STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235069	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinecrest Medical Care Facility	N15995 Main Street Powers, MI 49874

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted Based on interview and record review, the facility failed to honor the advanced directive for one Resident (R20) of four residents reviewed for advance directives. This deficient practice resulted in the potential for residents' decisions regarding end-of-life care and medical care to not be followed by the facility. Findings include: Resident #20 (R20) R20's medical record included an order for Do Not Resuscitate (DNR). R20 signed an Advanced Directive (AD) on July 2, 2014. The AD documented, in part: .I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible . A Minimum Data Set (MDS) assessment dated [DATE] documented R20 was not in a vegetative state or coma. The AD further read, in part: . Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued . A review of physician documentation in R20's record revealed documentation of R20 being alert and responding appropriately to the physician during examination. R20 appointed a Patient Advocate (PA) in the AD dated 7/2/2014. The designation of PA and directions for health care documented, in part: .To my family, doctors, and all concerned with my care: These instructions express my wishes about my health care. I want my family, doctors, and everyone else concerned with my care to act in accord with them . . c. A Patient Advocate may make a decision to withhold or withdraw treatment which would allow a Patient to die only if the patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision, and that the Patient acknowledges that such a decision could or would allow the Patient's death . (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No such clear and convincing power was granted to allow the PA to change the code status through this document. A medical determination form of competency was signed by two physicians on January 19, 2024, deeming R20 incapable of participating in medical treatment decisions. A Patient Advocate Consent form for DNR code status was signed and dated by R20's PA on 2/14/24. The form read, in part: .I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant . The Social Services Coordinator (Staff B) was interviewed on 7/24/24 at 12:50 p.m. Staff B confirmed she oversaw advanced directives in the facility. Documentation including R20's AD, code status order, and physician determination of capacity was reviewed with Staff B. After reviewing the documents, Staff B said, (R20's name) was competent to make his own decisions at the time he signed his Advanced Directive. Staff B was asked why the PA was offered a DNR option if R20 declared his choice of code status when he was cognitively competent to make his own choices and decisions. Staff B responded, I don't think (the PA's name) can sign for (R20's name) to be a DNR. Staff B confirmed there were no court-issued or legal documents allowing the PA to amend R20's choice of code status. Staff B attested there were no additional documents indicating R20 amended or rescinded his choice of code status as outlined in the AD. An undated policy Residents' Rights Regarding Treatment and Advance Directives read, in part: .It is the policy of this facility to support and facilitate a resident's right to request . medical or surgical treatment and to formulate an advance directive . Advanced directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provision of health care when the individual is incapacitated .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to report potential abuse to the State Agency as required for two Resident (R23 and R45) of three Residents reviewed for abuse reporting. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise specified. Resident #45 (R45) According to the Minimum Data Set (MDS) assessment, dated 4/10/24, R45 had a Brief Interview for Mental Status (BIMS) assessment and scored 03/15 which indicated severe cognitive impairment, with diagnoses including dementia and anxiety. On 7/25/24 at 9:45 AM, an observation was made of R45 in her bathroom being toileted with Certified Nurse Aide (CNA) P and CNA Q. R45 was sitting on the toilet and was noted to have a quarter sized circular bruise on her right thigh. Both CNA P and CNA Q were asked how long the bruise had been on R45's right thigh and if it was reported to management and replied, We are not sure. Neither of us had worked in the last couple of days. Review of the facility incident and accident report, dated 4/25/24, read in part, .found a bruise during morning care .there are 2 small skin discolorations on right upper thigh. It looked like in different stages of healing. Approximately 2 cm (centimeters) in circumference bigger area and approximately 1 cm next to it. Resident unable to give description. Further review of the report revealed that it was also reported to the family, Director of Nursing, and physician. Review of the facility incident and accident report, dated 5/27/24, read in part, .observed red bruising on left arm .bruises measuring 2.6 x 1.1 cm, 2.1 x 1.8 cm, and 1.0 x 2.1 cm, with multiple pin point red area's. Resident unable to give description. On 7/25/24 at 10:22 AM, an interview was conducted with the ADON/RN A and the Nursing Home Administrator (NHA) regarding the 4/25/24 and the 5/27/24 incident and accident reports from R45. The ADON/RN A and the NHA were both asked if either incident involving R45 were reported to the State Agency and replied, We did not report these, and we should have but we were not made aware of this incident. The ADON/RN A stated that, We are not getting the calls from the incident and accident reports. Sometimes they are not filled out correctly. The floor nurses don't know what's reportable and don't always call and get clarification. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Abuse, Neglect, and Exploitation, dated 5/2/23, read in part, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .Identification of Abuse, Neglect and Exploitation .B. Possible indicators of abuse include, but are not limited to .2. Physical marks such as bruises or pattered appearances such as a hand print .Investigation of Alleged Abuse, Neglect and Exploitation .Written procedures for investigations include .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation . 41978 Resident #23 (R23) R23 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia, anxiety and depression. Review of R23's Minimum Data Set (MDS) assessment, dated 4/26/2024, revealed she required substantial/maximal assistance with toileting, bathing, dressing and personal hygiene. Further review of the MDS assessment revealed R23 scored three out of 15 (3/15) on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. Review of R23's electronic medical record (EMR) revealed the following: 2/22/2024, 14:30 [2:30 p.m. Central Savings Time, CST]. Incident Note . CNA [Certified Nursing Assistant] noted a bruise to resident's left bicep during her bath this afternoon. [CNA] stated that resident did not bump her arm while getting into the tub . unaware of resident bumping her arm today. Resident was a partial this morning and therefore was dressed early this morning by night shift . DON . ADON notified. Review of R23's Injury report, dated 2/22/2024 at 2:22 p.m. CST, revealed the following written statements: CNA X, dated 2/22/2024: No known injuries while I was with [R23] today 2/22/24 or any days earlier. CNA CC, dated 2/22/2024: I was giving [R23] a bath when I noticed a red area on her upper left arm and a Band-Aid a little above the red area. CNA DD, dated 2/22/2024: I worked on 400 [Special Care Unit] from [7:00 a.m. - 3:00 p.m.] and became aware of [R23's] arm redness at 2:20 p.m. when I started for the day she was already dressed. CNA EE dated 2/22/2024: I partialed [sic] resident in her bed [at] approx. 5:30 a.m. she stayed in bed until 6:30ish [sic]. I did not see any red marks on her arm at any time during this period. Further review of R23's EMR revealed the following: 2/22/2024 at 2:18 p.m. Skin & Wound Evaluation V7.0 . Type: Bruise . Location: Upper left arm (inner) . New . Wound Measurements: Area 26.3 cm2 [cubic centimeters]. Length 5.7 cm. Width 5.5 cm .? (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/24/2024 at 4:18 p.m., the ADON reported the facility had not determined the cause of R23's bruising and application of a Band-Aid on 2/22/2024. The ADON confirmed an abuse investigation was not initiated and the incident was not reported to the SA. The DON, present during the interview, reported someone had to know what happened to cause the injury because R23 did not have access to Band-Aids and did not have the cognitive ability to apply a Band-Aid to her left inner arm.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to investigate potential abuse to the State Agency as required for two Resident (R#23 and R#45) of three Residents reviewed for abuse investigating. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise specified. Resident #45 (R45) According to the Minimum Data Set (MDS) assessment, dated 4/10/24, R45 had a Brief Interview for Mental Status (BIMS) assessment and scored 03/15 which indicates severe cognitive impairment, with diagnoses including dementia and anxiety. On 7/25/24 at 9:45 AM, an observation was made of R45 in her bathroom being toileted with Certified Nurse Aide (CNA) P and CNA Q. R45 was sitting on the toilet and was noted to have a quarter sized circular bruise on her right thigh. Both CNA P and CNA Q were asked how long the bruise had been on R45's right thigh and if it was reported to management and replied, We are not sure. Neither of us had worked in the last couple of days. Review of the facility incident and accident report, dated 4/25/24, read in part, .found a bruise during morning care .there are 2 small skin discolorations on right upper thigh. It looked like in different stages of healing. Approximately 2 cm (centimeters) in circumference bigger area and approximately 1 cm next to it. Resident unable to give description. Further review of the report revealed that it was also reported to the family, Director of Nursing, and physician. Review of witness statement, dated 4/25/24, from CNA V, read in part, I had not did cares on resident since Monday noc (night) 4/22/24 - I had not seen anything as of that date . Review of witness statement, dated 4/25/24, from CNA U, read in part, .I noted two bruises on (R45's) upper right thigh near vagina reported to (nurse) . Review of the facility incident and accident report, dated 5/27/24, read in part, .observed red bruising on left arm .bruises measuring 2.6 x 1.1 cm, 2.1 x 1.8 cm, and 1.0 x 2.1 cm, with multiple pin point red area's. Resident unable to give description. Review of witness statement, dated 5/27/24, from CNA W, read in part, .Left arm bruise .I did not notice bruise all day as she (R45) was wearing sweatshirt all day . Review of witness statement, dated 5/27/24, from CNA Q, read in part, .bruise left lower arm .daughter noticed the bruise she (R45) had a sweater on all day and didn't notice . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R45's two incident and accident reports, dated 4/25/24 and 5/27/24, revealed the lack of any other facility employees being interviewed for witness statements to include a full investigation was conducted per facility policy. Interviews were only done with immediate staff working R45's hallway and not all staff from that day on other halls worked, or the prior two days to rule out any type of abuse or neglect. On 7/25/24 at 10:22 AM, an interview was conducted with Assistant Director of Nursing (ADON)/Registered Nurse (RN) A and the Nursing Home Administrator (NHA) regarding the 4/25/24 and the 5/27/24 incident and accident reports for R45. RN A and the NHA were both asked if either incident involving R45 were fully investigated and replied, We did not fully investigate these, and we should have but we were not made aware of this incident. We would have interviewed all staff working the days the bruising had been discovered and the prior two days before those days. RN A stated that, We are not getting the calls from the incident and accident reports. Review of policy titled, Abuse, Neglect, and Exploitation, dated 5/2/23, read in part, .Investigation of Alleged Abuse, Neglect and Exploitation .Written procedures for investigations include .4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation . 41978 Resident #23 (R23) R23 was admitted to the facility on [DATE] and had diagnoses including Alzheimer's dementia, anxiety and depression. Review of R23's MDS assessment, dated 4/26/2024, revealed she required substantial/maximal assistance with toileting, bathing, dressing and personal hygiene. Further review of the MDS assessment revealed R23 scored three out of 15 (3/15) on the BIMS, indicating severe cognitive impairment. An observation on 7/24/2024 at 9:58 a.m. revealed CNA X and CNA DD assisting R23 with toileting in the shower room on the Special Care Unit (SCU). R23 was observed to have a large, linear purple bruise on the inner aspect of the back of her right lower leg. CNA X and CNA DD reported they were unaware of the bruising. CNA DD reported R23 often bumped herself. When care was completed, R23 was transferred from the toilet to her wheelchair which was positioned facing her. Upon standing, R23 was assisted to pivot so her buttocks were facing the chair. CNA DD placed a gait belt around R23's midsection and stood on the right side of the wheelchair with CNA X standing on the left. After R23 was pivoted so her buttocks were positioned over the wheelchair seat, CNA X lowered R23 to the seat by using her left hand and holding tightly onto the R23's left upper arm and lowered R23 to a seated position. Review of R23's electronic medical record (EMR) revealed the following: 7/18/2024 [7:53 a.m. Central Daylight Time] Skin/Wound Note . Resident noted to have a dark purple bruise to the back of left lower leg. Fading noted Resident noted to have a dark purple bruise to the back of right lower leg. Fading noted . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Injury report, dated 7/13/2024 at 6:00 a.m., revealed the following: [CNA FF] found 2 bruises on resident while giving her her [sic] weekly shower. One to left, lower inner leg that measures 3 cm [centimeters] by 4.5 cm and back of right lower leg that measures 3 cm by 3.5 cm. Resident unable to give description. Review of CNA FF's written statement, attached to the Injury report, revealed the following: 7/13/2024 . Bruises found on back of legs where foot pedals located. Noticed bruises on back of lower legs during her shower. Bruises located right where foot pedals of wheelchair hit. During review of R23's Injury reports on 7/24/2024 at 4:18 p.m., RN A reported no investigation was conducted to look into the cause of R23's bruises found on 7/13/2024. RN A stated CNA FF's written statement was not obtained until the current day, 7/24/2024. The ADON confirmed R23 had severe cognitive impairment and could not account for how the bruising occurred. The DON, present at the time of the interview, reported the injury should have been investigated to rule out abuse or mistreatment.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 40383 Based on interview and record review, the facility failed to provide written transfer notification to the resident and resident's representative including reason, effective dates, and the location to which the resident was being transferred for one Resident (R39), of two residents reviewed for transfers out of the facility. Findings include: All times are recorded in Eastern Daylight Time (EDT) unless otherwise noted. Resident #39 (R39) The medical record for R39 revealed a transfer to the hospital on 7/9/23. The medical record did not indicate a written notification of transfer was given to R39 or sent to her representative. During an interview on 7/25/24 at 10:58 AM, Administrative Staff C stated she did not send written notifications of hospitalization stays to any residents or their representatives. She was not aware this was required. Staff C stated the previous person in her position had retired. The facility policy titled Transfer and discharge date d 7/2024 was provided and read in part: 12. Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident . g. Provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on interview and record review, the facility failed to develop comprehensive care plans for two Residents (R41 and R54) of 17 residents reviewed for care planning. This deficient practice resulted in the lack of care plan goals and interventions, with the potential for unmet needs. Findings include: All times are recorded in Eastern Daylight Time (EDT) unless otherwise noted. Resident #54 (R54) R54 was admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure, congestive heart failure, diabetes, major depressive disorder, panic disorder, anxiety disorder, dementia and multiple fracture history. On 7/22/24 the facility presented a matrix with all residents listed which included conditions and concerns. R54 was listed as End of Life Care/Comfort Care/ Palliative Care. The Electronic Medical Record (EMR) reflected weights of: 7/22/24 187.0 pounds 6/24/24 199.0 pounds 4/22/24 220.0 pounds 1/22/24 232.0 pounds These weights indicated a 6% weight loss in one month, a 9% weight loss over three months, and a 19% weight loss over six months (all significant weight losses). On 7/22/24 at 1:28 PM, the lunch tray arrived in the room of R54, but he was sleeping and showed no interest in lunch. Certified Nurse Aide D stated, Right now he is not eating much at all. On 7/22/24 At 2:19 PM, R54's tray was observed as he was finished with lunch. R54 had eaten nothing. The lid remained on the beverage of milk and although the salisbury steak was cut up, nothing had been consumed. On 7/23/24 at 1:23 PM, family members were present and trying to encourage R54 to eat lunch. He was belligerent and non-compliant. R54's family member spoke to this surveyor in private and stated R54 was declining and the family wanted R54 comfortable on palliative care. The EMR for R54 was reviewed. No physician order or care plan for palliative care was found. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 11:25 AM, Registered Nurse (RN) E reviewed the EMR and stated, We don't have an order or a care plan for palliative care (for R54), but we probably should. On 7/25/24 at approximately 11:45 AM, Assistant Director of Nursing (ADON)/RN A stated R54 had a significant change assessment completed in March 2024 due to his decline. RN Aagreed a care plan for palliative care should have been written. The facility policy titled Providing End of Life Care dated 5/24/24 read in part, Recognition: Residents will be evaluated for end of life care concerns upon admission, during scheduled assessments, and upon change of condition or status . Preferences for palliative care, hospice care, and advance directives will be identified and documented in the medical record . The facility and resident/family will coordinate a plan of care, and will implement interventions in accordance with the comprehensive assessment, and the resident's needs, goals, and preferences. The plan of care will identify the care and services that each discipline will provide. 41978 Resident #41 (R41) R41 was admitted to the facility on [DATE] and had diagnoses including dementia and anxiety disorder. Review of R41's Minimum Data Set (MDS) assessment, dated 6/18/2024, revealed he was independent with mobility and walking. Further review of the MDS assessment revealed R41 scored five out of 10 (5/10) on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment. An observation on 7/22/2024 at 2:05 p.m., revealed R41 walking up and down the hallway near the entrance/exit of the SCU. At 2:08 p.m., Certified Nurse Assistant (CNA) X and an unidentified staff member entered the hallway from behind a closed door. CNA X turned to R41 and told the Resident to, come here, waving her hand down the hall toward the nurses' station. CNA X and the unidentified staff member continued down the hall to the dining room area. R41 stopped at the unattended nurses' station and was heard asking, will someone let me out, please while attempting to open the locked door leading to the nurses' station. R41 proceeded to walk down the hall and sat in a chair in the hallway between rooms [ROOM NUMBERS]. At 2:16 p.m., CNA X entered the hallway and approached R41 at which time R41 asked CNA X to, let me out, please. CNA X asked R41 where he wanted to go and R41 answered, home. During an interview outside the SCU medication storage room, on 7/24/2024 at 9:45 a.m., RN E reported R41 was noted to be more anxious and difficult to redirect during the previous shift. RN E stated R41's wandering and exit-seeking behavior seemed to worsen with the current attempt to reduce his psychotropic medications. During the interview, the SCU exit door alarm sounded and CNA X was observed running down the hall toward the exit door. Further observation revealed R41 pushing through the exit door and stepping off the unit as CNA X approached and redirected R41 back onto the unit. It was noted the exit door led to an unused portion of the building's second floor, the elevator and stairway. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 7/24/2024 at 7:46 a.m., revealed R41 sleeping in a reclining chair across from the nurses' station. CNA F was seated in a chair near the nurses' station window. During an interview at the time of the observation, CNA F reported she was seated in the living room to supervise R41. CNA F reported R41 was going in other resident's rooms and she consistently needed to redirect him throughout her shift. Review of R41's EMR revealed the following, in part: 6/15/2024, 23:00 [11:00 p.m.]. Progress Note. Patient was admitted to [acute care hospital] for advancing dementia with behavioral disturbance . now admitted to the facility for long-term care in the memory unit where he will be able to ambulate in a controlled environment . Review of R41's care plan revealed no focus area, goals or interventions related to his wandering, exit-seeking behavior, or elopement risk. During an interview on 7/24/2024 at 4:16 p.m., RN A confirmed R41's care plan did not include a focus area, goal or interventions related to his wandering, exit-seeking behavior, or elopement risk. The DON (Director of Nursing), who was present at the time of the interview, reported R41 was admitted to the facility for the primary reason of requiring increased supervision related to unsafe wandering. Review of the undated facility policy titled Comprehensive Care Plans, revealed the following, in part: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . that The comprehensive care plan will describe, at a minimum, the following: the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted Based on interview and record review, the facility failed to revise or update care plans to reflect residents' status for five Residents (R50, R39, R20, R32, and R29) of seventeen residents reviewed for care plans. This deficient practice resulted in the potential for inadequate care and unmet care needs. Findings include: The infection surveillance line list for July 2024 documented eleven residents with signs and symptoms of infections. Ten of the eleven residents received antibiotic therapy for infections. During an interview with the facility Infection Preventionist (IP) on 7/24/24 at 10:47 a.m., the IP was asked if care plans were developed for residents with symptomatic infections or if current care plans were amended and updated to include interventions for infections. The IP responded, some of them. Four of the residents listed on July 2024 line-listing were reviewed with the IP for care plans. Resident #50 (R50) was diagnosed with a Urinary Tract Infection (UTI) and subsequently prescribed the antibiotics Keflex on 7/10/24 and Bactrim DS on 7/15/24. R50 was documented on the July 2024 infection line list as having symptoms of increased fatigue and hematuria (blood in the urine). R50's medical record did not contain a care plan for the infection to provide staff with interventions to address R50's symptoms of infection. Resident #39 (R39) was diagnosed with a UTI and prescribed Rocephin and Macrobid starting 7/10/24. R39 had the following symptoms documented on the July 2024 infection line list: urinary urgency, lethargy, painful urination, mental changes, and decreased appetite. R39's medical record did not contain a care plan for the infection to provide staff with interventions to address R39's symptoms of infection. Resident #20 (R20) was diagnosed with a UTI and prescribed Levaquin starting 7/22/24. The documented symptoms on the July 2024 infection line list reflected R20 had painful urination and mental status changes. R20's medical record did not contain a care plan for the infection to provide staff with interventions to address R20's symptoms of infection. Resident #32 (R32) was admitted to the facility 6/6/24. A Minimum Data Set (MDS) assessment dated [DATE] documented R32 was infected with a multi drug resistant organism. R32 required Vancomycin administered via peripherally inserted central catheter (PICC - a tube inserted into a vein in the arm that passes to a larger vein near the heart) for Osteomyelitis (bone infection) of the vertebra. R32 was additionally diagnosed with a UTI on 7/22/24 for which he was started on Levaquin in addition to the Vancomycin. R32's medical record did not contain a care plan for the infections or the PICC to provide staff with interventions to address R32's infection or to maintain R32's PICC. 40383 Resident #29 (R29) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R29 was admitted to the facility on [DATE] with diagnoses including dysphasia (difficulty swallowing) , spasms of the esophagus, dementia, heart failure and stroke with left sided paralysis. The Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 of 15 indicating moderate cognitive impairment and the ability to transfer from chair to bed or off toilet required Substantial/maximal assistance - Helper does MORE THAN HALF the effort. This MDS also revealed R29 had a functional limitation in range of motion with impairment on one side for both upper and lower extremities. During an interview on 7/23/24 at 9:06 AM, R29 stated she had hurt her leg during a transfer early in the morning about 5 days ago. There was a question if the lift was used properly or used at all. On 7/23/24 the Nursing Home Administrator (NHA) presented the facility investigation on this concern which had been reported to the State Agency (SA). The investigation revealed that on 7/4/23 R29 had been transferred with the sit-to-stand lift and the resident had reported pain. That same day, R29 was transferred to the hospital for x -rays and further investigation. Upon return to the facility on [DATE], the resident had a leg immobilizer and assessed to need transfers with a maxi lift. During a telephone interview on 7/25/24 at 10:38 AM, Certified Nurse Aide (CNA) F stated she recalled the incident on 7/4/24 when she got R29 up as usual. CNA F stated she used the stand-up (sit-to-stand) lift as I always do. During an interview on 7/25/24 at 8:32 AM, CNA G stated R29 was recently changed to a maxi lift after she got the leg immobilizer. CNA G confirmed R29 used to be transferred with a sit-to-stand lift prior to her immobilizer being applied. The care plan for R29 was reviewed and listed an intervention of TRANSFER: The resident requires (Substantial assistance) by staff to move between surfaces as necessary. Use maxi lift until seen by ortho (orthopedics specialty). (Initiated on) 7/22/2024. During an interview on 7/25/24 at 8:27 AM, the Assistant Director of Nursing (ADON)/Registered Nurse (RN) A noted the care plan showed the sit to stand lift was changed to a maxi lift after the hospitalization on [DATE]. RN A stated the change to non-weight bearing and use of the maxi lift occurred as soon as R29 returned on 7/4/24, but the care plan was not updated until 7/22/24. RN A said the care plan should have been updated with the change in care. The facility policy titled Care Plan Revisions Upon Status Change dated 2023 read in part: The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change . The care plan will be updated with new or modified interventions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45123 Based on observation, interview, and record review, the facility failed to provide medication administration to meet professional standards 1.) administer antibiotics according to physician order and 2.) flush peripherally inserted central catheter (PICC) for one Resident #32 of four residents reviewed for medication administration. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise specified. Resident #32 (R32) Review of R32's physician order, dated 6/27/24, revealed an order for vancomycin 750 mg (milligrams) / 150 ml (milliliters), intravenously one time a day for sepsis until 8/6/24. On 7/23/24 at 7:50 AM, medication administration was observed with Licensed Practical Nurse (LPN) R for R32. LPN R accessed R32's PICC line using a 10 ml (milliliter) syringe filled with normal saline solution. LPN R failed to check for a blood return prior to administering the saline solution into the PICC line. R32's PICC line dressing was observed dated 7/10/24 indicating when the last time the dressing was changed. On 7/23/24 at 8:10 AM, an interview was conducted with LPN R and was asked if she checked for placement on R32's PICC line by pulling back on the syringe to watch for a blood return and replied, No, no one ever taught me that. I did not know I had to do that. LPN R was asked if R32's dressing was over due to be changed and replied, Yes, it should have been changed on the 17th last Wednesday. LPN R was asked who was responsible for PICC line dressing changes and replied, The Registered Nurses' (RNs'). LPN R was asked what she would do if she had a physician order that she could not complete and replied, I would go let one of the RN's know I needed them to complete the dressing change. Review of R32's physician order, dated 6/20/24, revealed an order to change PICC line dressing weekly and PRN (as needed), every day shift, every Wednesday. R32's treatment administration record (TAR) lacked PICC line dressing changes on 7/3/24 and 7/17/24. On 7/24/24 at 10:15 AM, medication administration was observed with LPN H for R32. LPN H accessed R32's PICC line using a 10 ml syringe filled with normal saline solution and failed to check for a blood return prior to administering the saline solution into the PICC line. On 7/24/24 at 10:20 AM, an interview was conducted with LPN H and was asked if he pulled back on the saline syringe before administering the saline solution into R32's PICC line and replied, No, I guess I forgot to do that. On 7/24/24 at 11:30 AM, an interview was conducted with the Assistant Director of Nursing/Registered Nurse (ADON/RN) A and was asked if the LPNs are trained on medication pass for PICC lines and replied, Yes. It is part of their nursing competencies. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility document titled, Licensed Practical Nurse Skills Checklist, for LPN H and LPN R, dated 5/20/24, revealed no current competencies for IV skills related to administration and maintenance. Review of policy titled, Peripherally Inserted Central Catheter Flushing, Locking, Removal, undated, read in part, Policy: It is the policy of this facility to ensure that peripherally inserted central catheters (PICC) are flushed, locked and removed consistent with current standards of practice .Compliance Guidelines .3. Peripherally inserted central catheters will be flushed and aspirated for blood return prior to each infusion to assess catheter functionality and prevent complications .Flushing .7. Slowly aspirate for a blood return to confirm device patency. 8. If blood return is not obtained, investigate for external causes of obstruction and notify physician if troubleshooting is ineffective .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to meet the nutritional needs and preferences for two Residents (R29 and R54) of 3 residents reviewed for nutrition. This deficient practice resulted in residents not receiving prescribed diet, food preferences, experiencing thirst, and potential risk for physical decline. Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted. Resident #29 (R29) R29 was admitted to the facility on [DATE] with diagnoses including dysphasia (difficulty swallowing) , spasms of the esophagus, dementia, heart failure and stroke with left side paralysis. The Electronic Medical Record (EMR) revealed the physician diet Order Summary: Start dated 11/1/23, Regular diet Pureed texture, Nectar/Mildly Thick consistency . texture varies per DPOA (Durable Power of Attorney) sm (small) portions, gravy w/pureed meat, extra gravy on side, super cereal at B(breakfast), super spuds L (lunch); magic cup thawed or yogurt as dessert, nectar water with all meals; pureed banana . On 7/23/24 at 9:31 AM, the breakfast meal for R29 was observed. The meal tray card indicated a diet order of Puree, nectar mild sm portions HF/HC and contained instructions to give a banana crushed up. This diet order did not match the physician order per the EMR. During an interview on 7/23/24 at 9:45 AM, Dietary Aide (Staff) L stated a banana is difficult to get to the right consistency, so I did not give (R29) one today. The banana was included in the physician's order and was indicated on the meal tray card to be given. Staff L could not explain why dietary staff did not use a mechanical kitchen device to puree the banana if there was really a concern for resident safety. On 7/24/24 at 9:37 AM, the breakfast meal for R29 was observed. No crushed banana was provided. The hand-written instructions on the meal card included yogurt. This surveyor requested CNA O obtain a yogurt for R29. CAN O asked R29 if she would like a yogurt and R29 responded she needed yogurt for her bowels. During an interview on 7/25/24 at 10:13 AM, Certified Dietary Manager (CDM) N discussed R29's preferences and said, She takes a long time to eat and takes small bites and should get it (crushed up banana). CDM N stated if the tray card said yogurt, it should have been on the tray. The EMR care plan read in part, (R29) has potential for unplanned/unexpected weight loss r/t (related to) Poor food/fluid intake with interventions including, Offer substitutes as requested or indicated. The resident prefers : pureed scrambled eggs at breakfast, mushed up banana at breakfast/dinner . Resident #54 (R54) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54 was admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure, congestive heart failure, diabetes, major depressive disorder, panic disorder, anxiety disorder, dementia and multiple fracture history. The current physician diet order as written on 3/1/2024, was Controlled Carb diet, Easy to Chew Texture, Regular/Thin consistency, 5 CHO (Carbohydrates)/meal, Large portions of ground meat; sugar cereal at B (breakfast), Large portions of Regular mashed potatoes at L/D (lunch/dinner). Colored plates. The Electronic Medical Record (EMR) reflected weights of: 1/22/24 232.0 pounds 4/22/24 220.0 pounds 6/24/24 199.0 pounds 7/22/24 187.0 pounds These weights indicated a 6% weight loss in one month, a 9% weight loss over three months, and a 19% weight loss over six months (all significant weight losses). On 7/22/24 at 1:22 PM, R54's lunch tray was observed and contained a salisbury steak which was not ground to the consistency specified in the physician's order. The tray card for R54 indicated a diet of CC, HF/HC and instructions of Large Portions ground meat w/gravy. On 7/22/24 at 1:28 PM, the lunch tray arrived in the room of R54, but he was sleeping and showed no interest in lunch. Certified Nurse Aide (CNA) D stated, Right now he is not eating much at all. The tray card for R54 indicated a diet of CC, HF/HC. CNA D was asked what type of diet R54 was on and could not answer what a CC HF/HC diet was and stated, There is a cheat sheet in the kitchen. I do not know what the diet is. On 7/22/24 at 2:19 PM, R54's tray was observed as he was finished with lunch. He had eaten nothing. The lid remained on the beverage of milk and although the salisbury steak was cut up, nothing had been consumed. During an interview on 7/22/24 at 1:48 PM, Dietary Aide (Staff) I was observed serving the lunch meal and stated those residents with mechanical soft or ground meat diets should have gotten ground chicken or ground salisbury steak. Staff I was asked what the HC/HF part of the diet order was. She thought HC was high calorie but did not know what HF was. Staff I found a sheet in the service area and HC/HF was defined as high calorie but the sheet did not indicate what HF stood for. Staff I said she would ask the dietary manager. During an interview on 7/22/24 at 1:52 PM, Dietary Aide (Staff) K was asked what the HC/HF part of the diet order was. Staff K said she was not sure what it was but maybe HF meant High Fructose? During an interview on 7/25/24 at 10:13 AM, CDM N stated We do not have a defined diet called HF/HC. The facility diet manual did not contain a diet called HF/HC. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/24 at 1:24 PM, two disposable 8 ounce cups of water and one 8 ounce cup with orange juice were observed on R54's bedside table. The table was across the room approximately 8 feet from the bed and not accessible to R54 who was lying in bed with his eyes closed. On 7/22/24 at 3:21 PM, R54 was heard to be crying out in a loud voice, Water. Water. I need some G** D*** water. CNA D went into the room and assisted R54 with the water and then placed the water back on the bedside table out of reach of R54. One minute later R54 exclaimed, I can't reach it. What good is it. Everyone is walking around doing nothing. On 7/22/24 at 3:24 PM, CNA D returned to R54's room with ice cream and R54 turned it down and said, Give me the water. On 7/22/24 at 3:47 PM, a disposable cup of water with straw was observed on the bedside table. R54 was in his bed. The bed was in the low position and the water was approximately 3 feet away and out of reach. On 7/24/24 at 3:18 PM, housekeeping staff GG stated Did you hear him (R54)? R54 had been crying out for water as he could not get to it. Staff GG said the water was too far from his bed and even when the bedside table was moved toward him his hands could not really reach it. The EMR care plan includes: The resident has potential for dehydration r/t diuretic use. The interventions included, The resident will maintain adequate hydration. Assure beverages of choice are offered to Resident. The facility policy titled Hydration and dated 4/2024 read in part: The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health . The resident's goals and preferences regarding hydration will be reflected in the resident's plan of care . Provide assistance with drinking. Ensure beverages are available and within reach.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40383 Based on observation, interview, and record review, the facility failed to provide sufficient staffing to meet the needs of the residents. This deficient practice resulted in an inability to provide needed services as voiced by 10 of 10 residents in attendance at a confidential group meeting and in an inability to sufficiently supervise 4 of 4 residents (R3, R17, R41, and R23) residing on the dementia unit. Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted. On 7/23/24 at 11:30 AM, a confidential group meeting was held with ten residents of the facility. In this meeting Resident C1 stated there was a poor attitude among the Certified Nurse Aides (CNAs). C1 stated, the CNAs did not want to listen and would say, they have been doing this for [AGE] years an implied they knew it all. C2 stated the CNAs do not seem to come in my room. C1 explained when she turns on her call light for help, the staff turn off the light and I have had accidents and have sat in soil for an hour or more. The group said the facility does not have enough staff. C3 stated while there are some awesome aides, others turn off the call lights and never help you. C8 stated we have to wait a long time especially on the weekends. C5 and C10 stated they both had accidents because the light was on, and no one would help them use the bathroom. One resident (who did not even want a confidential identifier as she felt there could be retaliation) said she almost fell as she decided she could no longer wait for a staff member and tried to walk to the bathroom herself. When the question was posed: How many of you feel the facility does not have enough staff, every member of the confidential group meeting stated there were not enough staff to take care of their needs. The minutes from previous Resident Council monthly meetings were reviewed. On 7/23/24 at 7:44 AM, the Resident Council minutes were reviewed. The 4/23/24 minutes noted in new business under the section Nursing/Aides: an issue with timely response to call lights was reported. The following meeting on 5/21/24 there was no mention of resolution or action taken on the call light concern. The June meeting was rescheduled to 7/1/24 and minutes under the section Nursing/Aides: recorded . Don't like them saying they're understaffed; we feel they use it as an excuse. We've heard them in the hallway talking. Beds are not being made completely/Neatly. (Education at the next CNA Meeting will be given). At the following meeting on 7/18/24 the paragraph from the Nursing/Aides section was repeated word for word in the Old Business section of the minutes. There were no responses of resolution, actions taken, or dates when the promised CNA education had occurred or was scheduled to address the staffing issues. 41978 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation upon entering the Special Care Unit (SCU), the facility's locked dementia/behavioral care unit, on 7/22/2024 at 1:18 p.m., revealed R17 ambulating using a front-wheeled walker, down the hall toward the entrance/exit of the SCU. There were no staff visible in the hallway at the time of the observation. R17 was looking into resident rooms as she walked down the hall and appeared lost. R17 was heard mumbling as she entered the doorway of room [ROOM NUMBER], maybe this is it, I don't know, I need help. R17 continued down the hall toward the nurses' station, found and entered her room then proceeded to lay down in her bed. R17 could be heard calling out from her room, ow, ow. At 1:26 p.m., an unidentified staff member entered the SCU and upon hearing R17 calling out, entered R17's room at which time R17 reported my knees are killing me. The unidentified staff member closed the door to R17's room to provide care for the resident. Further observation revealed nine residents sitting in the living room area outside the nurses' station and one Resident (R41) ambulating in the hallway toward the entrance/exit of the SCU. It was noted there were no staff present in the nurses' station, hallways or living room area at the time of the observation. On 7/22/2024 at 1:27 p.m., R41 was observed ambulating in the hallway of the SCU near the entrance/exit of the unit. R41 stopped in front of a locked utility room near the entrance/exit of the unit and proceeded to turn the doorknob in an attempt to enter the room. R41 then turned and walked back down the hallway toward the empty nurses' station, at which time R23 was observed self-propelling in her wheelchair from the dining room area toward her room across from the nurses' station. R41 followed R23 into her room and proceeded to push R23 in her wheelchair toward her bed and attempted to assist R23 to stand but was unsuccessful. R41 was heard stating we need to get closer [to the bed]. It was noted there were no footrests attached to R23's wheelchair at the time of the observation. R41 then proceeded to push R23 in her wheelchair toward her closet. At 1:33 p.m., the unidentified staff member exited R17's room and proceeded to walk toward the nurses' station at which time she saw R41 in R23's room. The unidentified staff member redirected R41 out of R23's room and toward the dining room area. At 1:37 p.m., R41 was observed ambulating aimlessly and unattended, up and down the hallway of the SCU. An observation on 7/22/2024 at 2:05 p.m., revealed R41 walking toward the entrance/exit of the SCU. No staff were present at the time of the observation. At 2:08 p.m., Certified Nurse Assistant (CNA) X and an unidentified staff member entered the hallway from behind a closed door. CNA X turned to R41 and told the Resident to, come here, waving her hand down the hall toward the nurses' station. CNA X and the unidentified staff member continued down the hall to the dining room area. R41 was observed to stop at the unattended nurses' station and was heard asking, will someone let me out, please while attempting to open the locked door leading to the nurses' station. R41 proceeded to walk down the hall and sat in a chair in the hallway between rooms [ROOM NUMBERS]. At 2:16 p.m., CNA X entered the hallway and approached R41 at which time R41 asked CNA X to, let me out, please. CNA X asked R41 where he wanted to go and R41 answered, home. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation upon entering the SCU on 7/23/2024 at 9:27 a.m., revealed no staff present in the hallway. R3 was observed ambulating with a front-wheeled walker down the hallway toward the entrance/exit of the unit. R3 appeared lost and confused and was heard saying, there's never anyone to ask . now to find my room. R3 walked to the entrance/exit door, turned and walked back down the hall toward the living room area. R3 stopped and entered R17's room, with R17 sleeping in bed, and looked around before exiting and heading back toward the living room and past her room proceeded to attempt to open the locked door to the empty nurses' station. R3 then walked to the living room and sat down in a chair near the nurses' station window. At 9:32 a.m., CNA X emerged from the dining room area. Further observation revealed CNA Y seated in the dining room providing dining assistance to two unidentified residents. During an interview at the time of the observation, CNA X reported this day there were two CNAs scheduled to work the SCU, herself and CNA Y. When asked if there were always two staff members present on the SCU, CNA X reported some days there was only one CNA scheduled to work on the SCU. CNA X reported a nurse was also assigned to the SCU, but the nurse would be split between the SCU, located on the second floor, and another unit on the first floor of the building, therefore was only present on the unit during medication pass. CNA X reported there are many residents residing on the SCU which required constant supervision. During an interview outside the SCU medication storage room, on 7/24/2024 at 9:45 a.m., Registered Nurse (RN) E reported R41 was noted to be more anxious and difficult to redirect during the previous shift. During the interview, the SCU exit door alarm sounded and CNA X was observed running down the hall toward the exit door. Further observation revealed R41 pushing through the exit door and stepping off the unit as CNA X approached and redirected R41 back onto the unit. It was noted the exit door led to an unused portion of the building's second floor, the elevator and stairway. An observation on 7/24/2024 at 7:46 a.m., revealed nine residents seated in the living area of the SCU. R41 was observed sleeping in a reclining chair across from the nurses' station. CNA F was seated in a chair near the nurses' station window. During an interview at the time of the observation, CNA F reported she was seated in the living room to supervise R41. CNA F reported R41 was going in other resident's rooms and she consistently needed to redirect him throughout her shift. When asked if a nurse was assigned to the SCU, CNA F reported a nurse would come up for medication pass earlier in the evening but then would leave the unit to go downstairs and attend to residents on the first floor of the facility and would come back up to the SCU, if summoned. Review of the facility staff Daily Schedule(s), for June 2024 through 7/25/2024, provided by Unit Manager, RN E, revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/08/2024: Shift 11:00 p.m. - 7:00 a.m. 200 Wing: One CNA worked 11:00 p.m. - 3:00 a.m. and one CNA worked 3:00 a.m. - 7:00 a.m. One charge nurse worked 11:00 p.m. - 7:00 a.m.; 300 Wing: One CNA worked 11:00 p.m. - 7:00 a.m. One charge nurse worked 11:00 a.m. - 3:00 a.m. and one charge nurse worked 3:00 a.m. - 7:00 a.m.; 100 Wing and Rooms 201, 202, 301 and 302: One CNA worked 11:00 p.m. - 7:00 a.m. No charge nurse scheduled. 400 Wing (SCU, Second Floor): One CNA worked 11:00 p.m. - 3:00 a.m. and one CNA worked 3:00 a.m. - 7:00 a.m. No charge nurse scheduled. Review of the Shift Staffing Summary, dated 6/08/2024 revealed a resident census of 61. Comparison of the Daily Schedule, and the Shift Staffing Summary, revealed the facility assessed the need of two licensed nursing staff and 6.5 unlicensed nursing staff for the 11:00 p.m. - 7:00 a.m. shift for a total need for direct care staff of 8.5. It was noted only four unlicensed nursing staff shifts were scheduled/worked and a total of two licensed nurse shifts worked for a total direct care staff of six. 6/22/2024: Shift 11:00 p.m. - 7:00 a.m. 200 Wing: One CNA worked entire shift. One CNA worked 3:00 a.m. - 7:00 a.m. One charge nurse worked entire shift; 300 Wing: Two CNAs worked entire shift. On charge nurse worked 11:00 p.m. - 3:00 a.m. and one charge nurse worked 3:00 a.m. - 7:00 a.m.; 100 Wing and Rooms 201, 202, 301 and 302: No staff worked/scheduled; 400 Wing (SCU, Second Floor): One CNA worked 11:00 p.m. - 3:00 a.m. Review of the Shift Staffing Summary, dated 6/22/2024 revealed a resident census of 62. Comparison of the Daily Schedule, and the Shift Staffing Summary, revealed the facility assessed the need of two licensed nursing staff and five on-duty unlicensed nursing staff for the 11:00 p.m. - 7:00 a.m. shift for a total need for direct care staff of seven. It was noted only four unlicensed nursing staff shifts and two licensed nursing staff shifts were worked for a total direct care staff of six. 6/23/2024: Shift 7:00 a.m. - 3:00 p.m. 200 Wing: Two CNAs worked entire shift. One charge nurse worked the entire shift; 300 Wing: Two CNAs and one charge nurse worked the entire shift; 100 Wing: no staff scheduled/worked; 400 Wing (SCU, Second Floor): One charge nurse worked 7:00 a.m. - 11:00 a.m. and one charge nurse worked 11:00 a.m. - 3:00 p.m. One CNA worked the entire shift. Review of the Shift Staffing Summary, revealed a resident census of 64. Comparison of the Daily Schedule, and the Shift Staffing summary, revealed the facility assessed the need of three licensed nursing staff and six scheduled/on-duty unlicensed nursing staff for the 7:00 a.m. - 3:00 p.m. shift for a total need for direct care staff of nine. It was noted only five unlicensed nursing staff, and three licensed nursing staff shifts were worked for a total direct care staff of eight. 7/06/2024: Shift 11:00 p.m. - 7:00 a.m. 200 Wing: One CNA and one charge nurse worked the entire shift. One CNA worked 11:00 p.m. - 3:00 a.m.; 300 Wing: One charge nurse worked 11:00 p.m. - 3:00 a.m. and one charge nurse worked 3:00 a.m. - 7:00 a.m. One CNA worked the entire shift and one CNA worked 11:00 p.m. - 3:00 a.m.; 100 Wing: no staff scheduled/worked. 400 Wing (SCU, Second Floor): One CNA worked 11:00 p.m. - 3:00 a.m. and one CNA worked 3:00 a.m. - 7:00 a.m. It was noted in review direct care staff scheduled/worked totaled four and one-half (4.5) for a total resident census of 62 per the Shift Staffing Summary, dated 7/06/2024. Further review of the Shift Staffing Summary, revealed an assessed need of six direct care staff for the 11:00 p.m. - 7:00 a.m. shift. Review of the resident population conditions provided by Human Resource Director, Staff Z revealed as of 7/25/2024 the resident population of 63 included the following: Eight residents requiring two-person assistance with transfers/care. Eight residents requiring the use of a sit-to stand lift for transfers. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nine residents requiring the use of a two-person assisted, total mechanical lift for transfers. 54 residents assessed as being at risk for falls. 12 residents assessed at risk for elopement. During an interview on 7/25/2024 at 11:05 a.m., the Director of Nursing (DON) reported staffing needs are based on resident acuity and total census. The DON reported the residents residing on the SCU had dementia or psychological conditions requiring increased safety needs and supervision. The DON stated she was new to the facility and was working on having the SCU fully staffed. The DON acknowledged a safety concern when only one staff member was working on the second-floor unit due to the constant need for supervision and the distance other staff would have to travel when called for assistance. Review of the Facility Assessment, dated 3/17/2024, revealed the following, in part: Our Resident Profile . 400 Wing is our Special Care Unit . accommodates 30 residents in total . To be a member of the Special Care Unit you must have cognitive impairment and/or behavioral issues and benefit from a more structured environment with less stimulation .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41978 Based on interview and record review, the facility failed to ensure nurse aides completed required dementia training and demonstrated the skills and techniques necessary to care for residents for three contracted Certified Nurse Assistants (CNAs F, AA and BB) of three contract nursing staff reviewed for competency evaluation, resulting in the potential for unmet physical and psychosocial needs for all 63 residents residing in the facility. Findings include: All times recorded in Eastern Daylight Time (EDT), unless otherwise noted. A review of CNA F's competency evaluation as provided by Human Resources Director, Staff Z on 7/24/2024 at 3:36 p.m., revealed a Skills Checklist by [contract company], dated 5/03/2024. Further review of the Skills Checklist, revealed the checklist to be a self-evaluation completed by CNA F indicating how frequently she performed tasks and how proficient she felt at the listed tasks. Further review of the documents provided by Staff Z revealed no further evaluation of CNA F's skills. Review of CNA F's education roster titled Core Mandatory Exam - Nursing, dated 4/18/2024, revealed no completion of dementia training prior to or after beginning care provision at the facility. A review of CNA AA's competency evaluation as provided by Human Resources Director, Staff Z on 7/24/2024 at 3:36 p.m., revealed a Skills Checklist by [contract company], dated 4/10/2024. Further review of the Skills Checklist, revealed the checklist to be a self-evaluation completed by CNA AA indicating how frequently she performed tasks and how proficient she felt at the listed tasks. Further review of the documents provided by Staff Z revealed no further evaluation of CNA AA's skills. Review of CNA AA's education roster titled Core Mandatory Exam - Nursing, dated 4/17/2024, revealed no completion of dementia training prior to or after beginning care provision at the facility. A review of CNA BB's competency evaluation as provided by Human Resources Director, Staff Z on 7/24/2024 at 3:36 p.m., revealed a Skills Checklist by [contract company], dated 7/09/2024. Further review of the Skills Checklist, revealed the checklist to be a self-evaluation completed by CNA BB indicating how frequently she performed tasks and how proficient she felt at the listed tasks. Further review of the documents provided by Staff Z revealed no further evaluation of CNA BB's skills. No education roster or Core Mandatory Exam - Nursing, was provided for CNA BB to show proof of completion of mandatory dementia training prior to beginning care provision at the facility. During an interview on 7/25/2024 at 11:35 a.m., Unit Manager, Registered Nurse (RN) E reported new hires were evaluated through utilization of a checklist during two days of orientation. RN E stated CNA staff assigned to new hire orientation were responsible for completing the checklists and determining competency and human resources monitors for completion. RN E confirmed CNAs F, AA and BB were no longer on orientation and provided care throughout the facility. When asked for the orientation/competency checklists for CNA F, CNA AA and CNA BB, RN E reported the staff person responsible for completion of the evaluations was no longer employed by the facility. RN E stated she was unable to determine if the CNAs were deemed competent prior to being allowed to perform resident care activities. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the personnel files for CNA F, CNA AA and CNA BB with Staff Z on 7/25/2024 at 12:07 p.m., revealed no further information related to skill evaluations or competency were available. Staff Z reported she accepted the documentation from the contract company and nursing administration would complete the evaluations, if necessary. On 7/25/2024 at 12:30 p.m., Staff Z presented [Facility] CNA Competency, forms for CNA F, AA and BB. Staff Z reported the forms were found in a box with other documents. Staff Z stated the forms were not complete. Review of CNA F's [Facility] CNA Competency, dated 5/15/2024, revealed the following sections were not evaluated: Assisting a resident at meals; catheter care; assisting a male resident with a urinal; assisting resident with a bedpan; cleaning and storage of dentures; assisting with oral care; shower or tub bath; peri-care male; and complete bed bath. Review of CNA AA's [Facility] CNA Competency, dated 5/15/2024, revealed the following sections were not evaluated: Assisting a resident at meals; catheter care; assisting a male resident with a urinal; assisting resident with a bedpan; cleaning and storage of dentures; assisting with oral care; shower or tub bath; peri-care male; and complete bed bath. Review of CNA BB's [Facility] CNA Competency, dated 4/23/2024, revealed the following sections were not evaluated: catheter care; shower or tub bath; and peri-care male. Review of the facility Job Description: Certified Nursing Assistant, revealed the following, in part: Functions and responsibilities of position. Functions related to direct care of the resident: personal hygiene and grooming (special attention or oral hygiene, care of nails . perineal care . offer nourishment and fluids, answering call signals . During an interview on 7/25/2024 at 12:19 p.m., the Assistant Director of Nursing (ADON) reported evaluations should be complete prior to CNA's providing care. The ADON stated it was the facility responsibility to ensure competency and the self-evaluations provided by the contract company did not demonstrate observed competency. Review of the Facility Assessment, dated 3/17/2024, revealed the following, in part: Services and care we offer based on our resident needs: Specific Care and Practices: Bathing, showers, oral/denture care . eating . incontinence prevention and care, intermittent or indwelling or other catheter . care of someone with cognitive impairment . We provide competency checks: Person-centered care . Activities of Daily Living Caring for resident with Alzheimer's and other dementia .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45123 Based on observation, interview, and record review, the facility failed to ensure a medication administration error rate of less than five percent, with three errors identified out of 30 opportunities, affecting two Residents (R30 and R32) of four residents observed for medication administration, resulting in a medication error rate of 10.00 percent. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise specified. On 7/23/24 at 7:50 AM, medication administration was observed with Licensed Practical Nurse (LPN) R for R30. LPN R was observed dispensing one torsemide 20 mg tab. LPN R was asked how many she dispensed and replied, One. That is how many he gets. After medications were verified, LPN R was made aware R30 had a recent order change related to drug amount for torsemide dispensed by pharmacy. Prior orders for R30 were to dispense one 40 mg tab and current supply was 20 mg. Review of R30's physician order, dated 7/12/24, revealed the current order for torsemide 20 mg, was to give 2 tablets by mouth one time a day for edema. On 7/24/24 at 10:15 AM, medication administration was observed with LPN H for R32. LPN H was observed accessing R32's PICC line with a 10 ml (milliliter) syringe filled with normal saline solution and failed to check for a blood return prior to administering the saline solution into the PICC line. LPN H was over an hour late in the administration of the antibiotic medication for R32. Review of R32's physician order, dated 6/27/24, revealed an order for vancomycin 750 mg (milligrams) / 150 ml (milliliters), intravenously one time a day for sepsis until 8/6/24. *Note administration timeliness is important in antibiotic delivery to maintain serum concentration for drug levels/dosing/treatment. On 7/24/24 at 1:55 PM, medication administration was observed with LPN H for R30. LPN H had primed two units, then dialed up the insulin pen to 12 units for R30, and set it on top of his medication cart. This Surveyor asked how many units he drew up for R30 and replied, Did I forget to prime it? I think I still need to prime it. LPN H picked up the pen and looked at the dose and then dialed one more unit up to equal 13 units. LPN H was stopped and asked if he had the correct dose and replied, I think so. No, I only need 12 units and I have 13 units. LPN H then primed two units out of the pen to now equal 11 units (administered to R30). During this same medication administration, LPN H was observed dispensing a calcium carbonate with all the rest of R30's medications. LPN H handed R30 all his medications in one cup. LPN H was asked if R30 should take them all at the same time including the calcium carbonate and replied, Oh, no. He takes that one last because he must chew it up. Review of R30's physician order, dated 7/4/24, revealed an order for insulin glargine subcutaneous solution pen-injector, inject 12 unit subcutaneously one time a day. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 2:30 PM, an interview was conducted with the Assistant Director of Nursing/Registered Nurse (ADON/RN) A who was made aware of the medication errors during medication pass. RN A replied, We have the sticker that the nurses can use to put on the medication cards when doses or concentrations are different. There should be a sticker on it. Calcium is always placed in a cup by itself and not mixed with all the other meds. LPN H gets very nervous if anyone watches him. We never have him train anyone. I will follow up on the insulin dose administered with him. Review of policy titled, Medication Administration, dated 2/14/24, read in part, Policy: Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection .10. Review MAR [medication administration record] to identify medication to be administered. 11. Compare medication source (bubble pack, vial .) with MAR to verify resident name, medication name, form, dose, route, and time .b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review, the facility failed to 1.) safely securing narcotic medications in one of two medication rooms; 2.) not dating biologicals in one of three medication carts reviewed for medication storage. Findings include: All times noted are Eastern Daylight Savings Time (EDST) unless otherwise specified. On [DATE] at 8:45 AM, an observation was made of the 200-hall medication cart. The 200-medication cart was found to have the following: a. Two undated and opened insulin pens; An observation was made on [DATE] at 8:20 AM, of the first-floor medication storage room. The first-floor medication storage room was found to have the following: a. Two vials and one liquid dropper bottle of lorazepam (scheduled II controlled substance) in a small refrigerator with no secondary lock. LPN T confirmed the lorazepam, which is a controlled substance should be under two locks. On [DATE] at 8:30 AM, an observation was made of LPN H preparing medication pass for a Resident #14 (R14) and LPN H dropped a tablet of carvedilol on top of the medication cart. LPN H picked it up and threw it in the medication cart trash. LPN H proceeded to dispense medications for R14 and dropped a doxycycline on top of the medication cart and again picked it up and threw it in the medication cart trash. LPN H continued to dispense medications for R14 and dropped twice in a row spironolactone on top of the medication cart and after the second time he dropped the medication on top of the medication cart, he picked the second spironolactone up with his bare hands and placed it in the medication cup he was preparing for R14. LPN H was without explanation of why he used his bare hands, did not perform hand hygiene, or used the second dropped spironolactone and placed it in the medication cup for R14. On [DATE] at 9:45 AM, an interview was conducted with the Assistant Director of Nursing/Registered Nurse (ADON/RN) A and was asked what the regulation was for storing controlled substances. RN A replied, They need to be double locked. RN A asked what this Surveyor was referring to and was told about how lorazepam was stored in the first-floor medication room refrigerator. RN A stated I do remember asking about that a little while ago. I told the maintenance guy we needed a lock on that refrigerator months ago. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of policy titled, Medication Storage, dated [DATE], read in part, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .2. Narcotics and Controlled Substances: a. Scheduled II drugs and back-up stock of Scheduled III, IV, and V medications are stored under a double-lock and key. B. Scheduled II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator . Review of policy titled, Destruction of Unused Drugs, undated, read in part, Policy: All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations .1. Drugs will be destroyed in a manner that renders the drugs unfit for human consumption and disposed of in compliance with all current and applicable state and federal requirements. 2. Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40383 Based on observation, interview, and record review, the facility failed to provide adaptive dining equipment for two Residents (R22 & R29) of three residents reviewed for adaptive dining equipment needs. This deficient practice resulted in increased difficulty with food consumption and independent eating with the potential for decreased food/fluid intake and risk for weight loss. Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted. Resident #22 (R22) On 7/22/24 at approximately 1:20 PM, the lunch meal was observed for R22. The meal tray card indicated Colored Plates be provided. R22 had her meal served on a white plate. During an interview on 7/22/24 at 1:49 PM, when asked for the purpose of the colored plates, Dietary aide (Staff) J explained they were used for those residents who were visually challenged. During an interview on 7/22/24 at 3:07 PM, R22 stated, I need colored plates. I am legally blind. R22 said they did not get one today. The Electronic Medical Record (EMR) for R22 revealed admission to the facility on [DATE] and the care plan included, The resident has impaired visual function with interventions including, The resident will maintain optimal quality of life within limitation imposed by visual function. Monitor/document/report .acute eye problems: . Sudden visual loss, Pupils dilated, gray or milky, c/o (complaints of) halos around lights, double vision, tunnel vision, blurred or hazy vision. On 7/24/24 at approximately 1:30 PM, the lunch meal was observed for R22. The tray card indicated Styrofoam Cups - all beverages. The coffee provided on the tray for R22 was observed in a regular mug and not in a Styrofoam cup. The care plan for R22 included, The resident has potential nutritional problems . with interventions including Provide Styrofoam cups for all beverages. Provide small cups for beverages- has hard time holding onto regular cups. Resident #29 (R29) R29 was admitted to the facility on [DATE] with diagnoses including dysphasia (difficulty swallowing) , spasms of the esophagus, dementia, heart failure and stroke with left side paralysis. The EMR revealed the physician diet order as follows: Order Summary: Start dated 11/1/23, Regular diet Pureed texture, Nectar/Mildly Thick consistency . texture varies per DPOA (Durable Power of Attorney) .nectar water with all meals; . (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/24 at 9:31 AM, the breakfast meal for R29 was observed. The meal tray card indicated a diet order of Puree, nectar mild sm (small) portions HF/HC with instructions to give small plastic teaspoon and straw. The beverages on the meal tray did not have straws. However, there was a straw in the thickened water on R29's bedside table. CNA HH stated R29 should not have straws with thickened liquids and did not know how the bedside beverage had a straw. R29 stated sometimes she does not have enough wind to get the fluid up the straw- it is thick. CNA HH stated they felt straws should not be given because R29 had too much difficulty using straws with thickened liquids and did not give a straw when offering a beverage. Although the tray card instructed straws should be given and the care plan also indicated straws should be given. On 7/24/24 at 9:37 AM, the breakfast meal for R29 was observed and the bedside water had a straw inserted but straws were not in the other beverages. CNA O stated it was standard practice that thickened liquids do not get straws and remarked the straw in the water is an error. CNA O stated they felt straws should not be given because R29 had too much difficulty using straws with thickened liquids and did not give a straw when offering a beverage. Although the tray card instructed straws should be given and the care plan also indicated straws should be given. The EMR care plan read in part, (R29) has a swallowing problem r/t (related to) Complaints of difficulty or pain with swallowing, difficulty with thin liquids, Swallowing assessment results, h/o (history of) stroke which resulted in swallowing problems. The interventions on R29's care plan included, Alternate small bites and sips. Use a teaspoon for eating. Use a straw for beverages and also Provide nectar thick water with meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235069	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinecrest Medical Care Facility	N15995 Main Street Powers, MI 49874

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49310 All times are in Eastern Daylight Time (EDT) unless otherwise noted Based on observation, interview, and record review, the facility failed to implement an infection prevention and control program in accordance with facility policies to prevent the potential transmission of communicable diseases and infections as evidenced by failure to: 1. Document signs and symptoms of infections. 2. Conduct departmental surveillance for adherence to infection control practices. 3. Handle meal trays for residents in transmission-based precautions in accordance with facility policy. 4. Provide barriers for insulin pens during medication administration. 5. Ensure urinary catheter drainage bag and tubing remained off the floor. This deficient practice resulted in the potential for the transmission of pathogens between residents and the spread of infectious organisms to all 63 residents in the facility. Findings include: The facility's Infection Prevention and Control Program was reviewed with the Infection Preventionist (IP) on 7/24/24 at 10:47 a.m. The IP explained the facility used a line list as part of a monthly infection surveillance to identify infections and determine if residents' symptoms met McGeer Criteria (a surveillance tool used to define types of infections). The IP explained each resident's signs and symptoms of infection were documented on a monthly line list to identify, track, trend, and correlate infections. The infection surveillance line list for May 2024 was reviewed. The line list contained the names of 13 residents. The column labeled symptoms was blank and did not document the symptoms of infections for any of the 13 listed residents. The IP was asked the location of the documentation of symptoms. The IP said the signs and symptoms of infection would be documented on the line list and said, I don't know how I missed that when shown the blank symptom column on the May 2024 line list. The IP was asked the process for conducting infection surveillance activities throughout the facility. The IP said departmental surveillance was conducted monthly by respective department managers. When asked if departmental surveillance had been completed for May, June, and July of 2024, the IP responded, Probably not. The IP presented a departmental surveillance form dated 7/17/24 by the dietary department. The IP confirmed no other department had conducted infection control and prevention rounds in their department during the quarter requested. When asked if the IP ever conducted surveillance rounds in the departments, the IP responded, No, but I need to. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy Infection Surveillance dated 12/15/23 read, in part: .updated McGeer criteria or other nationally-recognized surveillance criteria will be used to define infections .Surveillance activities will be monitored facility-wide, and may be broken down by department .The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: .signs and symptoms .Line charts will be used . 45123 On 7/24/24 at 8:30 AM, an observation was made of LPN H preparing medication pass for a Resident #14 (R14) and LPN H dropped a tablet of carvedilol on top of the medication cart. LPN H picked it up and threw it in the medication cart trash. LPN H proceeded to dispense medications for R14 and dropped a doxycycline on top of the medication cart and again picked it up and threw it in the medication cart trash. LPN H continued to dispense medications for R14 and dropped twice in a row spironolactone on top of the medication cart and after the second time he dropped the medication on top of the medication cart, he picked the second spironolactone up with his bare hands and placed it in the medication cup he was preparing for R14. LPN H was without explanation of why he used his bare hands, did not perform hand hygiene, or why he used the second dropped spironolactone and placed it in the medication cup for R14. On 7/24/24 at 1:55 PM, medication administration was observed with LPN H for R30. LPN H proceeded to R30's room to administer his medications. LPN H gave R30 his insulin and then placed the insulin pen on his bedside table without a barrier and then handed him his medication cup. LPN H returned the insulin pen back to the medication cart without wiping it off before returning it to the medication cart. On 7/24/24 at 9:45 AM, an interview was conducted with the Assistant Director of Nursing/Registered Nurse (ADON/RN) A and was asked what the proper destruction of medications was and replied, Nurses are required to take them to the medication room and use the drug buster container. RN A was asked if a barrier should be used on top of bedside tables if nurses need to set medications down that will be returned to the medication cart and replied, Yes, barriers are required in resident rooms if medical items are placed on bedside tables per policy. 40383 Resident #22 (R22) During a room visit on 7/22/24 at 2:55 PM, R22 was sitting in her wheelchair and her catheter tubing was observed extending from her pant leg and resting on the floor. During a dining room observation on 7/23/24 at 1:17 PM, R22 was sitting in her wheelchair and her catheter tubing was observed extending from her pant leg and resting on the floor. During a room visit on 7/25/24 at 10:00 AM, R22 was in bed and her catheter drainage bag was observed to be resting on the floor and not contained in a privacy bag. Licensed Practical Nurse (LPN) H was asked to observe the catheter drainage bag and said the drainage bag should not be touching the ground and proceeded to make corrections to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Electronic Medical Record (EMR) for R22 revealed a physician order dated 7/19/19 for an ongoing indwelling urinary catheter and diagnoses which included dysuria (difficult or painful urination). The care plan for R22 included, The resident has Indwelling Catheter. During an interview on 7/25/24 at 10:06 AM, when asked about the urinary catheter bag and tubing resting on the floor, RN A agreed the catheter tubing and drainage bag should be kept off the floor. The facility policy Catheter Care dated as reviewed 5/10/24 read in part, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use . Privacy bags will be available and catheter drainage bags will be covered at all times while in use .