STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235089	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tuscola County Medical Care Facility	1285 Cleaver Rd Caro, MI 48723

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to ensure care that was dignified and respectful treatment for two residents (Resident #96 and Resident #114) of two residents reviewed, resulting in a lack of acknowledgement and/or response to Resident #96's verbalization of discomfort and Resident #114's request for assistance, and the likelihood for feelings for insignificance and psychosocial distress utilizing the reasonable person concept. Findings include: Resident #96: On 10/15/24 at 8:33 AM, Resident #96 was observed in the dining room of the locked dementia care unit of the facility. The Resident was sitting in their wheelchair at a table with a plastic cushion behind their back and was repeatedly saying, Oh my back, oh my back. There were other residents sitting at the table eating as well as a Certified Nursing Assistant (CNA) U. Two other staff members were present in the dining room within hearing distance of Resident #96. When asked if they were okay, Resident #96 responded, Oh my back but did not provide further explanation. The Resident was leaning forward and back and displaying non-verbal signs and symptoms of pain. When asked if they ate breakfast yet, Resident #96 indicated they did not know, and CNA U verbalized they already ate. Neither CNA U nor any of the other staff members in the dining room acknowledged the Resident's verbalization of back discomfort. Record review revealed Resident #96 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, intervertebral disc disorders (condition where the discs separating the spinal bones break down), osteoarthritis, and falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required moderate assistance for bathing and personal hygiene. The MDS further revealed the Resident had received scheduled pain medication in the prior five-day period. Review of Resident #96's care plans revealed a care plan entitled, The resident has or is at risk for chronic pain r/t (related to) Arthritis (Initiated and Revised: 3/6/24). The care plan included the interventions: - Assess for pain using pain assessment tool appropriate for the Resident's cognitive status (Initiated: 3/6/24) (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: 235089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Monitor for presence of pain, effectiveness of intervention, adverse consequences . (Initiated: 3/6/24) Review of Resident #96's Medication Administration Record (MAR) and Health Care Provider (HCP) Orders revealed the Resident was receiving Ultram (opiate pain medication) 50 milligrams (mg) twice a day as well as Tylenol 8 Hour Arthritis Pain 650 mg three times a day. Documentation of pain on the MAR for 10/15/24 at 9:00 AM was zero out of 10 (indicating the Resident was experiencing no pain). Review of Resident #96's Progress Notes on 10/16/24 revealed no documentation related to the Resident complaining of discomfort on 10/15/24. Resident #114: On 10/14/24 at 11:27 AM, Resident #114 was not present in their room. On 10/15/24 at 8:33 AM, Resident #114 was observed in the dining room of the locked dementia care unit of the facility. The Resident's hair was uncombed and had a greasy appearance. When spoke to and asked questions, Resident #114 was pleasant, confused, and did not provide meaningful responses. Record review revealed Resident #114 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, dementia, and hypertension. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required set up to supervision assistance to complete dressing and personal hygiene. On 10/14/24 at 4:10 PM, Resident #114 was observed sitting at a table in the dining room in a wheelchair. CNA V was sitting next to the Resident at the same table. Upon entering the dining room, and approaching Resident #114, the Resident was heard saying they wanted to lay down. An interview was conducted with Resident #114 at this time. When asked how they were, Resident #114 replied, I'm really tired and they won't let me lay down. Resident #114 gestured toward CNA V. CNA V was sitting directly next to Resident #114 but did not verbally respond to the Resident. When asked why Resident #114 was not able to lay down, CNA V did not provide a response and called CNA Y, who was also in the dining room, to come to the table. CNA Y was then asked why Resident #114 was not able to lay down and replied, We are going to eat dinner soon. When queried how that prohibited the Resident from laying down and why no one would assist them to go back to their room when they were asking, CNA Y did not provide a response. CNA V then stated they would take Resident #114 back to their room. CNA V was observed pushing the Resident out of their room in their wheelchair to their room. At 4:30 PM on 10/14/24, Resident #114 was observed in their room. The Resident was in bed, positioned on their side with their eyes closed. On 10/16/24 at 11:18 AM, Resident #114 was observed sitting in their wheelchair in the dining room. The Resident was pleasantly confused and did not provide meaningful responses to questions. Review of facility provided Resident Mealtimes document detailed dinner was served in Resident #114's unit at 5:00 PM for the first cart and 6:15 PM for the second cart. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 10/16/24 at 2:00 PM. When queried regarding expectations of staff in relation to acknowledgment and responding to a resident's verbalization of discomfort and/or care needs, the DON indicated they expect staff to acknowledge and respond to residents. Observations of Resident #96 were relayed to the DON at this time including non-verbal signs/symptoms of pain, verbalization of Oh my back, and lack of staff response. When asked their thoughts, the DON replied, I would have to look into that. When queried regarding Resident #96's pain level being documented as zero, no further explanation was provided. The DON was then informed of observations of Resident #114 asking staff to assist them to go to their room and lay down. When asked, the DON expressed the Resident is able to go to their room and lay down whenever they want. The DON was then questioned why staff did not acknowledge or assist the Resident and replied, I will look into that. Review of facility policy/procedure entitled, Resident Rights (Reviewed 1/15/24) revealed, Policy . The resident has a right to a dignified existence, self-determination . 6. The resident has the right to refuse treatment, deny or withdraw consent at any time . 39. The resident has the right to be treated in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 40. The resident has the right to choose activities, schedules, and health care .