STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235536	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Care of Battle Creek	675 Wagner Drive Battle Creek, MI 49017

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 0600 Level of Harm - 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** This citation pertains to MI00149061 and MI00151480 Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from abuse for three of nine residents reviewed, resulting in resident-to-resident physical abuse, bruising for R11, bruising and bleeding for R12, and a head laceration requiring sutures and hospital admission for R17. Findings include: Review of the facility reported incident (involving R11 and R12) revealed on [DATE] While these residents were playing bingo, (R11) attacked (R12). R11 wheeled his wheelchair behind R12 and then started hitting him and biting him. R12 did not retaliate and was hit twice and bit twice. The second bite was enough to leave teeth marks . Review of the second facility reported incident (involving R11 and R12) revealed on [DATE], Resident (R12) was using the phone in the front lobby when resident (R11) wheeled behind him and tried to take the phone from him. (R12) started hitting (R11) and (R11) was hitting back ., another resident witnessed the altercation and called for help. A nurse responded and separated the residents. The witness acknowledged that both residents made contact with each other. It should be noted that the facility initially provided information related to the [DATE] incident. R11 Review of the medical record revealed Resident #11 (R11) was admitted to the facility on [DATE] with diagnoses that included hemiplegia, vascular dementia and generalized anxiety disorder. The Minimum Data Set (MDS) with an Assessment date (ARD) of [DATE] revealed R11 scored 12 out of 15 (mildly impaired cognition) on the Brief Interview for Mental Status (BIMS). Review of R11's progress notes revealed: [DATE] Resident hitting head on wall while cares being provided. Unable to redirect behavior. [DATE] I spoke with resident's guardian today regarding sending resident's referral somewhere that would be more suitable for behaviors. Guardian would like us to follow psych recommendations first and see if there is any improvement. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[DATE] Resident hitting and kicking at staff AM, grabbing and pulling at TV cord trying to pull from wall. [DATE] Social work met with resident in their room to discuss code status directive. Resident refused to sign upon getting very agitated, after her verbally sated that he wanted to be a full code. Resident jammed the pen into the paper which was clipped to a clip board and smacked the wall. [DATE] Resident pushed lunch tray off of table onto floor. Resident agitated with staff as they try to provide ADL care. [DATE] This writer returned from lunch to the news that (R11 and R12) got into another fight, This nurse spoke with (R11), who reported that (R12) was blocking the hallway. When (R11) tried to pass (R12), (R12) struck (R11) in the face. Resident assessed for injuries. Resident has a small scratch, 0.7cm long by 0.1 cm wide, over his left eye. Resident denies pain. [DATE] Resident has gone to a psych facility. Resident agreed to leave willingly . [DATE] Spoke with patients guardian rt patients increase of behaviors. SW (social worker) told guardian that patient has been becoming increasingly aggressive with staff and with other residents and facility recommends referral to inpatient psych. Guardian is agreeable to this . [DATE] writer observed res hit a picture with a glass pane in the hallway of south unit. R (right) hand ring finger (4th digit) has a small ST approx. 1cmx0.1cm . [DATE] Late Entry (R11) was in his wheelchair heading into the lobby to use the resident phone, which was in use by another resident. (R11) attempted to grab the phone from the other resident and then other resident began hitting (R11) to the left side of the face. Residents were immediately separated and safe. (R11) denied pain and was offered an ice pack for his left side of face, noted discoloration and swelling seen instantly after incident. [DATE] res (resident) cont. (continue) on 15min checks . [DATE] res cont on 15min checks . [DATE] res cont on 15min checks . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[DATE] At approximately 1420, the resident was noted in the dining room with activities running bingo. This nurse was alerted of an incident between this resident and another resident. Apparently, this resident was self-propelling around the table while the other residents were playing bingo when he went past another resident and per the activity's aide, this resident started to bite another resident. Per the activities staff, the other resident did not react to this resident, however it was noted that this resident did have scratches on his face and neck and a red mark on his nose. Per activity's aide this resident bit the other resident on the right shoulder and the right hand. A skin assessment was completed on this resident, and it was noted that this resident had red scratch marks in linear shape on both sides of his neck as well as linear shape scratch on the outer side of his right eye. Resident also noted to have a red spot on the end of his nose. Resident noted to remain with full function at this time and reports no pain. Resident states to this nurse that he did hit and bite the other resident, but the other resident hit him as well. The resident apologized to this nurse for fighting with the other resident. The resident is reminded that it is inappropriate to fight with other residents. Resident voiced understanding. Residents separated from each other by staff at the scene . [DATE] Resident noted to refuse to get out of bed this AM. Resident stated later. Resident then proceeded to yell out nurse several times. When entering the resident room, resident stated that he needed a hospital gown. When resident was given a gown, resident did not want this gown. Resident was then noted to call out nurse again down the hallway and kick over his bed side tray table. When this nurse entered the room, the resident stated that he needed a hospital wheelchair. This nurse asked him if he was ready to get out of bed. The resident stated that he was not ready to get out of bed yet. This nurse showed the resident that he had a w/c (wheelchair) in his room. The resident voiced understanding. All needs are noted to be met at this time. Will continue to monitor for behaviors throughout the shift and document as necessary. [DATE] Pt (patient) has been very behavioral tonight. Pt yelled for his meds shortly after the shift started. Administered medication and a pain pill. After 30 minutes was on the side of the bed yelling again for a staff member from first shift that had gone home. Pt was asked by staff could she help him pt ignored her. This writer moved cart so could make sure pt was not going to fall to the floor. Pt tried to move forward so the left side of the mattress was starting to life up. Staff repositioned pt on the mattress. Pt stopped trying to slide out of the bed. However pt started banging on the wall with hand inside the blanket and bothering the next door pt from his sleep. Pt slept well after that until he asked for something for pain again. Pt did state that he was sorry. On [DATE] at 1:24 PM, R11 was observed lying on his back in his bed. Strong smell of urine noted. Resident was covered with 2 blue pads. When asked if he could tell me anything about incidents were he had been physically touched or been touched by another resident he replied yes but did not offer any additional information. When asked a second time he began to stutter well, well, well and stated that she got fresh and so all I did was hang onto her finger. He reported that incident was with a staff member and could not recall any incidents with other residents then thanked me followed by good bye. R12 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed Resident 12 (R12) was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia, major depressive disorder and generalized anxiety disorder. The Minimum Data Set (MDS) with an Assessment date (ARD) of [DATE] revealed R12 scored 7 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). A review of R12's progress notes revealed: [DATE] Resident in room (redacted) struck resident in the doorway of room (redacted), resident separated. Resident in room (redacted) then began striking the nurse and they fell to floor, resident did not hit his head. Resident continued yelling at nurse, vital signs 97.1, 107/68, 64, 92% r/a (room air), resp (respirations) 17. Resident had no signs of injuries noted. No signs and symptoms of pain or discomfort. [DATE] This writer and the north unit manager were in the south nurses station attempting to do report when we heard this resident yelling in the hallway on Boardwalk. After a few minutes of this, we began to hear two voices shouting. This writer turned to look and saw that this resident from room (redacted) and the resident from room (redacted) (R12 and R17) had their hands on each, and were shouting at each other. This writer walked down the hall to intervene. The resident in room (redacted) (R17) fell and hit his head, which began to bleed. This writer tried to get this resident to sit down in his wheelchair, but he pulled this writer back with him, and we both tipped over backward and ended up on the floor. This resident began to hit this writer about the head and face, causing quite a lot of bleeding. This writer was finally able to get away from this resident. [DATE] This writer returned from lunch to the news that (R11) and (R12) got into another fight. This nurse spoke with (R11), who reported that (R12) was blocking the hallway. When (R11) tried to pass (R12) struck (R11) in the face. Resident was assessed for injuries. None were found. Resident denied pain. [DATE] Resident up in W/C (wheelchair) at start of shift asking for ride home, he was tearful when staff was unable to given rides . [DATE] Resident up during night asking staff to give him a ride home. No other behaviors noted this shift . [DATE] Guest called 911 yesterday evening from phone in lobby, stating that there were no nurses or staff and the building was abandoned. At that time there were 3 nurses and 3 CNAs (certified nursing assistants) on unit. Guest was reassured that staff were available to help at all times and was assisted back to room. Guest later accused nurses of sneaking pills to him. Guest reassured that he could take or not take meds as he wished . [DATE] In evening guest was noted wandering in halls, asking staff if they could give him a ride home. Explained to guest that he would need to be discharged by doctor before he could leave d/t (due to) memory issues and needing help with med administration. Reassured guest that his family knows they are here and will be in touch soon. No episodes of aggression or attempts at egress. Cont (continue) on 15 min checks . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[DATE] resident pulled fire alarm at front door. Writer asked resident why he would pull alarm. He stated he was going to continue pulling them until someone stops stealing all of his tools. Resident not easily redirected. [DATE] Resident hollering out this noc (night). When this nurse entered room to ask if he was in pain. He said No, I want my mom and dad. Will continue to monitor. [DATE] Before dinner, resident was out in hallway in his wheelchair and began repeatedly asking when he is going home. This nurse and other staff attempted to redirect the resident, but he became verbally aggressive and began moving toward the direction of room (redacted), whose occupant was shouting and cursing. This resident was redirected away from the direction of (redacted), and eventually settled down. [DATE] Resident returned to facility at approx. 2130, resident was tearful for short period, no aggression noted. Placed on 15 min checks . [DATE] (R12) has again had a physical interaction with a nurse and another resident causing physical harm. He is not able to be redirected, and this incident was not provoked. He sought out someone to harm. I have attempted to contact (redacted) inpatient psych. I spoke with nursing, (name redacted) she stated we are not taking him back, we are not a long-term care you are 911 called due to physical assault that he did to a nurse and another resident. [DATE] We reciaved (sp) a call from (name redacted) transportation company that R12 became physically aggressive on the way from inpatient psych returning to Pinnacle. To ensure (R12) and the driver's safety the driver pulled into the first business parking lot and called his base for assistance. Another driver came to the location, loaded R12 into his vehicle without incident and returned him to Pinnacle. DON (director of nursing) met with owner of (redacted name of transportation company) to discuss the situation. R12 was never left unattended or in an unsafe situation. (name of neuropsych group redacted) was called regarding the event, and they agreed to have R12 transported back to inpatient psych due to this recent escalation .R12 will be returning on the original petition and certification . [DATE] Social Service Director has been attempting to reach guardian via phone for the majority of the day to discuss the influx of more aggressive behaviors and R12 seeking out other residents and physically attacking them . [DATE] Follow up skin assessment following another resident-to-resident right middle finger at the first joint is bruised as it was Friday after the first resident-to-resident. The bruising in no larger, not swollen, and just slightly darker than Friday. R12 denies pain. [DATE] per witness statements: R12 was using the resident phone when another resident attempted to grab the phone from R12. R12 began hitting the other resident in the left side of the face, staff intervened instantly and ensure their safety, incident was witnessed by other residents that were in the lobby. [DATE] It was reported to writer by staff that this resident reached back hitting another resident and staff heard a smack. Staff separated both residents safely. Small bruises noted to back of right hand, denies pain . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	[DATE] res cont (resident continues) on 15 min checks . [DATE] res cont on 15 min checks . [DATE] res cont on 15 min checks . [DATE] res cont on 15 min checks . [DATE] Cont on 15 min checks [DATE] Resident is also noted to have two linear scratches to the right side of his mouth were he says that the other resident punch him (R12). [DATE] At approximately 1420, the resident was noted to be in the dining room playing bingo with activities. This nurse was alerted of an incident between this resident and another resident. Apparently, this resident was sitting at the table playing bingo when another resident was self-propelling around the dining room. Per the activities staff, the other resident was going past this resident when all of the sudden the other resident started to bite this resident. Once in the back of the right shoulder and once in the right hand. This resident was not noted to retaliate. A skin assessment was completed on this resident, and it was noted that this resident had red marks in a circular shape both on the back of his right shoulder between the top of his shoulder and his scapula as well as the third knuckle on his right hand . [DATE] Resident noted to be up this AM roam(ing) about the facility. Resident noted to yell at staff as well as pick up staff material from the front desk and carry them around the facility. This nurse had a chat with the resident about appropriate behavior and not getting into things that don't belong to him . [DATE] .Resident was noted to yell at staff this AM . [DATE] Resident noted to be yelling this AM. Yelling in hallway, yelling at kitchen staff for pushing carts down the hallway. Resident also noted to be inappropriate with staff, hitting staff rear end, etc . [DATE] Resident noted to be upset this AM. Resident noted to be questioning why he is here this AM . Resident noted to be swearing and yelling about why he is here and why we are holding him here, how he got here and where he is . [DATE] Up in wheelchair, alert x2 .Yelling and fussing about neighbor's radio. Staff intervened and turned down radio. Reminding patient not to enter anyone else's room. Patient eventually retreating to his own room and remained there quietly. On [DATE] at [DATE] at 1:24 PM, R11 was observed lying in his bed, covered with 2 blue pads with a strong urine odor present. R11's speech was stuttered, and he reported not recalling being the aggressor or victim in any incidents with other residents. It should be noted that the reasonable person would not expect that they would be harmed in his/her own home or a health care facility and would experience a negative psychosocial outcome. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	R12 had been discharged from the facility and unavailable for interview. R16 was listed as a witness for both incidents. On [DATE] at 2:12 PM, R16 was asked what he recalled about the incidents between R11 and R12. R16 reported that he saw 2 fights and that R11 is an a*sh*le. When asked what staff have done to keep residents safe he reported that they try to keep R11 out of his room. R16 went on to report R11 is a dumb*ass and he goes around in circles and turns tables around and everything, he should be gone too. On [DATE] at 12:39 PM, during an interview with Registered Nurse (RN) F, when asked what she recalled about an incident that occurred between R12 and another resident, she stated R12 did a lot of things and then reported that the resident that was struck by R12 was R15. When asked what she could tell me about R12's behaviors and any interventions put in place to keep R12 and other residents safe, she reported that you had to have a relationship with him and that he was sent out to psych a few times. Additional interventions that she noted were video games, TV, pop and fake chewing tobacco that he enjoyed. On [DATE] at 2:29 PM, during an interview with the Nursing Home Administrator (NHA) and director of nursing (DON), NHA reported that R12 had a history of acting out and due to a medical condition he was very easy to agitate. He further stated that the facility could have done a better job with care plans/interventions. Obviously he had a history and this was not a one off. I would see this as an acceleration of behavior and some behaviors just got worse and worse. He repeated that care plans and interventions were inadequate and he did not see a lot of new intervention put in place and I completely acknowledge that. When asked what interventions were put in place when both residents (R11 and R12) were involved in physical incidents on both [DATE] and again on [DATE], NHA reported the residents were immediately separated following both incidents. Discussed with NHA and DON that R11's chart revealed the facility had completed every 15 minute checks completed from 12/7-[DATE], a progress note from [DATE] indicated that they should continue and no documentation indicated they should end, and R11 and R12 were involved in a physical altercation on [DATE]. DON reported that an IDT (interdisciplinary team) should determine when it is appropriate to stop every 15 minute checks, which does not appear to have happened in this case. NHA added that in addition to an IDT discussion there should have been back up with a psychological re-evaluation for interventions to prevent further aggressive occurrences. R11 was care planned for being physically and verbally aggressive since [DATE] but no new interventions had been added except labs ordered on [DATE] and removal of his footboard on [DATE]. When asked if they could tell me why additional interventions were not put in place, DON confirmed the information I provided was correct and not additional information was provided. DON/NHA reported that they were not aware of any like residents being interviewed or screened, just that witness statements were taken. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility reported incident (involving R12 and R17) revealed on [DATE], at approximately 2:45 pm the unit nurse (name redacted) (RN G) reports a resident-to-resident altercation occurred. Resident #1 (R12) was heard yelling in the hallway. Within a few minutes multiple voices were heard shouting and both unit nurses (RN G and RN H) responded. Resident #2 (R17) fell out of his wheelchair and hit his head on the floor causing a head laceration that was bleeding. Resident#1 (R17) also verbalized that resident #2 (R12) had hit him. (name redacted) (RN G) held pressure to the head wound while (name redacted) (RN H) attempted to deescalate Resident #1 (R12). Resident #1 (R12) continued shouting and attempting to punch and kick staff. (name redacted) (RN G) immediately reported the incident to Director of Nursing and building administrator. The following interventions were put in place: the residents were separated immediately, and each resident was transported to the local emergency room (hospital name redacted) for prompt medical care . Staff member (name redacted) (RN H) went to the ER following his shift. Resident (last name redacted) (R17) had a laceration on his left temple which required stitches .Staff member (name redacted) (RN H) had a blackened eye and bloodied eye .The incident was witnessed and is substantiated. R17 Review of the medical record revealed Resident 17 (R17) was admitted to the facility on [DATE] with diagnoses that included history of falling, memory deficit following cerebrovascular disease, adjustment disorder with mixed anxiety and depressed mood. The Minimum Data Set (MDS) with an Assessment date (ARD) of [DATE] revealed R17 scored 8 out of 15 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS). A review of R17's progress notes revealed: [DATE] Removed 6 sutures from left forehead no s/s (signs or symptoms) of infection noted no bleeding steri strips applied. Denies pain or discomfort . [DATE] Resident was struck by another resident and fell in his room hitting his head. Laceration left temple, neuros wnl (neurological assessment within normal limits) .Applied pressure dressing to area and ice EMS (Emergency Medical Services) contact and resident transferred to (hospital name redacted) for eval (evaluation) and treat (treatment). [DATE] Guest yelling and swearing at staff repeatedly since early this morning. Difficult to soothe or calm. Does become more amenable after med admin. [DATE] Guest yelling and cursing at staff, also refusing care. Went back asleep after demanding to get up and then being upset that it was very early in the morning. [DATE] Resident yelling and cursing at staff re (about) I can't find my call light, which was right under his hand. Noted increase in emotional outbursts in early evening since Trazadone changed from BID (twice daily) to HS (at bedtime) only . [DATE] Resident increasily (sp) agitated and aggressive towards staff since Trazodone changed from BID (twice daily) to QD (once daily). Yells and swears at staff, up walking in room with unsteady gait. Able to calm but only temporarily and with great effort . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview with RN H, he reported that on [DATE]nd R12 was pushing himself up and down the hallway, muttering to himself (which he reported was normal behavior for R12), R12 was near R17's room, toward the end of the hallway, R12 had a raised voice and R17 came out of his room to tell him to stop being loud, then they began to exchange words. R17 was standing and R12 was in his wheelchair facing eachother and within seconds they had their hands on each other. They each had ahold of the others shirt. RN H went to intervene. He reported that R12 was strong and shortly after he got to the 2 residents R12 let go of R17 and R17 fell to the ground, hitting his head on the floor. His verbal account aligned with the information in the FRI investigation. RN H stated that he was the only nurse for 40-45 residents that night and that him and several other staff members had raised concerns that it was an unsafe assignment to both the scheduler and the administrator. RN H reported that R12 had a known history of being violent. On [DATE] at 2:38 PM, during in interview with NHA, when asked what he could tell me about the incident involving R12 and R17, he reported that from what he [NAME] there was an altercation, R12 struck and pushed R17, R17 fell over his chair and received a head laceration, staff intervened immediately then R12 stuck a nurse resulting in a black eye. R12 was known to be physically aggressive, when asked what interventions had been put in place to keep R17 and other residents safe, NHA reported that after the incident R12 was placed on every 15 minute checks. When asked if they were aware that staff had expressed concern that the nursing assignments were not safe, both NHA and DON said they were not aware. When asked if any like residents were interviewed/screened or assessed following this incident both NHA and DON were not aware that had occurred. A review of the facilities policy titled Abuse, Neglect and Exploitation, documented in part The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: increased supervision of the alleged victim and residents .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI00150826. Based on observation, interview, and record review, the facility failed to provide activities of daily living (ADL) assistance for two residents (Resident 14 and Resident 21) of three residents reviewed. Findings include: Resident #14 (R14) Review of the medical record revealed Resident #14 (R14) was admitted to the facility on [DATE] with diagnoses that included depression, need for assistance with personal care, reduced mobility, and muscle weakness. The Minimum Data Set (MDS) with an Assessment date (ARD) of 12/15/25 revealed R14 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS) and required substantial/maximal assistance with showering. On 4/9/25 at 12:38 PM, R14 was observed sitting in his power scooter, with stubble on his face and food/debris on his shirt and coat. R14 reported that he had been trying to get staff to shave him for at least 3 days and that he gets a shower about once per week, which he reported is an improvement from the past. Review of the shower/bath task revealed R14's shower days were Sunday/Thursday and no showers were documented for 3/20/25, 3/30/25 and 4/3/25. The record shows a ten day span that resident did not receive a shower and that in 30 days R14 only had 4 showers. In an interview on 4/9/25 at 12:57 PM, Certified Nursing Assistant (CNA) B reported that the facility documents showers and refusals of showers on paper shower sheets and in their electronic health record. In an interview on 4/15/25 at 3:35 PM with Director of Nursing (DON) it was confirmed that all shower sheets have been provided (either uploaded in the resident's electronic health record or a paper copy has been provided). DON reported that the expectation for showers is twice weekly or more often if a resident makes that request. She reported that completion of showers is not currently being formally audited but she does review the dashboard each morning and if a resident refuses a shower, she will encourage staff to offer one the following day. Review of the medical record revealed Resident #21 (R21) was admitted to the facility on [DATE] with diagnoses that included vascular dementia, generalized anxiety disorder, dependence on a wheelchair and schizoaffective disorder. The Minimum Data Set (MDS) with an Assessment date (ARD) of 12/31/24 revealed R14 scored 8 out of 15 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS) and required substantial/maximal assistance with showering. Resident #21 (R21) (continued on next page)

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	235536	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Care of Battle Creek	675 Wagner Drive Battle Creek, MI 49017

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower/bath task revealed R21's shower days were Tuesday/Friday and no showers were documented for 3/28/25, 4/11/25 and 4/15/25. The record revealed that in 30 days R21 only had 5 showers. On 4/17/25 at 10:48 AM, R21 was observed in the main dining room, sitting in a manual wheelchair. R21 was observed to be wearing sweatpants that were soiled with a white substance and food debris, his shirt was soiled as well. There was a body odor noted when resident raised or moved his arms. His hair was observed to be unkempt and sticking out of a beanie style hat. R21 could not state how often he received showers. A review of the facilities policy titled Activities of Daily Living (ADLs), documented in part A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** This citation pertains to MI00151617 and MI00150826 Based on observation, interview, and record review, the facility failed to obtain orders for catheter care and failed to properly maintain urinary catheters for two (Resident 10 and Resident 14) of three reviewed. Findings include: Resident #10 (R10) Review of the medical record revealed R10 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, depression, neuromuscular dysfunction of bladder and paraplegia. The Minimum Data Set (MDS) with an Assessment date (ARD) of 12/29/24 revealed R10 scored 15 out of 15 (intact cognition) on the Brief Interview for Mental Status (BIMS) and had an indwelling catheter. On 4/9/25 at 1:13 PM, R10 was observed lying in bed on her left side, with a urinary drainage bag observed hanging from the edge of her bed. R10 reported having problems with her suprapubic catheter frequently and that she needs to remind staff to flush it daily. R10 further reported being frustrated that she recently has had to be sent out to the emergency department three times related to the facility not properly maintaining her catheter, she became tearful while discussing this. On 4/14/25 at 2:06 PM, R10 reported that she continued to have to remind staff to flush her suprapubic catheter and that it is supposed to be done first thing in the morning but gets passed on to the night shift sometimes. She reported that it had not been completed yet that day. A review of the physicians' orders for R10 revealed the following: 1/5/25 Suprapubic catheter to gravity every shift. 1/16/25 Cleanse super pubic area with NS, Pat Dry, apply TAO cover with drain sponge. Change daily. 3/12/25 Flush catheter daily with 60mls of sterile water and prn, one time daily AND every 24 hours as needed. No previous order for flush was found. 3/30/25 Monitor 18fr suprapubic Cath output, two times per day. No previous order for monitoring urinary output was found. It should be noted that the resident has had a suprapubic catheter since September of 2024. A review of R10's Medication administration record and Treatment administration record (MAR/TAR) revealed: February 2025 MAR/TAR documentation of Suprapubic catheter to gravity every shift for stage 4 pressure injury to sacral region only. No documentation of flush, urinary output or catheter care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	January 2025 MAR/TAR documentation of Cleanse super pubic area with NS, Pat Dry, apply TAO cover with drain sponge. Change daily,, Cleanse super pubic area with NS (normal saline), Pat Dry cover with dressing BID two times a day tx and Suprapubic catheter to gravity every shift for stage 4 pressure injury to sacral region. No documentation of flush or urinary output. December 2024 MAR/TAR documentation of Cleanse super pubic area with NS (normal saline), and Pat Dry cover with dressing BID two times a day tx and Suprapubic catheter to gravity every shift for stage 4 pressure injury to sacral region. No documentation of flush or urinary output. November 2024 MAR/TAR documentation of Cleanse super pubic area with NS (normal saline), and Pat Dry cover with dressing BID two times a day tx and Suprapubic catheter to gravity every shift for stage 4 pressure injury to sacral region. No documentation of flush or urinary output. October 2024 MAR/TAR documentation of Cleanse super pubic area with NS (normal saline), and Pat Dry cover with dressing BID two times a day tx, Suprapubic catheter to gravity every shift for stage 4 pressure injury to sacral region. No documentation of flush or urinary output. September 2024 MAR/TAR documentation of Remove sutures from super pubic one time only for 1 Day tx which was completed on 9/26/24, Cleanse super pubic area with NS (normal saline), Pat Dry cover with dressing BID two times a day tx, Suprapubic catheter to gravity every shift for stage 4 pressure injury to sacral region. No documentation of flush or urinary output. A review of R10's medical record reviewed she was sent to the emergency department for complications related to her suprapubic catheter on 3/22/25, 3/26/25 and 3/30/25. Review of Emergency Department Note from 3/30/25 revealed the following: Patient presents with suprapubic catheter plugged. Patient was here last week for the same., Patient has a chronic indwelling suprapubic catheter. It was clogged last week and she had to come to the emergency department. Patient says that staff is supposed to be flushing her suprapubic catheter daily. She says nobody is flushing it which is why she has had to present to the emergency department several times for a dysfunctional catheter., Patient has suprapubic bladder distention that is tender to palpation on exam., 0700 bladder scan showed greater than 900 ml of urine in the bladder., 0720 a new nonlatex 18 French foley catheter was replaced by me .It did immediately drain over 1000 ml (milliliters) of urine. Patient did get immediate relief., 0730 .I reached out to the (facility name) and spoke with the attending physician (Physician C). He admitted to me the facility is understaffed, and it does not surprise him that her catheter is not being flushed regularly. In an interview with Physician C on 4/16/25 at 9:42 AM, when asked about R10's recent trips to the emergency room, stated that the resident had to be sent out to the emergency room due to the facility not having the proper supplies to replace it. When asked how often a suprapubic catheter should be flushed he reported that it would depend on the patient and that he would assume the nurses are fulfilling the orders as instructed. When asked what his expectation for monitoring catheter output he reported that it would depend on the individual patient and if there is a concern about output. When asked, in the absence of flushing wouldn't monitoring output help determine if the catheter was patent, he responded that it would depend on the individual patient and if they had a kidney problem they wouldn't have a lot of output. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/17/25 at 10:15 AM, during an interview with central supply staff D, it was reported that the supplies for R10's suprapubic catheter are super hard to find, that the facility currently has 2 sets in stock, that there was approximately a month that the facility did not have the necessary supplies. Central supply staff D further reported that she was unaware that the resident had to be sent out to the emergency department until about 2 weeks ago. When asked if she was aware of how often the catheter needed to be changed she responded that she did not know but thought that it was often. When asked if it would be important for her to know that information in order to assure the necessary supplies are on hand, she said it would be important and that she normally has a par level for supplies but she had not determined it for the suprapubic catheter supplies yet. A review of the facilities policy titled Suprapubic Catheterization, documented in part The care and maintenance of suprapubic catheters shall be in accordance with physician orders. The orders shall specify the type and size of catheter, and frequency of catheter changes . According to the Cleveland Clinic website (https://my.clevelandclinic.org/health/treatments/25028-suprapubic-catheter) It's important to rinse (flush) a suprapubic catheter with sterile water to help prevent blood clots from blocking the device and otherwise keep the catheter clean and working properly. You should flush your suprapubic catheter at least once a day. Resident #14 (R14) Review of the medical record revealed Resident #14 (R14) was admitted to the facility on [DATE] with diagnoses that included depression, need for assistance with personal care, reduced mobility, and muscle weakness. The Minimum Data Set (MDS) with an Assessment date (ARD) of 12/15/25 revealed R14 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). On 4/9/25 at 12:38 PM, R14 was observed in his room, with urinary catheter bag secured to his motorized scooter. When asked how often staff emptied his catheter bag he reported once or twice per day. When asked if staff are regularly cleaning his genitals, he reported that he doesn't think that they are and I know they don't spend anytime down there. Review of R14's progress notes revealed: 3/3/2025 Resident has a foley catheter; placed in patient in ER on [DATE], Foley has been patent draining clear yellow urine in bag and tubing. Resident has Dx (diagnosis) of Urinary Tract Infection . On 4/9/25 A review of R14's physician orders revealed no order for urinary catheter or any related urinary catheter orders (monitoring urinary output, catheter care). It should be noted that documentation in progress notes indicated that resident had a foley catheter placed on 3/1/25. A review of R14's [NAME] and Care plan both revealed no documentation of urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/10/25 at 2:01 PM, during an interview with Licensed Practical Nurse (LPN) E, when asked what care R14 receives specific to his urinary catheter, she reported that he received traditional catheter care, which included washing his penis from tip down with soap and water, at least three times per day. When asked if she had completed catheter care during her current shift, she replied that she had. When asked where it was documented she reported, on the TAR (treatment administration record). When asked if she could show me, she pulled up the TAR on her computer and said you made a liar out of me. She reported that it had been completed during his shower that day. When asked how often his urinary catheter collection bag should be emptied, she replied each shift. When asked where that is documented at she reported That is not in there either (documented in the computer). I will add it. On 4/10/25 at 2:11 PM, during an interview with Director of Nursing (DON) she reported that the expectation for urinary catheter orders would include, balloon size, French/size, diagnosis, catheter care every shift, flushes if needed and output/emptied each shift. DON was notified of R14 not having any orders in place related to his urinary catheter. DON reported that orders are normally placed by the admitting nurse with a second check from another staff nurse. A review of the facilities policy titled Catheter Care, documented in part Catheter care will be performed each shift and as needed by nursing personnel .