STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235513	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Fulton,the	4735 Ranger Rd Perrinton, MI 48871

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plan was reviewed and revised for one resident (Resident #8) out of 13 residents reviewed for quality care, resulting in hospitalization for a fracture sustained after a fall from staff use of the incorrect lift device. Findings: Resident #8 (R8) Review of an Admission Record reflected R8 admitted to the facility with diagnoses that included generalized osteoarthritis, hemiplegia and hemiparesis (weakness and partial paralysis) of the left non-dominant side following a stroke, history of traumatic brain injury and muscle weakness. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R8 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14/15. R8 was coded as using a wheelchair for mobility, did NOT walk, and was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity for sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed - to- chair transfers. Review of a Discharge assessment - return anticipated MDS dated [DATE] reflected R8 was Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity for sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed) and chair/bed - to- chair transfers. During an observation and interview on 11/18/2024 at 11:23 AM, R8 was sitting up in bed, a sling in place on her left arm. R8 reported her left hip and shoulder were painful due to an accident that occurred at the facility during a transfer, resulting in a broken arm. R8 said that before the accident occurred, she told staff she felt weak and tired from recent low blood pressures and thought she had another urinary tract infection when she slipped out of a sit-to-stand lift. (continued on next page)

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

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of a Fall incident report dated 9/1/2024 reflected Incident Description: This nurse was called to room. Nurse aides were standing around resident (R8) who was sitting on the floor, with an aide behind her. She slipped out of sit-to-stand during a transfer. The report indicated When resident goes outside, she is to be transferred via Hoyer (a full mechanical lift) to bed instead of sit-to-stand. She is tired from being outside and its hard for her to hold on. The report indicated R8 had a left shoulder injury and 10/10 pain level. Details in the report were limited and the complete fall investigation was requested. Review of a Verification of Investigation form dated 9/01/2024 reflected Resident (R8), who is AxOx3 (alert and oriented times 3, person, place, situation), fell when she let go of a sit-to-stand. She was a two person assist, and her CNAs (Certified Nurse Aides) (CNA H and CNA K) both testified that they had taken (R8) to the restroom, and were bringing her back to bed in the EZ sit-to-stand, when (R8) let go of the sling on the left side, and slid down to the floor through the lift sling (she was dragged down by her girth). (R8's) grey dress pullover was pulled up over her head. (R8's) shoulder hit the side of her bed when she went down. (R8) stated I was tired from the day, and I just let go. Current care plan includes a 2 person assist for transfers, and the care plan was followed. The care plan included with the investigation did not address R8's transfer status. A statement from CNA H indicated that R8's left arm was flaccid (limp) and R8 let go of the lift device with her right hand when she fell . Review of a Care Plan initiated on 11/28/2019, revised on 7/03/2024 indicated that R8 was at risk for fall related injury related to history of falls, hemiplegia/paresis left side, TBI (traumatic brain injury), needs assistance with ambulation with use of walker . The goal was that R8 would remain free from injury related to falls. Interventions included Encourage the resident to wear appropriate footwear as needed; ensure gait belt is on for all transfers . This care plan, in place at the time of R8's fall, conflicts with the MDS data which indicate R8 does not ambulate or use a walker for ambulation. Review of a Care Plan initiated 3/15/2024 and in place prior to R8's fall on 9/01/2024 reflects (R8) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): weakness d/t (due to) CVA (stroke) with left sided weakness, PVD (peripheral vascular disease), GERD (gastro-esophageal reflux disease), seizures, RLS (restless leg syndrome), HTN (high blood pressure), and OA (osteoarthritis). This care plan indicates R8 is unable to walk or ambulate and was dependent on staff for transfers. The care plan does NOT specify the number of staff or assistive devices required to transfer R8. During an interview on 11/20/2024 at 11:31 AM, Physical Therapy Assistant (PTA) L said R8 was on the therapy case load to evaluate R8 due to deconditioning and had been cut from services on 8/30/2024 due to lack of progress prior to being hospitalized after the fall and broken arm on 9/01/2024. PTA L reported that R8 was a max (maximum) assist with a sit-to-stand for transfers and required a Hoyer lift as needed. PTA L said she does not update care plans but gives transfer status recommendations to nursing staff in the form of a communication and education to staff. PTA L said that the intervention Hoyer as needed has been long standing. PTA L emphasized that staff can always use more support than required, but cannot offer less support than what is typical for a resident. The transfer status recommendations and communication forms were requested from PTA L at this time. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of Therapy Communication Forms dated 3/14/2022 indicated that R8 was to be transferred via EZ-stand for transfers <> (to and from) bed to wheelchair . The recommendation made over two years prior was not found in a comprehensive review of the care plan that was in place prior to R8's fall from the sit-to-stand device. During an interview on 11/20/2024 at 11:47 AM, the Director of Nursing (DON) reviewed the care plan that had been in place prior to R8's fall with fracture on 9/01/2024. The DON said that they were present at the facility on the day R8 fell . R8 had been outside most of the day, coming inside every few hours to be cared for, which likely weakened R8 and contributed to the fall. The DON confirmed that no specific directions pertaining to how R8 was to be transferred was documented in the care plan for self-care/mobility and confirmed that R8 did not walk using a walker anymore. Review of a hospital History of Physical Notes dated 9/2/2024 reflected History of Present Illness: (R8) is a 60 y.o. (year old) female who presents with past medical history notable for hypertension, hyperlipidemia, hemorrhagic CVA with residual left-sided weakness and obstructive sleep apnea who presents to the emergency room after a fall while being transferred from the wheelchair to a bed via a sit and stand device. The patient said that her blood pressures have been low and she apparently passed out briefly. Patient landed on her left side resulting in severe pain in the left arm. She was confirmed to have a fracture at the facility and was brought to the emergency room for evaluation/treatment. In the ED (Emergency Department) the patient was afebrile with low blood pressures documented around 87/68. Nontachycardic (no increased pulse). After IV (intravenous) fluids in the ER blood pressures have improved to systolic blood pressure close to 100. Currently she is asymptomatic but does want to go back to sleep. Further review of hospital records indicated R8 had a CT (computed tomography, an imaging exam) scan of the left shoulder without contrast which showed R8 had a Comminuted (a broken bone that has separated into three or more pieces; usually caused by a severe impact, such as a car accident or a serious fall), displaced, and angulated fracture of the surgical neck of the humerus. The hospital record also revealed R8 was diagnosed with Metabolic Encephalopathy and Sepsis without shock due to a UTI.

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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** 39056 Based on observation, interview, and record review, the facility failed to 1.) implement the facility policy for pressure injury/wound management, 2.) ensure pressure injury/wound assessments were comprehensive and accurate, and 3.) ensure treatments were promptly ordered and completed, for 2 of 13 residents (Resident #17 and #1) reviewed for alterations in skin integrity, resulting the development of preventable pressure injuries and the worsening of wounds. Findings: Resident #17 (R17) Review of an Admission Record revealed R17 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic respiratory failure, chronic heart failure, and diabetes. R17 was dependent on staff for all activities of daily living. According to the Nurse Notes, R17 was hospitalized from 11/3/24-11/7/24 for a UTI (urinary tract infection). Review of R17's Care Plan revealed the following concerns and interventions: (a) R17 is at risk for urinary tract infection and catheter-related trauma with the following intervention-Ensure catheter tubing is secured-Initiated: 08/25/2023, (b) R17 is at risk for impaired skin integrity/pressure injury R/T: weakness, mobility issues, low proteins, and incontinence of bowel, presence of catheter and tubing, non ambulatory, COPD, hoyer lift, fragile skin of sacrum r/t previously healed pressure ulcer and MASD (moisture associated skin damage), unable to reposition self with the following interventions-put barrier between skin and catheter tubing to avoid skin irritation and/or abrasion-initiated: 04/05/2024 .turn and reposition every two hours and PRN (as needed)-initiated: 03/26/2021 .Added to the care plan on 11/15/24 was MASD to right buttocks related to incontinence. Review of R17's readmission Nursing Comprehensive Evaluation dated 11/7/24 revealed: groin and perineal area reddened. No measurements were noted. Review of R17's Order Summary revealed that no new order for skin impairment treatment, noted on the admission assessment dated [DATE], were put into place until 11/11/24. Review of R17's Minimum Data Set, dated dated dated [DATE] (completed after returning from the hospital stay 11-3-24 to 11-7-24) revealed R17 did not have one or more unhealed pressure ulcer(s) at Stage 1 or higher and R17 was at risk of developing pressure ulcer. Review of R17's Electronic Medical Record revealed (a) no treatment order for a catheter securement device, (b) no comprehensive wound assessment following the skin breakdown identified on 11/7/24, (c) the guardian was not notified of the skin break down identified on 11/7/24, and (d) the physician was not notified of the skin concerns identified on 11/7/24. Review of R17's provider Progress Note dated 11/12/24, did not reflect a new/worsening pressure injury or skin impairment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R17's Order Summary with a start date of 11/15/24 revealed changes (increased care required) to the order initiated on 11/11/24 for the right buttocks wound care. Review of R17's Electronic Medical Record revealed no comprehensive wound assessment following the identification of the skin breakdown and/or worsening of the skin breakdown which resulted in a treatment order change dated 11/15/24 or guardian and physician notification of the skin breakdown and treatment changes. On 11/21/24 at 12:43 PM, R17's Skin & Wound Evaluation dated 11/17/24 was documented as complete. The wound now measured 0.8 cm (length) x 1.0 cm (width) x 0.1 cm (depth). The surrounding tissue was fragile and at risk for breakdown. It was documented that the guardian and the provider were notified on 11/21/24 of the skin breakdown. During an observation on 11/19/24 at 12:50 PM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/19/24 at 01:07 PM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/19/24 at 02:10 PM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/19/24 at 02:53 PM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/19/24 at 03:41 PM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/19/24 at 03:55 PM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/20/24 at 08:13 AM, R17 was sitting up in a broda chair in the dining room attempting to feed herself. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/20/24 at 08:42 AM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/20/24 at 09:26 AM, R17 was sitting up in a broda chair near the nurses station. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 11/20/24 at 10:45 AM, R17 was sitting up in a broda chair in the activity room. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/20/24 at 11:58 AM, R17 was sitting up in a broda chair in the activity room. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation on 11/20/24 at 12:34 PM, R17 was sitting up in a broda chair in the dining room attempting to feed herself. R17's heels were resting on the footrest and there were no offloading devices in place behind her left or right side. During an observation and interview on 11/20/24 at 01:04 PM, Certified Nursing Assistant (CNA) E brought R17 to her room to provide pericare. CNA E reported R17 got up before breakfast but had not provided pericare since that time. During an interview on 11/20/24 at 01:20 PM, R17 reported pain her buttocks. During an observation and interview on 11/20/24 at 01:25 PM, CNA E and CNA F were providing incontinence care for R17. R17 did not have a securement device in place and her urinary catheter tubing was under her thigh/buttocks. R17 was rolled to the left side exposing her buttocks and posterior thighs. On her right groin/upper posterior thigh there were 2 areas of deep ruddy red indentations where the incontinence brief and urinary catheter tubing had been pressing into her skin. CNA F reported R17 should have had a securement device in place for her urinary catheter and did not know how long she had been without it. R17 had dried stool (bowel movement) that was not easily wiped away noted on her buttocks that had contaminated the dressing on R17's right gluteal wound. The dressing border had lifted and there was stool under the dressing. Licensed Practical Nurse (LPN G) entered the room to perform a dressing change and reported she did not know how long R17 had been without the securement device. Review of R17's Skin & Wound Evaluation dated 11/20/24 at 2:11 PM revealed a Medical Device Related Pressure Injury Stage I on the Right Ischial Tuberosity, Medial identified as in-house acquired on identified on 11/20/24. The wound measured 5.5 cm (length) x 1.8 cm (width) . ensure catheter tubing anchor is in place and tubing in proper position . Confirming the presence of a new avoidable pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R17's contracted wound consultants Progress Note dated 11/20/24 revealed, . is being seen today for evaluation of a new wound site to the right groin/medial Ischial tuberosity, in addition to a follow-up of her right gluteal incontinence-associated dermatitis .On evaluation today after lunch, (R17) was alert. She reported pain at the newly observed wound site without other reports of pain during assessment or other wound interventions .Notes: Pain to groin area where the new wound is located .Indwelling Foley urinary catheter and incontinence brief associated devices appear to have created skin breakdown in the form of a Stage 1, non-blanching, medical device-related pressure wound along the right groin/medial ischial tuberosity. Positive for tenderness on palpation of the wound, erythema and ecchymosis. The wound site measures about 5.5 cm in length by about 1.8 cm in width, but without depth .a 3.5 x 2.5 cm area (without depth) that is red-pink, dermatitis noted to the right gluteus. An area of redness and bruising, 5.5 cm x 1.8 cm, was noted on the right posterior ischium area medially, where the incontinence brief and urinary catheter tubing had been laid onto the skin, showing skin that is reddened and non-blanching, with indentations and bruising in the shape of the incontinence brief edge, and urinary catheter tubing, pressure injury, which is tender on palpation .(Problem 1) .Skin moisture secondary to chronic urinary incontinence associated dermatitis located to the right gluteus, measuring 3.5 cm x 2.5 cm, no depth .(Note the resident had an indwelling foley catheter at the time of the assessment) .(Problem 2) .Contusion that is pink-red with ecchymosis, no edema or signs of infection noted to the right interior thigh, distal to the groin, appearing to be a medical device associated skin injury from chronic indwelling foley catheter and incontinence brief edge contact with the skin that likely caused friction injury. Nonblanching, the skin remains closed/intact. - Measured 5.5 cm x 1.8 cm, without depth . During an interview on 11/21/2024 at 8:54 AM, Assistant Director of Nursing (ADON) A reported that the provider and guardian should be notified at the time the skin breakdown is identified and documented in the Skin & Wound Evaluation. ADON A reported that the standard of practice was for R17's catheter securement device to be in place at all times. Review of the facility policy Skin Management last revised 8/14/24 revealed, Practice Guidelines (1.) Upon admission/re-admission all residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record .(3.) Appropriate preventative measures will be implemented on residents identified at risk and the interventions are documented on the care plan. 4. Residents admitted with any skin impairment will have: (a) Appropriate interventions implemented to promote healing, (b) A physician's order for treatment, and (c) Skin impairment location, measurements and characteristics documented. Review of the facility policy/procedure Indwelling urinary catheter (Foley) care and management last reviewed 11/20/24 revealed, .make sure the catheter is secured properly. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Medical device- related pressure injuries (MDRPIs) are injuries that result from the use of devices designed and applied for diagnostic or therapeutic purposes .Pay particular attention to areas located over bony prominence's; next to and around medical devices . Consider adults with medical devices (e.g., tubes, drainage systems, and oxygen devices) to be at risk for pressure injuries. Confirm that devices are not placed directly under an individual who is bedridden or immobile . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pgs. 1247-1260). Elsevier Health Sciences. Kindle Edition. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Early identification of high-risk patients helps prevent pressure injuries . Interventions aimed at prevention include turning and positioning to relieve pressure. Usually the time that a patient sits uninterrupted in a chair is limited to 1 hour. This interval is shortened in patients who are at very high risk for skin breakdown. Reposition patients frequently because uninterrupted pressure causes skin breakdown. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 845). Elsevier Health Sciences. Kindle Edition. 29073 Resident #1 (R1) Review of an Admission Record indicates R1 admitted to the facility with diagnoses that included schizoaffective disorder, muscle weakness, dependence on wheelchair, chronic venous insufficiency, peripheral vascular disease, and cerebral palsy. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R1 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14/15. R1 had Functional Limitation in Range of Motion on one side of the upper extremities and impairment on both lower extremities. R1 needed Substantial/maximal assistance with rolling to the left and right, sitting to lying, lying to sitting and was Dependent-Helper does ALL of the effort. Resident does none of the effort to complete the activity for sitting to standing, chair/bed-to-chair transfer and toileting. Section M - Skin Conditions indicated R1 was at risk of developing pressure ulcers and did not have any pressure ulcers at the time of the assessment. During an interview on 11/19/24 at 2:00 PM, R1 was seated in his wheelchair and reported he had a very sore bottom, and it felt like he sat on a nail. R1 said he would be willing to have his skin observed the next time he got transferred to bed. During an observation and interview on 11/19/24 at 2:19 PM, Certified Nurse Aide (CNA) B and CNA C transferred R1 using a mechanical lift into the bed. CNA B said R1 was last assisted/repositioned prior to lunch at 11:00 AM (three hours prior to the observation). R1's brief was dry, and the resident used the urinal before the CNA's rolled R1 to his right side, exposing his buttocks. Serosanguinous drainage was noted on the brief under R1's right coccygeal area, as well as reddened and blanchable skin. There was no evidence a barrier cream had been applied and CENA B said they would apply A & D ointment because that's all I have. The surveyor requested a nurse observe the wound at this time. During an observation and interview on 11/19/24 at 2:39 PM, the Director of Nursing (DON) assessed the open area and scab on R1's right coccygeal area. The DON verbalized her assessment as blanchable, reddened skin around an open area that measured 2.0 centimeters (cm) x 2.0 cm x 0.1 cm in depth with bloody drainage. The non-blanchable scab measured 0.8 cm x 0.8 cm with no measurable depth. The wound was cleaned with wound cleanser and chalmosyn (a barrier cream) was applied. Review of a Skin & Wound - Total Body Skin assessment dated [DATE] reflected R1's skin was intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a Nurses Notes dated 11/9/24 reflects (R1) has a dark scabbed area on right side of coccyx, approx. (approximately) 2.5 x 1 cm (centimeter). No drng (drainage) noted. (Medical Director) faxed, voice mail left for guardian, DON (Director of Nursing) notified. A corresponding Skin & Wound - Total Body Skin Assessment was not associated with the findings. Review of a Total Body Skin Assessment note dated 11/10/2024 reflected Pt (patient) buttocks red with open area noted to right side. Pt. BLE (bilateral lower extremities) are red/dry no open areas noted. Lotion/creams applied, reposition q (every) 2 hours and PRN. Up in w/c wheelchair for meals. Incont (incontinent) of b&b (bowel and bladder), wears briefs. The documentation did not reflect physician and other notifications had been made, measurements, or wound description had been documented upon discovery of an open area. Review of a Skin & Wound - Total Body Skin assessment dated [DATE] reflected R1 had no new wounds, despite a progress note that indicated R1 had a new open area. Review of a Skin & Wound - Total Body Skin assessment dated [DATE] reflected Enter the # of New Wounds - 6. New Wounds - yes. The form did not indicate the number of new wounds. Review of R1's November 2024 Treatment Administration Record (TAR) reflected Apply chamosyn (a skin protectant ointment that can be used to treat a variety of skin conditions, including diaper rash, minor burns, and cuts) to coccyx BID (twice a day), monitor site until healed two times a day for wound-Start Date-11/10/24-D/C (discontinue) Date-11/13/2024. Another order for the same treatment was initiated on 11/13/24 and changed the time from 8 AM and 8 PM to every day and night shift for skin management. Review of a Care Plan initiated 1/27/2020 reflected R1 was at risk for impaired skin integrity/pressure injury related to diagnoses. The Goal of the care plan focus area was to minimize