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37666 Based on interview and record review, the facility failed to develop person-centered comprehensive care plans for Code Status preferences for five residents (Resident #4, Resident #17, Resident #22, Resident #66, Resident #68) of 29 residents reviewed for care plans, resulting in the potential for residents not to receive individualized care, which could lead to a decline in condition, and/or a negative outcome. Findings Include: A record review of the facility policy titled, Comprehensive Care Plan, Care plan review and Care Plan Conferences, date implemented [DATE], date reviewed [DATE] and date revised [DATE], provided (The facility) will ensure that all residents have a Baseline Care Plan completed per the Baseline Care Plan Policy, and a comprehensive Care Plan in the e- chart within 7 days of completion of section Z of the Admission MDS assessment . The Care Plan will provide staff with guidelines on resident care needs . Resident #4: Advance Directives A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #4 indicated an admission to the facility on [DATE] and readmission on [DATE] with diagnoses: urinary tract infection, acute kidney failure, chronic kidney disease, diabetes, Parkinson's disease, obesity, Dementia and peripheral vascular disease. The MDS assessment dated [DATE] revealed the resident had moderate cognitive loss with a Brief Interview for Mental Status/BIMS score of ,d+[DATE] and the resident needed assistance with all care. On [DATE] at 4:13 PM, during a record review of the Advance Directives for Resident #4, the Code Status form dated [DATE] indicated the resident had No checked next to Cardiopulmonary Resuscitation (CPR), Use of Respirators, Ventilators, Tube Feeding, and Transfer to Acute Care Hospital. The Code Status form was signed by the resident's Durable Medical Power of Attorney on [DATE]. A review of the Comprehensive Care Plans for Resident #4 indicated there was no mention of the resident's Code Status preferences. Resident #17: Advance Directives A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #17 indicated an admission to the facility on [DATE] and readmission on [DATE] with diagnoses: Multiple Sclerosis, Dementia, history of Lyme disease, diabetes, COPD, and heart failure. The MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills and needed assistance with all care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Code Status form dated [DATE] identified several Code Status preferences by the resident: No was checked for the options Cardiopulmonary Resuscitation/CPR, Use of Respirators, Ventilators and Transfer to Acute Hospital. Yes was marked for Tube Feeding. The Other category listed Transfers to acute care hospital for tube feeding concerns and seizure activity as needed. The Code Status for was signed on [DATE] by the resident's Guardian. A review of the Care Plan for Resident #17 indicated there was no mention of the resident's Code status preferences for no CPR, no Use of a Respiratory/Ventilator or no Transfer to Acute Hospital. There was also no mention of the Other request to transfer to the acute care hospital for tube feeding concerns and seizure activity as needed. Resident #22: Advance Directives A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #22 identified an admission to the facility on [DATE] with diagnoses: Diabetes, heart disease, heart failure, COPD, arthritis, Alzheimer's, and a history of falls. The MDS assessment dated [DATE] indicated the resident had a BIMS score of ,d+[DATE] with moderate cognitive decline and needed assistance with all care. A review of the Code Status Form Do-Not-Resuscitate Order for Resident #22 revealed that the resident signed the form on [DATE]. A review of the Care Plans for Resident #22 revealed there was no mention of the resident's Advance Directives or Code status preferences. Resident #66: Advance Directives A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #66 indicated an admission to the facility on [DATE] with diagnoses: history of a stroke, left sided weakness, heart failure, Alzheimer's, and COPD. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of ,d+[DATE] and needed some assistance with care. A review of the Code Status form for Resident #66 revealed it was signed by the resident's DPOA on [DATE]th, 2024. The form was marked Yes for: Cardiopulmonary resuscitation (CPR), Use of respirator, ventilator, tube feeding and transfer to Acute care hospital. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Care Plans for Resident #66 indicated there was no mention of the resident's Advance Directives or Code Status preferences. Resident #68: Advance Directives A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #68 identified an admission to the facility on [DATE] and readmission on [DATE] with diagnoses: chronic kidney disease, heart failure, COPD, peripheral vascular disease, hypothyroidism, depression, anxiety, anemia, and obesity. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a BIMS score of , d+[DATE] and needed some assistance with all care. A review of the Code status form titled, Do-Not-Resuscitate Order indicated the resident signed the form on [DATE] for DNR/Do-Not-Resuscitate. A review of the Care Plans for Resident #68 revealed there was no mention of her Code Status preference. On [DATE] at 8:55 AM, Social Services/SS Director J was interviewed about Residents' Advance directives and code status preferences. The SS Director J said someone from Social Services reviewed the code status and advance directives with the resident or responsible party and nursing obtained an order for the code status. When asked if the residents' code status was Care Planned, she said she did not think it was care planned. Reviewed the resident's Care Plan with the SS Director and it did not mention the resident's code preferences.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on observation, interview and record review, the facility failed to ensure a safe environment to prevent skin tears and bruising for one resident (Resident #22) of 8 residents reviewed for accidents, resulting in Resident #22 suffering repeated skin tears and bruising. Findings Include: Resident #22: Accidents A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #22 identified a readmission to the facility on [DATE] with diagnoses: Diabetes, heart disease, heart failure, COPD, arthritis, Alzheimer's, and a history of falls. The MDS assessment dated [DATE] indicated the resident had a BIMS score of 9/15 with moderate cognitive decline and needed assistance with all care. On 10/14/2024 at 11:53 AM, Resident #22 was observed lying in bed; there were two handrails on the sides of the bed (grab bars). He was observed to have thick tan colored arm sleeves from his wrist to mid-upper arm on. Certified Nurse Aide/CENA P said the resident wore the sleeves to protect his arms because he repeatedly tried to climb out of bed. The aide said the resident would bump the rails and get skin tears on his arms. A review of the Incident and Accident Reports for Resident #22 revealed the following: Falls: Resident #22 had 2 falls over the last year- 5/27/2024, and 6/13/2024. 5/27/2024 at 2:15 PM- Resident found sitting on buttocks on floor beside bed, no injury, intervention to add 2 stacked mats beside the bed. The resident had recently completed antimicrobial treatment for C. Diff (a diarrheal infection) and a UTI (urinary tract infection). The report indicated the resident has confusion with UTI's. The resident's interventions were updated to include double stacked mattresses on the floor. 6/13/2024 at 11:40 AM- Resident #22 was found lying on floor next to his wheelchair with his bedside table tray in front of him. He had a laceration on his head 3 cm x 0.5 cm, hematoma 5.5 cm x 2.5 cm, bruise above left eye 7 cm x 3.5 cm. laceration left eye hematoma 1 cm x 1 cm. He was sent to the emergency room /ER and received 4 staples to the laceration on his head. The Incident and Accident Reports also identified Resident #22 as obtaining 13 skin tears and/or bruises from 11/23/2023- 10/3/2024. 11/23/2023 at 4:17 AM- 3.5 cm x 3.5 cm green purple bruise next to a skin tear right fore arm during transfer; The report provided, Predisposing Situation Factors: 'During Transfer'. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/10/2023 at 5:57 PM- Back of right hand between 1st and 2nd digit open 0.5 cm V shaped skin tear. At sight of an existing bruise. 12/14/2023 at 10:40 AM- 0.5cmx1cm left hand between 1st and 2nd digits. The report stated, It happened when my hand brushed against the sling in the lift. 1/11/2024 at 2:42 AM- Right hand bruises 2.5 cm x 1.5 cm dark purple bruise back of right hand at base of thumb. 1/18/2024 at 4:30 PM- Skin tear right upper arm during care. 2/22/2024 at 2:02 AM- Dark purple bruise back of right hand 1cm x 2 cm. 2/29/2024 at 2:49 AM-Bruising to left upper arm, top of left hand and right wrist. Resident stated he thought it was from transfer to chair. 6/23/2024 at 10:27 PM- 0.3 cm x 0.3 cm open area right elbow near a scab, fell [DATE]. 6/26/2024 11:00 PM- Purple yellow bruise right ankle 5 cm x 2.5 cm. 6/29/2024 at 2:39 PM- Skin tear left bicep 0.5cm x 0.5 cm. 7/17/2204 at 10:30 PM- Skin tear 2 cm x 4 cm left upper arm with fresh blood; 9/20/2024 at 3:15 AM- Found on mattress on floor next to bed, with 3 new skin tears: between elbow and wrist on forearm 3 cm; on left elbow 1 cm; above left elbow 2 cm x 1 cm. on left arm from the rails. Per report, Resident injuries consistent with his likely using arms and bumping into hard surfaces attempting to self-transfer to mats. 10/3/2024 at 3:24 AM- LUE (left upper extremity) 3cm x 3cm dark purple bruise; (right forearm) purple bruise 4.5 cm x 6.5 cm with 1 cm dry scabbed area. A review of the Care Plans for Resident #22 identified the following: Requires assist with ADL (activities of daily living) needs (related to) Fatigue, weakness, dementia, date initiated 5/4/2023 and revised 9/16/2024 with Interventions including: Mobility handles per Dr's order for safety during care provision, to assist with bed mobility Observe for injury or entrapment related to mobility handle use, date initiated 8/28/2023; Assist with bathing, grooming, meals, dressing and personal hygiene as needed, date initiated 5/4/2023. Per the MDS assessment dated [DATE], the resident was identified to be dependent for all care except for eating. He was not able to transfer on his own and could not ambulate (walk). The resident is at risk for falls related to decondition, impaired safety awareness, impaired mobility, date initiated 5/4/2023 and revised 9/16/2024 with Interventions including: T/F (transfer): 1 assist with Hoyer & medium sling . date initiated 8/17/2023 and revised 3/26/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22 was identified to have many injuries (skin tears and bruises); some of the injuries did not have an identified cause, but several listed the resident attempting to exit the bed on his own or he had injuries from transfers with the mechanical lift. There was 1-person assigned to assist the resident with transfers with the lift; there was no mention on whether this was safe for one person to manage the mechanical lift and ensure the resident's safety, as the resident was dependent with transfers. The resident has potential for impairment to skin integrity related to fragile skin, date initiated and revised 6/8/2023 with 2 Interventions, Follow facility protocols for treatment of injury, date initiated 6/22/2023 and Dermasaver BUE (bilateral upper extremities) (at all times), off q shift & check skin, date initiated 8/17/2023 and revised 9/25/2024. The resident was ordered arm sleeves (Dermasavers), but continued to develop injuries. In some instances, the injuries were outside the area the Dermasaver covered. There was no mention of the resident climbing or attempting to climb out of bed, or if the Mobility bars were causing bruising or skin tears. On 10/16/2024 at 9:50 AM, during an interview with Quality Nurse H, he was asked about the injuries that Resident #22 had obtained. Quality Nurse H said he investigated the incidents, and the resident was confused and attempted to get out of bed at times and that is why he had the 2 mattresses on the floor. He said the resident had fragile skin and the Dermasavers for his arms were provided to protect them. There was no explanation for injuries potentially from the Mobility bars or during transfers, as some of the injuries were similar and in the same locations. A review of the facility policy titled, Skin care, date implemented 4/16/2003, reviewed 11/4/2021 and revised 2/18/24 provided, . Weekly Skin Assessment Procedure: . Skin assessment to be complete by unit nurses on their scheduled day . Fragile Skin/Skin Tears/Abrasions . There was no mention of investigating the causes for the injuries. A review of the facility policy titled, Falls and Fall Risk, date approved 11/25/2002, reviewed 12/27/22 and revised 1/10/24 provided Policy: The goal of the (facility) is to improve the prevention and management of resident falls by assessing/identifying the resident's risk for falls. Then incorporating a treatment/management program related to the individual resident's needs, monitoring/evaluating the effectiveness of interventions that have been employed . A Restorative Nurse will review current ADL documentation during the fall review to assess for changes in level of assistance utilized with transfers . All falls are recorded on an incident report . The policy was specific to falls, and did not address other injuries or potential causes for injuries.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation interview and record review the facility failed to follow facility policy for indwelling catheter use for five residents (R17, R22, R51, R52, R106) of six residents reviewed, resulting in physician's orders not having catheter size, dignity bags touching the floor and recurrent UTI's (urinary tract infections). Findings include: Resident #52 (R52): R52 is [AGE] years old and was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dementia, neuromuscular dysfunction of the bladder and history of urinary tract infections. On 10/14/24 at 10:27AM, observation revealed that R52 had an indwelling catheter, the urine collection bag was hanging below the bed, covered by a dignity bed and off the floor. On 10/16/24, record review of the admission MDS (Minimum Data Set) revealed that R52 was admitted with an indwelling catheter. On 10/16/24, record review of R52's care plan revealed a care plan for the indwelling catheter that was last revised on 12/27/2023. The interventions/tasks for the care plan state the resident has a 16fr Foley catheter, last revised on 12/18/2023. A review of the October 2024 TAR (Treatment Administration Record) for R52 revealed that the catheter was last changed on October 5th, 2024. No documentation was located that revealed what size catheter was used during the change. On 10/16/24, record review revealed a physician's order for the indwelling catheter, order date 01/03/2024. The order reads, Foley Catheter. Change PRN (as needed). as needed for end of life. The order does not contain the size of the catheter On 10/17/24, an interview with RN (Registered Nurse) K. RN K was asked how they would know what size catheter a resident has. RN K stated that the indwelling catheters are labeled with the size and that the physician's order also states the size the catheter is. RN K was asked who updates the care plans and orders with catheter size. RN K stated the nurse managers do that. Resident #106 (R106): R106 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dementia, bladder-neck obstruction and neuromuscular dysfunction of the bladder. On 10/14/24 at 01:52PM, observation revealed that R106 had an indwelling catheter. The urine collection bag is covered by a dignity bag and the dignity bag is resting on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 10:26AM, record review of R106's physician's orders revealed that R106 has an order for an indwelling catheter for neuromuscular dysfunction of the bladder. The order is dated 01/26/2023 and reads, Foley Catheter. Change PRN. On 10/16/24 at 10:35AM, record review of R106's care plans revealed a care plan for an indwelling catheter, last revised on 08/15/2024. The interventions/tasks on the care plan state the resident has a 16fr indwelling catheter, last revised on 01/26/2023. On 10/16/24 at 10:40AM, record review of the October 2024 TAR for R106 revealed the catheter was changed on October 6, 2024 and it was documented that a 14fr indwelling catheter was used. Record review of the policy titled, Urinary Catheters: Insertion/Removal of Straight, Indwelling or Suprapubic Catheters, revised 11/27/2023 revealed: 1. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use of the catheter necessary, size of the catheter, and frequency of change (if applicable). 8. Keep urinary collection bags in a cloth bag/cover for discreteness and cleanliness. Maintain urinary collection bags below the level of the bladder per manufacturer ' s recommendations; typically, regular drainage bags are required to be placed below the level of the bladder while leg bags do not have the same restriction. Do not allow urinary collection bags or drainage tubing to rest on the floor. 