STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235532	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31197 Based on observation, interview, and record review, the facility failed to ensure a clean environment for 1 Resident #29 (R29) of 14 residents reviewed for clean environment, resulting in a consistent offensive odor coming from R29's bathroom. Findings include: R29 Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R29 was admitted to the facility on [DATE], with diagnosis of (but not limited to) Dementia (short and long-term memory impairment). Brief Interview for Mental Status (BIMS) reflected a score of 0 out of 15 which represented R29 had severe cognitive impairment. R29 required the assistance of 1 staff member with all activities of daily living. R29 was unable to answer questions related to the offensive odor and therefore the reasonable person will be applied to this concern. During the initial tour of the facility on 7/29/24 at approximately 10:10 AM there was a strong urine smell coming from room [ROOM NUMBER] that was more noticeable in the bathroom. During a subsequent observation and interview on 7/29/24 at approximately 12:30 PM, Certified Nurse Assistant (CNA) H was outside room [ROOM NUMBER] and was asked to observe the room and bathroom with this Surveyor. CNA H stated she could smell a strong urine odor and stated R29 often takes himself to the bathroom and misses. CNA H stated the staff routinely check it and clean the floor. CNA H stated the facility has tried everything to get the odor out but it persists. During an interview and observation on 7/31/24 at approximately 8:00 AM, CNA C was near room [ROOM NUMBER]. When asked about the odor, CNA C stated the odor is always there and worse in the bathroom. During an interview on 7/31/24 at 9:15 AM, the Nursing Home Administrator (NHA) stated the odor is coming from the bathroom in room [ROOM NUMBER]. The NHA verbalized a new plan to remove the tile flooring, reseal the toilet stool, and potentially an air purifier to eliminate the odor. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	39083 On 7/30/24 at 2:51 PM, during environmental tour, assisted by Maintenance Director P, a strong urine smell was observed in room [ROOM NUMBER]. Maintenance Director P confirmed the presence of a strong urine smell. The floor at the toilet area, in the bathroom of room [ROOM NUMBER], was observed to be wet with potential urine. The caulking around the toilet was observed to be worn, allowing for penetration of urine into the gaps around the toilet. Maintenance stated that the wax ring might be bad and he could replace it, and also look under the toilet for an opportunity to clean that area.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to maintain an accurate health record for 1 resident (Resident #33) of 14 residents reviewed for accuracy of medical records, resulting in unclear documentation and the potential for miscommunication and an unclear picture of the resident's health care status. Findings include: Resident #33 Review of an Admission Record revealed Resident #33 admitted to the facility on [DATE] with pertinent diagnoses which included legal blindness and obstructive and reflux uropathy. Review of Resident #33's physician communication form, dated 7/22/2024, revealed .Concerns: Resident only wants to see doctor about his pain (with) foley catheter (and) red collection drainage . Doctor Recommendation: Do (urinalysis) please . Review of Resident #33's nursing Progress Note, dated 7/23/2024 at 11:04 AM, revealed Registered Nurse (RN) A notified the physician of Resident #33's complaint of pain around his catheter site and bloody urine and received a physician order for a urinalysis with culture and sensitivity if indicated. Further review of the electronic medical record revealed no documentation of a urine sample being collected and no further documentation regarding this physician order. In an interview on 7/30/2024 at 11:15 AM, RN A reported she did not remember how she found out about Resident #33's catheter pain and discolored urine complaint. RN A reported she did not know whether Resident #33's ordered urine sample was collected and sent to the lab. RN A reported the Director of Nursing (DON) followed up with this situation. In an interview on 7/30/2024 at 11:20 AM, the DON reported she spoke to Medical Director J regarding Resident #33's order for a urinalysis with culture and sensitivity if indicated and they determined Resident #33 did not meet criteria for urine testing. The DON reported she did not document this conversation with Medical Director J in the medical record and should have. Review of facility policy/procedure Documentation in Medical Record, reviewed 2/23/2024, revealed .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care .

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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** 45410 Based on observation, interview, and record review, the facility failed to: 1) ensure proper posting of Enhanced Barrier Precaution (EBP) and Transmission Based Precaution (TBP) signage, 2) ensure proper use of Personal Protective Equipment (PPE), and 3) ensure prevention of contamination of treatment supplies and the treatment cart for 2 residents (Resident #33 and #394) of 3 residents reviewed for Transmission Based Precautions, resulting in the increased potential for cross-contamination, bacterial harborage and spread of infection throughout the facility. Findings include: Resident #33 Review of an Admission Record revealed Resident #33 admitted to the facility on [DATE] with pertinent diagnoses which included legal blindness and obstructive and reflux uropathy. Review of Resident #33's Physician's Orders, dated 4/12/2024, revealed an active order for EBP's. Review of a current EBP Care Plan problem/approach for Resident #33, edited 5/2/2024, directed staff to use gloves and a gown with urostomy/Foley care. In an observation on 7/29/2024 at 10:03 AM, Resident #33's door had no EBP or PPE instruction signage. In an interview on 7/29/2024 at 10:10 AM, Certified Nursing Assistant (CNA) E reported Resident #33 did not require any type of TBP's or EBP's. In an observation on 7/30/2024 at 2:47 PM in Resident #33's room, Licensed Practical Nurse (LPN) B changed Resident #33's urostomy dressing and completed catheter care without donning a gown. After catheter care was completed, LPN B used her contaminated gloves to carry the bottle of wound cleanser to Resident #33's bathroom. After washing her hands, LPN B carried the contaminated wound cleanser out of Resident #33's room and placed it back into the treatment cart near the nursing station. In an interview on 7/30/2024 at 3:00 PM, LPN B reported she had not been using a gown during Resident #33's catheter care and should have as he is in Enhanced Barrier Precautions because of his urinary catheter. In an interview on 7/29/2024 at 12:50 PM, the Director of Nursing (DON) reported Resident #33 had recently moved rooms and staff must have forgotten to move the signage for EBP's to his new door. Review of facility policy/procedure Enhanced Barrier Precautions, reviewed 4/17/2024, revealed .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms . An order for enhanced barrier precautions will be obtained for residents with any of the following . urinary catheters . Resident #394 (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 an Admission Record revealed Resident #394 admitted to the facility on [DATE] with pertinent diagnoses which included post procedural complications and neoplasm of the pancreas. Review of a current COVID 19 Care Plan intervention for Resident #394, created 7/29/2024, revealed . maintain isolation of resident . Review of Resident #394's Physician's Orders, started 7/31/2024, revealed Resident #394 was on TBP's. Review of Resident #394's Progress Notes, dated 7/28/2024 at 8:27 PM, revealed Resident #394 tested positive for COVID and was placed into isolation. In an observation and interview on 7/29/2024 at 9:49 AM, Resident #394's door was open and there was no signage for TBP's or instructions for use of PPE. Resident #394 reported she had tested positive for COVID the previous evening and I would have to wear a mask to enter the room. In an observation and interview on 7/29/2024 at 10:13 AM, Occupational Therapist (OT) K was donning PPE prior to entering Resident #394's room. OT K reported she was not aware Resident #394 had COVID until Resident #394 told her this a few minutes ago. There was no signage on Resident #394's door regarding TBP's or PPE requirements. In an observation and interview on 7/29/2024 at 10:17 AM, LPN B reported Resident #394 was on TBP's for COVID that was diagnosed the previous evening. There was no signage on Resident #394's door regarding TBP's or PPE requirements. In an interview on 7/29/2024 at 12:50 PM, the Director of Nursing (DON) reported Resident #394 tested positive for COVID the previous evening and nursing staff should have immediately placed signage for contact and droplet precautions on her door. Review of facility policy/procedure Transmission-Based (Isolation) Precautions, reviewed 2/24/2024, revealed .Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room, wing, or facility-wide. Additionally, either the (Center for Disease Control) category of transmission-based precautions . or instructions to see the nurse before entering will be included in the signage . Review of the Center for Disease Control Long-term Care Facilities Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/2024, revealed .28 . Does posting signs specifying the type of precautions and recommended PPE outside the resident room violate Health Insurance Portability and Accountability Act (HIPAA) and resident dignity? . No. Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the resident. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident .