STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235540	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Home Breton Rehabilitation & Living Centre	2589 44th St SE Grand Rapids, MI 49512

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38666 Based on observation, interview, and record review the facility failed to ensure urinary catheter equipment was consistently maintained in a secured and sanitary manner for 1 (Resident #36) of 2 residents reviewed for urinary catheter care, resulting in discomfort and pain at the urinary catheter insertion site and the potential for further catheter-associated urinary tract infections. Findings include: Review of Resident #36's most recent brief interview for mental status score, dated 2/6/25, was scored a 15 out of 15 suggesting Resident #36 was cognitively intact. Review of Resident #36's urology (branch of medicine focusing on the urinary system) consult note, dated 3/25/24, noted that Resident #36's primary diagnosis was Urinary retention and noted Resident #36 had an Atonic bladder (bladder (organ that holds urine) muscles don't fully contract) and an indwelling urethral catheter (tube inserted in the bladder through the penis to allow urine to flow). During observations and interview on 03/24/25 at 09:42 AM, upon entering Resident #36's (R36) room there was a sign on the door that indicated this resident was on enhanced barrier precautions (Enhanced barrier precautions are infection control interventions designed to reduce the spread of multidrug-resistant organisms). R36 was awake laying on his back in bed and a urinary catheter tube traveled down the side of the bed, from his right leg (catheter tubing was secured to the right leg by a white fabric strap), and down to the urinary catheter urine collection bag that was resting flat directly on the floor with the tube emptying spigot side up. R36 reported the catheter bag was often (R36 couldn't quantify exactly how many times) on the floor and it wasn't unusual to for the urinary catheter bag to be directly touching the floor. The urinary catheter bag was on the floor to the bottom left area of the bed which was closest to the entry door. R36 reported he had a recent urinary tract infection and received antibiotics to address it. R36 confirmed the catheter bag was directly on the facility floor; there was no barrier between the catheter bag and the floor. At 09:49 AM, Registered Nurse F entered R36's room, provided medication to the resident, and left the room. The urinary catheter bag remained on the floor unprotected with no barrier as the staff had not picked it up off the floor during the visit to R36's room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235540	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Home Breton Rehabilitation & Living Centre	2589 44th St SE Grand Rapids, MI 49512

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations and interview on 03/24/25 at 01:13 PM, Resident #36 (R36) and his urinary catheter tubing and bag were in nearly the same position they were at during the previous observation at 03/24/25 at 09:42 AM. The catheter bag was still laying directly on the facility floor with no barrier between the catheter bag and the floor. There was no device or bag affixed to the bed or near the bed to keep the catheter bag off the floor and to prevent potential tension in the urinary catheter tubing. As R36 turned himself independently from side to side in his bed the urinary catheter bag raised up off the floor and then back to resting on the floor flat again. During an interview on 03/25/25 at 12:38 PM, Certified Nurse Aide G reported urinary catheter bags should not be directly on the floor and there should be a barrier, such as a designated pad or the catheter bag be placed in the catheter holding bag that hangs from the bed frame, between the urinary catheter bag and the floor. During an interview on 03/25/25 at 03:41 PM, Director of Nursing (DON) B reported resident's urinary catheter bags, while laying in bed, should be placed in a privacy bag that hangs from the bed frame, in a plastic basin bin, or on a soaking pad that would create a barrier between the catheter bag and the floor. DON B confirmed Resident #36's urinary catheter bag should never be directly on the facility floor with no barrier. During an interview on 03/26/25 at 08:16 AM, Resident #36 (R36) showed his leg strap that held the urinary catheter tubing and reported when he moved in bed and the catheter bag was on the floor it would tug at his penis and stated it hurt. R36 reported the pain it caused was a 5 out of 10 (on a scale of zero being no pain and 10 being the highest level of pain). R36 confirmed this discomfort at times still occurred while the catheter tubing was secured to his leg with a leg strap and when the catheter bag was on the floor. R36 reported the leg strap often rides down his leg which would cause tension. R36 reported there were times staff placed his urinary catheter bag on a pad on the floor but the bag would end up directly on the floor as it moved as he moved in bed. R36 reported at times when the catheter was puling on his penis causing pain and the catheter bag was on the floor he would grab the tubing and pull it to give the tubing some slack to alleviate the discomfort. Review of R36's progress note, dated 3/12/25 at 9:24 PM, stated, CNA (certified nursing aide) mentioned to this writer around 21:30 (9:30 PM) that resident (Resident #36) has bloody urine in his bag when emptying it . resident (Resident #36) mentioned that when the tubing on the top is not positioned properly or the band that it tends to slide down and then ends up pulling . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235540	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Home Breton Rehabilitation & Living Centre	2589 44th St SE Grand Rapids, MI 49512

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #36's Infection Report, dated 3/12/2025, indicated, Time of Onset 9:30 PM .Acquired Where? Facility .Infection Type CAUTI (Catheter-associated Urinary Tract Infection) .Observed with gross hematuria (blood in urine) in catheter collection bag and drainage around meatus (opening of the urethra where urine exits) with c/o (complaint of) doscomfort (discomfort) at site as well. UTI (urinary tract infection) monitor started, CBC (Complete Blood Count; lab) showed elevated WBCs (white blood cells). UA (urine analysis) collected which also demonstrated abnormal values. C&S (culture and sensitivity; lab test to identify bacteria and determine susceptibility to antibiotics) returned with e coli (escherichia coli; bacteria) and kleb. p (Klebsiella pneumoniae; bacteria), macrobid (antibiotic) started as both organisms sensitive . Symptoms - Urinary Tract .gross hematuria, Urinary Catheter specimen culture with at least 10^5 cfu/ml (colony-forming unit per milliliter) of any organism(s) .Purulent (pus) discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis (coiled tube inside the scrotum), or prostate (small gland below the bladder in men) .Comments ABX (antibiotics) completed. Review of the Physician orders indicated Macrobid (antibiotic) was given Twice a Day x (for) 7 days For UTI (urinary tract infection) started on 3/16/25 with the last dose on 3/23/25. Review of Resident #36's urinary care plan, start date of 3/4/24, stated, (Resident #36) utilizes an indwelling catheter use secondary to urinary retention during hospitalization , also has dx (diagnosis) of benign prostatic hyperplasia (condition that the prostate grows larger than usual). Trial voiding (urinating without the catheter) failed prior to discharge from hospital. He (R36) has the potential for urinary tract infection r/t (related to) catheterization .secure catheter on leg to avoid tension .Enhanced barrier precautions with ADLs (activities of daily living) and cath (catheter) care . Review of Resident #36's Care Area Assessment Summary, dated 2/6/25, stated, .He (Resident #36) does require one person assistance for catheter care. Review of the facility's Catheter -Usage and Care policy, date last reviewed 03/2018, stated, Catheter-Associated Urinary Tract Infection (CAUTI) .In order to prevent a catheter-associated urinary tract infection (CAUTI) .do not allow catheter tubing, bag or spigot to touch the floor .bag comes in different lengths and extension tubing can be added/cut to size to avoid tension at the catheter insertion site. Review of the Centers for Disease Control and Prevention's Summary of Recommendations Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated 2009 and viewable at https://www.cdc.gov/infection-control/hcp/cauti/summary-of-recommendations.html, stated, .Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor.