STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36221 This citation pertains to Intake # MI00143491. Based on observation, interview, and record review, the facility failed to immediately treat a hot liquid burn per professional standards of practice in 1 of 5 residents (Resident #103) reviewed for quality of care, resulting in an Immediate Jeopardy when on 2/22/24 Resident #103 spilled a cup of hot liquid on her lap. Facility staff did not immediately apply cool liquid to the site to stop the burn, resulting in additional skin breakdown, prolonged healing, infection requiring IV (intravenous) antibiotics, and ongoing pain. Findings include: Review of an Admission Record revealed Resident #103 was a female, with pertinent diagnoses which included second-degree burn of thigh, skin infection, stroke with left sided weakness, peripheral vascular disease, dementia, and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 2/8/24, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated severe cognitive impairment. In an observation and interview on 4/10/24 at 9:57 AM, Resident #103 was in bed in her room, eating independently from her breakfast tray. No hot liquids observed on breakfast tray. Resident #103 reported she used to drink hot tea, but had a spill in the dining room which resulted in burns. Resident #103 reported her burns are still healing, and she goes out to the wound clinic for treatment. Review of an Incident/Accident report for Resident #103, dated 2/22/24 at 10:30 AM, revealed .Nurse was informed that resident spilled hot liquid on her lap while eating breakfast .Immediate Action Taken .Nurse had resident taken to the room where she resides and did a full skin assessment on her and the finding was red skin . Review of a Skin Assessment for Resident #103, dated 2/22/24 at 11:30 AM, revealed .Inner thighs have a red area to the skin due to a hot beverage getting spilled on her legs. Will continue to monitor the area until no longer red . No additional interventions noted. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/10/24 at 10:29 AM, Family Member LL reported Resident #103 had a hot liquid spill in the dining room on 2/22/24. Family Member LL reported Resident #103 spilled a cup of hot tea on her lap, which resulted in burns to both her legs and her buttocks. Family Member LL reported Resident #103 had to go to the wound clinic for care, and has treatments completed twice a day. Family Member LL reported Resident #103's wounds are painful, and stated .She still cries because it is so painful . Family Member LL reported staff did not know how to respond to the hot liquid spill, and stated .She sat in the (hot) water. They didn't know how to treat it . Review of a Health Status Note for Resident #103, dated 2/22/24 at 12:41 PM, revealed .Resident went to kitchen and asked for a cup of coffee. Kitchen manager gave resident a cup of coffee with a lid on the cup. Resident then took the lid off the cup of coffee and was trying to drink from the cup. Resident spilled the cup of coffee on her lap. Resident was immediately taken to her room to do a skin assessment of the area. Inner thighs had a red area to it. Cream was applied to the red area and clothes were changed. Resident was re-educated on the importance of keeping the lid on hot beverages. Staff will continue to monitor the area until it is healed . Note, no cool water was applied to stop the burning process prior to placing cream on the burns. Review of a Health Status Note for Resident #103, dated 2/22/24 at 4:46 PM, revealed .Resident was drinking hot liquids in the dining room for breakfast and spilled the hot beverage on her legs. A full skin assessment was performed after the incident. The finding was red area on the inner thigh. Resident c/o (complained of) pain at the area. Another skin assessment was performed at (4:00 PM) and the finding was blisters noted on the inner thighs all the way back to the buttocks. (Nurse Practitioner J) assessed the areas and gave orders to the nurse to start for wound care. Will continue to monitor the area until healed . Review of a Health Status Note for Resident #103, dated 2/22/24 at 5:40 PM, revealed .Measurement for blisters on inner thighs. Left thigh and buttocks blister 36cm (this runs all the way across left buttocks.) 36cm x 8cm. Right inner thigh 10.5cm x 5.5cm blister. skin tear below right thigh blister 5.5cm x 2.5cm . Review of a Physician's Progress Note for Resident #103, dated 2/23/24 at 11:39 AM, revealed .Apparently yesterday she was drinking hot tea and spilled her tea in her lap - subsequently skin was burned and nursing requesting evaluation .Second degree burns with two large blisters of left thigh - one intact and the second one has opened with pink wound bed .Second degree burns on right thigh with long nearly circumferential blister that is fluid filled and three additional circular burns with fluid filled blisters .Plan: Second degree burns on thighs after tea spilled in her lap. Cover open blister with TAO (triple antibiotic ointment) and sterile dressing, changing dressing daily and monitoring for drainage. Monitor fluid filled blisters and try to keep blisters intact - avoid friction or rubbing . In an observation on 4/10/24 at 12:24 PM, Assistant Director of Nursing (ADON) W and Licensed Practical Nurse (LPN) Q completed wound care for Resident #103. Observed extensive burns to Resident #103's right and left thighs, with reddened wound bases and a small amount of blood-tinged drainage. Observed Resident #103 flinch as the old dressings were removed from the wounds, and state .ow, ow, ow . while holding her hand over her mouth. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 4/10/24 at 2:53 PM, Registered Nurse (RN) AA reported she was Resident #103's assigned nurse on 2/22/24 when the hot liquid spill occurred. RN AA reported staff brought Resident #103 to the unit from the dining room immediately after the hot liquid spill. RN AA stated Resident #103 .had removed the top from her coffee cup and it had spilled on her lap . RN AA reported she brought Resident #103 to her room and removed her pants to assess the affected area. RN AA stated .There was slightly red skin . when the area was initially assessed. RN AA reported no other treatment or intervention was done at that time, and stated .just the assessment of the skin . RN AA reported later on that day, Resident #103 was complaining of pain. RN AA reported she completed another assessment of Resident #103's skin, and noted blisters had formed on her thighs. In an interview on 4/10/24 at 3:20 PM, Server DD reported she served Resident #103 a cup of hot tea with a lid on 2/22/24. Server DD stated .Next thing you know I hear her screaming .She had spilt it all over herself . Server DD reported she and Server EE immediately brought Resident #103 to her assigned nurse. Server DD reported that since the incident, she was educated that cool liquid should be immediately applied to the burned area. Server EE stated .I didn't know that was what we were supposed to do . In an interview on 4/10/24 at 4:01 PM, ADON W reported she was working the day Resident #103's burns occurred. ADON W reported after staff notified her of the incident, she went in to assess Resident #103's skin to determine the severity of the burn. ADON W stated when she assessed Resident #103's skin .It wasn't blistered at the time .It looked like a dark area on her skin . ADON W reported Resident #103 reported pain from the affected area. In an interview on 4/11/24 at 9:05 AM, Nurse Practitioner (NP) J reported she was notified after Resident #103's hot liquid spill on 2/22/24. NP J reported when she assessed the wounds, she noted second-degree burns on Resident #103's thighs. NP J reported after the incident, Resident #103 complained of increased pain and was sent out to the hospital on 2/25/24. NP J reported Resident #103 returned to the facility with orders to be seen at the wound clinic. NP J reported Resident #103's wounds began draining, her wound was cultured, and she was started on IV antibiotics. NP J reported topical lidocaine was initiated during dressing changes .because she is so painful . and a Foley catheter was placed for wound management. NP J reported Resident #103's wounds were .more than just superficial break down . Review of a Hospital After Visit Summary for Resident #103, dated 2/25/24, revealed .has second-degree burns on the inner thighs .A referral was placed to the burn clinic for follow-up . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Burn and Wound Center note for Resident #103, dated 2/27/24, revealed .Chief Complaint . evaluation and management of second degree burn on thighs .Location: bilateral thighs .Burn occurred due to staff handing pt (patient) a cup of hot tea and she spilled it on her lap .Wound #1 status is Open. Original cause of wound was Thermal Burn. The date acquired was: 2/22/2024. The wound is currently classified as a Partial Thickness wound with etiology of 2nd degree Burn and is located on the Right, Circumferential Upper Leg. The wound measures 26cm length x 23 cm width x 0.1cm depth .There is Fat Layer (Subcutaneous Tissue) exposed .There is a large amount of serous drainage noted. There is medium (34-66%) red granulation within the wound bed. There is a medium (34-66%) amount of necrotic tissue within the wound bed including Eschar .Wound #2 status is Open. Original cause of wound was Thermal Burn. The date acquired was: 2/22/2024. The wound is currently classified as a Full Thickness Without Exposed Support Structures wound with etiology of 2nd degree Burn and is located on the Left, Circumferential Upper Leg. The wound measures 8.5cm length x 18.5cm width x 0.1cm depth .There is Fat Layer (Subcutaneous Tissue) exposed .There is a large amount of serous drainage noted. There is medium (34-66%) red, pale granulation within the wound bed. There is a medium (34-66%) amount of necrotic tissue within the wound bed including Eschar . Review of a Burn and Wound Center note for Resident #103, dated 3/5/25, revealed Chief Complaint . evaluation and management of second degree burns on thighs .Pt has bilateral thigh burns due to a cup of hot water spilling on her thighs. The kitchen staff took pt back to her room which may have contributed to the burns depth . Review of a Health Status Note for Resident #103, dated 3/11/24 at 5:42 PM, revealed .Observed green drainage from burns on left and right thigh and buttocks. NP notified. Order to culture wound completed . Review of a Physician's Progress Note for Resident #103, dated 3/14/24 at 11:14 AM, revealed .Recent burns on upper thighs after spilling hot liquid - blistered - treated with antibiotic therapy Keflex and appeared to be improving .additionally going to the wound clinic .2 days ago nursing reported malodorous green discharge from wounds - wound cultures and grew Pseudomonas aeruginosa, E. coli, providencia stuartii, and Pseudomonas aeruginosa #2 .Wound dressings are changed twice daily according to wound clinic treatment .Increased pain noted with wound dressing changes .Plan: Burns on bilateral inner thigh now infected with multiple organisms. Ordered Midline placement by access RN .Cefepime IV twice daily for 10 days .Topical lidocaine prior to dressing changes and Tramadol . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Burn and Wound Center note for Resident #103, dated 3/19/24, revealed .Chief Complaint . evaluation and management of second degree burns on thighs .Wound #1 status is Open. Original cause of wound was Thermal Burn .The wound is currently classified as a Full Thickness Without Exposed Support Structures wound with etiology of 2nd degree Burn and is located on the Right, Circumferential Upper Leg. The wound measures 32cm length x 14cm width x 0.1cm depth .There is Fat Layer (Subcutaneous Tissue) exposed. There is a large amount of serous drainage noted. There is small (1-33%) red granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including Eschar and Adherent Slough .(note, this necrotic tissue had increased in size) .Wound #2 status is Open. Original cause of wound was Thermal Burn .The wound is currently classified as a Full Thickness Without Exposed Support Structures wound with etiology of 2nd degree Burn and is located on the Left, Circumferential Upper Leg. The wound measures 14cm length x 15cm width x 0.1cm depth .There is Fat Layer (Subcutaneous Tissue) exposed .There is a large amount of serous drainage noted. There is small (1-33%) red, pale granulation within the wound bed. There is a large (67-100%) amount of necrotic tissue within the wound bed including Eschar and Adherent Slough (note, this necrotic tissue had increased in size) .Per caregiver, Patient now on IV (intravenous) Cefepime . In an interview on 4/11/24 at 10:45 AM, Server EE reported he was present at the time of Resident #103's hot liquid spill on 2/22/24. Server EE stated .I heard her yell and then turned and rushed her to the nurses' station . Server EE reported cool water was not applied to Resident #103's burned area. In an interview on 4/11/24 at 3:36 PM, RN AA reported in regard to treatment immediately after a hot liquid spill, cool liquid should be applied to the affected area. RN AA reported in regard to Resident #103's burns that occurred on 2/22/24 cool liquid was not applied to the affected area immediately after the hot liquid spill occurred. RN AA stated this intervention .Wasn't anything I was thinking of at the time . Review of a WebMD article titled Thermal Burns Treatment, dated 2024, revealed .For All Burns .Stop Burning Immediately .Put out the fire or stop the person's contact with hot liquid, steam, or other material . Remove hot or burned clothing. If clothing sticks to the skin, cut or tear around it .Remove Constrictive Clothing Immediately .Take off jewelry, belts, and tight clothing. Burns can swell quickly. Then take the following steps: For First-Degree Burns (Affecting Top Layer of Skin) 1. Cool Burn .Hold burned