STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235612	A. Building B. Wing	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Freeman Nursing & Rehab Community	1805 Pyle Drive Kingsford, MI 49802

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35730 Based on observation, interview and record review, the facility failed to provide dignified care for two Residents (#1 and #6) of seven reviewed, and for all residents who required feeding assistance with meals. This deficient practice resulted in embarrassment and humiliation, based on the reasonable person standard, and the potential for worsening skin issues. Findings include: During an interview on 9/28/22 at 8:45 a.m., Registered Nurse (RN) A said there were six Residents who could not feed themselves and required staff assistance with meals. On 9/28/22 at 9:00 a.m. breakfast trays were being delivered to residents in their rooms. No one was eating in the dining room. On 9/29/22 at 7:45 a.m. RN A and RN B both confirm the dining room was not used, they were told, due to COVID-19. On 9/28/22 at 3:55 p.m., RN A was observed performing wound care for Resident #6 with the assistance of the Director of Nursing (DON). The DON used the bed controls to lower the head of the bed, without informing the Resident of what was happening. As the head of the bed went down, the Resident's head stayed rigid, above the pillow and he moaned in discomfort. The DON then proceeded to raise the entire bed for the care. RN A went into the bathroom to wash her hands when the DON leaned her body on the stacked legs of the Resident, resting her entire forearm along Resident #6's leg, while watching television, and not attending to the Resident's needs. This Surveyor requested the DON remove her weight from the Resident's legs and hip. This Surveyor had to make the request twice before the DON complied. As the DON stood up, her weight visibly came off the Resident's legs. During an interview on 9/29/22 at 8:45 a.m., the DON stated, I didn't realize I was leaning on him. When asked about the bed controls, the DON stated, I should have told him what I was doing. When asked why the dining room was not being used for meals, the DON stated, Staffing. When asked to explain, the DON stated, We have feeders. Most of our feeders go to the dining room. The DON further explained there was not enough staff to supervise and assist in the dining room so all meals were still being served in resident rooms. The DON used the term Feeders referring to residents who required assistance with meals, several times. Several minutes after the end of the interview, the DON returned to say the dining room was not being used due to COVID-19. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/29/22 at 10:26 a.m., Family Member (FM) C said he visited one day to find a urinary catheter drainage tube used as a straw in Resident #1's water cup. FM C provided a picture taken in the room on that day, showing a urinary catheter tube cut and inserted into the water cup as a straw. FM C said the Administrator (NHA) told him the facility did not have long straws to accommodate the large water cups. During an interview on 9/29/22 at 10:46 a.m., the NHA confirmed FM C's concern about Resident #1's straw being too short for him to use properly. The NHA denied knowledge about the catheter tubing used as a straw. The NHA confirmed the use of a urinary catheter tube as a straw was not dignified care. During an interview on 9/29/22 at 11:25 a.m., the DON was asked about the straw for Resident #1 and said Resident #1 was complaining he couldn't use the shorter straws so somebody came up with the idea to try the catheter tubing, but it didn't work. The Resident's Care Plan revealed, .Staff to show respect and dignity towards resident while providing cares and during interaction ., dated 5/27/22 The Policy Privacy, Dignity, and Confidentiality, dated 1/2022, did not mention dignity. The Booklet, Resident Rights, dated June 2018, confirmed given to Residents on admission, revealed on page 5, .The resident has a right to a dignified existence .Dignity, respect and quality of life .A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life .The facility must protect and promote the rights of the resident .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35730 Based on observation, interview and record review, the facility failed to identify and monitor a change of condition and follow the care plan regarding catheter secure device, for one Resident (#1), from three reviewed for change in condition. This deficient practice resulted in a urinary tract infection, with sepsis (a life threatening blood infection), endocarditis (a life threatening heart valve infection caused by sepsis) and necrotic (dead) untreatable toes, with admission to the hospital, and resultant end of life comfort care. Findings include: According to the electronic medical record (EMR), Resident #1 was admitted to the facility on [DATE], with dementia, hearing loss, urine retention with long term use catheter, high blood pressure, hand contractures, acute kidney failure, history of falls, weakness and unsteady gait. According to the Event Report, dated 8/7/22, Resident #1 fell out of bed on 8/7/22 at 1:15 a.m. The Resident stated he turned over in bed and fell out. The Resident suffered a large bruise to the right forehead. Vital signs at that time revealed Resident #1 had a temperature of 101.4, a lying blood pressure of 155/67, and a pulse of 153 (all indicative of early sepsis). The Report confirmed contributing factors including a urinary tract infection (UTI), cognitive impairments, hearing loss, and balance problems. The Report indicated Resident #1 was sent to the emergency department for evaluation, due to the bruise on the forehead, elevated temperature and pulse. The report further indicated the Resident was admitted for sepsis and UTI. The Witness Statement, dated 8/7/22, indicated Resident #1 toileted himself independently. The root cause analysis indicated the Resident was self transferring, but that was not congruent with the Resident's statement. The Care Plan instructed monitoring for changes in condition, dated 6/3/22. The Care Plan also instructed to monitor blood pressure for high blood pressure problem, dated 5/26/22, instructed to assist to bath room for safety, dated 5/26/22, a one person assist for transfers and ambulation, dated 5/26/22. The Care Plan also instructed the following, dated 5/26/22, Use adhesive leg anchor to secure (catheter) tubing NOT leg strap. dated 5/26/22. The hospital emergency room triage note, dated 8/7/22, revealed, .Chief Complaint: Altered mental status and confused and fall .was found on the floor in the nursing home, he has a [history] of dementia, but his mental status is altered .has a bruise and bump above right eye .has a [catheter] in place from nursing home . right leg is discolored/bluish from tight band around his upper thigh, left leg is warmer to touch than right leg . had fever, weakness, and trouble walking .Sepsis screen positive . The Discharge Summary from the hospital, printed 8/12/22, revealed sepsis (new diagnosis), endocarditis mitral valve (new diagnosis), and others. The education provided on discharge included a drawing with explanation of a catheter strap acting like a tourniquet resulting in loss of circulation to the toes causing infection and gangrene, not a candidate for surgery, with UTI, sepsis and endocarditis, not a candidate for surgery, on comfort care. The Summary also showed an echocardiogram finding of, .Anterior Mitral Leaflet is very much thickened with 1.5 cm (centimeter) diameter VALVE VEGETATION .Moderate Mitral Regurgitation present . (new findings). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The facility investigation of a complaint related to Resident #1's care revealed allegations of catheter secure device was too tight and caused foot problems, the facility did not identify a UTI, the facility did not change the catheter since admission, and the facility did not supervise the resident to prevent a fall. The investigation revealed the Resident told the nurse on duty (Now the Director of Nursing (DON)) his right leg was numb, after he fell from bed. The DON observed the right leg to be discolored. The DON checked the strap and did not find any concerns. (However, the care plan clearly instructed no strap device to be used.) The investigation confirmed a temperature of 101.6 and rapid pulse following the fall on 8/7/22. The DON said in the investigation there were no signs of infection prior to the fall. But, the hospital emergency room note of 8/7/22 noted the Resident was on doxycycline 100 mg (milligrams) twice daily for UTI. The investigation confirmed the catheter was not changed since admission from 5/26/22 to 7/4/22, when the order for monthly changes was discontinued. The rationale was the monthly change did not comport with CDC (Centers for Disease Control) guidelines. The investigation did not account for clarifying the order with the ordering provider. The order was simply not followed. During an interview on 9/29/22 at 10:32 a.m., Registered Nurse (RN) F confirmed no catheter changes were performed since admission on 5/26/22. The physician order, dated 5/26/22 instructed a change of the urinary catheter monthly. A statement as part of the facility investigation, dated 8/21/22, revealed, .He (Resident #1) is independent and self transfers . This was incongruent with the care plan. The statement was authored by CNA D an agency staff. The Interview, undated, with the DON, revealed the DON checked Resident #1's blood pressure on the shift of the fall on 8/7/22. But, the EMR revealed no vital signs documented since 8/4/22. The progress note, dated 8/7/22 revealed a temperature of 101.6 and pulse of 153, but no other vital signs. During an interview on 9/29/22 at 8:45 a.m., the DON confirmed she was the nurse on duty on 8/7/22 when Resident #1 fell from bed. The DON was asked about the condition and vital signs of the Resident when he fell . The DON did not directly answer. When asked if there was a sepsis protocol in place, the DON was confused and did not understand the question. When asked if there was a procedure to follow to detect early sepsis, the DON said she didn't think so. When asked what early sepsis signs and symptoms were the DON could not say except that blood pressures and temperatures could vary. When asked about the catheter secure device as an adhesive versus a strap design, the DON said she was not aware at the time it was supposed to be an adhesive device. On 9/28/22 at 1:15 p.m., Resident #1 was in the room in a wheel chair with the right foot uncovered. The entire foot was purple red with blotchy patches up to the mid shin. The second and third toes were black and stuck to the adjacent toes which were fluid filled and had excoriating skin. The toes were clearly infected and deadened. The Resident said he could not eat his lunch on the tray because he had to look at his foot and lost his appetite. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a follow up interview on 9/28/22 at 1:36 p.m., the DON was asked about a sepsis screening tool and whether one was used in the facility, and replied there was a McGeer's criteria used. The DON said she thought the McGeer's criteria was the sepsis screen but wasn't sure. Then, the DON said she didn't know what a sepsis screen was and none was used in the building, and she never was educated on using one as a floor nurse. On 9/29/22 at 9:30 a.m., Physician (Staff) E was at the bedside in Resident #1's room with Family Member (FM) C and this Surveyor. Staff E confirmed the Resident's right toes were necrotic and infected and dying due to a circulation (arterial) problem, not venous stasis, and that the Resident was not a surgical candidate for amputation of the foot. On 9/29/22 at 10:26 a.m., Resident #1 was observed asleep in the bed, with no mat on the floor (per care plan). FM C was in the room and said there was an indentation on the leg from the strap in the hospital and provided pictures taken by hospital staff confirming the indentation with markings where the strap was and included the discoloration of the right leg. FM C said the very next day after the Resident was readmitted to the facility the strap was back on the leg, and provided a picture of the same. The Care Plan revealed a problem of open area to right foot on 9/15/22 with diagnosis of venous stasis ulcer related to PVD (peripheral vascular disease, an arterial circulation disease). During an interview on 9/29/22 at 11:25 a.m., the DON was asked what the wounds (necrosis) of Resident #1's toes were, and responded they were arterial ulcers from PVD. When asked why the care plan said they were venous ulcers, the DON did not know. When asked if there was a difference in treatment and care for arterial versus venous ulcers, the DON stated, I don't know. The Event Report, authored by the DON, dated 9/13/22, revealed a venous ulcer on the top of the right second toe, with a scab. The policy Notification of Change, dated 2/2022, revealed, .The Licensed nurse will use professional judgement any time that in their opinion the resident requires immediate medical attention .When made aware of a change in condition of a resident the Licensed nurse will perform and assessment based on their professional judgement that may include: vital signs, mental status, major diagnosis, current pertinent medications .skin assessment .

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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** 35730 Based on observation, interview and record review, the facility failed to assess and treat pressure ulcers for one Resident (#6) from three reviewed for pressure ulcers. This deficient practice resulted in the worsening of the Resident's pressure ulcers to stage 4 with hospitalization , a wound vac system and pain. Findings include: During an interview on 9/28/22 at 3:46 p.m., Registered Nurse, (RN) A confirmed Resident #6 returned from the hospital on 9/27/22 with wound clinic orders for wounds to both hip wounds and two wounds to the back that had a wound vac system in place. RN A said the pharmacy did not yet have the ordered medication, but it would arrive the following day. RN A said she contacted the wound clinic who clarified the care could be done the following day for the wound vac. RN A confirmed she was the wound nurse in the building as of about one week after her hire the month prior. RN A said she took the certification classes, but was as yet unable to test for wound care certification. RN A said when she first saw Resident #6's wounds in August 2022, she was horrified; they were necrotic, infected and had an odor that forced her to use an aromatic under her nose while in the room. RN A said she insisted on sending the Resident to the emergency department to be evaluated and told facility leadership This is gonna kill him. According to the electronic medical record (EMR) Resident #6 was admitted on [DATE] with diagnoses including failure to thrive, encephalopathy, stage 2 pressure ulcer to back, deep tissue pressure ulcer to thoracic spine, weakness, falls, pulmonary fibrosis, dementia, slow heart rate, tremor, atrial fibrillation, and was severely cognitively impaired and dependent with bed mobility, transfers, and non ambulatory. On 9/28/22 at 3:55 p.m., wound care was observed provided by RN A with the Director of Nursing (DON) assisting. Resident #6 was uncovered to expose the wound vac tubing lying over the abdomen, indented into the very fragile, thin skin. Both RN A and the DON confirmed education was needed for all staff, visitors and the Resident regarding the tubing positioning as the observed situation would likely cause more wounds. Both hip trochanter bones had stage 4 approximately 4-6 cm (centimeter) round wounds with brown/gray wound bases that appeared dying and had areas of green, and were odorous. Both dressings were saturated with a brown exudate. RN A said the wounds were unstageable or stage 2 when the Resident left for the hospital and were most likely debrided to reveal the current wounds. RN A said the first time she saw the wounds the odor was unbearable and the wounds were clearly infected and uncared for. RN A provided care per orders, but did not treat the two back wounds that had the wound vac system in place. The Resident had a new deep tissue injury to the coccyx. RN A said the Resident was very difficult to reposition as he had rigidities and an uncooperative family member who came to reposition him incorrectly. The Resident's skin was very fragile, thin and translucent. The DON leaned her weight on the Resident's legs and this Surveyor had to ask twice before she lifted her weight from the Resident. RN A confirmed the wounds to the back were almost twice as large as prior to hospitalization and had significantly worsened from lack of appropriate care. The wound vac was not observed changed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/29/22 at 11:44 a.m., RN A said she didn't know how Resident #6's wounds got so bad, but when she was hired on 8/22/22 and saw them she insisted he go out to the hospital. RN A said the DON was the wound nurse then and no treatments for the infection was being provided; only dressings applied to control the drainage. The wounds were full of necrotic tissue. RN A said the corporate RN was in and saw the wounds and agreed to send the Resident out to the hospital. RN A said the DON was not doing the assessments and measurements weekly. During an interview on 9/29/22 at 11:48 a.m., RN F confirmed she saw Resident #6's wound with RN A and was immediately concerned and agreed to call the physician for an order to send the Resident to the hospital. RN F said the Resident's wound to the back was narrower, but slightly longer than a hand, half the size visualized dressed with the wound vac system. Weekly skin assessments revealed the following: 9/27/22: Stage 4 pressure ulcers to back and bilateral hips 9/12/22: No new areas. Pressure areas being monitored by treatment nurse. No areas of the body were marked. 9/6/22: Area on Left hip is beginning to open. 8/30/22: No areas of skin impairment was checked. 8/25/22: No new skin alterations noted. 8/19/22: No new shin alterations noted. 8/1/22: No changes noted to skin at this time. Wound to coccyx and back remain unchanged with [treatment] in place. 7/28/22: Pressure ulcers continue to coccyx and spine. Redness noted to right hip. 7/15/22, 7/12/22, 7/5/22 and 7/19/22: No areas of skin impairment. Weekly Pressure Ulcer Progress Reports revealed the following: 9/28/22 by RN A in house acquired stage 4 pressure ulcer to left hip (trochanter) with moderate (#4) pain, 5.3 X 6.1 X 1 cm with copious drainage, wet to dry dressings and deterioration noted, wound was stage 2 when resident was sent and admitted to hospital for wound infection. Resident returned with stage 4 with exposed muscle tissue Physician, dietician and family notified. In house acquired right hip stage 4 with moderate pain, 4.3 X 5 X 0.8 cm, with copious drainage, deteriorated. 9/9/22 By RN A right side spine unstageable admitted with wound, with moderate pain, 13.7 X 6.6 cm, copious drainage, purulent foul odor, deteriorated and a mid spine unstageable 11.8 X 4.3 with copious drainage, purulent and foul odor On 9/9/22 both hip wounds were staged at 2. From 8/9/22 to 9/28/22 all wounds almost doubled in size and went from stage 2 or unstageable ulcers to stage 4 ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #6's Care Plan revealed pressure ulcers to the back that were present on admission. The goal was to heal the ulcers without complications, target date 10/1/22. The Plan instructed assessments, dated 7/26/22, and skin inspections per protocol on 7/26/22. The Care Plan noted at risk for skin breakdown, with goal of skin remaining in tact, target date 10/1/22. The Care Plan had no mention of stage 4 pressure injuries to bilateral hips. The Care Plan was absent specific positioning instructions for the Resident's wounds. The policy Pressure Injury Prevention and Care, dated 1/2022, revealed, .To promote and facilitate pressure injury prevention and implement appropriate interventions and treatment of pressure injuries to promote and facilitate resolution of pressure injuries .Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution .Physician/provider will be notified if pressure injury shows sings of deterioration, infection, or no improvement for further evaluation and recommendations regarding treatment and interventions .Update the resident care plan to address the areas of pressure injury, and approaches initiated .

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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** 35730 Based on observation, interview and record review, the facility failed to implement appropriate interventions to prevent falls for three Residents (#1, #2 and #4) from three reviewed for falls. This deficient practice resulted in a fracture of the pinky finger for Resident #2, a fracture of the left arm for Resident #4 and a fall with hospitalization for Resident #1. Findings include: Resident #1 According to electronic medical record (EMR), Resident #1 was admitted to the facility on [DATE], with dementia, hearing loss, urine retention with long term use catheter, high blood pressure, hand contractures, acute kidney failure, history of falls, weakness and unsteady gait. An Event Report, dated 8/7/22 revealed Resident #1 fell from bed when he rolled over. The Resident suffered a bruise with a bump to the right forehead and was sent to the hospital and diagnosed and admitted with sepsis and urinary tract infection (UTI). The investigation revealed the Resident wore a strap type catheter secure device, in contrast to the Care Plan, which instructed an adhesive secure device only. The strap device cut off the circulation, according to hospital records, to the right leg, which became numb, causing an apparent fall from bed, and subsequent circulation problems resulting in necrotic toes and comfort measures only. The Care Plan was updated on 8/12/22 to place a fall mat on the floor next to the bed when the Resident was in bed. Several observations during the survey, including on 9/28/22 at 10:20 a.m. and 1:15 p.m., 9/29/22 at 7:50 a.m. and 8:28 a.m. and 9:30 a.m., revealed no floor mat in the room or in place on the floor when the Resident was in bed. The Care Plan also instructed to maintain frequently used items within reach, dated 8/21/22, and lock wheel chair brakes when transferring, dated 5/26/22, and one person assist with transfers with walker and gait belt, as well as with ambulation and toileting, dated 5/26/22. Resident #1 had two subsequent falls on 8/21/22 and 9/20/22. The Resident, according to the Event Report, was reaching for something from bed on 8/21/22. On 9/20/22, according to the Event Report, the Resident was returning from the bathroom, transferring to bed, alone. Resident #2 According to the EMR, Resident #2 was admitted on [DATE], was moderately cognitively impaired, with diagnoses including Parkinson's disease, heart attack, progressive neuropathy, depression, anxiety, hallucinations, weakness, tardive dyskinesia (involuntary movements secondary to certain medications) and others. The Resident required assistance with walking, toileting, and transfers. Resident #2 had 8 falls between 8/1/22 and 9/19/22, on 8/1/22, 8/4/22, 8/5/22, 9/2/22, 9/7/22, 9/15/22, 9/17/22, and 9/19/22. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/28/22 at 10:35 a.m., Resident #2 was observed in her room leaning over the right side of the wheel chair. The Resident had no activity or busying items in the room and paced in the chair around the room. The Event Report for the fall on 8/1/22 revealed Resident #2 was trying to pick up something from the floor. The Witness Statement, dated 8/1/22 authored by Staff G confirmed the Resident was trying to pick up a puzzle piece from the floor. The Witness Statement, dated 8/1/22, authored by Certified Nurse Aide (CNA) H revealed Resident #2 was anxious and wandering in and out of rooms and pulling at the bottom of the bed frame looking for the dog. The facility investigation revealed the Resident was sent to the hospital for evaluation following confusion, increased tardive dyskinesia symptoms, cold and clammy skin and was diagnosed with a concussion. The Care Plan instructed provide diversional activities, dated 8/4/22 and monitor, redirect and anticipate increased agitation, dated 2/24/22. The Event Report for the fall on 8/4/22 revealed the Resident was with family prior to the fall, and then found at the foot of the roommate's bed on the floor. The Witness Statement, dated 8/4/22 and authored by Licensed Practical Nurse (LPN) I, revealed the Resident went to look out the window at family leaving prior to the fall. The Care Plan instructed diversional activities following family visits. On 8/5/22 Resident #2 was self transferring, according to the Event Report, dated 8/5/22. The Care