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 _____	**10/11/2024**

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 an Abbreviated Survey from 10/4/24 to 10/11/24. Intakes: MI00145185, MI00145801, MI00146336, MI00146994, MI00147375 Census: 122	F0000		
F0689 SS= D	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: This citation pertains to Intake #MI00146336. Based on interview, and record review, the facility failed to provide adequate supervision to prevent elopement and respond appropriately to the alarm system in 1 of 3 residents (Resident #103) reviewed for wandering/elopement, resulting in Resident #103 exiting the facility unbeknownst to staff and the potential for injury. Findings include: Review of the policy/procedure "Elopement", dated 2/5/20, revealed "...It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. All residents will be assessed for behaviors or conditions that put them at risk for wandering/elopement. All residents so identified	F0689		

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

Electronically Signed | 10/27/2024

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.

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 _____	**10/11/2024**

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
	will have these issues addressed in their individual plan of care...Residents who have been assessed at risk for elopement/wandering shall be provided at least one of the following safety precautions by the facility...An adult electronic monitoring safety device will be used to notify/alert staff by sounding an alarm when the resident enters the perimeter around an alarmed door...Door alarms placed on facility exits...At no times shall a door alarm be turned off, without the continual supervision of the exit...When a door alarm sounds, staff members shall immediately respond to determine the cause of the alarm...The staff person responding to the alarm will check the outside of the building/vicinity of the area to determine if a resident has exited the building..." Review of an "Admission Record" revealed Resident #103 was a male, with pertinent diagnoses which included metabolic encephalopathy (a condition which results in impaired brain function), kidney disease, high blood pressure, heart disease, obstructive lung disease, and altered mental status. Review of a "Minimum Data Set" (MDS) assessment for Resident #103, with a reference date of 9/24/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 3, out of a total possible score of 15, which indicated severe cognitive impairment. Review of a "Wandering Risk Scale" assessment for Resident #103, with a reference date of 6/25/24, revealed he was considered "High Risk" for wandering/elopement. Review of a "Care Plan" for Resident #103 revealed the focus "...(Resident #103) has a history of and exhibits wandering and exit-seeking behavior in the facility. (Resident #103) will ask when he can exit the facility and return			

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 _____	**10/11/2024**

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
	home. His wandering behavior is likely related to recent SNF (Skilled Nursing Facility) placement, desire to return to the community, paired with cognitive impairment (DX (diagnosis): Metabolic Encephalopathy, Altered Mental Status) and labile mood..." initiated 6/25/24 and revised 7/18/24, with interventions which included "...WANDER ALERT (electronic monitoring safety device)...Check for placement q (every) shift and function per policy..." initiated 6/25/24. Review of a "General Progress Note" for Resident #103, dated 7/16/24 at 7:11 PM, revealed "...Resident is wandering and going into resident's rooms. He also attempted to (open) the exit doors..." Review of an "Incident Report" for Resident #103, dated 7/17/24 at 7:45 PM, revealed "...A resident (another resident) approached the nurse, stating that the front desk staff let a resident who was not supposed to be outside by themselves out of the front entrance. The nurse proceeded to the entrance and exit from the hall, where she noticed (Resident #103) almost off the facility campus, headed to the main road at the far end of the parking lot. The nurse asked the front desk staff how she let (Resident #103) out of the facility, to which she responded "I thought he was a visitor, and he asked to go to the parking lot". The nurse informed the front desk staff that the resident did not have an LOA (Leave of Absence) order to leave independently, so he had the bracelet on his left leg. It was alarming when the nurse helped him back into the facility...Reported by (Witness "Y") to ("Registered Nurse" (RN) "DD") - (Resident #103) was let out the front door after he asked the receptionist how to get out to the parking lot. (Resident #103) was not asked to sign out and did not have approved LOA. Resident reporting this to RN (Witness "Y") was alarmed something wasn't right because (they) noticed "he had a tether on, a white bracelet on his ankle", the			

