STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235358	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medilodge of Ludington	1000 E Tinkham Ave Ludington, MI 49431

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview, and record review, the facility failed to implement their abuse and neglect policy and procedure for 1 resident (R8) of 4 residents reviewed for abuse and neglect from a total sample of 13 residents, resulting in allegations of neglect not being reported to the state survey agency, allegations of neglect not being thoroughly investigated, the potential for abuse and neglect to go undetected, and the potential for residents not being protected from ongoing abuse and neglect. Findings: Review of an Admission Record reflected R8 admitted to the facility on [DATE] from a private home. Pertinent diagnoses included hemiplegia (complete paralysis) and hemiparesis (weakness or partial paralysis) on one side of the body due to a stroke; vascular dementia without behavioral disturbance, oropharyngeal dysphagia (swallowing problems), type 2 diabetes, and required the use of a suprapubic catheter to empty her bladder. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] indicated R8 required setup or clean-up assistance with eating, was totally dependent on staff for oral hygiene, toileting, dressing, personal hygiene, bed mobility including rolling, sitting up, lying down from sitting and transfers. R8 required the use of an indwelling urinary catheter and oxygen. During an observation and interview on 9/23/24 at 3:30 PM, R8's Family Member (FM) B indicated she was currently on a video call with R8's Durable Power of Attorney (DPOA) A. R8 was lying in bed awake. FM B and DPOA A reported they had serious ongoing, unresolved concerns and were waiting to speak to the Director of Nursing (DON). FM B and DPOA A reported R8 was at serious risk for aspiration and the facility was leaving thin liquids with straws at the bedside which had been discovered during this visit. Additionally, it was reported staff did not change R8's clothes for 4 days last week and was again found to be wearing the same clothing she had been observed wearing on 9/22/24 (the day before) while on an outing with the family. It was reported R8 was to have her suprapubic catheter changed weekly and the facility was not following this order, nor were facility staff using pull-up style incontinence briefs that family supplied for the facility per the resident's preference. DPOA A reported that on 9/17/24, another family member visited at 7:00 PM and recognized that R8 was in her bed and had not been served dinner. When the visitor questioned nursing staff, R8's tray was discovered untouched in the dining room due to staff had not recognized R8 was not in the dining room for dinner where she could be assisted to eat. According to DPOA A, the nurse on duty at the time said R8 would not have eaten if the visitor had not noticed. (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: 235358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Medilodge of Ludington		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 E Tinkham Ave Ludington, MI 49431	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 3:40 PM, the DON entered the room during the video call and indicated she was there because family had requested to speak about the ongoing problems being reported. During an interview on 9/24/24 at 1:00 PM, the DON reported she had not completed a complaint/grievance form related to the issues reported by FM B and DPOA A the day before but thought Certified Nurse Aide (CNA)/Resident Voice (RV) G had done so last week. The DON reported that the Nursing Home Administrator (NHA) was given the complaint/grievance forms for review. During an interview on 9/24/24 at 1:05 PM, the NHA reported that she had just returned from taking a few days off and was not sure if any concern forms related to R8 were in her mailbox. The NHA reviewed the forms in front of her and identified two complaints related to R8. The NHA reported that if a concern or complaint specifically mentions abuse or neglect, the matter would be reported to the state agency and an investigation completed. The NHA said the facility had not submitted any allegations of abuse or neglect on behalf of R8. Review of Quality Assistance Form documents, each dated 9/18/2024 indicated FM B reported to CNA/RV G assistance was needed regarding Care. Details on the first form specified In the same clothing for 4 days, not properly dressed (pants not pulled up). The second form, also reported on behalf of R8 by FM B specified Not using cups given for bedside. Styrofoam cups with thin liquids at bedside. Each of the forms had been filled in by CNA/RV G. No further details were noted on the forms, including staff assigned to review the concerns, a consideration of whether the concern would be reportable to the State Agency and/or follow-up and reporter satisfaction. There was not a concern form pertaining to R8 not being showered regularly and not being served dinner on 9/17/24. During an interview on 9/24/24 at 3:25 PM, CNA/RV G said she completed the two Quality Assistance Forms on 9/18/24 after FM B made it clear there were serious concerns related to R8's care. CNA/RV G said she immediately asked for assistance from Social Services Director (SSD) H and MDS nurse I because the complaints were serious and could be considered neglect. CNA/RV G said that staff needed to investigate right away to make sure the complaints were not reportable to the state agency. CNA/RV G said she felt she followed the chain of command in reporting alleged abuse or neglect to management staff as the NHA and DON were not available at that time. During an interview on 9/25/24 at 8:15 AM, SSD H said that on 9/18/24 he was notified by CNA/RV G that FM B and DPOA A had serious concerns about R8's care that included leaving thin liquids at the bedside, showers not being done, clothes not being changed for several days, and the evening before (9/17/24) R8 had not been served dinner. SSD H said he did not report the allegations to the NHA. SSD H reviewed R8's Electronic Medical Record (EMR) and confirmed he did not enter a progress not about the allegations reported by FM B and DPOA A. During a follow-up interview on 9/25/24 at 10:25 AM, the NHA said she was the facility abuse preventionist and staff were expected to report all allegations of abuse or neglect to her immediately. The NHA said that if a concern was reported that did not include the terms abuse and/or neglect she would need to clarify with the resident and/or family to determine whether an allegation was reportable. The NHA said she did not get a report of the complaints related to R8 from 9/17/24 and did not report any allegations regarding R8's care to the state agency. The NHA did not have an investigation to determine why R8 did not have her clothes changed for 4 days the week before, wasn't getting showered, nearly missed a meal and was being served fluids that placed her at risk for complications from aspiration pneumonia. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the State Operations Manual (SOM) revealed An individual (e.g., a resident, visitor, facility staff) who reports an alleged violation to facility staff does not have to explicitly characterize the situation as abuse, neglect, mistreatment, or exploitation in order to trigger the Federal requirements at S483.12(c). Rather, if facility staff could reasonably conclude that the potential exists for noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be considered to be reportable and require action under S483.12(c). Review of the facility policy Abuse, Neglect and Exploitation dated 10/24/2022 reflected Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse . The policy also specified B. Possible indicators of abuse include, but are not limited to: 1. Resident, staff, or family reports of abuse; . 8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and repositioning.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake #'s: MI00146057 and MI00145975 Based on interview and record review, the facility failed to follow professional standards of nursing practice for medication administration for 5 of 11 residents (Resident #3, #7, #11, #13, and #2), reviewed for the provision of nursing services, resulting in medication errors and medications being administered outside of the physician ordered parameters. Findings: Resident #3 (R3) Review of an Admission Record revealed R3 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: hypotension. Review of R3's Order Summary dated 9/3/24 revealed, Midodrine HCl Oral Tablet 10 MG (Midodrine HCl) Give 1 tablet by mouth with meals for hypotension Hold for systolic >120 (top number of blood pressure greater than 120). To be administered at 8:00 AM, 12:00 PM, and 6:00 PM (a blood pressure assessment was to be completed prior to each dose of Midodrine to ensure parameters were followed). Review of R3's September Medication Administration Record and Blood Pressure Summary revealed: *On 9/5/24 at 6:00 PM, R3's blood pressure was 128/79 and the Midodrine was administered. *On 9/8/24 R3's blood pressure was not assessed prior to the 6:00 PM dose of Midodrine but the Midodrine was held for the reason 4 = Vitals Outside of Parameters for Administration. *On 9/10/24 at 6:00 PM, R3's blood pressure was 134/93 and the Midodrine was administered. *On 9/11/24 R3's blood pressure was not assessed prior to the 6:00 PM dose of Midodrine and the blood pressure assessment obtained for the 12:00 PM dose was used. (A blood pressure of 88/55 was documented for the 12:00 PM and the 6:00 PM assessment and the Blood Pressure Summary reflected only 2 blood pressure assessments were obtained on 9/11/24.) *On 9/13/24 at 12:00 PM, R3's blood pressure was 127/84 and the Midodrine was administered. *On 9/14/24 R3's blood pressure was not assessed prior to the 8:00 Am dose of Midodrine and the blood pressure assessment obtained on 9/13/24 at 7:13 PM was used. Additionally, the 6:00 PM dose of Midodrine was held for 4 = Vitals Outside of Parameters for Administration however there was no blood pressure assessment documented. (A blood pressure of 115/72 was documented for the 6:00 PM dose on 9/13/24 and the 8:00 AM dose on 9/14/24. The Blood Pressure Summary reflected only 1 blood pressure assessment was obtained on 9/14/24.) *On 9/15/24 at 12:00 PM, R3's blood pressure was 140/80 and the Midodrine was administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*On 9/17/24 at 8:00 AM, R3's blood pressure was 147/84 and the Midodrine was administered. *On 9/18/24 at 8:00 AM, R3's blood pressure was 131/70 and the Midodrine was administered. *On 9/19/24 at 8:00 AM, R3's blood pressure was 158/85 and the Midodrine was administered. Resident #7 (R7) Review of an Admission Record revealed R7 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: type 2 diabetes. Review of R7's Order Summary dated 7/31/24 revealed, Lyumjev KwikPen 100 UNIT/ML Solution pen-injector Inject 2 unit subcutaneously two times a day for DM (Diabetes Mellitus) hold for glucose (blood sugar) < 110 (less than 110) . to be administered at 7:00 AM and 1:00 PM. Review of R7's Order Summary dated 7/31/24 revealed, Lyumjev KwikPen 100 UNIT/ML Solution pen-injector Inject 3 unit subcutaneously one time a day for DM hold for glucose <110 to be administered at 6:00 PM. (a blood sugar assessment was to be completed prior to each dose of Lyumjev to ensure parameters were followed-3 times a day). Review of R7's Blood Sugar Summary from 9/1/24-9/22/24 revealed: *There were no blood sugar assessments completed on 9/1/24, 9/3/24, 9/6/24, 9/7/24, 9/8/24, 9/10/24, 9/13/24, 9/14/24, 9/15/24, 9/19/24, or 9/20/24. *Only 1 blood sugar assessment was completed on 9/5/24, 9/9/24, 9/17/24, and 9/21/24. *Only 2 blood sugar assessments were completed on 9/2/24, 9/4/24, 9/11/24, 9/16/24, and 9/18/24. Review of R7's September Medication Administration Record revealed: *All 6:00 PM doses of Lyumjev were administered from 9/1/24-9/22/24 although a blood sugar assessment was not completed prior to the administration of each dose. *On 9/3/24 at 7:00 AM, R7 did not receive 2 units of Lyumjev for the reason 4 = Vitals Outside of Parameters for Administration although a blood sugar assessment was not completed. *On 9/6/24 at 1:00 PM, R7 did not receive 2 units of Lyumjev for the reason 4 = Vitals Outside of Parameters for Administration although a blood sugar assessment was not completed. *On 9/7/24 at 7:00 AM, R7 did not receive 2 units of Lyumjev for the reason 4 = Vitals Outside of Parameters for Administration although a blood sugar assessment was not completed. *On 9/8/24 at 7:00 AM, R7 did not receive 2 units of Lyumjev for the reason 4 = Vitals Outside of Parameters for Administration although a blood sugar assessment was not completed. *On 9/19/24 at 7:00 AM, R7 did not receive 2 units of Lyumjev for the reason 4 = Vitals Outside of Parameters for Administration although a blood sugar assessment was not completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: insomnia. Review of R11's Order Summary dated 8/24/24 revealed, Zaleplon Oral Capsule 5 MG (Zaleplon) Give 1 capsule by mouth at bedtime for insomnia. Review of R11's Control Substance Record revealed R11 did not receive a dose of Zaleplon on 9/14/24, 9/19/24, or 9/20/24. (The medication was not signed out confirming a dose was not removed from R11's medication supply to administer). Review of R11's September Medication Administration Record revealed that Zaleplon was documented as administered on 9/14/24, 9/19/24, and 9/20/24 (Indicated by a check mark and the nurses initials on date/time of administration.) Resident #13 (R13) Review of an Admission Record revealed R13 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety, schizoaffective disorder, and delusional disorders. Review of R13's Order Summary dated 12/15/22 revealed, LORazepam Tablet 0.5 MG Give 1 tablet by mouth in the morning for anxiety. Review of R13's Order Summary dated 12/15/22 revealed, LORazepam Tablet 0.5 MG Give 2 tablet by mouth at bedtime for anxiety. Review of R13's Control Substance Record revealed that on 9/16/24 at 2:40 PM a nurse signed out 1 tablet of ativan indicating the medication was removed from R13's medication supply. Review of R13's September Medication Administration Record revealed R13 did not receive the morning or bedtime dose of lorazepam on 9/16/24 due to 7 = Sleeping. Review of R13's Electronic Medical Record revealed no documentation that a second nurse witnessed the waste of the lorazepam (disposing of a controlled drug requires a licensed nurse to witness the destruction of the medication to ensure licensed nurses do not divert narcotics). Resident #2 (R2) Review of an Admission Record revealed R2 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pressure injuries and osteoarthritis. Review of R2's Order Summary dated 9/13/24 revealed, oxyCODONE HCl Oral Tablet 10 MG (Oxycodone HCl) Give 1 tablet by mouth every 12 hours as needed for extreme pain. Review of R2's Control Substance Record revealed that on 9/1/24 at 9:30 AM, 9/2/24 at 7:30 AM, 9/6/24 at 9:00 AM, and 9/18/24 at 9:50 AM R2 received a dose of oxycodone. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R2's September Medication Administration Record did not reflect that R2 received the as needed doses of her pain medication on 9/1/24 at 9:30 AM, 9/2/24 at 7:30 AM, 9/6/24 at 9:00 AM, or 9/18/24 at 9:50 AM. (Documentation of the administration of an as needed pain medication is essential to ensure licensed nurses are aware of the last time the pain medication was administered and an additional dose of the controlled medication is not administered which could result in a medication error/overdose). During an interview on 09/24/2024 at 4:33 PM, Director of Nursing (DON) reported that the expectation for the licensed nurses was to follow the physician ordered parameters and administer medications following professional standards of practice. DON reported that the licensed nurses are responsible for ensuring the providers orders are reviewed to their entirety prior to the medication administration to ensure all assessments are completed. On 09/24/2024 at 3:54 PM and again on 09/25/2024 at 11:48 AM, Director of Nursing (DON) was notified via email of the above concerns and was asked to provide any additional documentation from the resident Electronic Medical Records that reflected the provider orders were followed, and documentation was competed. On 09/25/2024 at 7:42 PM, DON provided resident statements that medications were administered on time and pain was controlled for R2, and R11, and an observation that R13 was not exhibiting symptoms of pain, distress or anxiety. There was no supporting documentation/rationale provided related to medications being administered outside of ordered parameters for R3 or R7. There was no supporting documentation/rationale provided related to controlled medications not being administered following professional standards of practice. DON stated, .Room for improvement identified with medication documentation. Will schedule license nurse education for compliance of medication documentation. Review of the facility policy Medication Administration dated 1/17/23 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters . 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. 18. If medication is a controlled substance, sign narcotic book . Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, (Nurses) are also responsible for documenting any preassessment data required with certain medications such as a blood pressure measurement for antihypertensive medications or laboratory values, as in the case of warfarin, before giving the medication. After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pp. 643-644). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, The seven rights of medication administration include the right medication, right dose, right patient, right route, right time, right documentation, and right indication. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 705). Elsevier Health Sciences. Kindle Edition.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview and record review, the facility failed to provide appropriate treatment and services and carry out Activities of Daily Living (ADL) assistance for 1 resident (R8) of 2 residents reviewed for ADLs from a total sample for 13 residents. Findings: Review of an Admission Record reflected R8 admitted to the facility on [DATE] from a private home. Pertinent diagnoses included hemiplegia (complete paralysis) and hemiparesis (weakness or partial paralysis) on one side of the body due to a stroke; vascular dementia without behavioral disturbance, oropharyngeal dysphagia (swallowing problems), type 2 diabetes, and required the use of a suprapubic catheter to empty her bladder. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] indicated R8 required setup or clean-up assistance with eating, was totally dependent on staff for oral hygiene, toileting, dressing, personal hygiene, bed mobility including rolling, sitting up, lying down from sitting and transfers. R8 required the use of an indwelling urinary catheter and oxygen. During an observation and interview on 9/23/24 at 3:30 PM, R8's Family Member (FM) B indicated she was currently on a video call with R8's Durable Power of Attorney (DPOA) A. R8 was lying in bed awake. FM B and DPOA A reported they had serious ongoing, unresolved concerns and were waiting to speak to the Director of Nursing (DON). FM B and DPOA A reported R8 was at serious risk for aspiration and the facility was leaving thin liquids with straws at the bedside which had been discovered during this visit. Additionally, it was reported staff did not change R8's clothes for 4 days last week and was again found to be wearing the same clothing she had been observed wearing on 9/22/24 (the day before) while on an outing with the family. It was reported R8 was to have her suprapubic catheter changed weekly and the facility was not following this order, nor were facility staff using pull-up style incontinence briefs that family supplied for the facility per the resident's preference. DPOA A reported that on 9/17/24, another family member visited at 7:00 PM and recognized that R8 was in her bed and had not been served dinner. When the visitor questioned nursing staff, R8's tray was discovered untouched in the dining room due to staff had not recognized R8 was not in the dining room for dinner where she could be assisted to eat. According to DPOA A, the nurse on duty at the time said R8 would not have eaten if the visitor had not noticed. Review of Quality Assistance Form documents, each dated 9/18/2024 indicated FM B reported to CNA/RV G assistance was needed regarding Care. Details on the first form specified In the same clothing for 4 days, not properly dressed (pants not pulled up). The second form, also reported on behalf of R8 by FM B specified Not using cups given for bedside. Styrofoam cups with thin liquids at bedside. Each of the forms had been filled in by CNA/RV G. No further details were noted on the forms, including staff assigned to review the concerns, a consideration of whether the concern would be reportable to the State Agency and/or follow-up and reporter satisfaction. There was not a concern form pertaining to R8 not being showered regularly and not being served dinner on 9/17/24. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 8:15 AM, SSD H said that on 9/18/24 he was notified by CNA/RV G that FM B and DPOA A had serious concerns about R8's care that included leaving thin liquids at the bedside, showers not being done, clothes not being changed for several days, and the evening before (9/17/24) R8 had not been served dinner. SSD H said he did not report the allegations to the NHA. SSD H reviewed R8's Electronic Medical Record (EMR) and confirmed he did not enter a progress not about the allegations reported by FM B and DPOA A. Review of Shower Task documentation from 9/5/24-9/25/24 reflected R8 had been showered 3 times since admitting to the facility (9/5, 9/12 & 9/23/24). Review of all Progress Notes documented during R8's stay did not reveal any indication R8 refused showers or had family report concerns related to Assistance with Daily Living (ADL) care, nutrition or hydration.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment for the care of a suprapubic catheter was carried out for 1 resident (R8) out of 13 residents reviewed for quality care, resulting in the potential for complications from infection and/or skin breakdown. Findings: Review of an Admission Record reflected R8 admitted to the facility on [DATE] from a private home. Pertinent diagnoses included hemiplegia (complete paralysis) and hemiparesis (weakness or partial paralysis) on one side of the body due to a stroke; vascular dementia without behavioral disturbance, oropharyngeal dysphagia (swallowing problems), type 2 diabetes, and required the use of a suprapubic catheter to empty her bladder. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] indicated R8 required setup or clean-up assistance with eating, was totally dependent on staff for oral hygiene, toileting, dressing, personal hygiene, bed mobility including rolling, sitting up, lying down from sitting and transfers. R8 required the use of an indwelling urinary catheter and oxygen. Review of a Care Plan initiated on 9/3/2024 indicated [R8] has an ADL (activities of daily living) self-care performance deficit related to history of CVA (stroke) affecting the right dominant side, dementia, anemia, suprapubic catheter, bowel incontinence. The care plan did not list interventions to care for R8's suprapubic catheter. Review of a Focus added to the Care Plan on 9/13/2024 indicated [R8] has a need for (indwelling suprapubic) catheter related of history of stroke. Goals of the focus area included Resident will have no signs of skin breakdown or irritation to peri-area through next review; resident will have reduced catheter-related complications through next review date. Interventions included, Report signs of peri-area redness, irritation, skin excoriation/breakdown to Physician/NP/PA. During an observation and interview on 9/25/24 at 9:37 AM, CNA N positioned R8 on her side and pulled down the incontinence brief. R8 had stool around her rectum, no barrier cream or residue from cream was on the skin. CNA N provided incontinence care, then positioned R8 on her back, a split drain sponge dated 9/20/24 (5 days prior) around the suprapubic catheter insertion site was visible. The dressing was soiled with brown and tan exudate, the skin around the catheter was reddened with partially dried and sticky tan mucous around the catheter tube insertion site. CNA N said she would report the observation to the nurse. Review of September 2024 Treatment Administration Record (TAR) reflected an order Remove dressing to s/p (suprapubic) cath (catheter) site, cleanse area and apply drain sponge to site daily and PRN (as needed) -Start Date- 9/5/24. The order was documented as being carried out one time on 9/13/24.