

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155849	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/27/2023
NAME OF PROVIDER OR SUPPLIER RIVER TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 120 PRESBYTERIAN AVE MADISON, IN 47250		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00418252. Complaint IN00418252 - Federal/State deficiency related to the allegations is cited at F690. Survey date: September 27, 2023 Facility number: 013535 Provider number: 155849 AIM number: 300018660 Census Bed Type: SNF/NF: 32 Residential: 23 Total: 55 Census Payor Type: Medicare: 11 Medicaid: 19 Other: 2 Total: 32 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 30, 2023.	F 000			
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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F 690	<p>Continued From page 1</p> <p>condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure staff irrigated a resident's (Resident B) Indwelling catheter with the correct dosage of acetic acid which resulted in burning pain and a transfer to the emergency department for 1 of 3 residents reviewed for Indwelling catheters.</p>	F 690	Past noncompliance: no plan of correction required.		

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F 690	<p>Continued From page 2</p> <p>Findings include:</p> <p>During an interview on 9/27/23 at 2:40 p.m., Resident B was observed resting in bed with her eyes open. She indicated RN 2 came in her room and asked if the "stuff" for her catheter was in her room and Resident B told her no. A few minutes later, RN 2 came in her room with a big jug and said she had gotten some vinegar to irrigate her catheter. As soon as the vinegar hit up in there, she told RN 2 to stop because it was "screaming burning". RN 2 replaced her catheter and then flushed it with normal saline. She ended up going to the emergency department (ED) due to the pain she had in her bladder. While at the ED, the physician explained to her that she had a chemical burn and that he needed to remove her catheter so he could insert lidocane (used for pain) gel. He then inserted a new catheter and she was given Tramadol (pain reliever) 25 mg (milligrams). After treatment she was sent back to the facility. She was only supposed to get 0.25% (percent) of vinegar but RN 2 used 5%.</p> <p>The clinical record for Resident B was reviewed on 9/27/23 at 12:08 p.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of the bladder and obstructive and reflux uropathy. The admission MDS (Minimum Data Set) assessment, dated 9/13/23, indicated the resident's cognition was intact.</p> <p>The physician's order, dated 9/17/23, indicated to irrigate Resident B's Indwelling catheter with acetic acid 0.25% daily, between 6:00 a.m. and 6:00 p.m., for a urinary tract infection.</p> <p>The September 2023 medication administration record indicated the resident's Indwelling catheter</p>	F 690			

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F 690	<p>Continued From page 3</p> <p>was irrigated, as ordered by the physician, by RN (Registered Nurse) 2.</p> <p>The Medication Error Event, dated 9/23/23 at 9:55 p.m., indicated RN 2 irrigated Resident B's Indwelling catheter with 5% vinegar non-diluted.</p> <p>The progress note, dated 9/23/23 at 11:14 p.m., indicated the resident was sent to the emergency department for complaints of bladder pain.</p> <p>The emergency department transfer report, dated 9/24/23 at 2:49 a.m., indicated Resident B reported her Indwelling catheter was irrigated with the wrong concentration of vinegar and has had burning pain since. The Foley currently in place was new but the pain had not resolved. At 3:54 a.m., the resident received Lidocaine 2%, 400 mg (milligrams)/20 ml (milliliters) uro-jet and Tramadol 25 mg for pain at 4:32 a.m.</p> <p>The emergency department transfer report lacked documentation of a chemical burn.</p> <p>During an interview on 9/27/23 at 1:56 p.m., the Director of Nursing indicated RN 2 could not find the acetic acid. She went to the kitchen and got a new container of vinegar and flushed with that. When the resident complained of burning, RN 2 changed the Indwelling catheter and irrigated with normal saline. The resident later complained of bladder pain and was sent to the emergency department.</p> <p>During an interview on 9/27/23 at 2:35 p.m., RN 5 indicated the 5 rights of medication administration included the right medication and the right dose.</p> <p>On 9/27/23 at 3:12 p.m., the Director of Nursing</p>	F 690			

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F 690	<p>Continued From page 4</p> <p>provided a current, undated copy of the document titled "General Guidelines for Administration of Medication". It included, but was not limited to, "Purpose...To maintain safety and comfort of the patient regarding the administration of medication...Procedure...When administering a medication, the following steps should be followed...Check the physician's order to verify dosage specifics...Make note of the "five rights" to assure the proper administration of the medication...Right medication...right dose...."</p> <p>The deficiency cited was corrected, on 9/25/23, prior to the start of the survey, when the facility completed staff education which included to check the physician's order to verify the specifics of the dosage, and to ensure the five rights of medication administration were followed to include the right medication and the right dose.</p> <p>This Federal tag relates to Complaint IN00418252</p> <p>3.1-41(a)</p>	F 690			