the risk of developing a pressure injury. Interventions included conduct weekly head to toe skin assessments, document and report abnormal findings to the physician; follow facility policies and protocols for the prevention and treatment of impaired skin integrity; observe skin with showers/cares, notify nurse immediately of any new areas of skin breakdown; refer to treatment POC (plan of care); turn and reposition (R1) every 2 hours and PRN (as needed) as allows. The interventions did not address R1's preference for sitting up in his wheelchair for most of the day and the requirement to offload pressure. Further review of the entire Care Plan did not reflect a focus, goals, or interventions related to R1's actual skin impairment/pressure injury identified on 11/09/2024 and 11/10/2024. During an interview on 11/20/24 at 9:50 AM, the Assistant Director of Nursing (ADON) A reported the open area discovered on R1 was classified as a stage 2 pressure ulcer. ADON A reported R1 has a history of stage 2 pressure ulcers, was incontinent and delusional. ADON A said R1 was not on a toileting schedule to address incontinence and did not like to lie down to relieve pressure. ADON A reported there was not a care plan intervention to off-load pressure while up in the wheelchair.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to intake #MI00148210 Based on interview and record review, the facility failed to provide enhanced supervision and assistance to residents with acute medical changes and significant medication changes, for two of five residents (Resident #32 and Resident #16) reviewed, resulting in a fractured left arm and a brain bleed for Resident #32 and a fractured right arm for Resident #16. Findings: Resident #32 (R32) Review of an Admission Record revealed R32 was an [AGE] year old female, originally admitted to the facility on [DATE], with pertinent diagnosis of seizure disorder, stroke with impaired speech, congestive heart failure, morbid obesity, impaired vision, muscle weakness, and pain in both knees. R32 required staff assistance for ambulation, bathing, and bed mobility (resident required substantial/maximal assistance x 1 to roll side to side, lying to sitting on side of bed, and sitting to lying), getting dressed, using the bathroom, and to transfer in and out of bed. Review of a Care Plan for R32 reflected the following relevant needs and interventions: (A) R32 is at risk for side effects from pain medications, initiated 03/14/24, with the following interventions: (1) monitor for respiratory depression-obtain respiratory rate, depth, and effort after administration of pain medications, (2) observe for altered mental status .dizziness, sedation, (3) observe for increased risk of falls .(B) R32 is at risk for adverse side effects from diuretic therapy for congestive heart failure, initiated 10/21/24, with the following intervention: (1) may cause dizziness, postural hypotension (a drop in blood pressure when changing positions), fatigue, and increased risk for falls .(C) R32 is at risk for falls and fall related injuries due to encephalopathy (any brain disease or disorder that affects the brain's structure or function. It can be caused by a number of things, including injury, disease, drugs, or chemicals. Encephalopathy can be temporary or permanent, and can lead to serious complications), impaired mobility, muscle weakness, heart failure, morbid obesity, seizure disorder, diuretic and opiod (pain medicine) use, initiated 07/14/22, with the following interventions: (1) anticipate and meet needs as needed and complete fall risk per protocol. Review of a Nursing Comprehensive-Quarterly Fall Assessment for R32, dated 10/11/24, reflected that there was No Risk for falls for this resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an Electronic Medication Administration Record (Emar) for R32, dated November 2024, revealed the following medications were prescribed: (a) Phenobarbital 97.2 MG (milligrams) at bedtime for seizure disorder (this medication is a hypnotic and causes sedation), (b) Lasix (a diuretic known to cause dizziness and a drop in blood pressure) 40 MG twice daily for swelling due to congestive heart failure (this is an increase from 20 MG twice daily, made on 11/03/24), and (c) Oxycodone (a powerful opiod pain medication) 10 MG twice daily from 11/1/24 to the morning of 11/5/24 and then doubled to 20 MG twice daily from the evening on 11/5/24 until the time of the fall on 11/11/24, as well as an additional order for Oxycodone 5 MG every 6 hours as needed for breakthrough pain, and (d) Clindamycin (antibiotic) 300 MG every 6 hours for infection for 10 days-start date 11/05/24 (This antibiotic can cause dizziness, fainting, or light headedness when getting up .(Mayo clinic Micromedex US L.P. 1973, [DATE]). The same Emar revealed no orders for staff to monitor and check orthostatic blood pressures (used to assess for a drop in blood pressure with position changes), or to monitor for side effects, including dizziness and sedation, following increased doses of Oxycodone and Lasix and the recent start of Clindamycin. Review of a facility Investigation, completed for an unwitnessed fall sustained by R32 on 11/11/24 at approximately 6 AM, revealed that R32 was found by staff on the floor face down in her room, and had sustained a right sided head injury and complained of left shoulder pain. X-rays completed at the facility showed a left upper arm fracture. Review of the last blood pressure obtained before R32's fall the morning of 11/11/24 was 108/80 (obtained 11/10/24 at 3:43 PM). The last recorded blood pressure for R32 with a systolic blood pressure below 110 was recorded on 02/19/24. Per the EHR (electronic health record), following the lower than usual blood pressure reading of 108/80 on 11/10/24 at 3:43 PM, R32 was administered a dose of Oxycodone 20 MG at bedtime and then another dose of Oxycodone 5 MG at 3:54 AM on 11/11/24. No indication of monitoring for side effects following those two doses of Oxycodone could not be located in the EHR. Review of an EMS (emergency medical services) ambulance run record, dated 11/11/24, revealed the following findings regarding R32: (a) EMS arrived at the facility at 1:34 PM, (b) were advised that an earlier x-ray showed a left arm fracture, (c) noted bruising to R32's right side of her face, and (d) was told by facility staff that the staff believed R32 tried to stand up from the bed and fell . Review of an emergency room Record dated 11/11/24 revealed R32 had sustained an acute intraventricular hemorrhage in the right lateral ventricle (a brain bleed) and confirmed the earlier findings of a fractured left arm. Resident #16 (R16) Review of an Admission Record revealed R16 was a [AGE] year old female, originally admitted to the facility on [DATE] with pertinent diagnoses of muscle weakness, anxiety disorder, developmental disorder, congestive heart failure, and dementia. Review of a Post Fall Evaluation dated 11/13/24 at 10:15 AM showed R16 fell in her room and fractured her right arm. Resident was weak from pneumonia. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an Emar for R16, dated November 2024, revealed the resident was started on Clindamycin (an antibiotic) 300 MG one tab twice daily for pneumonia starting 11/08/24. R16 was also prescribed Invega 3 MG one tab at bedtime and Abilify 15 MG one tab in the morning (both medications are antipsychotic and can cause blurred vision, confusion, sedation, orthostatic hypotension, and restlessness). Review of a task monitoring form for R16, that documented the amount of staff assistance needed to walk to and from the bathroom, revealed that on 11/7/24 through 11/10/24 R16 was independent to ambulate in her room. Documentation from 11/11/24 through the time of the fall on 11/13/24 showed R16 requested staff assistance to ambulate that ranged from partial to moderate assistance needed to complete dependence on staff. Review of a Provider Encounter Progress Note dated 11/11/24 revealed: Nursing called to report (R16) not getting better as expected. Very pale, lethargic, diminished lung sounds, and oxygen saturations were in the 70's (%) range while receiving 5 liters of oxygen. Review of a Fall Risk Care Plan for R16 reflected that no new safety interventions were put in place once the resident was (a) diagnosed with pneumonia, (b) started on an antibiotic, (c) requested staff assistance to ambulate to and from the bathroom, and (d) was reported to be lethargic and not doing better. During an interview on 11/20/24 at 3:48 PM, Certified Nurse Aide (CENA) H stated that after R16 was diagnosed with pneumonia, R16 had not been doing well, was weak, and was unsteady on her feet.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to ensure Medication Regimen Reviews were maintained in the resident's clinical record with documentation of the physician's response for 1 resident (R1) of 5 residents reviewed for medication regimen reviews. Findings include: Resident #1 (R1) Review of an Admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: schizoaffective disorder, psychotic disorder with delusions, and major depressive disorder. Review of R1's Order Summary revealed: QUEtiapine Fumarate (antipsychotic medication) Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth one time a day for Delusions/Hallucinations (Dated 10/23/24) QUEtiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for mood (Dated 6/19/24) VENLAFAXINE HCL ER (antidepressant medication) 37.5 MG CAP{90 EA} Give 1 capsule by mouth in the morning for depression (Dated 5/13/24) VENLAFAXINE HCL ER 75 MG CAP{90 EA} Give 75 mg by mouth in the morning for depression (Dated 6/27/23) Depakote (mood stabilization medication) Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for psychosis with delusions Review of R1's pharmacy Consultation Report dated 3/12/24 revealed, (R1) has orders for labs, but at the time of this review they were not available in the medical record. The missing lab values include: cbc (complete blood count), cmp (comprehensive metabolic panel), HgbA1C (glycohemoglobin) q (every) 3 months (Feb, May, Aug, Nov)-Lipids, hepatic panel, keppra, tsh, free t-4, ammonia & valporic Acid level Q (every) 6 mo (months) (Feb, Aug). Recommendation: Unless otherwise indicated, please ensure that ordered labs are obtained. Please disregard recommendation if these labs have been recently obtained. The consultation report was signed indicating facility staff received/reviewed the recommendations with Nurses please order all tests handwritten on the report. Review of R1's Laboratory Results from March to present revealed that only a BMP (basic metabolic panel) had been obtained/resulted following the pharmacist recommendations (on 3/26/2024, 4/11/2024, 5/15/2024, 7/5/2024, and 7/25/2024) despite R1's dosage increase in venlafaxine in May and quetiapine in June. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Order Summary revealed an order for CBC, CMP, HgbA1c Q-3 mo (Feb, May, Aug, Nov) Lipids, Hepatic Panel, Keppra, TSH, Free T-4, Ammonia & Valporiric (sic) Acid level Q6-mo (Feb, Aug) but was discontinued on 7/20/24. There was no physician rationale for the discontinuation of the labs noted in R1's Electronic Medical Record. Review of R1's Electronic Medical Record (EMR) revealed a monthly Medication Regimen Review (MRR) was completed on 4/15/24, 6/13/24, 8/12/24, and 11/11/24 with noted irregularities and/or recommendations. There were no Consultation Reports available for review in R1's EMR. A request for the pharmacy Consultation Reports/MRRs dated 4/15/24, 6/13/24, 8/12/24, and 11/11/24 were requested on 11/20/24 at 4:11 PM via email and received on 11/21/24 at 12:28 PM. Review of R1's pharmacy Consultation Report dated 4/15/24 revealed, (R1) has orders for labs, but at the time of this review they were not available in the medical record. The missing lab values include: CBC, CMP, HgbA1c Q-3mo (Feb, May, Aug, Nov)-Lipids, Hepatic Panel, Keppra, TSH, Free T-4, Ammonia & Valpoiric (sic) Acid level Q-6 mo (Feb, Aug). Recommendation: Unless otherwise indicated, please ensure that ordered labs are obtained. Please disregard recommendation if these labs have been recently obtained. There was no signature/initials of the provider on the report to indicate they were notified of the recommendations. Review of R1's pharmacy Consultation Report dated 6/13/24 revealed, (R1) has orders for labs, but at the time of this review they were not available in the medical record. The missing lab values include: HgbA1c Q-3mo (Feb, May, Aug, Nov)-Lipids, Hepatic Panel, Keppra, TSH, Free T-4, Ammonia & Valproic Acid level Q-6 mo (Feb, Aug). Recommendation: Unless otherwise indicated, please ensure that ordered labs are obtained. Please disregard recommendation if these labs have been recently obtained. Ok for labs was handwritten on the consultation report indicating the nursing staff were to ensure laboratory testing was completed. Review of R1's EMR revealed the recommended labs were not completed at that time. Review of R1's pharmacy Consultation Report dated 8/12/24 revealed, (R1) has orders for labs, but at the time of this review they were not available in the medical record. The missing lab values include: HgbA1c Q-3mo (Feb, May, Aug, Nov)-Lipids, Hepatic Panel, Keppra, TSH, Free T-4, Ammonia & Valproic Acid level Q-6 mo (Feb, Aug). Recommendation: Unless otherwise indicated, please ensure that ordered labs are obtained. Please disregard recommendation if these labs have been recently obtained. There was no signature/initials of the provider on the report to indicate they were notified of the recommendations. Review of R1's Psychiatric Consultation dated 10/17/24 revealed, Quetiapine 100mg one PO BID (by mouth twice a day) increased 06/19/24 .Start Quetiapine 50mg one PO QD (by mouth every day). Confirming quetiapine was increased on 6/19/24 and again on 10/17/24. Review of R1's pharmacy Consultation Report dated 11/11/24 revealed, (R1) receives Divalproex Sodium DR but does not have a trough concentration documented in the medical record with the previous 6 months. Recommendation: Please monitor a valproic acid trough concentration on the next convenient lab day, 1 week after any dosage changes, every 6 months thereafter, and as clinically indicated. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/21/24 at 12:28 PM, Director of Nursing (DON) confirmed the MMRs dated 4/15/24, 6/13/24, 8/12/24, and 11/11/24 were not in R1's EMR and were obtained from the pharmacy. DON confirmed R1 had not had the recommended laboratory tests completed. DON reported that she was not aware that the laboratory testing was to be ongoing while R1 was on psychotropic medications. DON reported that pharmacy recommendations should be reviewed by the provider once received with documentation by the provider that the recommendations were reviewed/instituted. DON confirmed that there was no documentation/rationale regarding the discontinuation of the routine laboratory tests by the provider or a rationale for why the pharmacist recommendations were not followed/implemented. Review of the FDA prescribing information for Seroquel revealed, Neuroleptic Malignant Syndrome (NMS): Manage with immediate discontinuation and close monitoring (5.4) o Metabolic Changes: Atypical antipsychotics have been associated with metabolic changes. These metabolic changes include hyperglycemia, dyslipidemia, and weight gain (5.5) o Hyperglycemia and Diabetes Mellitus: Monitor patients for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Monitor glucose regularly in patients with diabetes or at risk for diabetes o Dyslipidemia: Undesirable alterations have been observed in patients treated with atypical antipsychotics. Appropriate clinical monitoring is recommended, including fasting blood lipid testing at the beginning of, and periodically, during treatment o Weight Gain: Gain in body weight has been observed; clinical monitoring of weight is recommended o Tardive Dyskinesia: Discontinue if clinically appropriate .Leukopenia, Neutropenia and Agranulocytosis: Monitor complete blood count frequently during the first few months of treatment in patients with a pre-existing low white cell count or a history of leukopenia/neutropenia and discontinue SEROQUEL at the first sign of a decline in WBC in absence of other causative factors .Clinical trials with quetiapine demonstrated dose-related decreases in thyroid hormone levels .both TSH and free T4, in addition to clinical assessment, should be measured at baseline and at follow-up .Nevertheless, the presence of factors that might decrease pharmacokinetic clearance, increase the pharmacodynamic response to SEROQUEL, or cause poorer tolerance or orthostasis, should lead to consideration of a lower starting dose, slower titration, and careful monitoring during the initial dosing period in the elderly. Review of the FDA prescribing information for depakote revealed, .Valproate is metabolized almost entirely by the liver .Adverse reactions that have been reported with all dosage forms of valproate . Thrombocytopenia and inhibition of the secondary phase of platelet aggregation .laboratory test results include increases in serum bilirubin and abnormal changes in other liver function tests. These results may reflect potentially serious hepatotoxicity . Abnormal thyroid function tests . Hyperammonemia, hyponatremia, and inappropriate ADH secretion .Depakote or Depakene may cause other serious side effects including: Low blood count .High ammonia levels .low body temperature . Review of the FDA prescribing information for venlafaxine revealed, .ADVERSE REACTIONS .Abnormal Bleeding .Renal Impairment *Hepatic Impairment .Hyponatremia . Effexor XR was associated with mean final increases in serum cholesterol concentrations . Effexor XR was associated with mean final on-therapy increases in fasting serum triglycerides . SSRIs and SNRIs, including Effexor XR, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event . Venlafaxine is well absorbed and extensively metabolized in the liver . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Psychoactive Medication Management last revised 10/20/23 revealed, Policy-The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as appropriate and safety interventions to minimize the use of psychotropic medications in managing behaviors when non- pharmacological interventions have failed. Overview-Residents receiving psychoactive medications to treat behavioral symptoms are evaluated, monitored, and managed by the interdisciplinary team including, but not limited to, facility clinical staff, practitioner, and a pharmacist. The facility will provide appropriate treatment and services for residents who display or are diagnosed with a mental disorder or psychological adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder (or substance use disorders) .Monitor medication for efficacy, side effects and adverse consequences of the medication. Notify the practitioner of adverse consequences or side effects noted .When evaluating the residents progress, the practitioner reviews the total plan of care, orders, the resident's response to medication(s) and determines whether to continue, modify or stop a medication .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to implement an effective and current system of surveillance for staff illnesses to identify possible communicable diseases and infections to prevent the spread of an illness/outbreak, resulting in the potential for an outbreak to go undetected. Findings: Review of the April 2024 infection surveillance revealed there was no Employee Infection Log completed and no Infection Prevention Committee Meeting notes. Review of the May 2024 infection surveillance revealed there was no Employee Infection Log completed and no Infection Prevention Committee Meeting notes. Review of the June 2024 infection surveillance revealed there was no Employee Infection Log completed and no Infection Prevention Committee Meeting notes. Review of the July 2024 infection surveillance revealed there was no Employee Infection Log completed. Review of the Infection Prevention Committee Meeting notes dated August 2024 revealed, Review of data for Month/Year July 2024 .6. Employee health-employee outbreaks, exposures to blood and body fluids or communicable diseases was left blank. Review of the November 2024 Staff Case List (employee illness tracking) revealed 6 staff members were listed: On 11/5/24 a staff member was documented to have a Bacterial infection with a status of Resolved. The unit the staff member worked, residents that they came into contact with, the date last worked, the date the infection resolved, and the date they returned to work was not listed. On 11/11/24 a staff member was listed with no Infection Type with a status of Resolved. The symptoms, the unit the staff member worked, residents that they came into contact with, the date last worked, the date the infection resolved, and the date they returned to work was not listed. On 11/15/24 a staff member was listed with no Infection Type with a status of Resolved. The symptoms, the unit the staff member worked, residents that they came into contact with, the date last worked, the date the infection resolved, and the date they returned to work was not listed. On 11/15/24 a staff member was listed with no Infection Type with a status of Resolved. The symptoms, the unit the staff member worked, residents that they came into contact with, the date last worked, the date the infection resolved, and the date they returned to work was not listed. Resident #23 (R23) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an Admission Record revealed R23 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and schizophrenia. R23 had been diagnosed with a UTI in the Emergency Department and discharged with an antibiotic. Review of the August and September 2024 Infection Surveillance Monthly Report revealed R23 was not listed. Additionally, R23's laboratory documentation revealed, mixed flora. No Significant pathogens isolated and therefore no culture and sensitivity testing was completed. R23's symptoms, onset of symptoms, laboratory results/confirmed diagnosis, and antibiotic use was not included for the purpose of tracking and trending infections. During an interview on 11/21/2024 at 8:32 AM, Infection Control Preventionist (ICP) A reported that she was not the active ICP from April-July and could not speak to why employee infection surveillance had not been completed. ICP reported the employee illness/call-offs should be tracked in real time to prevent the spread of an infection/outbreak. ICP A confirmed there was no Employee Infection Log completed from April-July 2024. ICP A reported that residents prescribed an antibiotic are included on the Infection Surveillance Monthly Report however, residents with symptoms of infection but do not get prescribed antibiotics are not included. ICP A reported that identified residents that may have infection by reviewing daily charting notes completed by the floor nurses, reviews the dashboard in the Electronic Health System, and reviews the staff/provider chat system. ICP A reported the expectation was for the floor nurses to document signs/symptoms of infection and report those symptoms to the management team. During an interview on 11/21/24 at 12:15 PM, Director of Nursing (DON) and ICP A reported that residents exhibiting symptoms of an infection are not listed on the Infection Surveillance Monthly Report but instead are tracked using a Resident at Risk list and discussed weekly in the Resident at Risk Meeting. Residents ordered antibiotics were to be listed on the Infection Surveillance Monthly Report. Review of the facility policy Infection Prevention Program Overview last revised 10/11/23 revealed, INFECTION PREVENTION PROGRAM-MISSION OF PROGRAM- The facility establishes a program under which it: Investigates, identifies, prevents, reports and controls infections and communicable disease for all residents, staff, contractors, consultants, volunteers, visitors and others who provided care and services to the residents on behalf of the facility, and students in the facility's nurse aide training program or from affiliated academic institutions . The major activities of the program are: A. Surveillance of infections with implementation of control measures and prevention of infections * There is on-going monitoring to identify possible communicable diseases or infections among guests/residents and personnel and subsequent documentation of infections that occur. *Preventing the spread of infections is accomplished by use of standard precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness. *Staff and guest/resident education will focus on risk of infection and practices to decrease the risk. B. Outbreak Investigation *Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks . DIVISION OF RESPONSIBILITIES FOR INFECTION PREVENTION ACTIVITIES . (continued on next page)

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	235513	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels of Fulton,the	4735 Ranger Rd Perrinton, MI 48871

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A. Infection Preventionist (IP) *The IP serves as the coordinator of an Infection Control program. The designated IP should have primary training in either nursing, medical technology, microbiology, or epidemiology or other related field and must possess additional training in infection prevention and control. *Responsibilities may include: *Collecting, analyzing, and providing infection data and trends to nursing staff and healthcare practitioners *Consulting on infection risk assessment, prevention, and control strategies *Providing education and training; Implementing evidence based infection control practices including those mandated by regulatory and licensing agencies . REPORTING MECHANISMS FOR INFECTION PREVENTION A. Resident infection cases are monitored by the IP (Infection Preventionist). The IP completes the Infection Surveillance Tracking Tool in InfectionWatch and: 1. Reports to the Infection Prevention Committee 2. Provides feedback to staff as needed. 3. Reports notifiable disease to the local health department as directed. B. Employee infections are reported by the employee to his/her supervisor then to the IP. The IP enters the employee infection data into InfectionWatch and reports to the: 1. Infection Prevention Committee monthly 2. The QAPI Committee on a quarterly or more often as needed. C. Compliance with Infection Prevention practice is monitored and documented by the IP through surveillance and observation .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to 1.) implement and operationalize an antibiotic stewardship program and 2.) ensure accurate monitoring and documentation of infections for 3 residents (Resident #23, #30, and #192) out of 6 residents reviewed for antibiotic use and treatment. Findings: Resident #23 (R23) Review of an Admission Record revealed R23 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: dementia and schizophrenia. R23 had been diagnosed with a UTI in the Emergency Department and discharged with an antibiotic. Review of R23's provider Progress Note dated 8/29/24 revealed, .Per nursing report, patient wandering into other patients rooms and grabbing things and putting in mouth .Patient incont (incontinent) now and not attending to self care needs. Recent Ua negative . There were no additional genitourinary symptoms and/or infectious process symptoms documented prior to the start of the antibiotic. Review of R23's Nurses Note dated 8/29/2024 revealed, res (resident) returned back from ER with DX (diagnosis) of UTI order to start macrobid in AM X 5 DAYS came back at approx 1645 (4:45 PM). There was not documentation that the provider was notified of the order for the antibiotic, that McGeer Criteria was initiated/followed, or that the culture result was reviewed on 8/30/24. Review of R23's Order Summary dated 8/29/24 revealed, Nitrofurantoin Macrocrystal Oral Capsule 100 MG Give 1 capsule by mouth two times a day until 09/04/2024. Review of R23's Microbiology Report dated 8/30/24 revealed, mixed flora. No Significant pathogens isolated and therefore no culture and sensitivity testing was completed. The report was signed by the provider on 9/5/24 following the completion of the antibiotic. Review of R23's Electronic Medical Record revealed no documentation of UTI symptoms, onset of symptoms, McGeer Criteria, or a rationale for the use of the antibiotic prescribed in the Emergency Department. Resident #30 (R30) Review of an Admission Record revealed R30 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: overactive bladder and multiple sclerosis. Review of R30's Nurses Note dated 8/13/2024 revealed, Resident brief is soaked with blood and numerous blood clots in brief. Abdomen is nondistended, painful when palpated .order for resident to be sent to ER. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R30's provider Progress Note dated 8/13/2024 revealed, Patient with large vaginal bleeding and clots that persisted for > 6 hours. Also with low abdominal pain. Patient sent to ER for further evaluation. Review of R30's Electronic Medical Record revealed no documentation McGeer Criteria or a rationale for the use of the antibiotic prescribed in the Emergency Department prior to culture results. Review of R30's Nurses Note dated 8/14/2024 revealed, .denies pain with no noted blood in urine. Started on antibiotic for UTI, receiving Keflex 500mg BID (twice a day) . Review of R30's Nurses Note dated 8/16/2024 revealed, Resident began Augmentin today r/t (related to) treatment-resistant infection Review of R30's Nurses Note dated 8/16/2024 revealed, Husband notified of new antibiotic order d/t resistance of previous ATB. Review of R30's Order Summary 8/13/24 revealed Keflex Oral Capsule 500 MG (Cephalexin) Give 1 capsule by mouth two times a day for infection for 10 Days. Review of R30's Order Summary 8/13/24 revealed Keflex Oral Capsule 500 MG (Cephalexin) Give 1 capsule by mouth two times a day for Cystitis until 8/23/24. Review of R30's Microbiology Report dated 8/15/24 revealed the bacteria from R30's urine was resistant to Keflex. Review of R30's Medication Administration Record revealed R30 received 6 doses of Keflex from 8/13/24-8/16/24 prior to the start of a susceptible antibiotic. Resident #192 (R192) Review of an Admission Record revealed R192 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: lupus and history of kidney stones. Review of R192's Nurses Note dated 9/8/2024 revealed, Resident out via EMS d/t (due to) c/o (complaints of) pain 9/10 Rt (right) flank area, states it is kidney stones as she has experienced before. VSS (vital signs stable) .UA (urinalysis) from yesterday not returned yet. Provider notified, order obtained to send to ER. Review of R192's Nurses Note dated 9/8/2024 revealed, Returned from ER, CT neg for kidney stones, UA pos for UTI with Cipro started. Resident restinq (sic) quietly at this time, states pain 5/10. Provider notified. Review of R192's Electronic Medical Record revealed no documentation McGeer Criteria or a rationale for the use of the antibiotic prescribed in the Emergency Department prior to culture results. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R192's provider Progress Note dated 9/8/2024 revealed, .Notified by nursing that resident was sent to ER per her request d/t c/o intolerable flank pain, hx (history) of kidney stones. Nurse later updated that pt was sent back, no kidney stones, but + UTI, was started on Cipro .no previous u/A Cx (urinalysis/culture) available. Macrobid BID x 5 days ordered. Nurse to follow up on cx results . Review of R192's Nurses Note dated 9/8/2024 revealed, Macrobid ordered, awaiting urine c/s (culture and sensitivity) result. Review of R192's Microbiology Report dated 8/15/24 revealed the bacteria from R192's urine was resistant to Macrobid. Review of R192's Order Summary dated 9/8/24 revealed, Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth every 12 hours for UTI for 5 Days. Review of R192's Medication Administration Record revealed R192 received 4 doses of Macrobid from 9/8/24-9/10/24 prior to the start of a susceptible antibiotic. During an interview on 11/21/2024 at 8:32 AM, Infection Control Preventionist (ICP) A reported that the facility utilizes the McGeer Criteria for antibiotic stewardship. ICP A reported that if a resident is started on an antibiotic for a UTI while in the Emergency Department, follow up calls are made to ensure a copy of the culture and sensitivity are obtained and the appropriate antibiotic is ordered. ICP A reported that antibiotics are not initiated prior to the culture and sensitivity reports unless a rationale/risk vs benefit is completed by the provider. During an interview on 11/21/24 at 12:15 PM, Director of Nursing (DON) and ICP A reported that residents were often discharged from the emergency room with a diagnosis of a UTI and an order for antibiotics. DON reported that management nurses needed to ensure cultures were followed up on in a timely manner and appropriate antibiotics were administered. ICP A reported that residents exhibiting symptoms of an infection are not listed on the Infection Surveillance Monthly Report but instead are tracked using a Resident at Risk list. ICP A reported that McGeer Criteria was used for antibiotic stewardship as a guideline but was not completed in the Electronic Medical Record. ICP A reported licensed nurses and providers are expected to follow McGeer Criteria. ICP A reported if a resident triggers for symptoms of infection nurses are expected to document the progression of the symptoms in order for management to follow up daily and review at the weekly Resident at Risk meeting. DON reported that R23 had new mental status changes, was newly incontinent, and was not eating well which was why she was sent to the emergency department and the antibiotic was continued upon her return. DON and ICP A confirmed that R23, R30, and R192's symptoms were not documented in the Electronic Health Record and agreed that the symptoms documented did not meet McGeer Criteria. On 11/21/24 at 9:17 AM a request for R23, R30, and R192's McGeer Criteria documentation, risk versus benefit and/or provider rationale for the initiation of antibiotics prior to culture results was requested via email. No supporting documentation was received prior to survey exit. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Infection Control Antibiotic Stewardship & MDROs (Multi Drug Resistant Organisms) last revised 9/9/22 revealed, .2. The medical director and director of nursing will use his/her influence as medical and nursing leaders to help ensure antibiotics are prescribed only when appropriate. 3. The infection preventionist will be responsible for promoting and overseeing antibiotic stewardship activities in the facility. Responsibilities include educating employees about the importance of antibiotic stewardship, and adhering to programs that prevent the spread of infection and improve antibiotic use .9. Healthcare acquired (nosocomial) infections and use of antimicrobial agents will be tracked and trended. Infection surveillance and trending of infections will be a key component of our QAPI process. The facility has adopted the McGeer's criteria for infection surveillance definitions. 10. The facility will communicate with the physician based on guest/resident history, evaluation, signs and symptoms, and diagnostic tests if applicable of suspected guest/resident infections to determine the best course of treatment. 11. Laboratory and diagnostic testing will be used judiciously. Positive urine tests do not always warrant an additional culture and sensitivity in the absence of clinical signs and symptoms of infection. When a culture is positive, antibiograms and lab results will be utilized to help prescribers select the best antibiotic for each guest/resident based on the guidelines for prescribing protocols. 12. When antibiotics are prescribed, compliance with dosing is essential. Guests/residents should be educated to take the full dose for the period of time prescribed by the physician. Licensed nurses will monitor for possible side effects of prescribed antibiotics . Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, .resistance to key antibiotics are becoming more common in all health care settings .The increased resistance is associated with the frequent and sometimes inappropriate use of antibiotics over the years in all settings (i.e., acute care, ambulatory care, clinics, and long-term care) .A culture result may show growth of an organism in the absence of infection. For example, in the older adult bacterial growth in urine without clinical symptoms does not always indicate the presence of a UTI .Many laboratory studies are often necessary when a patient is suspected of having an infectious or communicable disease (Box 28.14). You collect body fluids and secretions suspected of containing infectious organisms for culture and sensitivity tests. After a specimen is sent to a laboratory, the laboratory technologist identifies the microorganisms growing in the culture. Additional test results indicate the antibiotics to which the organisms are resistant or sensitive. Sensitivity reports determine which antibiotics used in treatment are effective and need to be ordered for treatment. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (pgs. 425-443). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, UTIs are characterized by location (i.e., upper urinary tract [kidney] or lower urinary tract [bladder, urethra]) and have signs and symptoms of infection. Bacteriuria, or bacteria in the urine, does not always mean that there is a UTI. In the absence of symptoms, the presence of bacteria in the urine as found on a urine culture is called asymptomatic bacteriuria and is not considered an infection and should not be treated with antibiotics. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1152). Elsevier Health Sciences. Kindle Edition.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26222 Based on observation, interview, and record review, the facility failed to ensure that residents' rooms (#' 1) had the required square footage, resulting in the potential for resident discomfort and crowding. Findings include: On 11/18/24 at 10:00 AM, resident room [ROOM NUMBER] (single occupancy, 100 square feet required) was measured to be 9 feet 6 inches by ten feet three inches, totaling 97 square feet. Interview with the Maintenance Director at this time revealed that there had been no changes to room size or configuration. Review of the room sheets confirmed the measurements and bed occupancy. There were no negative outcomes for the resident identified residing in room [ROOM NUMBER].