Plan instructed assist of one with transfers, dated 6/17/22. On 9/2/22, Resident #2 was trying to pick up food from the floor and fell . On 9/7/22, Resident #2 said she tripped over the fall mat while trying to walk to the bathroom. On 9/15/22, Resident #2 was walking back to bed from the bathroom when she fell . On 9/17/22, Resident #2 could not remember what she was doing when she was found on the floor in the room. The progress note, dated 9/17/22, revealed, .was on floor with feet toward door and head toward window, lying on her right side, there was an area of pooling blood under her head .right hand .Large hematoma rose beneath middle knuckle on dorsal side of hand and resident was unable to squeeze my fingers with that hand. Sent to [hospital] . The progress note, dated 9/18/22, revealed a fracture of the right pinky as a result of the fall. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	The investigation following the fall with fracture did not discuss prior falls at all, nor analyze time of day, staffing, visitations (problematic trigger according to the care plan) or other possible root causes. On 9/19/22, Resident #2 was trying to pick up her spoon when she fell . None of the above events demonstrated sufficient root cause analyses to determine why Resident #2 continued to fall or interventions to prevent repeated falls based on a root cause. Resident #4 According to the EMR, Resident #4 was admitted on [DATE] with diagnoses including dementia with behavior, weakness unsteady on feet, chronic obstructive pulmonary disease, anxiety, schizoaffective disorder, depression, and was severely cognitively impaired. The Resident required extensive assistance for transfers, walking and toileting. The Event Report, dated 8/21/22, revealed Resident #4 was found on the floor on his knees, leaning on the bed with his left arm between the bed and the recliner. The left arm was painful and the Resident would not allow assessment by the nurse. The Resident had no footwear on. The Witness Statement, dated 8/21/22, authored by CNA J revealed transferring the Resident was more difficult since 8/19/22 and he reported increased back pain. The Witness Statement, dated 8/21/22, authored by CNA K also revealed Resident #4 had increased back pain for several days prior and nursing was aware. The Witness Statement, dated 8/21/22, authored by CNA L also noted decreased mobility over the previous couple of weeks. The progress note, dated 8/21/22, authored by Registered Nurse (RN) B, revealed, .Resident was found on his knees next to bed and recliner, with his left arm between the bed and recliner .was crying out My arm! I can't move it, it hurts! The facility investigation revealed R #4 had a fractured left arm, and was returned to the facility from the hospital, with a sling. The investigation concluded a fall with fracture but did not address the decreased mobility in the investigation or show that during the prior weeks when the decrease was known, any new interventions were put into place to prevent a fall. During an interview on 9/28/22 at 1:36 p.m. the Director of Nursing (DON) said the social services designee had access to care plans and she herself updated them after falls, but to be honest with you, I don't know who else does this. The DON confirmed floor nurses did not update care plans following falls. During an interview on 9/29/22 at 9:40 a.m., RN B said she remembered vividly Resident #4's fall on 8/21/22. RN B confirmed the Resident was never independent with transfers and usually needed assistance of one or two staff with the sit to stand lift. RN B described the fall and her response, which was congruent with the investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The policy Fall Prevention and Management, dated 1/2022, revealed, .to assess resident risk for falls and implement interventions to reduce the incidence of falls and/or mitigate the risk of injury related to falls . Licensed nurses will complete fall risk assessments on residents upon admission, quarterly, and [as needed] .The Director of Nursing of clinical leader will review post-fall documentation to ensure .contributing factors have been identified .If intervention/preventive measure is appropriate based on the root-cause of the fall . care plan has been updated .Communication to direct care staff .complete an evaluation detail and investigation analysis summary .

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35730 Based on observation, interview and record review, the facility failed to appropriately assess, monitor and care for a urinary catheter, for one Resident (#1), from three reviewed for catheter care. This deficient practice resulted in repeated urinary tract infections (UTI), circulatory deficiency, sepsis, with endocarditis (a life threatening heart muscle infection), hospitalization with necrotic toes, and subsequent end of life comfort care. Findings include: According to electronic medical record (EMR), Resident #1 was admitted to the facility on [DATE], with dementia, hearing loss, urine retention with long use catheter, high blood pressure, hand contractures, acute kidney failure, history of falls, weakness and unsteady gait. According to the Event Report, dated 8/7/22, Resident #1 fell out of bed on 8/7/22 at 1:15 a.m. The Resident stated he turned over in bed and fell out. The Resident suffered a large bruise to the right forehead, had a temperature of 101.4, a lying blood pressure of 155/67, and a pulse of 153 (all indicative of early sepsis). The Report confirmed contributing factors including a urinary tract infection (UTI), cognitive impairments, hearing loss, and balance problems. The Report indicated Resident #1 was sent to the emergency department for evaluation, due to the bruise on the forehead, elevated temperature and pulse. The report further indicated the Resident was admitted for sepsis and UTI. The Witness Statement, dated 8/7/22, indicated Resident #1 toileted himself independently. The root cause analysis indicated the Resident was self transferring, but that was not congruent with the Resident's statement. The Care Plan instructed monitoring for changes in condition, dated 6/3/22. The Care Plan also instructed to monitor blood pressure for high blood pressure problem, dated 5/26/22, instructed to assist to bath room for safety, dated 5/26/22, a one person assist for transfers and ambulation, dated 5/26/22. The Care Plan also instructed the following, dated 5/26/22, Use adhesive leg anchor to secure (catheter) tubing NOT leg strap. dated 5/26/22. The hospital emergency room triage note, dated 8/7/22, revealed, .Chief Complaint: Altered mental status and confused and fall .was found on the floor in the nursing home, he has a [history] of dementia, but his mental status is altered .has a bruise and bump above right eye .has a [catheter] in place from nursing home . right leg is discolored/bluish from tight band around his upper thigh, left leg is warmer to touch than right leg . had fever, weakness, and trouble walking .Sepsis screen positive . The Discharge Summary from the hospital, printed 8/12/22, revealed sepsis, endocarditis mitral valve, and others. The education provided on discharge included a drawing with explanation of a catheter strap acting like a tourniquet resulting in loss of circulation to the toes with infection and gangrene, not a candidate for surgery, with UTI, sepsis and endocarditis, not a candidate for surgery, on comfort care. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The facility investigation of a complaint related to Resident #1's care revealed allegations of catheter secure device was too tight and caused foot problems, the facility did not identify a UTI, the facility did not change the catheter since admission, and the facility did not supervise the resident to prevent a fall. The investigation revealed the Resident told the nurse on duty (Now the Director of Nursing (DON)) his right leg was numb, after he fell from bed. The DON observed the right leg to be discolored. The DON checked the strap and did not find any concerns. (However, the care plan clearly instructed no strap device to be used.) The investigation confirmed a temperature of 101.6 and rapid pulse following the fall on 8/7/22. The DON said in the investigation there were no signs of infection prior to the fall. But, the hospital emergency room note of 8/7/22 noted the Resident was on doxycycline 100 mg (milligrams) twice daily for UTI. And the facility Event Report, authored by the DON, noted a UTI as a contributing factor in the fall. The investigation confirmed the catheter was not changed since admission from 5/26/22 to 7/4/22, when the order for monthly changes was discontinued. The rationale was the monthly change did not comport with CDC (Centers for Disease Control) guidelines. The investigation did not account for clarifying the order with the ordering provider. The order was simply not followed. Resident #1's Care Plan revealed .signs of UTI (acute confusion .fever .) During an interview on 9/29/22 at 10:32 a.m., Registered Nurse (RN) F confirmed no catheter changes were performed since admission on 5/26/22. The physician order, dated 5/26/22 instructed a change of the urinary catheter monthly. A statement as part of the facility investigation, dated 8/21/22, revealed, .He (Resident #1) is independent and self transfers . This was incongruent with the care plan. The statement was authored by CNA D an agency staff. The Interview, undated, with the DON, revealed the DON checked Resident #1's blood pressure on the shift of the fall on 8/7/22. But, the EMR revealed no vital signs documented since 8/4/22. The progress note, dated 8/7/22 revealed a temperature of 101.6 and pulse of 153, but no other vital signs. During an interview on 9/29/22 at 8:45 a.m., the DON confirmed she was the nurse on duty on 8/7/22 when Resident #1 fell from bed. The DON was asked about the condition and vital signs of the Resident when he fell . The DON did not directly answer. When asked if there was a sepsis protocol in place, the DON was confused and did not understand the question. When asked if there was a procedure to follow to detect early sepsis, the DON said she didn't think so. When asked what early sepsis signs and symptoms were the DON could not say except that blood pressures and temperatures could vary. When asked about the catheter secure device as an adhesive versus a strap design, the DON said she was not aware at the time it was supposed to be an adhesive device. On 9/28/22 at 1:15 p.m., Resident #1 was in the room in a wheel chair with the right foot uncovered. The entire foot was purple red with blotchy patches up to the mid shin. The second and third toes were black and stuck to the adjacent toes which were fluid filled and had excoriating skin. The toes were clearly infected and deadened. The Resident said he could not eat his lunch on the tray because he had to look at his foot and lost his appetite. The catheter drainage bag was hanging on the wheel chair arm above the level of the bladder. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/28/22 at 1:33 p.m., RN A confirmed the catheter drainage bag should always be below the level of the bladder and not on the floor. During an interview on 9/28/22 at 1:36 p.m., the DON confirmed the catheter drainage bag should always be below the level of the bladder and not on the floor. The DON said Resident #1 would throw his drainage bag on the floor. When asked if any education or care plan interventions for education/explanation of the drainage bag was in place or happened previously, the DON confirmed it was not. During a follow up interview on 9/28/22 at 1:36 p.m., the DON was asked about a sepsis screening tool and whether one was used in the facility, and replied there was a McGeer's criteria used. The DON said she thought the McGeer's criteria was the sepsis screen but wasn't sure. Then, the DON said she didn't know what a sepsis screen was and none was used in the building, and she never was educated on using one as a floor nurse. On 9/28/22 at 2:55 p.m., CNA M was observed performing catheter care with Resident #1. There was white pus at the insertion site, which CNA M confirmed was not normal. RN A and the DON came to assess and both confirmed the pus was not normal. The DON, also the Infection Preventionist, said there was a urine analysis and culture awaiting results. The DON later confirmed a positive UTI. The Resident's urine was orange/yellow and clear in the drainage bag. The Resident's penis was deeply split at least two inches below the meatus and had a side insertion site for the catheter. There was a streak of bright redness in the penial tissue from the head to the catheter insertion site. On 9/29/22 at 9:30 a.m., Physician (Staff) E was at the bedside in Resident #1's room with Family Member (FM) C and this Surveyor. Staff E confirmed the Resident's right toes were necrotic and infected and dying due to a circulation (arterial) problem, not venous stasis, and that the Resident was not a surgical candidate for amputation of the foot. On 9/29/22 at 10:26 a.m., Resident #1 was observed asleep in the bed, with no mat on the floor (per care plan). The catheter drainage bag was on the floor not covered by a dignity bag. FM C was in the room and said there was an indentation on the leg from the strap in the hospital and provided pictures taken by hospital staff confirming the indentation with markings where the strap was and included the discoloration of the right leg. FM C said the very next day after the Resident was readmitted to the facility the strap was back on the leg, and provided a picture of the same. During an interview on 9/28/22 at 2:07 p.m., RN A confirmed she was the wound nurse and Resident #1's toes were arterial wounds that started as a small scabbed wound to the second right toe on re-admission from the hospital. At that time, the right second and third toes were blackened and stuck to the adjacent toes, which were pus filled with macerated skin. RN A said cleaning between the toes was not possible due to the toes would most likely fall off if moved. The right foot was cold according to RN A. The entire foot was reddened to the ankle. The Care Plan revealed a problem of open area to right foot on 9/15/22 with diagnosis of venous stasis ulcer related to PVD (peripheral vascular disease, an arterial circulation disease). During an interview on 9/29/22 at 11:25 a.m., the DON was asked what the wounds (necrosis) on Resident #1's toes were, and responded they were arterial ulcers from PVD. When asked why the care plan said they were venous ulcers, the DON did not know. When asked if there was a difference in treatment and care for arterial versus venous ulcers, the DON stated, I don't know. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The Event Report, authored by the DON, dated 9/13/22, revealed a venous ulcer on the top of the right second toe, with a scab. During an interview on 9/29/22 at 9:20 a.m., the DON confirmed she checked the drainage bag strap for tightness on the day of the fall, but didn't know then that the secure device was supposed to be an adhesive device, not a strap. On 9/29/22 at 9:30 a.m., Resident #1 was in the room with Staff E and Family Member (FM) C. The catheter drainage bag was on the floor. The Care Plan had no documented education of Resident #1 explaining the importance of keeping the drainage bag off the floor or below the bladder, or the medical need for the catheter. The policy, Incontinence Management, dated 1/2022, and confirmed by the DON on 9/29/22 at 3:28 p.m. as the only policy addressing catheter care, revealed, .Care planned approaches for catheter usage will include avoidance of infection, signs and symptoms of infection including pain, medical necessity for ongoing usage . avoidance of problems resulting of continued catheter usage .Based on current professional standards of practice, information and education for the resident .on the identification of risks and benefits for the use of a catheter must be documented .