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 _____	**10/11/2024**

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
	receptionist "got up and punched in the code to make the alarm stop and then went back to her seat and continued to look at her cell phone". RN was informed by (Witness "Y") immediately after incident..." Review of a "General Progress Note" for Resident #103, dated 7/17/24 at 8:30 PM, revealed "...(A resident) notified the nurse a resident was outside with (an) alarm on (WANDER ALERT)...The nurse proceeded to the entrance and exit from the hall, where she noticed (Resident #103), walking to the driveway, toward the road. Noted the front desk clerk was at the desk, and the alarm did sound and the (WANDER ALERT) was observed on his left leg. Immediately the nurse went to (Resident #103) to assist him back to the facility...(Resident #103) (was asked) where he was going and responded that he was looking for a cab or bus to get home...(WANDER ALERT) expiration and function (checked) and in good working order...All doors (checked) for function, alarming appropriately. Immediate intervention: placed on 1:1 (direct supervision) and (Care Plan) updated..." Review of a Physician "Progress Note" for Resident #103, dated 7/18/24, revealed "...He is seen today after an episode of elopement that occurred yesterday evening. He had a functioning (WANDER ALERT) in place but he was allowed out by front desk staff. He was found in the far end of the parking lot by nursing staff and was redirected back into the building without incident...he was placed on 1:1 supervision..." In an interview on 10/10/24 at 3:11 PM, Witness "Y", a resident at the facility, reported they observed Resident #103 approach the receptionist at the front desk on 7/17/24, ask how to get out of the building, then exit through the front door. Witness "Y" reported the receptionist at the desk			

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 _____	**10/11/2024**

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
	"...didn't try to stop him or nothing. I told the nurse..." Witness "Y" stated "...I said that's not a visitor. The front desk girl didn't even care..." Witness "Y" reported a door alarm did sound when Resident #103 exited the facility. Attempted to contact RN "DD via phone on 10/10/24 at 3:50 PM for an interview. Phone number provided no longer in service. In an interview on 10/10/24 at 4:24 PM, with Administrator "A" and "Director of Nursing" (DON) "B", Administrator "A" and DON "B" reported Witness "Y" approached RN "DD" to report what they had observed. Administrator "A" and DON "B" reported RN "DD" responded immediately, and at that point Resident #103 was outside the building in the parking lot. Administrator "A" and DON "B" reported Resident #103 was able to be redirected back inside the facility, his WANDER ALERT bracelet was in place, and the door alarms did sound. Administrator "A" reported she spoke with Receptionist "M" about the incident and discovered Receptionist "M" heard the alarm go off but did not respond appropriately. In an interview on 10/11/24 at 1:47 PM, "Licensed Practical Nurse" (LPN) "X" reported Resident #103's elopement on 7/17/24 occurred within an hour of evening shift change. LPN "X" reported RN "DD" approached to notify her that Resident #103 had eloped and went out into the parking lot. LPN "X" reported when she approached Resident #103 after he was brought back into the facility, he was sitting calmly at the desk with a WANDER ALERT bracelet in place. LPN "X" stated "...The receptionist heard the alarm and didn't react..." LPN "X" reported after Resident #103's elopement on 7/17/24, 1:1 supervision was initiated.			

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 _____	**10/11/2024**

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
	Review of an "Employee Statement" from Receptionist "M", dated 7/17/24, revealed "...Can you tell me what happened? I was at (the) front desk and the resident approached the door I opened it and he walked out. Did you know he was a resident? No, we get new residents all the time how am I supposed to know who is a visitor and who is a resident? Did he sign out as visitor or resident? No. When you heard the alarm going off did you check to see if he was a resident who was not supposed to go (outside)? No that thing makes noise all the time (indicating the alarm system) so I just turned it off..." The facility was granted a Past Non-Compliance at the time of exit due to no further like incidents had occurred, the facility re-trained pertinent staff, the Elopement policy was reviewed and deemed appropriate, and the facility had achieved sustained compliance. Therefore, no plan of correction will be required.			
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(h) Medical records. §483.70(h)(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(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of	F0842	F- 842 Resident Identifiable Information-Medical Record Accuracy Element One: The Interdisciplinary Team (IDT) assessed and evaluated Resident #107; the findings were unremarkable. It was noted that this resident did not make further attempts during this assessment period and exited the facility without a Leave of absence order (LOA). Hence, the care plan was reviewed and revised. Element Two: This practice could affect residents at high risk of wandering outside the facility without an LOA order. The facility has identified residents at high risk of exiting the facility who require supervision and thus do not have an order to go on an LOA independently. The	10/30/2024

