gastrointestinal illness. CNAs provide direct care to residents which increases the risk of the spread of an illness to the vulnerable population. On 2/10/24-2/11/24 a CNA called off of work for "throwing up." The form did not include a date she could return to work without the risk of the spread of a gastrointestinal illness. On 2/18/24 and 2/19/24 a nurse called off of work			

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	for elevated temperature, sore throat, and muscle pain. On 2/21/24 the nurse called off for "bronchitis, blood nose, fever." There was no return to work date documented. On 3/6/24 at 2:00 PM Nursing Home Administrator reported that the nurse returned to work on 2/22/24. There was no indication that the DON ensure she was 24 hours fever free prior to returning to work. On 2/22/24 a CNA called off of work for "throwing up." The form did not include a date she could return to work without the risk of the spread of a gastrointestinal illness. On 2/29/24 a housekeeping employee called off of work for vomiting. The form did not include a date she could return to work without the risk of the spread of a gastrointestinal illness. On 2/29/24 and 3/1/24 a confidential staff member called off of work for a cough and sore throat. It was identified on 3/1/24 at 10:15 PM that the staff member tested positive for influenza A. This employee was not included in the Infection Control Program/employee surveillance reviewed with the DON and was not listed on the "Respiratory Surveillance Line List." On 2/28/24 and 2/29/24 a CNA had called in for vomiting. This employee was not included in the Infection Control Program/employee surveillance reviewed with the DON. There were 24 employee call-offs for "sick" for the month of February 2024. Review of the facility policy, "Infection Prevention and Control Surveillance" adopted 7/11/18revealed, "PURPOSE: To conduct surveillance of resident and employee infections to guide prevention activities. POLICY: The Infection Preventionist/designee does surveillance			

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	of infections among residents, employees, volunteers and visitors. I. The Infection Preventionist/designee does surveillance of healthcare-associated infections by ...D. Review of the Infection Report Form, 24 Hour Report, or morning clinical/stand-up meeting E. Personal consultation with volunteers, employees and visitors F. Follow-up on communicable disease exposure G. Maintenance of the employee infection record ... Surveillance documentation is maintained on the: A. Line Listing of the Monthly Infection Surveillance Log *Monthly Infection Surveillance Summary Report *Monthly Summary Infection Control Graph B. Log of Employee/Volunteer/Visitor Infections." DPS 2 Based on interview and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the residents in the facility. Findings include: During a review of the facilities documentation of their Water Management Plan, provided by Maintenance Director "D", at 12:55 PM on 3/4/24 it was found that the facility tests for free chlorine every two weeks and flushes some minimum use fixtures weekly. Further review of the total free chlorine checks found numerous results of 0.00 parts per million (ppm) from tested hot water samples over the last year. When asked what was to be done if any of the samples came back as 0.00 ppm, DM "D" stated that he was just told to document the results and was not sure if there was			

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	any corrective action. An interview with MD "D", at 10:30 AM on 3/5/24, found that the facilities policy and procedure was "pretty short" and that it didn't give much guidance on how to carry out the Water Management Plan. The facility was not able to provide a completed CDC toolkit, and provided no reference to following: the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) Guidelines for the reduction of Legionella, having done an annual assessment, or documentation of having a water management team assigned.			