11. When a catheter is changed, note the change in the resident's electronic medical record making sure to record the date, catheter type, and size. Update Indwelling Catheter Tracking Log (located in TCMCF Official Forms Folder) 37666 Resident #17: Urinary Catheter or UTI A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #17 indicated an admission to the facility on [DATE] and readmission on 11/2/2023 with diagnoses: Multiple Sclerosis, Dementia, history of Lyme disease, diabetes, COPD, epilepsy, neuromuscular dysfunction of bladder and heart failure. The MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills and needed assistance with all care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the physician orders for Resident #17 identified the following: Foley catheter. Change as needed for neurogenic bladder, start date 4/26/2024. On 10/14/2024 at 12:38 PM, Resident #17 was observed lying in bed. A urinary catheter/Foley catheter drainage bag was observed inside a black cloth bag sitting on the floor. The catheter bag was bent over in the middle, so the urine could not flow freely into the bag. A review of the Care Plans for Resident #17 revealed the following: The resident has Indwelling Catheter (Foley) in place r/t (related to): Neurogenic bladder, date initiated 8/30/2016 and revised 4/26/2024. On 10/17/2024 an intervention was added, The resident has (16 Fr (size)) Foley. Position catheter bag and tubing below the level of the bladder, date initiated and revised 10/17/2024; Keep in cloth bag for discreetness/cleanliness, date initiated and revised 4/26/2024. Resident #22: Urinary Catheter or UTI A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #22 identified a readmission to the facility on [DATE] with diagnoses: Diabetes, heart disease, heart failure, COPD, arthritis, Alzheimer's, and a history of falls. The MDS assessment dated [DATE] indicated the resident had a BIMS score of 9/15 with moderate cognitive decline and needed assistance with all care. A review of the physician orders indicated Resident #22 had a supra-pubic urinary catheter with a start date of 5/20/2024. On 10/14/2024 at 11:48 AM, Resident #22 was observed lying in bed resting. The urinary catheter tubing had cloudy colored urine in it. The urinary catheter bag was sitting inside a black cloth bag that was sitting on the floor under the bed and behind 2 mattresses that were sitting on the floor. Certified Nurse Aide/CENA P entered the room and said the resident had a history of UTI's/Urinary tract infections. The aide was assisting the resident A review of the Care Plans for Resident #22 revealed the following: The resident has history of) recurrent Urinary Tract infections, dated initiated 5/5/2023 and revised 5/29/2024 with Interventions including: Observe urine characteristics and report to physician as indicated, date initiated 5/20/2024 and revised 7/25/2024. There was no mention of keeping the urinary catheter bag and or the black cloth bag off the floor to aid in preventing contamination. The resident has a suprapubic catheter in place (related to): Neurogenic bladder, date initiated 7/26/2023 and revised 12/28/2023 with Interventions including: Catheter are per policy and procedure, dated 7/26/2023. There was no mention of maintaining the urinary catheter bag or the black cloth bag from touching the floor. (continued on next page)

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 10/16/2024, Resident #22 was observed lying in bed and his urinary catheter bag was observed sitting inside a black cloth bag on the floor behind two mattresses stacked on the floor next to his bed. Nurse Q entered the resident's room and was asked about the catheter bag lying on the floor. The nurse moved the two mattresses slightly away from the side of the bed and the urinary catheter bag was observed inside a cloth black bag on the floor. The nurse said it should have been off the floor. He laid on his back on the mattresses on the floor and used two ties on the bag to lift it and tied it under the bed frame.

On 10/17/2024 at 9:45 AM, Resident #22 was observed lying in bed waiting for wound care with Nurse R and Nurse Aide S. The urinary catheter bag was inside a black cloth bag and was tied on the end of the bed; hanging off the floor as the bed was raised to accommodate wound care. The black cover bag was very stained and soiled. The 2 mattresses that had been lying on the floor beside the bed were moved against the wall by the window during the wound care. Both mattresses were very soiled: brown with dirt stains. Both mattresses had tears, open areas and with ends that appeared shredded and tattered. The mattresses were previously leaning against the catheter bag.

A review of the Association for Professionals in Infection Control and Epidemiology: Guide to Preventing Catheter-Associated Urinary Tract Infections, first edition, April 2014 identified the following: . Drainage System Safety- Sterile, continuously closed drainage systems became the standard of care based on an uncontrolled study published in 1966 demonstrating a reduction in the risk of infection in short-term catheterized patients wit the use of a closed system. Recent data also include the finding that disconnection of the drainage system is a risk factor for bacteriuria. The catheter tubing should allow free flow of urine and kinking of tubing should be avoided. The urine bag should be kept below the level of the bladder and kept off the floor .

39059

Resident #51:

On 10/14/2024, at 4:33 PM, Resident #51 was lying in their bed. Their Foley catheter drainage bag was covered with a blue cotton bag. The blue cotton bag was resting on the floor.

On 10/16/24, at 11:00 AM, a record review of Resident #51's electronic medical record revealed a readmission on 09/30/2024 with diagnoses that included Dysphagia, Multiple Sclerosis and Pneumonitis due to Inhalation of food and vomit. Resident #51 required extensive assistance with Activities of Daily Living and had intact cognition.

A review of the physician orders revealed Foley Catheter, prn as needed Change indwelling Foley catheter as needed for Leakage, obstruction, breaks in system or S/S (signs and symptoms) of UTI (urinary tract infection) . Start Date 09/30/2024 . There was no size of the Foley catheter listed on the physician's order.

A review of the Kardex revealed no direction as to when to change the blue cotton catheter bag cover or to keep the urinary catheter bag off the floor.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the care plan The resident has an indwelling catheter in place R/T (related to) Neuromuscular Dysfunction of Bladder Date Initiated: 03/14/2024 . Intervention/Task . Catheter care per policy & procedure. Date Initiated: 03/14/2024 CATHETER: The resident 16fr Foley 10 ml balloon. Position catheter bag and tubing below the level of the bladder. Revision on: 03/18/2024 Keep in cloth bag for discreteness/cleanliness. Date Initiated: 03/14/2024 . There was no intervention as to when to change the blue cotton catheter bag cover or to keep the urinary catheter bag off the floor. On 10/17/2024, at 8:30 AM, Resident #51 was lying in their bed. Their bed was in a low position. Their urinary catheter bag was inside a blue cotton bag which was resting on the floor. The overbed table leg was pushed against the catheter drainage bag touching the tubing. On 10/17/24, at 8:35 AM, an observation along with Nurse M was conducted of Resident #51's urinary catheter bag. Nurse M was asked if the blue bag covering the urinary catheter bag should be on the floor and Nurse M stated, no, that might have been midnight shift, pulled the bedside table back and raised the bed. Nurse M was asked how often the blue bags get replaced and Nurse M stated, I believe weekly and exited the room. On 10/17/24, at 10:06 AM, During Infection Control Task, Infection Control Nurse O was asked how often the blue cotton urinary drainage bag covers were laundered and IC Nurse O stated, as needed.