STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235471	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plainwell	320 Brigham St Plainwell, MI 49080

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47955 Based on interview and record review the facility failed to ensure accurate documentation of advance directives for 1 (Resident #5) of 18 residents reviewed for advance directive documentation. Findings include: Resident #5 Review of an Admission Record revealed Resident #5 had pertinent diagnoses which included: multiple sclerosis (disabling disease of the brain and spinal cord (central nervous system)). Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 8/26/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #5 was cognitively intact. Review of Resident #5's medical record on 10/8/24 at 12:35 PM., revealed a document titled Advance Directives/Medical Treatment Decisions signed by Resident #5 and dated 3/20/2020 with the selection of .I do not choose to formulate or issues any advance directives at this time . noted. No other advance directive form was noted in Resident #5's medical record. Review of Order Summary for Resident #5 revealed .DNR (do not resuscitate) with comfort measures . active 3/20/2024. Review of Care Plan for Resident #5 revealed Focus .Resident #5 has advance directives- DNR revised on 7/17/2024 .Goal . Resident #5's advance directives will be honored .dated 3/20/2020 . Interventions . Code status will be reviewed on a quarterly basis and PRN (as needed) initiated on 3/27/2020 . Resident #5 has decided to be a DNR initiated on 3/20/2024 . On 10/9/24 at 10:57 AM., review of Resident #5's hard chart/paper chart located at the nurse's station included in the front of the chart a blue piece of paper with the words Full Code printed on it encased in a plastic sleeve. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/9/24 at 10:57 AM., Registered Nurse (RN) H reported a resident's code status should be completed at admission by the admitting nurse. RN H reported any nurse could update a resident's code status when there was a change. RN H reported a resident's code status was not valid until it was signed by witnesses and the physician. In an interview on 10/9/24 at 11:03 AM., Licensed Practical Nurse (LPN) N reported any nurses could update a code status form. LPN N reported the physician had to sign a new order and the computer system needed to be updated. Review of Admission/Readmission Note dated 3/1/2024 at 16:20 PM (4:20 PM) authored by LPN/MDS E revealed no notation regard discussion of advance directive. In an interview on 10/9/24 at 10:47 AM., Licensed Practical Nurse/ Minimum Data Set (LPN/MDS) E reported she had a conversation with Resident #5 regarding a changed in her code status when she returned to the facility following a hospital stay on 3/1/24 and that she would have documented in a progress note that conversation. LPN/MDS E reported she was unable to locate the signed copy of Resident #5's wishes to be a DNR. Review of Admission/Readmission Note dated 3/1/2024 at 16:20 PM (4:20 PM) authored by LPN/MDS E revealed no notation regard discussion of advance directive. In an interview on 10/9/24 at 2:02 PM., Social Services Director (SSD) TT reported the nursing department does advance directives on admission. SSD TT stated I don't do them here. SSD TT reported code status is clarified during care conferences and care conferences are done about every three months. In an interview on 10/10/24 at 8:43 PM., LPN/MDS E reported she was unable to locate a copy of Resident #5's updated signed advance directives. At exit conference Nursing Home Administrator (NHA) A provide several printed papers from Resident #5's medial record to this surveyor as a demonstration of accurate documentation of Resident #5's advance directive wishes. Review of the papers from Resident #5's medical record provided by NHA A at exit conference revealed no noted advanced directive documentation signed by both Resident #5 and the physician indicating her wish to be a DNR. Review of facility policy titled Advance Directives with a review date of 11/28/2023 revealed .an advance directive is a written document prepared by the resident as to how he/she wants medical decisions to be made should he or she lost the ability to make decisions .each time the resident is admitted to the facility, quarterly, and when a change in condition is noted in the resident's condition, the facility should revie the advanced directive .should focus on if the existing advance directive and the advance directives match the current goals of care for the resident. The social services director or designee should document this conversation in the medical record and assist as needed with updating the documents that need revision .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intake#: MI00146614 Based on interviews, and record review, the facility failed to protect the residents right to be free from abuse for 2 (Resident's #61 and #80) of 8 residents reviewed for abuse, resulting in residents experiencing physical restraint, physical and/or verbal aggression, fear, and emotional distress. Findings include: Review of a facility policy, Area of Focus: Abuse and Neglect with a reference date of 11/27/23, revealed: Each resident has the right to be free from abuse .this includes but is not limited to .physical or chemical restraint . Residents must not be subjected to abuse by .other residents . Resident #80 Review of an Admission Record revealed Resident #80, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: metabolic encephalopathy (serious condition that occurs when brain function is disrupted due to metabolic problems, irritability and agitation are symptoms of the condition), cognitive communication deficit (a difficulty with communication based by issues with memory, attention, problem solving), and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #80, with a reference date of 7/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #80 was severely cognitively impaired. Review of a Care Plan for Resident #80, with a reference date of 8/19/24, revealed a focus/goal/interventions of: Focus: (Resident #80) has potential to be physically aggressive due to dementia. Goal: The resident will not harm self or others through the review date. Interventions: analyze times of day, places, circumstances, triggers .modify environment .observe and report any s/sx (signs and symptoms) of resident posing danger to self and others . Review of a nursing Skilled Note with a reference date of 8/5/24 revealed Pt is confused and needs constant redirection . Review of a History of Present Illness report for Resident #80, authored by a contractual behavioral health services provider, with a reference date of 8/19/24 revealed: .on 8/10 she (Resident #80) grabbed roommates arm and was yelling at her, so she was moved to another room. On 8/16 she (Resident #80) pulled her roommate from her w/c (wheelchair) and onto the floor and laid on top of her to prevent her from leaving . In an interview on 10/8/24 at 1:42pm, Family Member (FM) CCC reported Resident #80 had gotten increasingly confused and argumentative since her admission to the facility. FM CCC reported Resident #80 thinks things are happening but she really has no idea what she's doing. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #61 Review of an Admission Record revealed Resident #61, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cognitive communication deficit, depression, adjustment disorder with mixed anxiety and depression. Review of a Minimum Data Set (MDS) assessment for Resident #61, with a reference date of 9/2/24 revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #61 was moderately cognitively impaired. Section D of the MDS revealed Resident #61 experienced feeling down, depressed, or hopeless 2-6 days of the 14-day assessment period. Section E revealed Resident #61 did not display physical or verbal aggression toward others. Section GG revealed Resident #61 required the use of a wheelchair for mobility. Review of a Care Plan for Resident #61, with a reference date of 12/26/23, revealed a focus/goal/interventions of: Focus: Episodes of tearfulness regarding placement; resident demonstrating difficulty adjusting to SNF (skilled nursing facility) placement .Goal: (Resident #61 name) will have improved mood state happier, calmer appearance, no s/s (signs and symptoms) of depression, anxiety or sadness through next review. Interventions .observe mood to determine if problems seem to be related to external causes . Review of an Incident Report with a reference date of 8/16/24 revealed .at approximately 9:00pm (Certified Nursing Assistant EE) witnessed (Resident #61) being held down by (Resident #80) . (Resident #61) was on the floor, face up with her wheelchair next her and (Resident #80) was seen on top of her, holding her down. In an interview on 10/8/24 at 1:27pm, Resident #61 was unable to comment related to the incident that took place on 8/16/24, but did say I'm stuck here when asked about how she felt about being at the facility. In an interview on 10/9/24, at 1:01pm, Certified Nursing Assistant (CNA) EE reported on 8/16/24 at approximately 9:00pm she heard a female resident frantically calling for help over and over from the hallway. CNA EE reported she ran to the hall because the call for help sounded desperate and she found Resident #61 on the floor, restrained by Resident #80. CNA EE described Resident #61 as being restrained on the floor in a manner that looked like a wrestling hold, as Resident #80's knee applied force to Resident #61's outstretched right arm and Resident #80's hands applied force to the back of Resident #61's neck. CNA EE reported both residents said that Resident #80 pulled Resident #61 out of her wheelchair as she tried to exit their shared room and then restrained Resident #61 on the floor. CNA EE reported Resident #80 was very confused and kept saying she (Resident #61) is too drunk, and she can't go out tonight. When further queried, CNA EE reported Resident #61 cried and was fearful following the event, even after Resident #80 was removed from the area. CNA EE described Resident #61 as in shock about what happened to her. Attempts to contact Resident #61's guardian were unsuccessful prior to the completion of the survey. Using the reasonable person concept, though Resident #61 had decreased ability to verbally express his own thoughts due to her cognitive communication deficit, she clearly experienced emotional distress and fear following the physical altercation and restraint she experienced on 8/16/24.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to provide a bed-hold to 2 of 3 residents (Resident #41, and #2) reviewed for hospitalization , resulting in the potential for the residents to not return to their same room upon readmission. Findings include: Review of a facility Bed-Hold Policy last reviewed 9/5/24 revealed, Policy The Bed-hold policy should be given upon admission, upon transfer of a resident to the hospital (if in an emergency within 24 hours), or the resident goes on therapeutic leave of absence. The facility will provide written information to the resident or resident representative the nursing facility policy on bed-hold periods and the residents return to the facility to ensure that residents are made aware of a facility's bed-hold and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility . Resident #41 Review of an Admission Record revealed Resident #41 was a male, readmitted to the facility on [DATE] with pertinent diagnoses which included: encounter for surgical aftercare following surgery on the skin and subcutaneous tissue and pain in left shoulder. Review of a Health Status Note for Resident #41 dated 7/1/24 at 4:11 PM revealed, Note Text: Dr. (name omitted) evaluated patient today, c/o (complaints of) increased swelling and pain of left shoulder. Gave orders for CT scan (a type of medical imaging that uses x-rays) with contrast of left shoulder and chest, for a mass. Offered to give patient an increase in pain medication, patient declined at this time. Will continue to monitor. Review of a Health Status Note for Resident #41 dated 7/15/24 at 12:18 AM revealed, Note Text: Received text from MD (medical doctor) stating that resident needed to go to ER (emergency room) r/t (related to) recent CT results of left shoulder showing a leaking abscess and DVT (deep vein thrombosis - a blood clot). Resident aware and in agreement. Review of Resident #41's medical record on 10/10/24 at 9:40 AM revealed no evidence that Resident #41 was provided a bed-hold for the hospitalization on [DATE]. On 10/10/24 at 9:55 AM, Director of Nursing (DON) B was requested, via electronic correspondence, to provide a copy of Resident #41's bed-hold notice for his hospitalization on [DATE]. On 10/10/24 at 10:25 AM, DON B responded to request, via electronic correspondence, that the facility was unable to locate the form. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/10/24 at 10:31 AM on the Bridge unit, Licensed Practical Nurse (LPN) S reported to this surveyor that blank bed-hold forms were located in a hanging file on the door behind the nurses' station and confirmed that residents who were sent to the hospital should have a bed-hold notice provided to them. 38384 R2 According to the Minimum Data Set (MDS) dated [DATE], scored 13/15 (cognitively intact) on his BIMS (Brief Interview Mental Status), with diagnoses included) Parkinson's (progressive brain disorder that causes movement problems, stiffness, and other issues such as hallucinations), seizures, bipolar disease manic depression (mental illness that causes extreme mood swings), and schizophrenia (Symptoms include psychosis, such as hallucinations, delusions, or disorganized thoughts or speech). Review of R2's medical record's section eINTERACT Transfers revealed the resident was transferred to the hospital 6 times in 2024 with no Bed Hold form provided to the resident on 5/27, 7/7, 9/5, 9/18, 10/3, and 10/5. During an interview and record review on 10/08/24 at 2:09 PM, R2 stated, I don't have a guardian. I was sent to the hospital last night and I don't have any paperwork that tells me I would have to pay for a room when I come back here. Reviewed paperwork on the resident's bedside table with the resident that was not a Bed Hold notification. During an interview and record review on 10/9/24 at 1:10 PM Director of Nursing (DON) B stated while reviewing R2's medical record, Bed Holds should be filled out with each transfer or admission to the hospital. The forms are to be kept at the nurse's station and filled out by the nurse and given to the resident or resident representative to reviewed and signed. The form is then given to Medical Records who then scans the form into the resident's medical record. I do not see a Bed Hold for any of (R2's) transfers. During an interview and record review on 10/9/24 at 1:15 PM, Unit Manager/Licensed Practical Nurse (UM/LPN) J stated, A Bed Hold Notification should be offered to each resident or their representative/guardian when they are transferred to the hospital. The policy is on the back of each notification to remind staff on how to handle the form. The UM then looked through Bridge Unit's filing drawer stating, Forms used by nurses are kept in a filing drawer for both of the nurse's stations. The Bed Hold form should be kept here. Looking twice through the files of forms that were in alphabetical order, the UM stated, I do not see the Bed Hold form in here. This is not my unit. During an observation, interview, and record review on 10/9/24 at 2:50 PM, Medical Records UU stated Bed Hold forms are uploaded in the eMAR when I get them. I scan them into resident medical records and save the paper copy so I can double-check they got into the eMAR. After the check is made, I destroy the paper copy. I looked earlier today with the DON and did not see anything (referring to Bed Hold forms) that was uploaded in the eMAR for (R2). I looked in the basket where I keep documents to be scanned and double-checked with the DON also, and there was nothing. I am pretty much caught up with all the documents that need to be scanned for all residents.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47955 Based on observation, interview and record review the facility failed to revise a person centered care plan for 1 (Resident #11) of 18 reviewed for person centered care plan revision resulting in an inaccurate reflection of the resident's current care needs. Findings include: Resident #11 Review of an Admission Record revealed Resident #11 had pertinent diagnoses which included: Pressure ulcer of the sacral region (the base of the spine just above the buttock) stage 3 (full-thickness loss of skin). Review of a Minimum Data Set (MDS) assessment for Resident #11, with a reference date of 8/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #11 was cognitively intact. Review of Care Plan for Resident #11 revealed Focus .indwelling catheter: pressure wound coccyx, initiated on 9/4/2024 .intervention .has a 16 F (french) foley catheter with a 10 cc baloon, positon catheter bag and tubing below the level of the bladder . During an observation on 10/8/24 at 10:16 AM., Resident #11 was in bed in her room sleeping. No noted drainage bag for urine was observed. Review of Care Management Note IDT/RAR for Resident #11 dated 9/20/24 at 14:09 (2:09) PM., revealed Wound vac has been DC'd (discontinued) .foley catheter is also going to be removed . Review of Infection Note for Resident #11 dated 9/22/24 revealed .resident is . incontinent of bowel and bladder . During an observation on 10/9/24 at 11:21 AM., Resident #11 told Licensed Practical Nurse Unit Manager (LPNUM) J I have to pee. In an interview on 10/9/24 at 11:39 PM., Director of Rehab Services (DRS) II reported that Resident #11 was not continent of bowel or bladder and did not have a foley catheter. In an interview on 10/9/24 at 3:41 PM., LPNUM J reported Resident #11 was incontinent of bowel and bladder and did not have a foley catheter at this time. LPNUM J confirmed Resident #11 had a care plan in place for an indwelling catheter, and the care plan should have been updated when the indwelling catheter was no longer used.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41982 Based on interview and record review, the facility failed to consistently provide restorative exercises per therapy recommendations for 1 (Resident #76) of 1 resident reviewed for position/mobility, resulting in the potential for pain, stiffness, and avoidable decline. Findings include: Resident #76 Review of an Admission Record revealed Resident #76 was a female, with pertinent diagnoses which included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a stroke) affecting left non-dominant side. Review of a Minimum Data Set (MDS) assessment for Resident #76, with a reference date of 9/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #76 was cognitively intact. Further review of said MDS revealed Resident #76 had a Functional Limitation in Range of Motion of upper and lower extremity of one side. In an interview on 10/8/24 at 12:11 PM, Resident #76 reported she was paralyzed on her left side due to having had multiple strokes. Resident #76 reported she had received therapy for a while but not anymore because her insurance wouldn't pay for it. Resident #76 reported she now received restorative exercises on her left side instead. In an interview on 10/9/24 at 10:16 AM, Director of Rehabilitation Services (DRS) II confirmed Resident #76 was on a restorative program that was developed by therapy but administered by Restorative Aide (RA) T and overseen by Restorative Program Nurse (RPN) D. Review of a Restorative Nursing Communication Tool dated 8/9/24 for Resident #76 revealed, Problem: LUE (left upper extremity) tone from stroke, RUE (right upper extremity) weakness Goal: PROM (passive range of motion) to LUE in all planes, RUE exercises Days per week: 3-5x/wk (3 to 5 times per week) Minutes per day: 15 . Review of Resident #76's restorative treatment calendars (documentation of when restorative exercises were performed with Resident #76) from 8/13/24 (when documentation started) through 10/9/24 (date of review) revealed Resident #76 received her restorative exercises a total of 6 times out of 24 opportunities (8 weeks x a minimum of 3 times per week). In an interview on 10/9/24 at 10:28 AM, RPN D reported the restorative program had been inconsistent because RA T had had some days off work and because RA T had gotten pulled to the floor to work as a Certified Nursing Assistant (CNA) at times. RPN D reported she did not perform restorative exercises on residents (including Resident #76) in RA T's absence. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/9/24 at 1:24 PM, RA T reported she was the only restorative aide and when she had days off work, there was nobody to cover her restorative duties. RA T reported she got pulled to the floor to work as a CNA and to give residents their showers once or twice a week. RA T reported when a resident did not receive their restorative exercises as they should, their muscles could get stiff and affect their range of motion. In a follow-up interview on 10/10/24 at 8:17 AM, RPN D reported the facility had realized the restorative exercises had not been getting done consistently and that the facility had created a plan to get things caught up, but it was not yet fully implemented. In an interview on 10/10/24 at 9:47 AM, Director of Nursing (DON) B reported when the facility had done an audit of the restorative program in September, it was determined that there was room for improvement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure appropriate care for a resident with an indwelling foley catheter (tube inserted into the bladder to drain urine) in one resident (R63) of 1 residents reviewed for catheter care, resulting in the potential for urinary tract injury and/or infection. Findings include: According to the Minimum Data Set (MDS) dated [DATE], scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status) with diagnoses that included obstructive uropathy that required her to be dependent on staff for her ADLs (activities of daily living) and the use of an indwelling catheter. Review of R63's Order Summary dated 12/1/23, revealed, Change catheter bag as needed for infection, obstruction, or when the closed system is compromised. R63's Order Summary dated 7/22/24, revealed, Indwelling catheter to straight drainage. Size: 22 Fr (French referring to the size of the tubing) Bulb: 30 cc (amount of normal saline (NS) the balloon holds to keep it in place inside the bladder). Change for infection, obstruction or when the closed system is compromised as needed. Review of R63's Care Plan, revised on 7/26/2024, focused on urinary retention related to neurogenic bladder and the use of an indwelling urinary foley catheter (22 French (outer dimension of catheter tubing) with a 30cc balloon (keeps system in place in bladder) to gravity drain. The goal was for the resident to be/remain free from catheter-related trauma using interventions that included catheter care every shift, check tubing for kinks each shift, observe for and report to medical doctor for signs/symptoms of a UTI (urinary tract infection) including blood-tinged urine, cloudiness, and deepening of urine color. During an observation and interview on 10/08/24 at 10:14 AM, R63 was receiving incontinence and wound care when the resident was observed to have an indwelling catheter with a leg strap attached to the inside of her left thigh. No urine was visible in the tubing that connected the catheter and urine collection bag. The urine collection bag had 50 cc of dark red urine. R63's brief was saturated with a dark yellow urine. Certified Nursing Assistant (CNA) W stated, (R63's) catheter leaks all the time. It is not certain if the balloon is too small or what is going on. The catheter has not been changed in a while. The nurse, (Licensed Practical Nurse (LPN) N) knows the catheter leaks urine. She, (referring to R63), should not have to have a leaky catheter. She already has a pressure ulcer, and the leaking urine could cause more skin issues. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/9/24 at 2:25 PM, R63 was receiving incontinence care. As CNAs FFF and BB began incontinence care, CNA FFF stated, (R63's) brief is saturated with urine even though she has an indwelling catheter. Her catheter leaking is an ongoing problem. The catheter has not been changed. The nurses know this is happening. Observed the resident's brief to be saturated with a dark colored urine. The protective pad and fitted sheet under the resident was also saturated with urine. The indwelling catheter was attached to a urine collection bag. The bag held 75 cc of dark red urine. During an interview on 10/10/24 at 10:30 AM, Director of Nursing (DON) B stated, I am not sure about (R63's) indwelling catheter leaking. You will have to check with her Unit Manager. During an interview and record review on 10/10/24 at 10:45 AM, Unit Manager/Licensed Practical Nurse (UM) J stated, I have talked about removing the catheter for (R63) which loosens up the bladder and lets the resident urinate. Removing the catheter has not happened yet and I've not heard anything else about what to do for the resident. R63's Progress Note dated 3/23/2024 07:20 AM, revealed, Health Status Note Text: Foley catheter changed at this time due to leaking. 16 F 30cc catheter inserted without difficulty. Draining amber colored urine. Review of facility procedure Indwelling Urinary Catheter (Foley) Care and Management reviewed 9/12/2024, revealed, .Monitor the catheter daily and assess for complications resulting from the use of an indwelling catheter such as symptoms of blockage with associated bypassing urine .Develop an individualized care plan based on assessment findings and revise as needed. For the resident with an indwelling urinary catheter, include a component to inform the resident and representative about the risks and benefits of catheter use and identify approaches to minimize the risk of infection by addressing personal hygiene measures, catheter/tubing/bag care, and educating the resident and representative regarding signs and symptoms of a urinary tract infection .inspect the urinary catheter system for disconnections and leakage because a sterile, continuously closed system is necessary to reduce the risk of CAUTI (catheter-associated urinary tract infection).Replace the catheter and drainage system using sterile no-touch technique when . leakage occurs .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on interview and record review the facility failed to identify Post Traumatic Stress Disorder (PTSD) triggers and develop and implement care plan interventions to mitigate emotional triggers in 1 (Resident #47) of 5 reviewed for trauma informed care resulting in the potential for re-traumatization due to staff not being informed or knowledgeable of the resident's past trauma and unmet care needs. Findings include: Review of Witness Statement dated 8/29/2024 revealed I (Name Omitted) witnessed Resident #79 verbal assault and threaten Resident #47. The Resident #79 stated she would slap the shit out of you if Resident #47 did not shut the f*** up. The witness was noted to report Resident #79 repeated the threatening statement to Resident #47 more than once. Repeated attempts to contact witness were unsuccessful. Review of an Admission Record revealed Resident #47 had pertinent diagnoses which included: Post traumatic stress disorder, dementia with psychotic disturbance, adjustment disorder with mixed disturbance of emotions and conducts, and obsessive-compulsive disorder. Review of a Minimum Data Set (MDS) assessment section C (Cognitive Patters) dated 6/29/24 for Resident #47, revealed memory problems, and cognitive skills for daily decision making severely impaired. Section E Behavior revealed Resident #47's behavior of verbal outbursts not directed towards others was significantly disruptive to care or living environment. Review of Resident #47's record revealed a diagnosis of PTSD on 1/25/2024 and no trauma informed care assessment after Resident #47 received a diagnosis of PTSD. Review of Care Plan for Resident #47 revealed no developed care plan with focus, goals or interventions related to PTSD or any possible triggers. Review of Social Service Assessment for Resident #47 dated 5/17/24 revealed .Does resident have a current psychiatric-related diagnosis .yes .Depression, Bipolar .Describe resident's current status .specifically address problem areas or interventions that social services is currently reviewing .has severe cognition impairment . There was no indication that Resident #47 has a diagnosis of PTSD or that Social Services was assessing Resident #47 for any triggers. On 10/8/24 at 9:06 AM., Resident #47 was observed in her wheelchair in her room and can be heard yelling out in a monosyllable AH type noise, no actual noted word in the vocalization. Resident #47 looked at this surveyor when her name was spoken but did not respond. Resident #47 continued to yell out. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/9/24 at 10:19 AM., Resident #47 was observed in her wheelchair in her room sitting with her legs crossed and her hands resting in her lap. Resident #47 appeared to be staring off in the distance, not focusing, and appeared to be groggy. Resident #47 did not respond when this surveyor spoke her name. In an interview on 10/9/24 at 10:22 AM., Licensed Practical Nurse (LPN) N reported Resident #47 has PTSD and was abused. LPN N reported she was unaware of any identified triggers. In an interview on 10/9/24 at 10:45 AM., LPN/Minimum Data Set (LPN/MDS) E reported Resident #47 was abused before she admitted to the facility. LPN/MDS E reported she was unaware of Resident #47's triggers. On 10/9/24 at 3:08 PM., Resident #47 was observed in her bed in her room with the door cracked open and Resident #47 was yelling out a monosyllable AH word/noise. Review of Progress Notes for Resident #47 dated 8/29/24 at 21:47 (9:47 PM) revealed .other resident was noted lining [leaning-sic] over this resident and telling her if you dont shut up I will shut you up. Other resident was removed from the room . Review of Incident Report for Resident #47 dated 8/29/2024 at 21:39 (9:39 PM) revealed .Resident was in her bed and an other resident came in her room and lined (sic) over her and told her if she didn't shut up she would shut her up . Review of a word document attached to an incident report for Resident #47 with no date revealed .I spoke with Resident #79 on [DATE], in the evening after it had been reported to me that she was found by a CNA over another resident's bed telling the resident to shut up or she would shut her up . In an interview on 10/10/24 at 9:26 AM., Registered Nurse/Infection Preventionist (RN/IP) K reported she was working on floor the night Resident #79 was noted by a CNA to be standing over Resident #47's bed yelling at her to shut up or she would shut her up. In an interview on 10/10/24 at 11:44 AM., LPN/Unit Manager (LPN/UM) J reported Resident #47 might have a diagnosis of PTSD, but she was unsure. LPN/UM J reviewed Resident #47's record and confirmed Resident #47 had a diagnosis of PTSD and no care plan or interventions in place related to her diagnosis of PTSD. LPN/UM J reported she had no knowledge of Resident #47's triggers. In an interview on 10/10/24 at 1:08 PM., Social Services Director (SSD) TT reported trauma assessments should be completed at admission and with a new diagnosis if indicated. SSD TT confirmed Resident #47 was diagnosed with PTSD in January of 2024 and she did not have a trauma informed assessment or a care plan following the diagnosis of PTSD. SSD TT reported care plans for residents are reviewed with each care conference about every 3 months. In an interview on 10/10/24 at 1:21 PM., SSD TT reported that Resident #79 standing over Resident #47's bed, yelling at her could be retraumatizing for Resident #47.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, or serve food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents who consume food from the kitchen. Findings include: During a tour of the kitchen, at 8:35 AM on [DATE], it was observed that a full pan containing two beef roasts was found with a vented top in a shelf in the walk-in cooler. When asked when this item was cooled, Food Service Director (FSD) JJ stated it was cooked off yesterday and then cooled down. When asked if there was a cooling log for the item. FSD JJ stated that their cooling log is filled out with an erasable marker and it looks like it was erased when cleaning was being done. A temperature of the roast at this time was found to be 42.5F when checked with a rapid read thermometer. Additional food product temperatures were taken at this time and found to be between ,d+[DATE]F in the walk-in cooler. The ambient air thermometer was found to be 38F. When asked who would have followed the cooling process for the beef roast, FSD JJ stated it was the pm cook yesterday. When asked if he was aware of the required time and temperature relationship for proper cooling. FSD JJ was unable to state the regulation requirement for time and temperature. When asked what needed to be done with the roast at this point, FSD JJ stated it will be discarded. During an interview with [NAME] LL, at 11:47 AM on [DATE], it was found that the roast was cooked off around 12:30 PM to 1:00 PM on [DATE], and that the product sat out for ,d+[DATE] minutes and then was vented and placed into the cooler. When asked what temperature the product was when placed into the cooler, [NAME] LL stated between 160F and 170F. When asked what time the product would have reached 41F. [NAME] LL was unsure and stated that he was not around for it to finish cooling. According to the 2017 FDA Food Code section ,d+[DATE].14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . According to the 2017 FDA Food Code section ,d+[DATE].15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S ,d+[DATE].14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph ,d+[DATE].11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Doing a tour of the kitchen, at 9:05 AM on [DATE], it was observed that the Qt-40 quaternary ammonium test strips were found to have expired on [DATE]. When asked if there were more test strips, FSD JJ stated that the backup strips in his office were also expired and that he will have to order more. According to the 2017 FDA Food Code section ,d+[DATE].14 Sanitizing Solutions, Testing Devices. A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided. During a tour of the kitchen, at 9:10 AM on [DATE], it was observed that a drawer containing clean utensils was found with excess accumulation of crumb debris. When asked how often the clean utensil drawers get cleaned, FSD JJ stated it gets done weekly and it gets logged by staff. Next to the clean utensil drawers were a stack of muffin tins that were found with excess debris and crumbs. When asked if staff use these tins, [NAME] NN stated that she hasn't seen them used in over year. During a tour of the kitchen, at 9:15 AM on [DATE], it was observed that the can opener on the cook line was found with an accumulation of black debris on the blade and holder that is attached to the table. When asked if it was used today, no staff acknowledge that they had used it yet. Observation of the pots and pans storage rack, at 9:18 AM on [DATE], found a bus tub container with an assortment of kitchen equipment. An interview with [NAME] NN and FSD JJ found that staff don't really use a lot of the items in the bus tub. Observation of the bus tub found a butter dispenser with a colander wheel for butter. When asked if anyone uses the butter wheel, [NAME] NN stated that one of the another cook uses it at times for toast, but she doesn't believe anyone else does. Underneath the wheel and inside the container a dead moth, crumb accumulation, and yellow sticky debris. During a tour of the preparation area, at 9:35 AM on [DATE], it was observed that another can opener was found with an accumulation of debris around the blade and holder of the unit. During a tour of the dish machine area, at 9:38 AM on [DATE], it was observed that the floor juncture under the dish machine was found missing vinyl coving and no longer protecting the juncture from water. Observation at this time found excess debris in this area, around and underneath the dish machine line. During a tour of the dry storage room, at 9:42 AM on [DATE], it was observed that an accumulation of dirt and grime was present around the perimeter of the floor and around and near the legs of storage racks. Under the right-side rack, when walking into the dry storage room, dried splatter debris was evident around the bottom wall and vinyl coving perimeter. According to the 2017 FDA Food Code section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. According to the 2017 FDA Food Code section ,d+[DATE].12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the dish machine area. at 9:39 AM on [DATE], it was found that the dish machine unit requires a 160F for the wash cycle, according to the dish machines manufacturer's data plate. Observation of the machine in use found that it was running between 155F-160F as staff were using it to clean dishes. Observation of the Dish Log, dated [DATE], found that 19 out of 24 logged wash temperatures were found to be below the required minimum of 160F. A return observation of the dish machine log, at 12:15 PM on [DATE], found additional dish machine wash temperatures logged below the required 160F minimum wash temperatures on the machine. According to the 2017 FDA Food Code section ,d+[DATE].110 Mechanical Warewashing Equipment, Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: . (3) For a single tank, conveyor, dual temperature machine, 71oC (160oF)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to ensure an effective infection control program that included: 1. appropriate hand hygiene and glove use during resident care in 1 of 18 residents (R63), 2. cleaning and disinfecting of resident equipment for 3 of 18 residents (R36, Resident #67, and Resident #11), 3. implementation of Enhanced Barrier Precautions (EBP) per standards of practices for 1 of 18 residents (Resident #11) all reviewed for infection control, and 4. maintain an active and ongoing plan for reducing the risk of opportunistic pathogens of premise plumbing, resulting in the potential for cross-contamination, harborage of bacteria, and increased infections in a vulnerable population. Findings include: R63 According to the Minimum Data Set (MDS) dated [DATE], scored 13/15 (cognitively intact) on her BIMS (Brief Interview Mental Status) with diagnoses that included atrial fibrillation (abnormal heart rhythm) and Parkinson's disease Incontinence of bowel and bladder required her to be dependent on staff for her ADLs (activities of daily living). Section M-Skin Conditions indicated the resident had one unstageable pressure ulcer. Review of R63's Physician Orders dated 12/1/2023, indicated catheter care was to be provided every shift. Review of R63's Physician Orders dated 10/3/2024, indicated wound care to the resident's coccyx was to be provided daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/08/24 at 10:14 AM of R63, CDC (Centers for Disease Control) EBP signage was on the outside of resident's door along with an isolation cart with PPE. No designated waste containers for gowns or contaminated waste were visible in the hall or room. The EBP signage indicated gown and gloves were to be worn for wound care. Hospice Registered Nurse (RN) XX and Certified Nursing Assistant (CNA) W gathered supplies for wound care then donned (put on) gown and gloves. After arranging supplies on resident's bedside table, RN XX rolled the resident onto her right side revealing fecal matter in the brief. RN XX then removed the urine and BM soiled brief from resident's left side, touching the resident's urinary catheter tube with her contaminated hands. RN XX then removed her gloves, and donned new gloves without performing hand hygiene. Observing the urine saturated bed sheets, RN XX pulled the sheets off the foot of the bed and rolled the soiled brief under resident. At this time, CNA V entered the room to assist. RN XX began putting clean sheets on at the foot of the bed while still wearing the gloves she used to roll the soiled brief under the resident. With CNA W and CNA V to the resident's right side, RN XX rolled the soiled sheets and briefs under the left side of resident. With the contaminated gloves still on, RN XX observed the dressing that covered a wound to the resident's coccyx to not be labeled or dated then removed it. RN XX removed her gloves, donned new ones without performing hand hygiene, and proceeded to clean the coccyx wound. After measuring the wound, RN XX removed her gloves, donned new gloves without performing hand hygiene, began to prepare a new dressing. She rummaged through resident's closet and her work bag looking for marker. While still wearing the same gloves, RN XX placed the optifoam dressing in the wound and labeled the cover dressing with an ink pen provided by CNA W. During this, R63 had a BM requiring RN XX to remove the optifoam and dressing. Both optifoam and dressing were laid on the bedside table without a protective barrier. The optifoam had exudates from wound. Using wipes, RN XX cleaned the BM from the resident's bottom, removed gloves, and donned new gloves without performing hand hygiene. Once again, RN XX placed the optifoam and dressing to the wound. While wearing the same gloves, RN XX folded the barrier/chuck pad, clean brief under resident and rolled her towards herself. CNA W assisted. RN XX then placed soiled items in the garbage and returned to the resident's bedside without removing contaminated gloves. CNA W began to put pillow case on pillow without changing gloves, until the resident was rolled onto her back at which time RN XX examined the PEG (g-tube) dressing with contaminated gloves. She then gave both CNAs wipes to clean the resident's front peri area of BM. CNA W used a washcloth with soap and water to clean BM. Again, the resident had a BM. RN XX rolled the resident onto her left side, cleaned the BM from around the dressing, removed her gloves, and donned new ones without performing hand hygiene. CNA V removed her gloves and donned new gloves without performing hand hygiene. RN XX used wipes to clean front resident's peri area, placed them in garbage and did not change gloves to assist with putting on a clean brief. RN and both CNAs boosted resident up in bed. RN XX placed a pillow between resident's knees. With same gloves, RN XX gathered leftover supplies from bedside table, while CNA W stated if R63's brief was saturated with urine if the indwelling catheter should be changed. RN XX stated she would check with her manager. RN XX stated, Hand hygiene should be done before staff enter room and after they leave, and in between changing gloves, I was able to do hand hygiene in between cares and changing out my gloves. It was noted RN XX had not performed hand hygiene when changing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/9/24 at 2:15 PM, R63 was receiving incontinence care from CNA FFF and CNA BB. The resident's brief was saturated with urine along with BM (bowel movement). Both CNAs donned gown and gloves. CNA FFF used a wipe to clean the resident's front peri-area then used the same wipe to run up approximately 10 of the indwelling catheter tubing. The CNAs rolled the resident to her right side when they discovered the draw sheet (used to position resident) was wet with urine. Without changing gloves and performing hand hygiene, CNA FFF handed the urine bag to CNA BB on the resident's left side. Then both CNAs folded a clean draw sheet over the top of the resident and laid it on top of her. The resident was rolled to her left side and the wet draw sheet was removed from under her. Without removing gloves and performing hand hygiene, the CNAs placed the clean draw sheet and a protective pad underneath the resident. CNA FFF went to the resident's cupboard to retrieve a package of wet wipes, dropped wipes on the floor, picked them up and placed them in the garbage. Without changing gloves and performing hand hygiene, both CNAs placed a clean brief on R63, adjusted her gown over her, put a wedge behind her right back rolling her onto her left side, and placed pillows between her knees. Without changing gloves or performing hand hygiene, CNA FFF took the call light and handed it to CNA BB who placed it near the resident's hands and smoothed the sheets over the resident. CNA FFF stated, Hand hygiene should be done, and gloves changed when the gloves are soiled. I should have changed my gloves when I touched the catheter and call light. CNA BB stated, Hand hygiene and glove change should have been done after the catheter was touched and anytime the gloves are soiled. We, (referring to herself and CNA FFF) probably should have changed gloves when they touched the soiled areas. During an interview on 10/10/24 at 9:15 AM, RN Staff Training/Development D and RN/Infection Control Preventionist (ICP) K stated, Only a partial number of the facility's CNAs attended the Skills Fair last week that included hand hygiene during incontinence/pericare care. Hands should be cleaned before donning gloves. The Skills Fair taught staff to use washcloths with soap and water and to use the onion method which includes using one swipe down, fold over, another swipe down, until all clean sides of the washcloth are used. Staff were told to use the larger wipes to clean bowel movement. When staff go from a soiled area to a clean area, gloves should be removed and hand hygiene performed before putting on clean gloves. A wipe or washcloth should not be used to clean the peri area then used to clean the indwelling catheter tubing for infection control purposes. When a resident has a pressure ulcer and wears a brief that becomes saturated with urine, that soils the wound dressing, the brief and the dressing both have to be changed. Not changing the wound dressing could cause the wound to become infected and not heal. Resident equipment Review of R63's Physician Orders dated 7/8/2024, indicated the resident was to receive enteral feedings of Jevity 1.5, a tan-colored liquid, for 13 hours beginning at 7:00 PM and ending at 8:00 AM. Observed on 10/08/24 at 10:14 AM, R63's tube feeding pump, pole and base were splattered with a dried tan substance that resembled tube feeding. Observed on 10/08/24 at 12:35 PM, R63's tube feeding pump, pole and base were splattered with a dried tan substance that resembled tube feeding. Observed on 10/9/24 at 2:35 PM, R63's tube feeding pump, pole and base were splattered with a dried tan substance that resembled tube feeding. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235471	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plainwell	320 Brigham St Plainwell, MI 49080

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/10/24 at 8:15 AM, with Unit Manager (UM) J, stated while observing R63's tube feeding pump and pole, (R63's) probably should not have that on there. Anytime tube feeding gets on equipment it should be cleaned off for infection control purposes. That looks to be tube feeding on the pole, pump, the pole base, and even the floor. That should have been cleaned up by now since she (R63) was done with her feeding this morning. 47955 Resident #67 Review of an Admission Record revealed Resident #67 had pertinent diagnoses which included: Gastrostomy (tube inserted into the stomach for administration of formula for nutrition) and dysphagia (difficulty swallowing). Review of a Minimum Data Set (MDS) assessment for Resident #67, with a reference date of 9/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #11 was cognitively intact. Review of Order Summary for Resident #67 revealed .Enteral Feed Order in the evening Jevity 1.5 90 mL/hr (milliliters per hour) runs for 14 hours ordered on 7/26/2024 .Clean oxygen concentrator filter with soap and water weekly every Thursday . ordered 3/8/2024 . Enhanced barrier precautions diagnosis foley; g-tube every shift . ordered 4/3/24 . In observations on 10/8/24 10:20 AM. and 3:15 PM, 10/9/24 9:42 AM and 3:15 PM., and 10/10/24 at 8:22 AM. , a feeding pump affixed to a pole located at Resident #67's bedside was noted to be soiled with dirt, debris and what appeared to splattered dried formula. An oxygen concentrator in Resident #67's room was noted to have what appeared to be splattered dried formula on the front of it. In an interview on 10/9/24 at 3:15 PM., Resident #67 reported he received formula through the feeding pump daily and he only used the oxygen as needed. In an interview on 10/10/24 at 9:38 AM., Housekeeping Assistant (HA) PP reported feeding pumps, poles, oxygen concentrators were a part of the monthly deep clean list, and fans should be wiped down daily if they were dusty. In an observation and interview on 10/10/24 at 11:31 PM., Housekeeping Supervisor (HS) OO observed the fan in Resident #11's room and confirmed it was soiled with dirt and debris and dust and needed to be cleaned. HS OO observed the feeding pump, pole, and oxygen concentrator in Resident #67's room and confirmed it was soiled with dirt, debris, and what appeared to be splattered formula and needed to be cleaned. HS OO reported feeding pumps, poles, and oxygen concentrators were to be cleaned by the CNAs and the fan should be dusted by housekeeping daily, and the blades of a fan cleaned monthly. Resident #11 Review of an Admission Record revealed Resident #11 had pertinent diagnoses which included: Pressure ulcer of the sacral region (the base of the spine just above the buttock) stage 3 (full-thickness loss of skin). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Minimum Data Set (MDS) assessment for Resident #11, with a reference date of 8/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #11 was cognitively intact. Review of Order Summary Report for Resident #11 revealed .wound care to sacrum, cleanse wound with NS (normal saline) pat dry, apply hydrofera blue and cover with coversite changed Mondays, Wednesdays, and Fridays as needed for soiled, loose, or missing .order on 10/4/24 . Enhanced barrier precautions diagnosis wound and history of MDRO every shift for pressure ulcer, history of MDRO (multidrug resistant organism, an infection that is resistant to antibiotic treatments), and foley catheter . ordered on 9/20/24 . On 10/9/24 at 3:17 PM., Certified Nurse Assistant (CNA) V was observed in Resident #11's room, providing peri-care and was not wearing a gown. CNA V reported she should be wearing a gown since Resident #11 was under enhanced barrier precautions. Signage was observed on Resident #11's room door indicated the need for a gown and gloves to be worn during high contact cares, including incontinenence care. On 10/9/24 at 3:17 PM., Licensed Practical Nurse/Unit Manager (LPN/UM) J was observed applying a gown outside of Resident #11's room and entering Resident #11's room, placing dressing supplies onto a bedside table creating a clean field, and washing her hands. LPN/UM J was then observed exiting Resident #11's room, retrieving supplies from the treatment cart in the hallway outside of Resident #11's room, reentering Resident #11's room and applying gloves, and repositioning Resident #11 in bed. LPN/UM J did not perform hand hygiene before applying gloves. LPN/UM J was then observed touching Resident #11's sacral area wound with her gloved hands, then soaking gauze with normal saline both retrieved from the clean field on the bedside table with her gloved hands and cleaning Resident #11's wound. LPN/UM J was then observed depositing the soiled gauze used to clean Resident #11's wound into the clean field with clean supplies on the bedside table. LPN/UM J then removed her gloves and placed them on top of the soiled gauze in the clean field. LPN/UM J was observed reaching into her pocket under the disposable gown to retrieve scissors she then placed into the clean field on the bedside table. It was noted that the scissors were never cleaned by LPN/UM J during the care observation. In an interview on 10/9/24 at 3:33 PM., LPN/UM J reported she had placed the soiled gauze and gloves into the clean field, and she should have had the garbage or a bag available to place soiled supplies. LPN/UM J reported she should have retrieved and cleaned her scissors before she placed them into the clean field or used them, and she should have cleaned them when she was done. In an interview on 10/9/24 at 3:41 PM., Director of Nursing (DON) B reported her expectations were that soiled dressing supplies should not be placed into a clean dressing field and should be placed directly into a bag for disposal. DON B reported her expectations were that scissors were cleaned and placed into the clean supply field before a dressing change was started. In observations on 10/8/24 at 10:16 AM, and 3:15 PM., 10/9/24 at 9:30 AM, 11:30 AM., and 3:35 PM., and 10/10/24 at 8:35 AM., a pedestal fan located in Resident #11's room was soiled with dirt and debris on the base and the grate covering facing the resident. In an interview on 10/8/24 at 3:15 PM., Resident #11 reported she had the fan pointed at her so she can feel the air move. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	38905 During a tour of the facility, at 9:41 AM on 10/10/24, with Maintenance Director (MD) QQ, it was found the housekeeping closet on the ambulance entrance hallway had hot water bleeding into the cold-water supply through the mixing valve of the eye wash station. Upon feeling the cold-water line of the faucet fixture the surveyor noted it was warm to the touch. MD QQ stated it might be from the eye wash station mixing valve, and that he would have to investigate. During a tour of the facility, at 9:44 AM on 10/10/24, observation of a mechanical room on the therapy hall found a water line coming out from the back of the closet to the front of the closet, near the floor, with an on and off valve, and made a 90 degree turn upwards and was cut at the end. At this time the valve was able to be turned on with water running through the line. MD QQ was unaware of the line in the closet. During a tour of the laundry room, at 10:34 PM on 10/10/24, it was observed that two light fixtures were found to not be shielded or protected from breakage. These light fixtures were over the clean laundry area where the dryers are located and where staff fold laundry. During a tour of the basement central supply, at 11:00 AM on 10/10/24, it was observed that a water line was found behind the storage rack for briefs. Although no handles were on the fixture, MD QQ was unsure about its presence or whether it was capped off or working. During a perimeter tour of the facility, starting at 2:17 PM on 10/10/24, it was observed that some outside hose bibs, on the south side of the facility, were found to have been left on and were connected to hoses and atmospheric vacuum breakers (AVB). AVB's are not approved for constant back pressure and will degrade the integrity of the device over time. On the [NAME] and North side of the facility, two outside hose bibs were found with a hose connected and turned off, but not protected by an AVB. Outside hose bibs should have some type of backflow prevention if a hose is to be attached between uses.