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 _____	10/11/2024

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
	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 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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(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: This citation pertains to Intake # MI00146994.		identified residents were reviewed with the IDT, and progress was reviewed; as of 10/30/2024, no residents exited the facility who required supervision. Elements Three: The Director of Nursing/ Designee re-educated licensed nurses to ensure that residents exit the facility without supervision/ no independent LOA. Hence, the licensed nurses' documents in the medical record reflect the behaviors of the affected residents, even in instances when staff follow residents outside of the facility. Licensed nurses will be re-educated by 10/30/2024 or the beginning of their next shift. Element Four: The Director of Nursing/ Designee will conduct a random audit of 5 residents weekly for 4 weeks, then monthly for two months or until substantial compliance. Thus, if residents exit the facility without an LOA order, licensed nurses have documentation in the medical records that reflects the behaviors, and care plans are reviewed and revised as needed. Any concerns noted will be addressed promptly. Furthermore, the audit results will be presented to the QAPI committee monthly for review and consideration of further corrective actions until substantial compliance has been decided upon. Element Five: The Director of Nursing will be responsible for compliance with the regulation by 10/30/2024 and after that.	

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 _____	**10/11/2024**

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
	Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in 1 of 4 residents (Resident #107) reviewed for accuracy of medical records, resulting in an inaccurate behavior record and the potential for providers to not have an accurate picture of resident status and condition. 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 an "Admission Record" revealed Resident #107 was a male, with pertinent diagnoses which included dementia, high blood pressure, malnutrition, chronic pain, and a history of falls. Review of a "Minimum Data Set" (MDS) assessment for Resident #107, with a reference date of 8/22/24, revealed a "Brief Interview for Mental Status" (BIMS) score of 12, out of a total possible score of 15, which indicated moderate cognitive impairment. Review of a "Wandering Risk Scale" assessment for Resident #107, dated 7/18/24, revealed he was "At Risk" for wandering/elopement. Review of a "Care Plan" for Resident #107 revealed the focus "...Resident is an elopement risk and/or exhibits wandering behavior..." initiated 6/16/23 and revised 8/1/24, with			

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 _____	**10/11/2024**

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
	interventions which included "...WANDER ALERT (electronic monitoring safety device)...Check for placement q (every) shift and function per policy..." initiated 6/16/23 and revised 8/1/24. Review of a "Care Plan" for Resident #107 revealed the focus "...Resident is/has potential to be verbally aggressive towards staff due to ineffective coping skills, mental/emotional illness, poor impulse control. (Resident #107) enjoys coloring/drawing and voices enjoying sharing his artwork with others. Some days his artwork is a successful intervention to keep him busy while other days he voices frustration regarding need for facility placement..." initiated 9/19/23 and revised 10/10/23, with interventions which included "...Monitor behavior and document observation and attempted interventions per facility protocol..." initiated 9/19/23. In an observation and interview on 10/4/24 at 12:10 PM, Resident #107 was noted in bed in his room. Resident #107 stated "...I would like to get out of here...There is nothing wrong with my legs. I can walk and talk. I just want to get out of here..." Observed a WANDER ALERT bracelet on Resident #107's right ankle. In an email sent to Administrator "A" and "Director of Nursing" (DON) "B" on 10/4/24 at 1:06 PM, requested all incident/accident reports for Resident #107 for the past six months. No incident/accident reports were provided. In an interview on 10/10/24 at 9:15 AM, Social Services Director "I" reported Resident #107 attempted to elope from the facility in July 2024 and stated "...staff had to run after him down the street..." Social Services Director "I" reported Resident #107 has a history of			