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 39059 Based on observation, interview and record review, the facility failed to update and follow care planned interventions for one resident (Resident #51) of two residents reviewed for tube feeding, resulting in the head of the bed being at 19 degrees during tube feeding with the likelihood of decreased tube feeding dose, aspiration and/or pneumonia. Findings include: Resident #51: On 10/16/24, at 11:00 AM, a record review of Resident #51's electronic medical record revealed a readmission on 09/30/2024 with diagnoses that included Dysphagia, Multiple Sclerosis and Pneumonitis due to Inhalation of food and vomit. Resident #51 required extensive assistance with Activities of Daily Living and had intact cognition. A review of the physician orders revealed . Jevity 1.5 Cal Liquid (Nutritional Supplements) Directions Give 60 ml enterally . Start Date 10/9/2024 . Ensure HOB is elevated 30 degrees for duration of feeding and 60 minutes after feeding complete Line up yellow markings on bed and headboard . Start Date 09/30/2024 . A review of the Kardex revealed . Resident Care . Yellow markings lined up R/T (related to) TF (tube feed) . A review of the care plan The resident requires tube feeding tube r/t Dysphagia, Resident has G-tube Date Initiated: 03/14/2024 . Interventions/Tasks . Current TF regimen: Jevity 1.5 45 ml until 1080 cc infused 400 mLs flushes for A shift and 400 mLs flushes for B shift Date Initiated: 09/12/2024 . HOB @ 30 degrees during & after T.F. for an hour, use wall timer Date Initiated: 03/15/2024 . Visualize hourly Date Initiated: 09/30/2024 Yellow marking lined up R/T T.F. Date Initiated: 09/30/2024 One hour after tube feed done, lower HOB Date Initiated: 09/30/2024 On 10/17/24, at 8:30 AM, Resident #51 was lying in their bed on their left side. Their tube feeding pump was running and the tubing was hooked to the resident. The head of the bed appeared low. A measurement of the bed frame and head of the bed revealed an angle of only 19 degrees incline. On 10/17/24, at 8:35 AM, an observation of Resident #51's head of the bed was conducted with Nurse M. Nurse M was asked if the head of the bed was high enough and Nurse M offered there used to be a yellow line on the head board to show the proper height but I don't see the yellow tape. There was a faint line on the headboard which appeared if there was tape at one point. The top of the mattress was below the faint line. Nurse M was asked if the top of the mattress should be above the faint line or the bed frame and Nurse M stated, I believe the bed frame and raised the head of the bed to allow the bed frame to be even with the faint line.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to follow physician's orders for oxygen administration for one resident (Resident #117) of one resident reviewed for oxygen administration, resulting in the oxygen flow rate being administered not matching the Kardex or care plan. Findings include: Resident #117 (R117): R117 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include COPD (Chronic Obstructive Pulmonary Disease), chronic pulmonary edema, anxiety and anemia. On 10/14/24 at 09:56AM, R117 was observed sitting in a reclining chair with oxygen being administered at 3LPM (liters per minute) via NC (nasal cannula). The oxygen tubing was dated 10/10. On 10/15/24 at 08:58AM, R117 was observed sleeping in bed, oxygen was being administered at 3LPM via NC. On 10/16/24 at 03:57PM, R117 was asked if they are on oxygen continuously. R117 stated they use oxygen all the time and currently use 3LPM. The oxygen concentrator was observed set to 3LPM and the humidification bottle was empty. On 10/16/24 at 03:59PM, an interview was conducted with CNA (Certified Nursing Assistant) L. CNA L was asked who sets the oxygen flow rate for residents. CNA L stated the nurses set the rate, CNA L also stated that the aides are not allowed to set the rate or change it. CNA L was asked where they would look in the EMR (Electronic Medical Record) to see what the rate is supposed to be for a resident on oxygen in order to make sure it is set correctly. CNA L replied they would look In the Kardex (an area in the EMR that CNA's have access to and helps to guide their care) and the rate should be available, if not, CNA L stated they can check the physician orders and see what the rate should be. On 10/16/24 at 04:15PM, record review of the Kardex revealed that R117 was on continuous oxygen via NC at 2LPM. The care plan for altered respiratory status, last revised on 06/03/2024, revealed an intervention/task that stated R117 is on continuous oxygen via nasal cannula at 2LPM. Humidified as needed, last revised on 06/03/2024. On 10/16/24 at 04:20PM, record review of the physician's order for oxygen administration states, PRN(as needed) oxygen at 1-6LPM via nasal cannula for signs and symptoms of respiratory distress and/or to maintain oxygen saturation greater than/equal to 90%. May humidify PRN for resident comfort. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 09:22AM, an interview was conducted with RN (Registered Nurse) K. RN K was asked how they confirm the rate of oxygen administration for residents. RN K stated the nurses have a standing order for oxygen for 1-6LPM to titrate to the residents needs. RN K stated when a resident admits from the hospital they set the rate to the hospital order, monitor the oxygen saturation levels and confirm if that is a good rate for the resident. RN K stated the physician will be notified if the rate needs to change but the staff nurses can immediately titrate it according to the standing order. RN K was asked how would a CNA know what the rate should be, so they can confirm if it is correct or not. RN K stated the CNA's will come to the nurses and ask what the rate is and then confirm if it is correct on the oxygen concentrator or portable tank. Review of the policy titled, Oxygen Delivery Systems, revised 11/15/23, revealed: 5. Nursing Guidelines for Oxygen Therapy: a. Licensed staff using oxygen equipment will be trained in its operation, safety precautions, and manufacturer ' s instructions for using the equipment. Training will occur upon hire and periodically for review of safety guidelines and usage requirements. b. Oxygen therapy requires a Physician's Order, except in the case of an emergency. Standing orders for oxygen are found in policy # 701-222 Standing Order Protocols c. Follow the order from the physician for flow rate, device and specific parameters related to oxygen saturation levels. d. Humidification is appropriate for discomfort associated with mucous membranes and can be added prn. e. Using pulse oximetry, maintain Oxygen Saturation greater than or equal to 90% or per Physician ' s order. f. Oxygen saturation should be monitored every shift while resident is receiving continuous oxygen or has an order for PRN oxygen. g. If oxygen is not used for a period of 1 week, obtain an order to have oxygen therapy discontinued due to non-use. Review of the policy titled, Standing Order Protocols, last revised 5/30/24, revealed: POLICY: The Medical Director of TCMCC has outlined protocols to give Nurses the authority to (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiate treatment to maintain the health and well-being of a resident until the physician can be notified. OXYGEN THERAPY: For signs of respiratory distress and/or oxygen saturation less than 90%: O2 1-6 L/min. per Nasal Cannula to maintain O2 sat greater than or equal to 90%. Humidify PRN for complaints of dry mucous membranes. Check oxygen saturation every shift and as needed For oxygen saturation less than 90% and/or continued signs of respiratory distress after implementing above standing order, contact the physician for further orders regarding oxygen flow rate and oxygen delivery device.

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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. 37668 Based on observation, interview and record review, the facility failed to ensure that medications and medical supplies were stored and disposed of per professional standards of practice in two of five medication rooms resulting in expired medications and medical supplies, lack of refrigerated vaccine temperature monitoring per CDC recommendations, and the potential for residents to have procedures and testing completed with expired supplies and to receive expired medications with altered potency and efficacy. Findings include: A tour of the Second Redwood Medication Room was completed with Unit Manager Registered Nurse (RN) T on 10/17/24 at 8:34 AM. The following exited medications and medical supplies were present in the medication room: - ProSource NoCarb 15-gram Protein, 30 fluid ounce (oz) container, Expired: 9/28/24 - UTI-Stat, 30 fluid oz container, Expired 7/27/24 - 100 tablet bottle of Aspirin 81 mg tablets, Expired: 9/24 - Three bottles of Prevacid 15 mg tablets with 14 tablets per bottle for Resident #14, Expired 6/24 - Universal Viral Transport for Viruses (Covid) laboratory sample, Expired: 10/9/24 - 20 mL (milliliter) oral dispenser syringe, Expired: 7/30/24 - 24 g (gauge) IV (intravenous) Catheter BD Insyte Autoguard (for IV insertion and medication administration), Expired: 11/30/22 - Point-Lok Sharps Safety devices, quantity 12, Expired: 12/4/22 When queried regarding the expired medications and medical supplies, RN T confirmed the medications and supplies were expired and indicated they would dispose of them. A tour of the medication refrigerator in the medication storage room revealed vaccines were stored on the top shelf of the refrigerator along with other medications. A review of the temperature monitoring log for the refrigerator revealed temperatures monitoring documentation was completed once per day (24-hour period). When queried if vaccines are always stored in the medication refrigerator, RN T revealed vaccines are frequently stored in the refrigerator. When asked how often the temperatures are checked, RN T responded once daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/24 at 9:06 AM, a tour of the Second Hickory Medication Room was completed with the Assistant Director of Nursing (ADON). The following expired medications were noted in the medication room: - Bottle of 100 Vitamin E 200 IU (International Units) softgels - Bottle of 100 Acetaminophen 325 mg tablets - Bottle of Geri-kot (stool softener) 8.6 mg tablets, Expired: 4/24 - Four containers of Banatrol Plus (anti-diarrheal solution) 0.38 oz containers, Expired: 8/5/24 Review of facility policy/procedure entitled, Storage and Labeling of Medication and Biologics (Reviewed: 12/14/23) revealed, 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, segregation, and security . 1. General Guidelines: a. All drugs and biological's will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . 8. Expiration dates will be monitored to ensure that all medications are removed from distribution prior to expiration date. Nurses will check stock medications when removing them from storage are to ensure expired medications are not placed in the medication cart for use. The expiration date assures that the drug meets applicable standards of strength, quality & purity at the time of use. When the label shows only a month and a year, the implied expiration date is the last day of that month. 9. Out-dated stock medications / supplies will be disposed of in a pharmaceutical destruction container or returned to our contracted pharmacy for disposal if appropriate. Review of the Centers for Disease Control (CDC) Vaccine Storage and Handling Toolkit (Updated: 3/29/24) revealed, Vaccine Storage and Temperature Monitoring Equipment . Check and record storage unit minimum and maximum temperatures at the start of each workday. If your TMD (Temperature Monitoring Device) does not read minimum/maximum temperatures, then check and record the current temperature a minimum of two times per workday (at the start and end of the workday) . Reference: US Centers for Disease Control and Prevention. (2024, March 29). Vaccine Storage and Handling Toolkit. https://www.cdc.gov/vaccines/hcp/storage-handling/?CDC_AAref_Val=https://www.cdc.gov/vaccines/hcp/admin/storage-handling.html

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37666 Based on interview and record review, the facility failed to implement a yearly Quality Assessment Process Improvement (QAPI) Plan specific to the facility's population and concerns to ensure correction of deficiencies necessary to ensure resident safety and quality of life for 127 residents of the facility, resulting in the potential for negative physical and psychosocial outcomes for all 127 residents of the facility. Findings Include: FACILITY QAPI and QAA On 10/17/24 at 2:23 PM, the Administrator was interviewed about the facilities QAA/QAPI program. The Administrator said he oversaw the QAPI program at the facility; he said the committee met monthly, except for December. He said they met the quarterly meeting requirements. When asked to review the committee attendance forms. The Administrator provided a document with 3 paragraphs; he said he had typed the names of those in attendance and those that were not present for the meetings and were excused. The entries he provided did not meet the attendee requirements as the Medical Director/Physician did not attend on one of the meetings provided. When asked again to review the attendance forms, the Administrator would not let the surveyor see the original documents. He provided another typed date that met the quarterly requirement. When asked about the processes for the QAPI program, the Administrator responded We meet that requirement. The Administrator was asked how areas of focus were identified for improvement and he said the committee focused on Quality measures. When asked for further specifics he said he was not sure if he could relay that information. During the review of the QAPI program with the Administrator, he was asked if the QAPI committee had completed a yearly performance improvement project (PIP) and he stated, No. The question was re-worded, and a performance improvement project definition was clarified with the Administrator and he said he knew what it was, and they had not completed one. The review of the QAPI program continued and the Administrator said he thought the committee might have completed a performance improvement project (PIP). He said he would have to check on it. No further information about a performance improvement was received prior to exit on 10/17/2024 at 4:40 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility 1) Failed to ensure analyzed observational data of personal cares with a continued spread of a Multi-Drug Resistant Organism (MDRO), 2) Failed to ensure proper Personal Protection Equipment (PPE) use, 3) Failed to ensure proper hand hygiene, 4) Failed to ensure proper wound care, 5) Failed to ensure proper perineal (peri) care for two residents (Resident #40, Resident $45) of two residents reviewed for peri-care and 6) Failed to prevent a wound infection for one resident (Resident #45) of three residents reviewed for wound care, resulting in the continued in-house spread of Proteus Mirabilis infections, staff not following enhanced barrier precautions and providing clean cares with the likelihood of the further spread of infections. Findings include: On 10/16/24, at 11:56 AM, a record review of the facility provided infection control line listing revealed the following case counts of In-House MDRO Urinary Tract Infections (UTI): 5/2024 Case List revealed 6 Urinary Tract Infections. 6/2024 Case List revealed 6 Urinary Tract Infections. 7/2024 Case List revealed 12 Urinary Tract Infections. 8/2024 Case List revealed 5 Urinary Tract Infections. 9/2024 Case List revealed 3 Urinary Tract Infections. 10/2024 Case List revealed 1 Urinary Tract Infections. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

\On 10/16/24, at 2:05 PM, a record review of provided Urinary Tract Infection Investigation documentation and culture results along with Infection Control (IC) Nurse O for five residents revealed the Urinary Tract Infections were caused by Proteus Mirabilis with Resident #46 having a Proteus Mirabilis urinary tract infection on 1/19/2024, 3/25/2024, 7/8/2024 and 8/15/2024. IC Nurse O was asked what the Urinary Tract Infection Investigation revealed and IC Nurse O offered, that they did research on Proteus Mirabilis and did staff education on preventing UTI's. IC Nurse O offered they did focused education on (nursing unit) where Proteus Mirabilis was found. IC Nurse O was asked to hypothesize the spread of the proteus mirabilis infection (MDRO) to Resident #45's wound and if there was any spread from Resident #46's MDRO urine infection with the same MDRO. The IC Nurse O offered that yes, (Resident #46) and (Resident #45) are on the same group so I did hand hygiene audits on those care givers but did not see breaches in those groups. IC Nurse O was asked if they watch the Nurses provide wound care or catheter care and IC Nurse O offered, the nurse managers due the wound care observations and that they didn't see any reeducation's provided by the nurse managers. IC Nurse O offered that they planned a jeopardy game for infection control education specific to spreading infections. IC Nurse O was asked if the MDRO proteus mirabilis could be spread by hand contact and IC Nurse O stated, not that I'm seeing but doesn't mean it isn't happening. IC Nurse O offered the summary on the line listing for July, 2024 which revealed: 5/12 urine cultures grew Proteus Mirabilis, a natural gastrointestinal flora Most common reason for its presence in urine is due to ascension from the GI tract, Foley catheters facilitate this . Notified medical director of observation and analysis, he state P. mirabilis is common GI pathogen responsible for UTI & diabetic wounds, not likely the result of transmission-stated, P. Mirabilis, E. coli infections are the result of the person's own GI bacteria. It is highly unlikely that that transmission of those bacteria to cause UTI could occur during the provision of care. After [AGE] years of practice, I've never heard of that happening.

On 10/17/24, at 9:31 AM, CNA N was observed performing all am care for Resident #45. CNA N performed hand hygiene, donned a gown and gloves. CNA N opened up the closet door with their gloved hands, removed the basin, personals and clothing, walked through the closed privacy curtain touching the curtain with their left gloved hand. CNA N then entered the bathroom and filled the basin with water. CNA N entered the residents area after touching the privacy curtain. CNA N set the basin down on the bedside table, grabbed the bed remote and changed the position of the bed with the same gloves on. CNA N removed the covers, and the foot cushions underneath Resident #45's right foot. CNA N now walked back through the privacy curtain touching the curtain with both gloved hands and returned into the residents are with more washcloths. With the same gloves on, CNA N performed perineal care as Resident #45 was soiled with urine and a small amount of bowel movement. CNA N grabbed chamosyn cream out of the closet and applied cream to Resident #45's buttock area and placed a new incontinent brief on. Still with the same gloves on, CNA N adjusted the bed sheet and performed range of motion to the residents legs, positioned the wedge under the left leg and the pillow under the right foot. With the same gloves on, CNA N assisted the resident with new clothing, deodorant and finished with combing their hair. CNA N walked to the bathroom dried out the basin with paper towels, reentered the resident area and placed the personal items inside the basin, opened up the closet, placed the items inside. CNA N assisted Resident #45 with repositioning using the bed remote. CNA N doffed their gown and gloves and used hand gel for hand hygiene upon exit of the room . The privacy curtain was observed to have brown spots on it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/17/24, at 9:46 AM, an observation of Nurse M was conducted of Resident #45's diabetes injections and their right foot wound care. Nurse M entered the room set down the supplies, performed hand hygiene, donned a gown and gloves. Nurse M gave the resident an injection to their right arm and then to their abdomen. With the same gloves on, Nurse M propped up Resident #45's right leg onto a cushion and removed their sock and dirty dressing from their right heel. The dressing had dark bloody drainage noted. Nurse N removed their gloves and discarded. Nurse M then entered their left pocket with their left hand, pulled out a pair of gloves and donned the gloves at the bedside without performing hand hygiene. Nurse M cleaned the wound and opened up the new dressing. Nurse M with their left gloved hand pulled aside the front of their gown, entered their right pocket with their gloved right hand, removed their black marker, wrote the date on the new dressing and then placed the black marker back into their right pocket. Nurse M then placed the new dressing over top of the wound on Resident #45's right heel. Nurse M placed the same sock onto the heel. Nurse M adjusted the residents blankets, tied up the garbage, doffed their gown and gloves and performed hand hygiene at the sink. Nurse M washed their hands for only a total of six seconds. Nurse M returned to the bedside to adjust the bed with the bed remote, grabbed their dirty garbage and exited the room. A review of Resident #45's lab results revealed Foot, Right, Wound Swab Collected 09/18/2024 . Moderate Escherichia coli Moderate Proteus Mirabilis Moderate Enterococcus species . Susceptibility . Proteus Mirabilis R (resistant) . On 10/17/24, at 10:06 AM, Infection Control Nurse (IC) O was asked to explain the facility expectations for proper perineal care and IC Nurse O offered, the expectation is to wash hands from dirty to clean care. IC Nurse O was asked if perineal care was considered dirty and IC Nurse O offered, yes, peri-care is dirty. IC Nurse O was alerted the observation of CNA N touched multiple surfaces with their gloved hands prior to peri-care and after peri-care for Resident #45. IC Nurse O asked the surveyor why CNA N wasn't stopped by the surveyor. IC Nurse O was also alerted of Resident #45's wound care observation with Nurse M. IC Nurse O was asked again to provide all environmental rounds, peri-care audits, hand hygiene audits, wound care audits and PPE audits to ensure staff compliance with infection control standards. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/17/24, at 11:17 AM, a record review of the provided Monthly Summary Data and provided environmental rounds along with IC Nurse O was conducted. The View Monthly Summary Data for June, July, August and September 2024 revealed 30 hand hygiene and 30 PPE audits for each month were conducted. There was no staff education provided for the Gown and Gloves audits that had failures each month. A review of the provided Environmental Room Attendants Checklist 10/10/24 revealed a checklist for Bedrooms, Bathrooms/Showers and Carts. There were check marks but no additional data that explained what the check marks meant. IC Nurse O clarified the environmental rounds check list was completed by the cleaning staff. IC Nurse O provided a typed document that revealed the following: During bi-weekly rounds we observe 12 wound care, peri-care and hand hygiene observations monthly x 12 months. In the last 24 months there were no observed concerns. During the educational fair all CENA's were observed for peri-care and hand hygiene observations. Concerns were addressed and real-time education was provided. General education followed for all direct care staff. IC Nurse O was asked if the peri-care observations were on actual residents and IC Nurse O stated, No, a mannequin. IC Nurse O was asked to clarify when and why there should be actual Resident peri-care audits of the staff and IC Nurse O stated, if there was a concern. IC Nurse O was asked to provide additional data for all staff/care audits, audits on cleaning reusable medical equipment, linen transportation, hand hygiene, wound care and peri-care. IC Nurse O stated, that was QAPI protected information and offered that the residents had their own medical equipment. IC Nurse O was again asked to provide audits on cleaning reusable medical equipment for all equipment other than glucometers. Prior to exit, there were no peri-care audits, wound care audits and audits on cleaning reusable medical equipment. Once the facility was alerted of exit, a document was offered of a printed spread sheet of numerous papers that were provided to show proof of audits of care although was not readable as it was all separated by page. During exit conference, the Administrator was alerted of the document share and was offered the opportunity to send any additional documents that clarified the data or proved audits of personal cares for ensuring staff were following Infection Control Standards. According to Centers for Disease Control and Prevention . Infection Prevention in Long-term Care Facility Residents .Healthcare-Associated Infections (HAI) . Long-term care facilities provide many services, both medical and personal care, to people who are unable to live without help. If you live in a nursing home, assisted living facility or other long-term care facility, you have a higher risk of getting an infection. There are steps you can take to reduce your risk . Keep your hands clean. Remind staff and visitors to keep their hands clean . According to National Library of Medicine, P. mirabilis has swarming motility and the ability to self-elongate and secrete a polysaccharide when in contact with solid surfaces; this allows for attachment and easy motility along surfaces (e.g. medical equipment) . Proteus is found abundantly in soil and water, and although it is part of the normal human intestinal flora . it has been know to cause serious infections in humans . Proteus infection can be avoided with proper sanitation and hygiene, such as adequate sterilization of medical equipment and surfaces . 37668 Resident #40: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review revealed Resident #40 was admitted to the facility on [DATE] with diagnoses which included dementia, pressure ulcers (wounds caused by pressure), quadriplegia, and contractures. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required maximum to total assistance to complete all Activities of Daily Living (ADL). Review of documentation in Resident #40's Electronic Medical Record (EMR) revealed Resident #40 had a current treatment in place to the top of their left foot. The treatment detailed, Everyday shift every Mon, Thu . cleanse with normal saline or sterile H2O, apply medihoney, cover with silicone dressing (mepilex) (Start Date: 9/16/24) Review of Resident #40's TCMCC Weekly Nursing assessment dated [DATE] specified, Left foot continues with open area 0.5 x 0.5 cm (centimeters), dressing was changed today and is currently dry and intact . A wound care observation was completed with Wound Care Licensed Practical Nurse (LPN) R on 10/17/24 at 10:01 AM. LPN R was observed removing the dressing on Resident #40's left foot pressure ulcer wound. LPN R was then observed removing their gloves and donning a new pair without performing hand hygiene after removing soiled gloves. 37666 A review of the Association for Professionals in Infection Control and Epidemiology: Guide to Preventing Catheter-Associated Urinary Tract Infections, first edition, April 2014 identified the following: . Urinary tract infections are one of the five most common types of healthcare-associated infection (HAI), and along with other device-associated infections (e.g., central catheter-associated bloodstream infections and ventilator-associated pneumonia) account for 25.6 percent of all hospital HAI's . Catheter-associated urinary tract infection (CAUTI) has been associated with increased morbidity, mortality, hospital cost, and length of stay. Bacteriuria also leads to unnecessary antimicrobial use, and urinary drainage systems can be reservoirs for multidrug-resistant bacteria and a source of transmission to other patients . The source of microorganisms causing CAUTI can be endogenous-typically via meatal, rectal, or vaginal colonization- or exogenous, such as via equipment or contaminated hands of healthcare personnel .Drainage System Safety- Sterile, continuously closed drainage systems became the standard of care based on an uncontrolled study published in 1966 demonstrating a reduction in the risk of infection in short-term catheterized patients with the use of a closed system. Recent data also include the finding that disconnection of the drainage system is a risk factor for bacteriuria. The catheter tubing should allow free flow of urine and kinking of tubing should be avoided. The urine bag should be kept below the level of the bladder and kept off the floor . Resident #17: Urinary Catheter or UTI A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #17 indicated an admission to the facility on [DATE] and readmission on 11/2/2023 with diagnoses: Multiple Sclerosis, Dementia, history of Lyme disease, diabetes, COPD, epilepsy, neuromuscular dysfunction of bladder and heart failure. The MDS assessment dated [DATE] revealed the resident had severely impaired cognitive skills and needed assistance with all care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the physician orders for Resident #17 identified the following: Foley catheter. Change as needed for neurogenic bladder, start date 4/26/2024. On 10/14/2024 at 12:38 PM, Resident #17 was observed lying in bed. A urinary catheter/Foley catheter drainage bag was observed inside a black cloth bag sitting on the floor. The catheter bag was bent over in the middle, so the urine could not flow freely into the bag. A review of the Care Plans for Resident #17 revealed the following: The resident has Indwelling Catheter (Foley) in place r/t (related to): Neurogenic bladder, date initiated 8/30/2016 and revised 4/26/2024. On 10/17/2024 an intervention was added, The resident has (16 Fr (size)) Foley. Position catheter bag and tubing below the level of the bladder, date initiated and revised 10/17/2024; Keep in cloth bag for discreetness/cleanliness, date initiated and revised 4/26/2024. A review of the Infection Line Listing for May 2024 indicated Resident #17 was identified to have a Catheter Associated Urinary Tract Infection (CAUTI) on 5/13/2024. The infectious organism was Escherichia coli (E. coli) and the resident was treated with antibiotics. Resident #22: Urinary Catheter or UTI A record review of the Face sheet and Minimum Data Set/MDS assessment for Resident #22 identified a readmission to the facility on [DATE] with diagnoses: Diabetes, heart disease, heart failure, COPD, arthritis, Alzheimer's, and a history of falls. The MDS assessment dated [DATE] indicated the resident had a BIMS score of 9/15 with moderate cognitive decline and needed assistance with all care. A review of the physician orders indicated Resident #22 had a supra-pubic urinary catheter with a start date of 5/20/2024. On 10/14/2024 at 11:48 AM, Resident #22 was observed lying in bed resting. The urinary catheter tubing had cloudy colored urine in it. The urinary catheter bag was sitting inside a black cloth bag that was sitting on the floor under the bed and behind 2 mattresses that were sitting on the floor. Certified Nurse Aide/CENA P entered the room and said the resident had a history of UTI's/Urinary tract infections. The aide was assisting the resident A review of the Care Plans for Resident #22 revealed the following: The resident has history of) recurrent Urinary Tract infections, dated initiated 5/5/2023 and revised 5/29/2024 with Interventions including: Observe urine characteristics and report to physician as indicated, date initiated 5/20/2024 and revised 7/25/2024. There was no mention of keeping the urinary catheter bag and or the black cloth bag off the floor to aid in preventing contamination. The resident has a suprapubic catheter in place (related to): Neurogenic bladder, date initiated 7/26/2023 and revised 12/28/2023 with Interventions including: Catheter are per policy and procedure, dated 7/26/2023. There was no mention of maintaining the urinary catheter bag or the black cloth bag from touching the floor to prevent contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/16/2024, Resident #22 was observed lying in bed and his urinary catheter bag was observed sitting inside a black cloth bag on the floor behind two mattresses stacked on the floor next to his bed. Nurse Q entered the resident's room and was asked about the catheter bag lying on the floor. The nurse moved the two mattresses slightly away from the side of the bed and the urinary catheter bag was observed inside a cloth black bag on the floor. The nurse said it should have been off the floor. He laid on his back on the mattresses on the floor and used two ties on the bag to lift it and tied it under the bed frame. On 10/17/2024 at 9:45 AM, Resident #22 was observed lying in bed waiting for wound care with Nurse R and Nurse Aide S. The urinary catheter bag was inside a black cloth bag and was tied on the end of the bed; hanging off the floor as the bed was raised to accommodate wound care. The black cover bag was very stained and soiled. The 2 mattresses that had been lying on the floor beside the bed were moved against the wall by the window during the wound care. Both mattresses were very soiled: brown with dirt stains. Both mattresses had tears, open areas and with ends that appeared shredded and tattered. The mattresses were previously leaning against the catheter bag. A review of the Infection Line Listing for May 2024-September 2024 identified Resident #22 as developing a urinary tract infection on 5/20/2024. The infectious organism was Escherichia coli and the resident was treated with antibiotics. The Infection Line List also listed Resident #22 as having urinary tract infections on 2/11/2024 with Enterobacter cloacae, 1/23/2024 with E. coli, 12/15/2023 with E. coli and Enterococcus faecalis. The Infection Line List identified Resident #22 as developing Clostridium (Clostridioides) difficile (C. diff) a severe infection with diarrhea that can lead to colitis, on 6/25/2024. Centers for Disease Control and Prevention- CDC: About C. diff: . Most cases of C. diff occur when you've been taking antibiotics for something else or not long after you've finished . That's because antibiotics that fight bacterial infections by killing bad germs can also kill the good germs. These good germs protect the body against harmful infection like C. diff infection . The Infection Line List for August 2024 indicated Resident #22 develop another urinary tract infection on 8/26/2024. The infectious organisms were Enterococcus faecium, Escherichia coli and Klebsiella pneumoniae. The resident was treated with antibiotics.