skin under cool (not cold) running water or immerse in cool water until the pain subsides. Use compresses if running water isn't available .For Second-Degree Burns (Affecting Top 2 Layers of Skin) 1. Cool Burn .Immerse in cool water for 10 or 15 minutes. Use compresses if running water isn't available. Don't apply ice. It can lower body temperature and cause further pain and damage . Obtained from https://www.webmd.com/first-aid/thermal-heat-or-fire-burns-treatment Review of a Cleveland Clinic article titled Second-Degree Burn, dated 2022, revealed .Care and Treatment . Use cool water to gently wash your burn. Try to keep your burn area under water for at least five minutes, up to 30 minutes. Gently pat the burn dry with a clean towel . Obtained from https://my.clevelandclinic.org/health/symptoms/24527-second-degree-burn (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an American Family Physician article titled Outpatient Burn Care: Prevention and Treatment, dated 2020, revealed .Most patients with burn injuries are treated as outpatients. Two key determinants of the need for referral to a burn center are burn depth and percentage of total body surface area involved. All burn injuries are considered trauma, prompting immediate evaluation for concomitant injuries. Initial treatment is directed at stopping the burn process. Superficial (first-degree) burns involve only the epidermal layer and require simple first-aid techniques with over-the-counter pain relievers. Partial-thickness (second-degree) burns are subdivided into two categories: superficial and deep. Superficial partial-thickness burns extend into the dermis, may take up to three weeks to heal, and require advanced dressings to protect the wound and promote a moist environment. Deep partial-thickness burns require immediate referral to a burn surgeon for possible early tangential excision .Pruritus, hypertrophic scarring, and permanent hyperpigmentation are long-term complications of partial-thickness burns. Burn injuries are more likely to occur in children and older people .Burn injuries are dynamic in nature, and even minor-appearing injuries can worsen with time (burn wound conversion) and need to be reassessed in 24 to 72 hours. Superficial partial-thickness burns can deepen spontaneously to deep partial-thickness or full-thickness involvement within 48 hours. Depth can also increase because of inadequate treatment or superinfection .For all types of minor burn injuries, the goals of initial treatment are to minimize the extent of the burn, clean the wound, and address pain. For scalds, immediate clothing removal lessens burn injury .Active cooling of the burn surface with running tap water (at 46.4 F [8 C] to 77 F [25 C]) for at least 20 minutes has been shown to reduce burn depth, improve healing time, and decrease grafting requirements. Cooling should commence within 30 minutes of the initial burn, but emerging evidence suggests this benefit may be achieved up to three hours after the burn. Wet dressings are not effective at cooling wounds. Ice should not be used because of its vasoconstrictive effects and risk of further tissue injury . Obtained from https://www.aafp.org/pubs/afp/issues/2020/0415/p463.html On 4/11/24, Administrator A was notified of an Immediate Jeopardy that began on 2/22/24 when the facility failed to immediately treat Resident #103's hot liquid burn per professional standards of practice. On 4/12/24, this surveyor verified the facility completed the following to remove the Immediate Jeopardy: 1. Resident #103 was assessed by the Licensed Nurse and Nurse Practitioner on 2/22/2024 with new orders for continued assessment of the reddened area. On 2/23/24 new orders were obtained for wound treatment. Based upon continued nursing assessment, Resident #103 was sent to the ER (emergency room) for evaluation on 2/25/24 and was referred to the Wound Clinic to obtain further treatment orders. Facility staff are trained, based upon the policy, to apply cool liquid immediately after a hot liquid spill and take the resident to a licensed nurse for further assessment and treatment. Per protocol, nurses report to the provider and obtain orders for treatment. 2. Residents residing in the community were reassessed for safety with hot liquids by the Director of Nursing or designee by 3/01/2024. Care plans were updated to reflect appropriate interventions. Hot liquid evaluations were added to the admissions checklist to ensure residents are assessed upon admission. 3. The policy/procedure for Hot Liquid Safety was reviewed by Administrator A on 2/23/2024 with updates as necessary. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 2/23/2024 education was initiated for all active staff on the policy/procedure for Hot Liquid Safety through the Relias platform (a computer-based training system). This education includes directions to pour cool liquid on the spill immediately and escort the resident to their nurse. The policy also ensures nursing staff assess the area for 24 hours after the incident. Nursing staff should take direction from the provider for further treatment of the area. Education has been completed by 142 out of 157 employees. Employees who have not yet completed their education have not worked the floor since 3/01/2024. 5. The Director of Nursing or designee will conduct a daily audit of residents, Monday through Friday, during meal service to ensure appropriate interventions for hot liquid spills are in place per resident care plan. During the weekend, licensed professionals on shift should continue to follow the policy by offering clothing protectors to all residents and providing a lid for all hot liquids. This audit will continue for 12 weeks. 6. The Dining Services Manager will conduct a daily audit of the coffee machine for 12 weeks to ensure temperatures of hot liquids are not greater than 140 degrees based upon the policy. This policy was adopted via The Compliance Store, and has references observed: Centers for Medicare and Medicaid Services. State Operations Manual, Appendix PP: Guidance to Surveyors, F-689 Free of Accidents Hazards / Supervision / Devices. Should a resident request their hot liquids be hotter than what is indicated in the policy, the community would utilize the Resident Assessment process where the Interdisciplinary Team would review the request, assess the resident, assess the staff ability to accommodate the request, and if the accommodation can be made, discuss how to provide that service in a safe manner. All documentation would then go into the resident care plan. 7. Results of the audits will be brought to the Quality Assurance Performance Improvement Committee meetings for review. Any changes to the auditing process will be determined by the QAPI Committee. The Administrator is responsible for attaining and maintaining compliance. Compliance was attained by 3/01/2024. 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 Hot Liquid Safety policy was developed and implemented, and the facility had achieved sustained compliance. Therefore, no plan of correction will be required.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 36221 This citation pertains to Intake # MI00143491. Based on observation, interview, and record review, the facility failed to ensure catheter tubing was secured to prevent pulling per physician order in 1 of 2 residents (Resident #103) reviewed for indwelling catheter care, resulting in the potential for dislodgement of the catheter tubing, the potential for urethral damage, and pain/discomfort. Findings include: Review of an Admission Record revealed Resident #103 was a female, with pertinent diagnoses which included second-degree burn of thigh, skin infection, stroke with left sided weakness. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 2/8/24, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated severe cognitive impairment. In an observation and interview on 4/10/24 at 9:57 AM, Resident #103 was in bed in her room, eating independently from her breakfast tray. Resident #103 reported she used to drink hot tea, but had a spill in the dining room which resulted in burns. Resident #103 reported her burns are still healing, and she goes out to the wound clinic for treatment. A Foley catheter bag was observed hanging on the side of Resident #103's bed. Review of an Order Summary Report for Resident #103 revealed the active physician order .Change foley catheter leg securement device every night shift every Sun (Sunday) for trauma prevention . with a start date of 3/17/24. In an observation on 4/10/24 at 12:24 PM, Assistant Director of Nursing (ADON) W and Licensed Practical Nurse (LPN) Q completed wound care for Resident #103. Noted a Foley catheter in place, with no securement device observed to prevent pulling/tugging on the catheter tubing. ADON W and LPN Q assisted Resident #103 to roll onto her left side. Noted the Foley catheter tubing was taut in this position, with the drainage bag hanging on the right side of Resident #103's bed. In an interview on 4/11/24 at 9:05 AM, Nurse Practitioner (NP) J reported she was notified after Resident #103's hot liquid spill on 2/22/24. NP J reported topical lidocaine was initiated during dressing changes . because she was so painful . and a Foley catheter was placed for wound management. Review of a Health Status Note for Resident #103, dated 3/15/24 at 1:57 PM, revealed .Resident has wounds to bilateral thighs, buttocks. Due to the wounds NP has ordered to insert a foley catheter until wounds have healed . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 4/17/24 at 8:54 AM, Certified Nursing Assistant (CNA) X and CNA V completed morning care for Resident #103. Observed a Foley catheter drainage bag hanging on the side of Resident #103's bed. Observed CNA V empty Resident #103's Foley catheter drainage bag, with clear yellow urine noted in the tubing. No catheter securement device noted to prevent pulling/tugging on the catheter tubing. CNA X reported typically residents with catheter have a strap on their leg to hold the catheter tubing in place. CNA X reported she is unsure why Resident #103 does not have a catheter securement device. In an observation and interview on 4/17/24 at 10:07 AM, ADON W and Unit Manager R completed wound care for Resident #103. Noted Resident #103 had a Foley catheter in place, with no securement device in use. ADON W reported Resident #103 .used to . use a strap style catheter securement device, however, she complained the strap was irritating her skin .so we took it off . ADON W reported she inquired yesterday (4/16/24) if a different style of catheter securement device could be ordered. Observed ADON W and Unit Manager R turn Resident #103 onto her left side. Noted Resident #103's catheter tubing appeared taught throughout care. Review of the Medication Administration Record (MAR) for Resident #103, for April 2024, revealed the order . Change foley catheter leg securement device every night shift every Sun for trauma prevention . was documented as .5=Hold/See Nurse Notes . on 4/7/24 and 4/14/24. Review of an Administration Note for Resident #103, dated 4/8/24 at 5:29 AM, revealed .Change foley catheter leg securement device .every night shift every Sun for trauma prevention .Awaiting from purchasing . Review of an Administration Note for Resident #103, dated 4/15/24 at 5:19 AM, revealed .Change foley catheter leg securement device .every night shift every Sun for trauma prevention .awaiting new device from purchasing . In an interview on 4/17/24 at 4:05 PM, Unit Manager R reported on 4/7/24, the regular catheter securement device was not available on the unit, so Resident #103's catheter securement device could not be changed. Unit Manager R reported on 4/14/24, nursing staff determined Resident #103 required a different style of catheter securement device, so a new style was ordered. Review of a Purchase Order revealed the facility placed an order for catheter securement devices on 4/16/24. Review of a Centers for Disease Control and Prevention (CDC) presentation titled Indwelling Urinary Catheter Insertion and Maintenance, no date, revealed .Maintenance: Catheter Care Essentials .Properly secure catheters to prevent movement and urethral traction .Maintain Unobstructed Urine Flow . Use a catheter securement device to anchor the catheter . Retrieved from https://www.cdc.gov/infectioncontrol/pdf/strive/CAUTI104-508.pdf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 36221 This citation pertains to Intake # MI00143491. Based on observation, interview, and record review, the facility failed to implement physician orders for pain management during wound care in 1 of 5 residents (Resident #103) reviewed for medication administration, resulting in pain during wound care and the potential for decreased quality of life. Findings include: Review of an Admission Record revealed Resident #103 was a female, with pertinent diagnoses which included second-degree burn of thigh and skin infection. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 2/8/24, revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated severe cognitive impairment. In an observation and interview on 4/10/24 at 9:57 AM, Resident #103 was in bed in her room, eating independently from her breakfast tray. Resident #103 reported she used to drink hot tea, but had a spill in the dining room which resulted in burns. Resident #103 reported her burns are still healing, and she goes out to the wound clinic for treatment. In an interview on 4/10/24 at 10:29 AM, Family Member LL reported Resident #103 had a hot liquid spill in the dining room on 2/22/24. Family Member LL reported Resident #103 spilled a cup of hot tea on her lap, which resulted in burns to both her legs and her buttocks. Family Member LL reported Resident #103 had to go to the wound clinic for care, and has treatments completed twice a day. Family Member LL reported Resident #103's wounds are painful, and stated .She still cries because it is so painful . Review