STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235103	A. BUILDING _____ B. WING _____	06/30/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0626 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 745. Based on interview and record review the facility failed to permit a resident readmission to the facility in 1 of 3 residents (Resident #106) reviewed for admission and discharge resulting in Resident #106 not being allowed to return to the facility. Findings include: Review of the Centers for Disease Control (CDC) guidance (undated) revealed, The following are potential steps that can be taken to reduce the spread of COVID-19 in your facility. The guidance further revealed if the Resident is tested & COVID-19 negative then .Admit resident . Review of the Face Sheet revealed Resident #106 was a [AGE] year old male admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #106 had a mental status of independent for making his own decisions. Review of the electronic medical record revealed Resident #106 was discharged on [DATE]. During an interview on 6/23/20 at 9:47 am, Family Member (FM) S stated Resident #106 had left the facility to come home to visit his sick (with Covid-19) spouse and was not allowed to return to the facility. During an interview on 6/24/20 at 11:58 am, Social Worker (SW) C stated Resident #106 had .scheduled his own transportation to take him home. SW C stated, per CDC guidelines he (Resident #106) would have to go to the hospital if Resident #106 was to return to the facility. During an interview on 6/24/20 at 2:15 pm and 6/25/20 at 1:40 pm, Nursing Home Administrator (NHA) A stated, he (Resident #106) was discharged because that was his choice. NHA A stated Resident #106 was not allowed to return to the facility after because the facility knew he's (Resident #106) exposed to Covid 19. NHA A stated Resident #106 would had to have been sent to the hospital to be tested for Covid 19. NHA A stated, we (facility) did not want to readmit him (Resident #106) back to the facility because of the risk without a Covid 19 test. NHA A stated, we (facility) require a negative Covid (Covid 19) test prior to admission. Review of the Hospital Notes dated 6/10/20 revealed Resident #106 wanted to visit his wife at home and patient (Resident #106) no longer has a place to live. The Hospital Notes revealed hospital social worker .did get in contact with the facility and the facility stated .at this time they (facility) will not allow him (Resident #106) to return to the facility. The Hospital notes revealed the emergency room Physician stated, I do not feel patient is safe to be discharged from the hospital. The Hospital Notes further revealed, A COVID-19 test was performed and COVID-19 was not detected. During an interview on 6/23/20 at 9:47 am, Family Member (FM) S stated after he was discharged from the facility He (Resident #101) went to the hospital and now he's (Resident #106) residing at another facility since this one wouldn't take him back. Review of the Emergency Department Discharge record dated 6/10/20 at 2:27 pm revealed, He (Resident #106) apparently sign the paperwork and when he returned back to the facility, he was told he could not reenter and that he had signed himself out of the facility. After further discussion with social Work, it appears patient was actually aware that he was signing himself out and stated that he did not care because he wanted to visit his wife is he has not seen her in quite some time and she has been recently ill. Regardless, patient no longer has a place to live. He is a 3 limb [MEDICAL CONDITION] and has a history of [MEDICAL CONDITION] on [MEDICAL TREATMENT] Monday Wednesday Friday. He did go through a full run of [MEDICAL TREATMENT] today. He has no complaints at this time. Spoke with MSW who did get in contact with the facility. They say at this time they will not allow him to return. His son is at bedside however he feels he cannot accommodate him at home as a his house is not wheelchair friendly. Additionally, patient's wife and daughter would not be able to manage him at home by themselves as well. This is not reverse with many options and at this time I do not feel patient is safe to be discharged from the hospital. Will need to work on placement. This plan was discussed with the patient he is understanding. I spoke with hospitalist who agrees to admit for placement. Review of the Michigan Department of Health and Human Services document dated 4/16/20 revealed the facility received Covid-19 Regional Hub designation on 4/16/20 and was now eligible to receive additional function to support expenditures related to Covid-19. According to the document, Acceptance of additional funding constitutes agreement to: Admit individuals that are Covid-19 positive, a Person Under Investigation (PUI) or who display one or more of the principle symptoms of Covid-19 symptoms within current capacity standards and consistent with guidance from MDHHS, the Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services (CMS). The document was signed as accepted by a facility representative on 4/21/20 at 4:15 pm.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide sufficient staffing to meet resident needs for 1 of 3 residents (Resident #103) reviewed for facility staffing resulting in unmet resident needs. Findings include: Review of the Policy Staffing dated 7/11/18 revealed, Our facility provides adequate staffing to meet needed care and services for our resident population. The Policy further revealed the facility would maintain .adequate staffing on each shift to ensure that our resident's needs and services are met. Review of the Face Sheet revealed Resident #103 was a [AGE] year old female admitted to the facility on [DATE] and diagnosed with [REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] revealed Resident #103 had a brief interview for mental status (BIMS) score of 15 out of 15 which indicated she was cognitively intact. The MDS further revealed Resident #103 was an extensive assist of 2 staff members for toilet assistance. During an observation on 6/23/20 at 8:52 am, Resident #103 was noted to be in her bed on her back. During an interview on 6/23/20 at 8:52 am, Resident #103 there was not enough staff to assist her. Resident #103 stated when she rang her call light she would 'have to wait, sometimes up to an hour. Resident #103 stated, I go (urinate) in my diaper and I feel like they (facility) don't care, I don't feel comfortable when I'm wet. During an interview on 6/23/20 at 9:21 am, Certified Nurse Aide (CNA) F stated there were .a lot of 2 person assist residents on the 600 hall (the hall which Resident #103 resided). CNA F stated all staff try to answer (call lights) as soon as they can but not all the time can staff get to the call lights quickly and sometimes residents have to wait for call lights to be answered. During an interview on 6/23/20 at 9:28 am, CNA E stated on 600 hall residents were a lot of work because of the amount of 2 person assist residents. CNA E stated, that's an issue getting to call lights timely because of the limited number of staff after 11 in the morning. CNA E stated residents are always waiting for call lights to be answered. During an interview on 6/25/20 at 9:27 am, CNA N stated on 600 hall there's 5 of us (CNA's) until 11 am then there was 4 CNA's for the 600 hall. CNA N stated on 600 hall there were a lot of total care residents and a lot of needs to be met on the hall (600 hall). During an interview on 6/25/20 at 9:40 am, CNA O stated 600 hall had more 2 person assist residents which if you're with somebody (resident) and a call light goes off then that resident had to wait. CNA O stated morning staffing would decrease at 11 am when 1 of the CNA's would go

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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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) home. During an interview on 6/25/20 at 8:23 am, Scheduler L stated on 600 hall almost every resident was a 2 person assist. Scheduler L stated, yes everyday 600 hall CNA staff would decrease by 1 staff member at 11 am and then down to 3 CNA's at 3 pm for 46 residents. Review of the Daily Staffing dated 6/24/20 revealed 2 documented nursing staff and 5 CNA staff until 11 am and then 4 CNA staff after 11 am for 46 residents residing on the 600 hall. Review of the facility census report dated 6/24/20 revealed, 15 of the 46 residents residing on the 600 hall were 2 person assist. During an interview on 6/25/20 at 8:33 am, Scheduler L stated the 600 hall staffing was based on unit .census of the unit with a staff ratio of 10 to 1 (indicated 10 residents to 1 staff member).