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 _____	**10/11/2024**

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
	wandering/elopement behaviors and wears a WANDER ALERT bracelet. Social Services Director "I" later clarified that the attempted elopement occurred on 7/28/24. In an interview on 10/10/24 at 1:25 PM, Administrator "A" reported when Resident #107 attempted to elope from the facility on 7/28/24, he was never out of sight of staff. Administrator "A" reported Resident #107 exited through the front door and Receptionist "K" yelled for help and kept eyes on him while nursing staff responded. Administrator "A" reported Resident #107 often enjoys sitting in the front lobby area, but that day "...took off..." out the door. In an interview on 10/10/24 at 1:37 PM, "Certified Nursing Assistant" (CNA) "J" reported she was charting at the desk when Receptionist "K" notified her that Resident #107 had exited the facility. CNA "J" reported when she got outside, Resident #107 was in the driveway, not far from the main entrance. CNA "J" reported Resident #107 had followed another resident out while the doors were open and stated "...he knew what he was doing..." CNA "J" reported Resident #107 continued to walk away from the facility and she followed. CNA "J" reported Resident #107 was agitated and resistant to redirection. CNA "J" reported Resident #107 walked out along the main road, and ended up crossing the four-lane, divided street. CNA "J" stated "...I followed him the whole time but didn't get too close because he seemed threatened. I had eyes on him the whole time..." CNA "J" reported she instructed "Licensed Practical Nurse" (LPN) "L", who had also came to assist, to get her car and help bring him back inside. CNA "J" reported LPN "L" was able to redirect Resident #107 to get into the vehicle and return to the facility. CNA "J" reported she did not document the incident in Resident #107's medical record or write a statement about what had occurred.			

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 _____	**10/11/2024**

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
	In an interview on 10/10/24 at 1:58 PM, LPN "L" reported the morning of Resident #107's attempted elopement on 7/28/24, he was in the hallway more than usual. LPN "L" reported she and CNA "J" redirected him to his room for breakfast. LPN "L" reported after breakfast, Resident #107 was sitting in one of the chairs in the main entryway. LPN "L" reported Receptionist "K" got CNA "J's" attention to tell her Resident #107 had exited the facility while the doors were open for another resident. LPN "L" reported CNA "J" immediately went after Resident #107 and she (LPN "L") followed after them. LPN "L" reported after Resident #107 left the property, she (LPN "L") went to get her vehicle while CNA "J" continued to follow Resident #107 on foot. LPN "L" reported she was ultimately able to redirect Resident #107 into the vehicle and bring him back to the facility. LPN "L" reported she did not document the incident/attempted elopement and stated "...I was told if we were in visual sight of the individual that I didn't need to do anything further..." LPN "L" reported documentation for escalation of behaviors is typically completed in the "Progress Notes". In an interview on 10/10/24 at 2:45 PM, LPN "L" reported Resident #107 had removed his WANDER ALERT bracelet prior to his attempted elopement on 7/28/24. LPN "L" reported she put a new WANDER ALERT bracelet on his right ankle that day and updated the "Physician Orders". Review of the "Progress Notes" for Resident #107 revealed no documentation on 7/28/24 related to his escalation of behaviors, including the removal of his WANDER ALERT bracelet and attempted elopement.			

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 _____	**10/11/2024**

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
	Review of the "Standard Assessments" list for Resident #107 revealed no assessments were completed on 7/28/24. Review of the electronic "Treatment Administration Record" (TAR) for Resident #107, for July 2024, revealed the order "...BEHAVIOR TRACKING: Document # of hallucinations/delusions...every shift...Complete based on individual observation of patient and discussion with other care team members..." had no documentation (was blank) for 7/28/24 day shift. In an interview on 10/10/24 at 3:55 PM, Receptionist "K" reported she was at the front desk when Resident #107 attempted to elope on 7/28/24. Receptionist "K" reported another resident in a wheelchair signed out and was going out the front door when Resident #107 got up from a nearby chair and went out the door. Receptionist "K" stated "...I tried to stop him, telling him he didn't sign out..." Receptionist "K" reported Resident #107 waved her off and continued out the building. Receptionist "K" reported she notified CNA "J" and LPN "L" who went after Resident #107 into the parking lot and brought him back to the building a short time later. Receptionist "K" reported a door alarm did not sound when Resident #107 exited the building on 7/28/24. In an interview on 10/10/24 at 4:24 PM with Administrator "A" and "Director of Nursing" (DON) "B", DON "B" reported she was notified of Resident #107's attempted elopement on 7/28/24, shortly after it occurred. DON "B" reported the intention was to sit down with the staff involved and document what happened in an "Interdisciplinary Team" (IDT) note, and complete an incident report. DON "B" stated "...I missed making sure it was done...I got caught up			

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 _____	**10/11/2024**

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
	in something else..."			
F0880 SS= D	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 §483.71 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 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	F0880	F-880 Infection Prevention & Control Element One Hallways 600 and 400 are no longer experiencing a COVID-19 outbreak that requires contact isolation, assuring the doffing and donning of PPE (N-95, gloves, gown, and eye protector). The infection tracking log for this month has thus been updated to reflect this matter. Element Two All residents have the potential to be affected by this practice. The facility has evaluated residents for signs and symptoms of infection or worsening symptoms. Based on infection control report data and a review of the past 72 hours, no residents currently need contact isolation due COVID-19 as of 10/30/2024. Element Three The Administrator and Director of Nursing reviewed the following policies and procedures, including the contact precaution policy and procedure. They determined that they met regulatory standards of practice, especially regarding the doffing and donning of PPE. The Director of Nursing/ Designee re-educated all staff, emphasizing the need to perform correct hand hygiene, doffing, and donning PPE using contact isolation due to COVID-19. Nursing staff not re-educated by 10/30/2024 will receive education before their next scheduled shift. Element Four The Director of Nursing/ Designee will audit	10/30/2024

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 _____	**10/11/2024**

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
	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: Based on observation, interview, and record review, the facility failed to implement posted transmission-based precautions and don required "Personal Protective Equipment" (PPE) prior to entering COVID-19 positive resident rooms in 2 of 2 rooms reviewed for transmission-based precautions, resulting in the potential for cross-contamination and the development and spread of infection to a vulnerable population. Findings include: Review of the policy/procedure "COVID-19 Core Practices", dated 5/11/23, revealed "...The facility will follow recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Resident placement for suspected or confirmed SARS-CoV-2 (COVID-19)...It is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2...Staff members entering a resident room with suspected or confirmed SARS-CoV-2 should use all recommended PPE, which includes use of		five staff weekly and then every two weeks for four weeks to ensure proper hand hygiene, doffing, and PPE donning for those residents in contact isolation due to COVID-19. Any concerns identified will be addressed promptly. Furthermore, the audit results will be presented to the QAPI committee monthly for review and consideration of further corrective actions until substantial compliance has been determined. Element Five The Director of Nursing/designee will ensure that substantial compliance has been attained through this plan of correction by 10/30/2024 and sustained compliance after that.	