of a Physician's Progress Note for Resident #103, dated 3/14/24 at 11:14 AM, revealed .Recent burns on upper thighs after spilling hot liquid - blistered - treated with antibiotic therapy Keflex and appeared to be improving .additionally going to the wound clinic .2 days ago nursing reported malodorous green discharge from wounds - wound cultures and grew Pseudomonas aeruginosa, E. coli, providencia stuartii, and Pseudomonas aeruginosa #2 .Wound dressings are changed twice daily according to wound clinic treatment .Increased pain noted with wound dressing changes .Plan .Topical lidocaine prior to dressing changes and Tramadol . Review of a Health Status Note for Resident #103, dated 3/14/24 at 12:09 PM, revealed .NP ordered lidocaine ointment 5% to be applied to wounds 10-15 minutes prior to treatment. This nurse put new orders in with an arrival date of medication tonight . Review of an Order Summary Report for Resident #103, revealed the active physician order .Lidocaine External Ointment 5 % (Lidocaine) Apply to Burns topically two times a day for Treatment to burns Apply lidocaine to wounds 10-15 mins (minutes) prior to treatment . with a start date of 3/15/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 4/10/24 at 12:24 PM, Assistant Director of Nursing (ADON) W and Licensed Practical Nurse (LPN) Q completed wound care for Resident #103. Observed extensive burns to Resident #103's right and left thighs, with reddened wound bases and a small amount of blood-tinged drainage. Observed Resident #103 flinch as the old dressings were removed from the wounds, and state . ow, ow, ow . while holding her hand over her mouth. After Resident #103's wounds were cleaned and dried, Lidocaine External Ointment 5% was applied to the perimeter of Resident #103's wounds. Resident #103 stated .It hurts, it hurts so much . LPN Q then wiped off the excess Lidocaine External Ointment 5% from the perimeter of Resident #103's wounds, and Hydrogel was applied to the wound beds. Noted nursing staff did not wait 10-15 minutes for the Lidocaine External Ointment 5% to take effect prior to completion of wound care for Resident #103. LPN Q reported Resident #103 receives scheduled Tylenol for pain, 1000 mg three times a day. LPN Q reported Resident #103 has PRN (as needed) Tramadol available as well, however this medication .doesn't really make a difference for (Resident #103) with the wound care . In an interview on 4/11/24 at 9:05 AM, Nurse Practitioner (NP) J reported she was notified after Resident #103's hot liquid spill on 2/22/24. NP J reported when she assessed the wounds, she noted second-degree burns on Resident #103's thighs. NP J reported after the incident, Resident #103 complained of increased pain and was sent out to the hospital on 2/25/24. NP J reported Resident #103 returned to the facility with orders to be seen at the wound clinic. NP J reported topical lidocaine was initiated during dressing changes . because she was so painful . NP J reported Resident #103's wounds were .more than just superficial break down . NP J reported in regard to the ordered lidocaine, the wound should be cleaned/dried and the lidocaine should be applied around the edges of the wound. NP J reported the lidocaine should be left on the area, and nursing staff should wait 8-10 minutes for the lidocaine to take effect. NP J stated .The goal is obviously for pain management . In an observation on 4/17/24 at 10:07 AM, ADON W and Unit Manager R completed wound care for Resident #103. Resident #103 stated .oh that hurts . as the old dressings were removed and the sites were cleaned. ADON W applied Lidocaine Ointment 5% to the perimeter of Resident #103's bilateral thigh wounds. Unit Manager R stated to Resident #103 .We are just going to let the lidocaine sit for a little bit .So you can get all numbed up . Noted ADON W waited approximately five minutes before application of Resident #103's wound dressing to the top portions of her thighs. As the new dressing was applied, Resident #103 stated .It hurts, it hurts . ADON W and Unit Manager R turned Resident #103 onto her left side, and applied Lidocaine Ointment 5% to the perimeter of the wound on the bottom of her left thigh. Noted ADON W waited approximately one minute before application of Resident #103's wound dressing to the bottom of her left thigh. In an interview on 4/17/24 at 2:42 PM, LPN M reported in regard to Resident #103's order for lidocaine ointment to be applied to the wounds .I think they want you to wait 10-15 minutes . before completion of wound care. Review of the policy/procedure Pain Management, dated 3/29/24, revealed .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .