STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235414	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at West Branch	445 S Valley St West Branch, MI 48661

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Number MI00144251 Based on interview and record review the facility failed to 1. Complete a bowel assessment and monitoring with resident's complaints of pain and rectal bleeding; 2. Document the clinical rationale for the administration of an enema and 3. Perform the proper administration of an enema for one resident (Resident #61), resulting in the inappropriate administration of an enema, multiple partial thickness anal mucosa tears, full thickness rectal tear and partial thickness anal mucosa laceration that required surgical repair. Findings Include: Resident #61: On 5/6/2024 at 11:40 AM, a review was completed of Resident #61's medical records and it revealed he was admitted to the facility on [DATE] with diagnoses of Anemia, Chronic Kidney Disease, Diabetes and Heart Disease. Resident #61 was cognitively intact and able to make his needs known. Further of his records yielded the following: Care Plan: The resident has Anemia .monitor/document/report PRN following s/sx (signs and symptoms) of anemia: Pallor, Fatigue, Dizziness, Syncope, Headache, Palpations, Weakness, feeling cold, low hgb/hct (hemoglobin/hematocrit), SOB (shortness of breath), Sore tongue, Chest pain, Tinnitus, Changes in cognition . (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/7/2024 at 1:55 PM, an interview was conducted with Resident #61 regarding the enema he received at the facility and subsequent transfer to the emergency room . Resident #61 shared he pressed his call light as he needed assistance to the restroom to have a bowel movement. Staff took a while to respond by the time staff arrived, he was constipated and no longer could pass the stool. Resident #61 informed staff of this and stated he would likely require an enema. They prepared the resident for the procedure and positioned him in bed. He stated the nurse did not have lubricant and he informed her that she needed it. Upon lubricating the tip of the enema container Nurse B started poking the tip of enema in/out of his anal canal multiple times. Resident #61 reported the nurse poked my colon full of holes and tore it. Resident #61 shared during the enema he was in excruciating pain and screamed throughout the entire procedure. After the enema was completed, he went to the bathroom and was bleeding rectally. Resident #61 reported he was moved to a different room after the enema and pleaded to be sent to the emergency room for his rectal bleeding but they would not call 911. The resident stated because his wishes were not being honored, he called his friend to the facility to advocate for him and after eight hours of agony the nurse finally called 911 to have him transferred to the emergency room . While in the ER he received two bags of blood and was transferred to another hospital and had rectal surgery to repair the multiple lacerations and tears in his rectum. Progress Notes: 1/3/2024 at 17:15: .93 yom (year old male) admitted to hospital on 12/27/2023 from doctors office r/t (related to) low hemoglobin of 7.0 received 1 unit of blood. Current hemoglobin 7.6 .last BM (bowl movement) was 1/2/24, cont (continue) B/B (bowel/bladder) uses urinal . 1/9/2024 at 11:45: EMAR - Administration Note: Fleet Enema Enema 7-19 GM/118ML Insert 1 application rectally every 24 hours as needed for Constipation.IF NO BM DOCUMENTED X 4 DAYS FOLLOWING ADMINISTRATION OF DULCOLAX SUPPOSITORY .per resident request r/t (related to) having constipation, noted to be having blood in stool r/t straining. 1/9/2024 at 11:46: Resident states that has been having constipation for the last four days. noted to have blood in toilet from straining, resident has no noted bowel movement noted at the rectum. Resident assisted to lay down on side and enema give, with noted hard stool in the rectum, blood noted to be coming out of the rectum along with enema solution. Resident feeling pressure, assisted to the toilet, noted to have small hard stool with red blood . 1/9/2024 at 12:47: Resident assisted to the toilet again with noted blood in the stool with XXL stool noted in the toilet . 1/9/2024 at 18:57: resident states he feeling shaky and hot. Assessment completed. family at bedside . 1/9/2024 at 19:15: resident transferred to (emergency room) via (EMS) with family present. Documentation Survey Report: Review was completed of Resident #61 bowel continence during his time at the facility. Resident #61 had bowel movements on the following days: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- 1/5/2024 at 14:25 had a medium, formed/normal bowel movement. - 1/5/2024 at 21:52, had a medium, formed/normal bowel movement. - 1/7/2024 at 14:29, had a medium, formed/normal bowel movement. - 1/9/2024 at 02:46, had a medium, formed/normal bowel movement. - 1/9/2024 at 13:37, had a large, formed/normal bowel movement. January MAR (Medication Administration Record): - Milk of Magnesia Suspension 400 MG/5ML o Administered 1/8/2024 at 1115 - Fleet Enema 7-19 GM/118ML o Administered on 1/9/2024 at 1145 Pain Level Assessment: 1/9/2024 at 10:06: 0 1/8/2024 at 08:07: 0 1/4/2024 at 20:30: 0 1/4/2024 at 10:39: 0 EMS (Emergency Medical Services) Run Report 1/9/2024: Dispatch: (facility) for male who thinks his hemoglobin is low and shaking .pt (patient) seated in chair with 4 or 5 blankets wrapped around per family .because he was shivering and cold pt was to weak to stand and pivot even with help so he was lifted by family and crew using sheet .When pt uncovered from all the blankets he was hot to the touch. Per RN pt was complaining of being cold and no intervention was done other than calling 911 . It can be noted from review of the Resident #61's bowel continence log he had four bowel movements at the facility prior to the enema being administered on 1/9/2024. There was no other documentation located that indicated why other bowel protocol methods were not initiated prior to administration of the enema. Furthermore, Resident #61 was not assessed by the facility prior to being sent to the emergency room at his behest even after complaints of rectal pain. His last documented pain assessment was on 1/9/2024 at 10:06 AM which was an hour and forty-five minutes before his enema (administered at 11:45 AM) and nine hours before he was transported to the emergency room (approximately 7:01 PM). Emergency Department Notes 1/9/2024-1/10/2024: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	.93-year -old male presenting to the emergency department chief complaint of abdominal pain that is generalized and worsening throughout the day. He did receive an enema earlier today at nursing home and states he is having rectal bleeding since .Temp: 100.6. Pulse: 104 .Patient was given 1 L (Liter) normal saline initially and given the injury to the rectum CT of abdomen and pelvis was obtained .It does show trauma to the rectal region with subcutaneous air into the rectus femoris on the right. This is consistent with rectal perforation. Patient was given IV Rocephin on arrival .he did speak with (physician) and he recommended transfer to facility with colorectal surgery he precipitously declined in his condition requiring 2 units of packed red blood cells for hypotension and blood loss after repeat H&H (hemoglobin and hematocrit) showed drop in hemoglobin to 7.0 .Patient was transferred for acute GI (gastrointestinal) bleed secondary to rectal laceration .Pt arrives via EMS from nursing home. C/O abd pain and rectal bleeding after an enema . On 5/7/2024 at 3:05 PM, an interview was held with Nurse A regarding Resident #61's assessment and monitoring prior to being transported to the emergency room . Nurse A explained he had transferred from the other unit and was her patient for a just few hours. The nurse recalled he had an enema earlier in the day, but she was not the one that administered it. Nurse A recalled Resident #61's face being flushed and his adamancy about being sent the hospital for rectal bleeding as he stated he hurt down there. She attempted to adjust the thermostat but was not successful as it's for the entire unit and not per room. She stated she was not sure if the room was just too warm for the resident. Nurse A was asked if an assessment was completed of the resident to include his rectum, and she stated she completed vitals and neuro checks which were stable and the rest of the assessment would be listed in a progress notes. Nurse A and this writer reviewed her progress notes for Resident #61, and Nurse A did not see where she completed an assessment of the resident as it related to his complaints of rectal bleeding. Nurse A was queried as to the potential complications from a an enema and she responded bleeding, tearing at that bowel and perforated rectum. During an assessment she would look for bleeding at the rectum, change in vital signs and respiratory status. Nurse A was unable to recall why Resident #61 was so adamant regarding being transferred to the emergency room but she contacted the physician and received orders to send him out per his request. On 5/7/2024 at 5:08 PM, an interview was conducted with Nurse B regarding the enema administered to Resident #61. The nurse recalled the resident being upset as he was struggling to have a bowel movement and there was some blood in his stool when pushing. Nurse B stated he requested an enema, and she informed him she did not feel comfortable administering one, but he was insistent and she obliged. With the assistance of CNA R they positioned Resident #61 on his right side, and he was facing the aid. Nurse B lubricated the tip of the enema but struggled to advance it into the anal canal as there was a lot of stool at the opening and she felt resistance. Nurse B reported she pulled the tip out and reinserted it multiple times from side to side and upon pulling it out the tip was covered with feces. Nurse B stated the majority of the liquid came back out and Resident #61 requested manual deimpaction but she declined as she was not comfortable doing that given the blood in his stool. She stated she did complete rectal stimulation around the anal canal with her knuckles after the enema was completed. Review was completed of Nurse A and B facility training record and it yielded the following results: Nurse A (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Nurse A completed facility competency on 7/11/2023 that stated she Meets/Exceeds Standards, in the following areas: -Enemas: Identifies situations requiring an enema. Demonstrates process for administering an enema. -Change of Condition- General: Explains stop and watch process. Demonstrates ability to monitor and document vital signs. Understands specific assessments needed for change of conditions and charting. Identifies when to perform Neuro checks. Describes the 24 hour report, where to find it and how to use it. -Change of Condition- Genitourinary Assessment: Performs Genitourinary assessment to incorporate color, odor, amount, pain with urination, abdominal discomfort, fever, quality of stream and bladder incontinence. -Charting: Nurse properly demonstrates charting for the following situations: antidepressants, behaviors, I&O. appetite, and monitoring/weight changes. -Rectal Checks/Suppository Insertion: demonstrates ability to perform rectal checks . identified situations requiring suppository use. Demonstrates ability to properly inset and remove suppository. Nurse B Nurse Skills Checklist completed on 6/5/2023 included the following skills area that Nurse B was deemed competent in: -Suppository Administration -Enemas Nurse B completed facility competency on 7/11/2023 that stated she Meets/Exceeds Standards, in the following areas: -Enemas: Identifies situations requiring an enema. Demonstrates process for administering an enema. -Rectal Checks/Suppository Insertion: demonstrates ability to perform rectal checks . identified situations requiring suppository use. Demonstrates ability to properly inset and remove suppository. On 5/8/2024 at 11:26 AM, an interview was conducted with CNA R regarding Resident #61's enema that she assisted Nurse B with. CNA R recalled answering the residents light and him requesting an enema to help him have a bowel movement. The CNA informed the nurse and then assisted with the procedure. Once Resident #61 was positioned Nurse B inserted the enema and he began to yell out that it hurt but insisted they continue with the procedure. CNA R recalled the resident being impacted as the nurse stated there was a lot of stool in the canal and maybe that was why it hurt during insertion. CNA R stated the entire enema was administered and much of the fluid came back out upon completion and the tip of the enema was covered in feces. EMS Run Report 1/10/2024: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	.Dispatched to (emergency room) for STAT ALS (Advanced Life Support) transfer to (hospital). Report from RN (Registered Nurse): pt is 93 y/o M brought from nursing home c/o (complaints of) abd (abdomen pain) after an enema. Tests show he has perforated rectum and severe hemorrhage. Pt was given blood and blood pressure was monitored by an art line in ED (Emergency Department) .Pt is being transferred to (hospital) for colo-rectal surgery . Resident #61 was transferred to a secondary hospital on 1/10/2024 for rectal surgery and the records indicated the following: Patient was evaluated by (physician) from general surgery, will plan to go to the OR for further treatment and evaluation of possible injury to the rectal wall .Postoperative Diagnosis: Anorectal trauma; Procedure Name: Rectal examination under anesthesia with repair two full-thickness anorectal injuries .Operative Summary [AGE] year-old male who had some constipation issues over the past few days .The reportedly did some manual disimpaction followed by enema. Patient reported extreme pain during the enema which was described as without lubricant and very forceful. He began having rectal bleeding after this and presented to an outside facility. He was found to have perirectal subcutaneous emphysema .Upon examination in the emergency department a laceration was visualized anteriorly .I recommended he undergo emergency rectal examination under anesthesia with repairs as indicated .Operative technique: .A [NAME] rectal retractor was then used to inspect the anorectal mucosa circumferentially. The anterior injury began in the anal mucosa and extended proximally into the rectal mucosa and was full thickness in its midportion and proximally. In addition there were multiple nearly circumferential partial-thickness injuries to the anal mucosa without active bleeding .Non bleeding hemorrhoidal disease was also visualized. In the posterior midline there was a laceration visualized 2 cm proximal to the dentate line with full-thickness component through the rectal wall approximately 1/2 cm in length. This area was thoroughly irrigated and inspected. The injury was closed with a running 3-0 locking Vicryl suture. The anterior injury was also irrigated and closed with running locking 3-0 Vicryl suture .Findings: Multiple nearly circumferential partial-thickness tears of the anal mucosa. Posteriorly 1-1/2 cm full-thickness rectal tear 2 cm proximal to the dentate line washed out and repaired .Anteriorly 3 cm partial-thickness lacerations of the anal mucosa extending into rectal mucosa with full-thickness component also repaired .Gelforam soaked in thrombin packed into anorectal canal XXX[AGE] year-old male .who is admitted after a transfer from outlying emergency department with complaints of anorectal pain. Patient has had issues constipation, and at outlying nursing facility had an enema. Almost immediately after the enema, began having severe rectal bleeding and pain. He was transferred to our facility for surgical evaluation. He did have imaging done at outside facility, which showed subcutaneous emphysema tracking from the gluteal cleft to the sphincter complex .Patient went for rectal examination under anesthesia on 1/10/2024, found to have full thickness and rectal injuries .He was started on broad-spectrum IV antibiotics for infection prophylaxis .discharged home once general surgery cleared him . On 5/9/2024 at 12:50 PM, an interview was conducted with the DON (Director of Nursing) regarding Resident #61's enema and subsequent injuries. The DON reported the day he was transferred to the emergency room he had two large bowel movements and had requested an enema. When the nurse started to insert the enema, she could feel fecal matter and she pulled out the enema and observed feces on the tip of it. The DON recalled the nurse calling about the resident's request to be sent out to the emergency room and agreeing with the report of the resident she presented. The DON was informed the account this writer received versus what was told to her did not align. The DON was informed of the account of the procedure provided by Nurse B and she stated she would have expected the nurse to complete external stimulation of the anal canal prior to the enema if the resident was impacted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review was completed of facility policy entitled, Constipation Protocol, revised 10/2020. The policy stated, . Any resident with history of fecal impaction will be checked routinely for active bowel sounds and abdominal distention .If a resident had not had a bowel movement in the past 48-72 hours notify the residents attending physician .The following is suggested protocol .Day 1: Give Polyethylene Glycol such as (Miralax) 17 grams with 8 ounces of fluid. Day 2: If no BM give Bisacodyl suppository such as (Dulcolax). If no BM give Saline enema such as (Fleets). Review was completed of facility policy entitled, Ready to Use Enema, revised 10/2010. The policy stated, . 13. Separate the buttocks so you can see the anal area; 14. Gently insert the enema tip through the anus into the rectum; 15. Slowly squeeze the enema bottle until all the solution has been expelled from the bottle into the rectum . Review was completed of, [NAME] and [NAME] Clinical Nursing Skills & Techniques, 9th edition, copyright 2024.Administering an Enema .If pain occurs or you feel resistance at nay time during procedure, stop and discuss with health care provider. Do not force 4. Insert lubricated tip of container gently into anal canal toward umbilicus. Adult 7.5-10 cm(centimeter) (3-4 inches) .5. Roll plastic bottle from bottom to tip until all solution has entered the rectum and colon. Instruct patient to retain solution until urge to defecate occurs, usually 2 to 5 minutes if impaction is present, remove it (see Skill 35.2) .Fecal impaction .6. Lubricate gloved index finger and middle finger of dominate hand with anesthetic lubricant; 7. Instruct patient to take slow deep breaths during procedure. Gradually and gently insert gloved index finger and feel anus relax around finger. Insert middle finger; 8. Gradually advance fingers slowly along rectal wall toward umbilicus; 9. Gently loosen fecal mass by moving fingers in scissors motion to fragment fecal mass. Work finger into hardened mass; 10. Work stool downward toward end of rectum. Remove small sections of feces and discard in bedpan .Contraindications for Fecal Management Systems .Fecal impaction .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Numbers MI00134226, MI00134335, and MI00136587. Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedure for pressure ulcer (wounds caused by pressure) prevention and management and ensure accurate and complete documentation for four residents (Resident #9, Resident #36, Resident #59, and Resident #67) of four residents reviewed, resulting in a lack of implementation of planned and meaningful interventions, pressure ulcer development, pressure ulcer worsening, unnecessary pain, and the likelihood for decline in overall health status. Findings include: Resident #9: On 5/6/24 at 11:10 AM, Resident #9 was observed sitting in a powered wheelchair in their room. Their spouse was present in the room and an interview was completed. When queried regarding their stay at the facility, Resident #9 revealed they came to the facility for therapy after being in the hospital and planned to discharge home. When queried regarding their electric wheelchair, Resident #9 revealed it was their personal chair from home. Resident #9 revealed they had Multiple Sclerosis (MS- disabling autoimmune of the central nervous system causing permanent disability) and limited mobility. Resident #9 was asked if they had any wounds and stated, Pressure ulcer on my butt. When queried if the pressure ulcer developed at the facility, Resident #9 replied that it did. Resident #9 was asked if they experienced pain from the pressure ulcer and replied yes. Record review revealed Resident #9 was admitted to the facility on [DATE] with diagnoses which included MS, diabetes mellitus, paraplegia (lower extremity paralysis), acute respiratory failure, tracheostomy (surgically created opening in the front of the neck to the trachea to allow air exchange), suprapubic catheter (surgically created opening through the abdominal wall to the bladder to allow for urine drainage), cerebral infarction (stroke) affecting right side, and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required substantial/maximum to total assistance to complete dressing, bathing, and mobility. The MDS further revealed the Resident was at risk for pressure ulcer development but did not have any pressure ulcers. Review of the facility-provided CMS-802 form detailed Resident #9 had a facility-acquired (FA) Stage 3 (full thickness tissue loss with visible subcutaneous fat). Review of Resident #9's Electronic Medical Record (EMR) revealed a care plan entitled, The resident has actual impairment to skin integrity AEB (As Evidenced By) wound to tracheostomy r/t tracheostomy status, Accidental decannulation requiring ER visit to reinsert. 4/23/24- Trach removed by ENT / Decannulated. 4/30/2024- Stage 3 PI (Pressure Injury) to Right posterior thigh (Initiated: 4/17/24). The care plan included the following interventions: - Evaluate resident for S/SX (signs/symptoms) of possible infections (Initiated: 4/18/24) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Pain: Evaluate residents for changes in pain level and if appropriate request a scheduled pain medication from physician (Initiated: 4/18/24) - Ensure that heels are elevated while resident is lying in bed (Initiated: 5/1/24) - Encourage res to only stay in her WC an hour at a time for off-loading purposes (Initiated: 5/1/24) - Follow facility protocols for treatment of injury (Initiated: 5/1/24) - The resident needs APM (Alternating Pressure Mattress) mattress to protect the skin while in bed (Initiated: 5/1/24) - The resident needs WC cushion to protect the skin while up in chair (Initiated: 5/1/24) - Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations (Initiated: 4/18/24). A second care plan entitled, The resident has potential for impairment to skin integrity r/t (related to) Multiple sclerosis, Decreased mobility Right Hemiplegia s/p (status post) CVA (stroke) . (Initiated: 4/15/24) was noted in Resident #9's EMR. The care plan included the following interventions: - Apply barrier cream per facility protocol to help protect skin from excess moisture (Initiated: 4/15/24) - Encourage that heels are elevated while resident is lying in bed (Initiated: 4/15/24) - Dietary Consult as needed (Initiated: 4/15/24) - Monitor skin when providing cares, notify nurse of any changes in skin appearance (Initiated: 4/15/24) - Nutritional Supplements as ordered (Initiated: 4/15/24) - Pressure reduction bed mattress (Initiated: 4/15/24) - Wheelchair pressure reduction cushion (Initiated: 4/15/24) Review of Resident #9's Visual/Bedside Kardex revealed the Resident required two assist for bed mobility and two assist with a Hoyer (full mechanical lift) for transferring in and out of bed. Review of documentation in Resident #9's EMR revealed the following: - 4/28/24 at 5:38 AM: Daily Skilled Nursing Note . Resident is receiving skilled services for . Wound Care . New skin issue noted this shift . to right buttocks, to be abrasion W/TX (with treatment) in place (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 4/28/24 at 11:13 AM: Wound Evaluation . MASD (Moisture Associated Skin Damage) . Rear Right Thigh . New . Length 4.14 cm (centimeters) . Width 2.52 cm . Wound Bed: Granulation . Bleeding . Exudate . Moderate . Sanguineous/Bloody . Periwound: Edges: Attached . Surrounding Tissue: Denuded (exposed, damaged, or missing tissue) . Excoriated (skin erosion) . Treatment . Calcium alginate . foam . Notes: history of MASD and wounds to bilateral buttock . Will address pressure as well as potential for MASD turning into pressure injury. APM mattress ordered. Res has own [NAME] with built in cushion. Res and family declined ROHO cushion. Incontinence cares continued to keep resident dry. Education Res encouraged to turn and reposition at least q 2 hours as well as only get up in WC (wheelchair) for 1 hour at a time . - 4/28/24 at 2:18 PM: Daily Skilled Nursing Note . Resident is receiving skilled services for . Wound Care . Resident with pressure wound . open area to buttocks. Encouraged resident to lay down after meals; treatment in place. - 4/30/24 at 8:30 AM: Wound Evaluation .Pressure - Stage 3 . Rear Right Thigh . Deteriorating - 2 days old . Acquired: In-House Acquired . Length: 7.28 cm . Width: 5.06 cm . Deepest Point: 0.1 cm . Wound Bed . Granulation . 50% . Slough (dead tissue that is liquid or wet) . 50% . Exudate . Light . Serosanguineous . Edges: Attached . Surrounding Tissue: Fragile, Macerated . Treatment . Calcium alginate . Foam, Silicone . Additional Care . Cushion . Incontinence management . Moisture barrier . Moisture control . Healable . Progress: Deteriorating . Notes: APM mattress ordered. Res declined ROHO cushion to WC as has a built-in cushion on [NAME] 'specially made for (them)'. Dark areas noted to wound are blanchable. - 5/1/24 at 1:10 PM: Skin/Wound Note . APM mattress ordered . declined ROHO cushion to WC as has a built-in cushion on [NAME] (electric wheelchair) 'specially made for (Resident)'. Dark areas noted to wound are blanchable. Res encouraged not to stay in wc (wheelchair) for more than 1 hour at time. Also, encouraged to turn and reposition at least q (every) 2 hours to off load right buttock area. Review of Resident #9's Health Care Provider Orders, Medication Administration Record (MAR), and Treatment Administration Record (TAR) revealed the following: - Rt (right) gluteal fold -- cleanse with NS (Normal Saline), apply calcium alginate (wound care treatment indicated for moderate to heavily draining wounds including stage three to four pressure ulcers) to wound bed . Cover with comfort foam, Apply zinc (protective skin barrier ointment) to peri wound every night shift for wound care (Start Date: 4/28/24; Discontinued: 5/1/24). Note: the treatment was not completed on 5/1/24 - Santyl External Ointment (debriding wound care treatment used to remove necrotic/dead tissue) 250 unit/gm (gram) . Apply to Right Posterior Thigh topically as needed for Missing / Soiled Dressing (Start Date: 5/1/24) The treatment was documented as completed once on 5/5/24. - Santyl External Ointment 250 unit/gm . Apply to Right Posterior Thigh (pressure ulcer) topically every day shift for Stage 3 . Cleanse Right Posterior thigh with normal saline. Pat dry. Apply Santyl to wound base. Cover with large silicone foam (Start Date: 5/2/24) (continued on next page)

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	235414	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	Note: The treatment was not completed on 5/4/24. - APM mattress to bed. Settings: Comfort Level #3. Check for proper functioning q shift. every shift for APM (Start: 5/6/14 at 6:00 PM) On 5/7/24 at 11:26 AM, Resident #9 was sitting in their electric wheelchair in their room near the doorway. The Resident was grasping their hands together and displayed an uncomfortable appearance. When asked how long they had been sitting up in their chair, Resident #9 responded they had been up since before breakfast because they got a shower in the morning. Resident #9 was asked if they recalled what time they got up and revealed they did not know but that it had been a few hours. Resident #9 then stated they were waiting for a staff member to assist them to go back to bed but had to wait because their Certified Nursing Assistant (CNA) went to lunch. Resident #9 verbalized they were told they should not sit up in their chair all day because of the pressure ulcer on their bottom. When queried why they had to wait for their CNA to go to lunch before going back to bed, Resident #9 explained the CNA had answered their call light and told them they would put them back in bed after they took their lunch break and found another staff member to help. Resident #9 was then asked if they were able to reposition themselves in the chair and indicated they could not. When asked if the staff assisted to reposition them in the chair when they were sitting up, Resident #9 replied they did not. On 5/8/24 at 8:36 AM, an observation of Resident #9 was completed in their room. The room lighting was dim with the shade covering three quarters of the window and the room lights off. The Resident was in bed, positioned on their back with their eyes open. When queried regarding pain, Resident #9 stated their butt hurt. Resident #9 was asked to rate the pain on a numerical scale from zero (no pain) to 10 (worst imaginable pain) and stated, Eight. At 8:38 AM on 5/8/24, an interview was completed with Registered Nurse (RN) A. When queried regarding Resident #9's wound, RN A confirmed the Resident had a facility-acquired pressure ulcer. RN A was asked when they would be completing Resident #9's dressing change and stated, Usually in afternoon. RN A indicated they would inform this Surveyor prior to wound care treatment completion for observation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An observation of wound care for Resident #9 was completed on 5/8/24 at 11:07 AM with Unit Manager Wound Care RN P and RN A. RN P was observed obtaining supplies from the treatment cart prior to entering the room. When queried regarding the current wound and treatment, RN P stated, Santyl to the right posterior thigh. RN P also stated they were also obtaining wound cultures because it (wound) is worsening. When asked if the wound had an odor, RN P verbalized it did and they had contacted the Physician to get an order for wound cultures. RN P was asked if they were going to obtain wound measurement and stated, We do pictures (computer image program which calculates wound length and width). When asked it the pictures measure wound depth, RN P replied, No. Okay, I see your point. Upon entering the room, Resident #9 was observed in bed positioned on their back. When queried if they had gotten out of bed since our last conversation, Resident #9 indicated they had not. Resident #9 was positioned on their left side by RN A and RN P. The staff removed the Resident's brief, and a pungent, foul odor was immediately noted. The dressing in place over the right rear buttocks/thigh was observed to be thoroughly saturated with a grey colored drainage which had leaked onto the surrounding skin and was present on the removed brief. RN P proceeded to remove the soiled dressing and the pungent, foul odor increased and permeated the room. The soiled dressing was saturated with a distinct malodorous off-white/ grey/light green colored drainage. The foul odor remained after the wound bed was cleansed by RN P with normal saline on a gauze pad. The wound was semi-circular shaped and slightly smaller than a softball with defined borders. The wound bed was approximately 90% necrotic black colored eschar and white slough with detectable depth. A visible area of tunneling was observed within the wound bed. When queried regarding the tunneling, RN P revealed they were not aware of any tunneling previously. When queried regarding the depth of the wound/tunnel, RN P measured the depth and stated, 2.7 (cm). RN P proceeded to measure the wound bed and stated, 7.5 (cm) by 8 (cm). RN P was observed applying Santyl ointment to the wound bed to the entire bed of the wound and areas of healthy tissue surrounding the wound bed. RN P then applied a new dressing and the Resident was positioned on their back in bed by RN A and RN P. An interview and review of Resident #9's EMR was completed with RN P on 5/8/24 at 12:15 PM. When queried regarding Resident #9's pressure ulcer, RN P verified the pressure ulcer was facility-acquired. RN P was asked about facility documentation indicating the pressure ulcer was a Stage 3 and stated, It is unstageable (full thickness tissue loss where the actual depth of the wound cannot be determined due to the wound bed being covered with slough and/or eschar) now. RN P revealed the pressure ulcer had progressively deteriorated. When queried regarding the pressure ulcer development and the Resident's skin integrity upon admission in that area, RN P replied, Tissue looked good when they got here. RN P was then asked the Resident's risk for pressure ulcer development upon admission and revealed they were at high risk. When queried what interventions are implemented for Resident's admitted to the facility with a high risk for pressure ulcer development, RN P indicated all facility mattresses are pressure redistributing. RN P was asked to clarify if they were saying Resident #9 had an alternating air mattress in place since they were admitted and responded they did not. RN P explained that the regular mattress facility mattresses are pressure redistributing, and that the facility does not implement specialty/alternating air mattresses until a Resident develops a pressure ulcer. RN P indicated the care plan and interventions in place at the time the pressure ulcer developed where included on the potential for impairment to skin integrity care plan. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A follow up interview was conducted with RN P on 5/8/24 at 2:06 PM. When queried regarding the Wound Evaluation documentation in Resident #9's EMR classifying the wound as MASD on 4/28/24, RN P stated, We thought it was moisture at first. When queried why they thought it was moisture, as the Resident had a urinary catheter and documentation indicates the Resident's skin was consistently warm and dry, RN P did not provide an explanation. RN P indicated the pressure ulcer developed quickly. When asked if anything had changed in the Resident's medical condition and/or mobility status prior to the pressure ulcer being identified, RN P stated, The family brought in the (electric wheelchair) and they like to sit in it. When queried if the cushion on the electric wheelchair was pressure reducing as indicated on the care plan, RN P replied, The family was adamant regarding the cushion in place on the wheelchair now. RN P explained the family had told them that the cushion was made for that electric wheelchair and to fit the Resident and they did not want the facility to remove the attached cushion and place one on top of the plain seat. When asked if they were saying the family was concerned that a generic pressure reduction wheelchair cushion would not fit the electric chair appropriately and create other concerns, RN P indicated the Resident's family believed the cushion was a pressure reduction cushion. RN P was asked if they had investigated the current cushion in place on the electric wheelchair and/or looked for pressure reduction cushions designed for that electric wheelchair and replied, No. When asked why they had not, if they were concerned that sitting in the electric wheelchair was a cause of the pressure ulcer, RN P revealed they had not thought of that. When asked if staff should be assisting the Resident to reposition in their chair when sitting up, RN P replied, If they let us. When asked if staff should document if a Resident refuses to turn/reposition, RN P stated, Yes, the nurse should. RN P revealed CNA's are supposed to inform the Resident's nurse and the nurse documents the refusal as CNA's do not have access to the same documentation system. When queried what specific interventions were implemented prior to Resident #9's developing a pressure ulcer, RN P stated, Regular, pressure redistribution mattress, barrier cream with incontinence, and an RD (Registered Dietician) consult. When queried if Resident #9 should have been turned and repositioned due to their high risk of pressure ulcer development, RN P confirmed. RN P was asked the frequency in which dependent Resident's should be turned and repositioned, RN P replied, Every two hours. When asked why that intervention was not included on the care plan, RN P did not provide a response. When asked if staff document when and/or the frequency in which Residents are turned/repositioned, RN P stated, Do not document. When queried if Resident #9 required two-person assistance for turning and repositioning, RN P confirmed they did. When queried how they knew the Resident was being turned and repositioned every two hours prior to the pressure ulcer developing, RN P revealed they were unable to say they were. When asked why more frequent turning and repositioning following the pressure ulcer development, RN P did not provide a response. RN P was then asked why the alternating air mattress was not added to the Resident's care plan until 5/1/24 and not added to the TAR with settings until 5/6/24 when the area was first identified on 4/28/24. RN P was unable to explain the different dates on the care plan and the TAR. When asked when the alternating air mattress was actually applied to the Resident's bed, RN P verbalized the mattress was ordered on 5/1/24 but was unable to state when it was applied. RN P stated they would look for a work order for the mattress application. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #9 was observed in their room on 5/9/24 at 8:54 AM. The Resident was in bed, positioned on their back. When queried regarding the frequency in which staff reposition them in bed, Resident #9 stated, They don't. With further inquiry, Resident #9 revealed staff turn them in their bed when they provide incontinence care and when they place the sling under them to get them in and out of bed. When asked how frequently that occurs, Resident #9 indicated three or four times a day. Resident #9 was then asked if staff had spoken to them about the cushion in their electric wheelchair and indicated they had. Resident #9 revealed the cushion was made for the chair and that was the reason they did not want staff to remove it. When asked if they would be open to a different cushion, if it would provide better pressure reduction/redistribution and was fitted to the chair, Resident #9 replied they would be. An observation of the electric wheelchair revealed it was a Pride Mobility brand. The seat cushion was black, approximately 3 inches tall, and felt like foam when depressed. A copy of a Delivery Order for Resident #9's alternating air mattress was received and reviewed. The Order detailed, Submitted: 5/1/24 . Updated: 5/6/24 . The document included a delivery date of 5/1/24 but did not indicate if the date was the actual or planned delivery date. Resident #59: Review of intake documentation dated received 1/12/23 and 1/17/23 detailed concerns related to Resident #59 developing a pressure ulcer and infection while at the facility. An interview was completed with Confidential Witness S on 5/7/24 at 10:17 AM. When queried regarding Resident #59, Confidential Witness S revealed the Resident passed away. When asked about their stay at the facility, Confidential Witness S revealed Resident #45 fell at home, broke their hip, and had been sent to the facility for therapy. Confidential Witness S detailed they were present when Resident #59 was admitted to the facility and revealed the facility staff would not take the Resident to their room or assist them to get comfortable until all the admission documentation was signed. Confidential Witness S stated, (Resident #45) was hurting so bad and they were sitting in a wheelchair. Confidential Witness S indicated they should have taken the Resident out of the facility right then because the care continued to decline. When queried regarding their concerns, Confidential Witness S stated, (Resident #59) got a bedsore while they were there and specified Family Member Confidential Witness T, who is a nurse, found the pressure ulcer and informed facility staff. Confidential Witness S stated, The person (nurse) who was there when (Confidential Witness T) noticed it (pressure ulcer) didn't even know (Resident #59) had it. When queried how Confidential Witness T identified the pressure ulcer, Confidential Witness S indicated they were assisting to provide care to the Resident. Confidential Witness S stated, They didn't have enough staff. When asked why they stated the facility did not have adequate staff, Confidential Witness S replied, While we were there, no one even came in to move (turn/reposition) (Resident #59). Confidential Witness S verbalized someone from the Resident's family was at the facility daily to assist Resident #59. With further inquiry, Confidential Witness S revealed the pressure ulcer became infected and stunk. Per Confidential Witness S, the Resident was transferred to the hospital at the request of the family and did not return to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/7/24 at 10:32 AM, an interview was completed with Confidential Witness T. When queried regarding Resident #59's stay at the facility, Witness T verbalized the Resident developed a pressure ulcer and had an elevated [NAME] Blood Cell (WBC) count (indicating infection) that was not addressed in a timely manner. Confidential Witness T revealed they were with the Resident when they were discharged from the hospital and observed the hospital staff complete a skin assessment prior to discharge. Confidential Witness T stated, (Resident #59's) butt was a bit red but not open. Confidential Witness T continued, Three or four days after (Resident #59) was (at facility), they started complaining that their butt hurt so bad. When asked if the facility staff assessed Resident #59's complaints of pain, Confidential Witness T replied they did not. Confidential Witness T then stated, The next day Physical Therapy was in there (Resident #59's room). We turned (the Resident) and there was a hole, a huge decub (decubitus or pressure ulcer). They (staff) didn't even know about it. When queried if they were referring to Physical Therapy or nursing staff not knowing about the pressure ulcer, Confidential Witness T verbalized neither were aware. Confidential Witness T then stated, The nurse came in and was really rude to me. Confidential Witness T revealed the nurse left the room and then came back in and told me (Resident #59) had a really high WBC a couple days prior. I think it was 30 (normal is less than 11). When asked what happened then, Confidential Witness T stated, The nurse asked me if I thought (Resident #59) needed to go to the ER and I said absolutely. (Resident #59) went to the ER that day and got admitted . Confidential Witness T revealed the Resident got lots of IV's (intravenous medications) and wound care. Never went back to the facility. Confidential Witness T was asked how frequently they were at the facility and replied, Every day. When queried how frequently staff turned and repositioned the Resident, Confidential Witness T stated, I never saw them turn (Resident #59). When asked if the Resident has a specialty and./or alternating air mattress in place, Confidential Witness T replied, No. Resident #59's medical records were not present in the facility Electronic Medical Record (EMR). An interview was conducted with the Director of Nursing (DON) and Clinical Director Registered Nurse O on 5/7/24 at 9:30 AM. Per the staff, a different EMR system was in use at the time of Resident #59 stay in the facility. Records from the previous EMR, including Medication Administration Record (MAR), Treatment Administration Record (TAR), order summary of all healthcare provider orders during stay, care plan, progress notes, wound documentation, face sheet, and all Incident and Accident Reports were requested from the facility Director of Nursing (DON) at this time. An email was received from the facility Administrator on 5/7/24 at 1:47 PM stating there were no Incident and Accident reports for Resident #59. Review of Resident #59's medical record revealed the Resident was admitted to the facility on [DATE] with diagnoses which included right femur fracture and nondisplaced sacrum fracture, falls, dementia, and heart disease. Review of the Nursing Evaluation Admission assessment dated [DATE] revealed the Resident was alert and orientated to person place, time, and situation, required staff assistance to complete Activities of Daily Living (ADL), and had no alterations in skin integrity. The medical record revealed Resident #59 was discharged from the facility and transferred to the hospital emergency department on 1/10/24. Review of documentation in the EMR revealed the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- 1/3/23 at 1:47 PM: Nursing Evaluation (Admit .) . Resident admitted from (hospital) . Skin Integrity: The resident has skin integrity concerns. 0 . Resident is alert. Resident is oriented x 4 (person, place, time, & situation) . Resident has no nutritional risk factors noted . incontinent of bladder . incontinent of bowel . weakness . needs assistance with ADL's . Signed by Nurse U - 1/3/23 at 1:47 PM: Nursing Evaluation (Admit .) . Resident admitted from (hospital) . Skin Integrity: The resident has skin integrity concerns. 0 . Resident has nutritional risk factor r/t (related to) presence of pressure ulcer. Resident has nutritional risk factor r/t: surgical incision . Resident is confused . continent of bladder . continent of bowel . needs assistance with ADL's . Signed by Nurse U and Nurse V. The provided documentation did not indicate when the assessments were signed. - 1/4/23 at 1:35 PM: Skin & Wound Evaluation . Pressure . Deep Tissue Injury: Persistent non- blanchable deep red, maroon or purple discoloration . Location: Coccyx . Present on Admission . New . Length: 5.2 cm . Width: 1.5 cm . Depth: Not Applicable . Wound Bed . Pink or Red . Treatment (Blank) . Additional Care: (Blank) . Progress: New . - 1/8/23 at 3:06 PM: Health Status Note (nurses note) . 1+ pitting edema noted in BLE (Bilateral Lower Extremities); increased edema noted on right femur fracture side. (Family) states increased confusion/ changed mentation in resident. Dr. notified. New orders received and noted. - 1/10/23 at 10:59 AM: Skin & Wound Evaluation . Pressure . Stage 2 (partial thickness tissue loss) . Location: (Blank) . In-House acquired . New . Length: 2.7 cm . Width 2.5 cm . Wound Bed . Intact serum filled blister . Surrounding Tissue . Blister . Erythema: Redness of the skin - may be intense bright red to dark red or purple . Edema (swelling) . Pitting edema extends < 4 cm around wound . Treatment (Blank) . Additional Care: (Blank) . Progress: New . - 1/10/23 at 11:07 AM: Skin & Wound Evaluation . Pressure . Deep Tissue Injury . Coccyx . Present on Admission . New . Length: 4.4 cm . Width: 2.6 cm . Depth: 0.2 cm . Wound Bed . Eschar . Exudate: Light . Sanguineous/Bloody . Pain Frequency: Continuous . Treatment (Blank) . Additional Care: (Blank) . Progress: Deteriorating . - 1/10/23 at 1:55 PM: Health Status Note (nurses note) . res with abnormal labs WBC of 30, worsening of wounds. orders to send to ER for eval. (Family) in room [ROOM NUMBER] called report given . No wound images were included/provided with the Skin & Wound Evaluation assessments to assist in identifying unidentified wound location. A review of the provided Order Summary Report for Resident #59 was completed. There were no orders with a Start Date of 1/8/23. A copy of Resident #59's care plan and MAR were requested but not received. Review of Resident #59's TAR and order summary the Resident had a wound care order and treatment for their right hip surgical incision but there were no orders and/or treatments in place for a coccyx pressure ulcer and no new orders for the pressure ulcer identified on 4/10/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Wound Care RN P on 5/8/24 at 2:06 PM. Provided wound documentation for Resident #59 was reviewed with RN P at this time. When queried regarding the location of the newly identified Stage two pressure was on 1/10/23, RN P confirmed the assessment did not specify and they did not know. When queried regarding the lack of treatment and/or interventions, RN P was unable to provide an explanation. An interview and review of provided documentation for Resident #59 was completed with RN O on 5/9/24 at 9:00 AM. When queried regarding the location of the facility acquired stage two pressure ulcer on 1/10/23, RN O confirmed the assessment did not include the location of the wound. When queried regarding the coccyx wound worsening, RN O indicated they would need to review the medical record. With further inquiry regarding the wound location, treatments for both pressure ulcers, and interventions in place to prevent worsening, RN O stated they would review the documentation and follow up with responses. No additional information was received by the conclusion of the survey. The facility wound care/treatment and pressure ulcer policies/procedures were requested from the Administrator on 5/7/24 at 9:42 AM. The policy/procedure entitled, Skin Protection Guide (Effective Date: 7/7/21) was received. Review of the policy/procedure revealed, To provide evidenced based practice standards for the care and treatment of skin. To ensure residents that admit and reside at our facility are evaluated and provided individualized interventions to prevent, reduce and treat skin breakdown . Evaluation . The first step in the prevention of PU/PI's, is the identification of the resident at risk . An admission evaluation helps identify residents at risk of developing a PU/PI, and residents with existing PU/PI's. Because a resident at risk can develop a PU/PI within hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent PU/PI: Skin should be examined as soon as possible upon admission, re-admission or return. Where possible, prioritize completion of the skin evaluation within the first 2 hours . Pressure is the primary cause of pressure injuries. An effective turning and repositioning schedule can help reduce the risk of developing a pressure injury . 22927 Record review of the National Press [TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 22927 Based on observation, interview, and record review, the facility failed to to change a urinary catheter causing recurrent urinary tract infections (UTI) for one resident (Resident #18), resulting in Resident #18's urinary catheter not being changed per physician's orders, which caused recurrent urinary tract infection with the likelihood for prolonged illness and hospitalization . Findings include: Record review of the facility 'Urinary Tract Infections/Bacteriuria-Clinical Protocol' policy dated 4/2018 revealed the physician and staff will identify individuals with a history of symptomatic urinary tract infections, and those who have risk factors (for example, an indwelling urinary catheter, kidney stones, urinary outflow obstruction, etc) for URIs. Monitoring: (2.) When a resident has a persistent or recurrent urinary tract infection after treatment with antibiotics, the physician will review the situation carefully with the nursing staff and consider other or additional issues (such as urinary obstruction or indwelling catheter change or removal) before prescribing additional courses of antibiotics. Physicians should justify continuing or resuming antibiotic treatment beyond an initial course. Record review of the facility 'Urinary Indwelling Catheter Management Guideline' policy dated 11/28/2017 revealed indwelling catheters may be associated with significant complications, including bacteremia, febrile episodes, bladder stones, fistula formation, and erosion of the urethra, epididymitis, chronic renal inflammation, and pyelonephritis . catheter and drainage bags should be changed based on clinical indications such as: Infection . Resident #18: Observation and interview on 05/06/24 at 10:56 AM with Resident #18 stated that there was no bathroom in the room and the one down the hall is always busy. Observed Resident #18 was seated at edge of bed with his smoke apron fold on his pillow and talking about the smoke times changing. Record review on 05/06/24 at 01:04 PM of Resident #18's May 2024 Medication Administration Record (MAR) revealed the resident was on an antibiotic cephalexin 500mg oral 4 times daily for 7 days started 5/5/2024 for urinary tract infection (UTI). In an interview and records review on 05/08/24 at 07:26 AM with Licensed Practical Nurse/Infection Control Preventionist/Unit Manager (LPN/ICP/UM) N acknowledged that the facility followed the Mcgeer's UA collection recommends changing the catheter indwelling portion and collect from the clean catheter a sample of urine for laboratory use. Record review of Resident #18's medical record with LPN/ICP/UM N revealed: On 8/5/23 urinalysis laboratory results of Proteus Miribilis and was treated with antibiotic Rocephin intramuscular (IM) 1gram once daily for 5 days for urinary tract infection. Record review of Resident #18's medical record with LPN/ICP/UM N revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235414	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at West Branch	445 S Valley St West Branch, MI 48661

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #18's Treatment Administration Record (TAR) dated August 2023 revealed urinary (Foley) catheter changed on 8/19/2023. Record review of Resident #18's August 2023 Physician order to change Foley catheter every 30 days. Record review of the September 2023 MAR/TAR revealed the order to change urinary catheter on 9/19/2023 was blank as no performed. Record review of Resident #18's October 2023 MAR/TAR noted urinary catheter was changed on 10/18/23. Record review of Resident #18's hospital record dated 10/25/23 of a Gram-Negative urinalysis report. Record review of Resident #18's Medication Administration Record (MAR) revealed antibiotic Bactrim 800/160 mg oral twice daily from 10/25/2023 through 11/10/2023. Record review of Resident #18's November 2023 MAR/TAR revealed there was no urinary catheter care or urinary catheter change orders on the MAR/TAR. Record review of Resident #18's December 2023 MAR/TAR revealed there was no catheter care or change urinary catheter orders on the MAR/TAR. Record review of Resident #18's January 2024 Urinalysis (UA) dated 1/2/2023 noted Citrobacter Freundii and Pseudomonas Aeruginosa and enterococcus Faecalis. LPN/ICP/UM N stated that the catheter was changed at the hospital and that Resident #18 went to the hospital with sepsis. Record review of Resident #18's February 2024 MAR/TAR noted that no urinary catheter change was noted. Record review of resident #18's urinalysis report dated 2/22/2024 results of positive with Serratia fonticola and enterococcus Faecalis. Resident #18 was treated on 2/20/2024 with antibiotics of Rocephin 1 gram intramuscular one time daily for urinary tract infection for 5 days, and then on 2/22/2024 started Macrobid 100mg oral twice daily for 7 days for urinary tract infection. The February 2024 Treatment Administration Record for Foley catheter care every shift and as needed revealed there to be blank spot as not performed. Record review of Resident #18's Nursing progress note dated 2/20/2024 at 3:45 AM noted: UA obtained after changing collection bag. Per day shift nurse in report, Unit Manager P stated no need to change catheter. Record review of Resident #18's March 2024 MAR/TAR no Foley catheter change noted. Record review of Resident #18's April 2024 MAR/TAR revealed no Foley catheter change. The April 2024 Treatment Administration Record for Foley catheter care every shift and as needed revealed there to be blank spots as not performed. Record review of Resident #18's May 2024 Medication Administration Record (MAR) revealed that Resident #18 started antibiotic cephalexin (Keflex) 500mg oral tablet by mount four (4) times a day for urinary tract infection for 7 days. In an interview and record review on 05/08/24 at 07:39 AM with Licensed Practical Nurse/Infection Control Preventionist/Unit Manager (LPN/ICP/UM) N acknowledged the May 2024 Urinary tract infection was being treated with Keflex 500mg PO 4x daily and that there were recurrent urinary tract infections for Resident #18. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of 'Monthly Infection Control Log (Line List)' dated May 2024 revealed that Resident #18 was listed on 5/4/2024 with urine infection with organism pending but started Keflex (antibiotic medication) on 5/5/2024 and was documented as facility acquired.