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 _____	**10/11/2024**

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
	a NIOSH approved N95 or equivalent or higher-level respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face), gloves, and gown..." In an observation on 10/4/24 at 11:23 AM, noted a resident room with an open door and an activated call light on the 600 Hall. Observed signage on the door which indicated "Special Droplet/Contact Precautions" were in place. Per the signage, staff were to wear a N-95 mask, eye protection (face shield or goggles), and don a gown and gloves prior to entering the room. Noted the sign stated "KEEP DOOR CLOSED". Observed "Certified Nursing Assistant" (CNA) "H" respond to the activated call light wearing a surgical mask. Noted CNA "H" did not change to a N-95 mask, or don any additional PPE prior to entering the room. Noted the PPE bin in the hallway outside the room only contained disposable gowns. No N-95 masks, gloves, or eye protection available. In an interview on 10/4/24 at 11:30 AM, CNA "H" reported she was not aware that any additional transmission-based precautions were in place for the room with the posted "Special Droplet/Contact Precautions" sign on the 600 Hall. CNA "H" reported she did not see the sign because the door to the room was open. CNA "H" reported for a room with "Special Droplet/Contact Precautions" in place, PPE should be worn into the room for the care of either resident (regardless of infection status). In an observation on 10/4/24 at 11:33 AM, "Licensed Practical Nurse" (LPN) "V" donned a gown, in addition to a surgical mask already worn, prior to entering a resident room with signage on the door that indicated "Special Droplet/Contact Precautions" were in place on the 600 Hall. Note this was the same room previously			

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 _____	**10/11/2024**

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
	entered by CNA "H". Per the signage, staff were to wear a N-95 mask, eye protection (face shield or goggles), and don a gown and gloves prior to entering the room. No N-95 mask, gloves, or eye protection utilized by LPN "V" while in the "Special Droplet/Contact Precautions" room. In an interview on 10/4/24 at 11:37 AM, LPN "V" reported the room on the 600 Hall with the "Special Droplet/Contact Precautions" in place had two residents, one who had a current COVID-19 infection and the other who had tested negative for COVID-19. LPN "V" reported the policy is to shelter COVID-19 positive residents in place to reduce the risk of contaminating someone else. LPN "V" reported staff try and keep the door to the room closed "...as much as possible..." LPN "V" reported PPE required in the "Special Droplet/Contact Precautions" room was a N-95 mask and gown. LPN "V" reported gloves were worn if they came in contact with the resident. LPN "V" reported she only wore a surgical mask into the "Special Droplet/Contact Precautions" room because she went to speak with the COVID-19 negative resident, and did not provide any care to the resident who was COVID-19 positive. LPN "V" reported when she entered the room, N-95 masks were not available in the PPE bin. LPN "V" acknowledged the required PPE should be worn when entering the "Special Droplet/Contact Precautions" room, not just specifically for the care of the COVID-19 positive resident. In an interview on 10/10/24 at 11:49 AM, CNA "P" reported residents who test positive for COVID-19 are placed on "Special Droplet/Contact Precautions" which require the use of PPE, which included a gown, gloves, eye protection, and N-95 mask. In an observation on 10/11/24 at 1:33 PM, noted			

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 _____	**10/11/2024**

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
	a resident room with an open door on the 400 Hall. Observed signage on the door which indicated "Special Droplet/Contact Precautions" were in place. Per the signage, staff were to wear a N-95 mask, eye protection (face shield or goggles), and don a gown and gloves prior to entering the room. Noted the sign stated "KEEP DOOR CLOSED". Observed Activity Director "W" talking with a resident in the room, while wearing only a surgical mask for PPE. Noted the resident she was speaking with was currently COVID-19 positive. In an observation and interview on 10/11/24 at 1:38 PM, Activity Director "W" exited the COVID-19 positive resident room. Noted Activity Director "W" continued to wear the surgical mask previously worn within the COVID-19 positive resident room. Activity Director "W" indicated the signage on the door listing PPE was only for direct care or when there was the chance to come into contact with body fluids. Noted after exiting the room, Activity Director "W" left the door to the room open. In an interview on 10/11/24 at 3:02 PM, "Director of Nursing" (DON)/Infection Preventionist "B" reported residents who test positive for COVID-19 are placed on "Special Droplet/Contact Precautions", which require the use of a N-95 mask, gown, gloves, and goggles or a face shield. DON/Infection Preventionist "B" reported if one resident tests positive for COVID-19, and the other negative in the same room, the facility shelters the residents in place and places both residents on "Special Droplet/Contact Precautions". DON/Infection Preventionist "B" reported the PPE required for both the COVID-19 positive and COVID-19 negative resident in the "Special Droplet/Contact Precautions" room was the same.			