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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00368788, IN00369109 and a Covid-19 Focused Infection Control Survey. Complaint IN00368788 - Substantiated. Federal/state deficiencies related to the allegations are cited at F622, F690, and F842. Complaint IN00369109 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677. Unrelated deficiencies are cited. Survey dates: December 17, 20, and 21, 2021 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 18 Medicaid: 53 Other: 28 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 28, 2021	F 0000	**The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation.** **This provider respectfully requests that State Report Plan of Correction be considered the Letter of Credible Allegation. The provider alleges compliance as of 1-19-2022** **The facility respectfully requests a desk review for this Plan of Correction relative to the low scope and severity of this survey in lieu of a post-survey revisit.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) 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, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility			

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	in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to provide a dignity cover for 2 of 3 residents reviewed for dignity related to urinary catheter usage. (Resident D and E) Findings include: 1. The clinical record for Resident D was reviewed on 12/20/2021 at 12:01 p.m. The diagnoses include, but are not limited to, dependence on respirator, personal history of urinary tract infection, stage 3 pressure ulcer, and stage 4 pressure ulcer. An Admission Minimum Date Set, dated 9/2/2021, indicated Resident D had impaired cognition, needed extensive to total assistance for all activities of daily living, and had an indwelling urinary catheter in place. An observation of Resident D on 12/20/2021 at 2:20 p.m., indicated he was resting in bed. He had his urinary catheter bag hanging of the frame of the bed without a dignity cover and a medium amount of yellow urine was visible in the collection bag. 2. The clinical record for Resident E was reviewed on 12/20/2021 at 12:55 p.m. The diagnoses include, but are not limited to, tracheostomy, cerebral infarction (stroke), and narcolepsy. A Significant Change Minimum Date Set, dated	F 0550	**F 550: Resident Rights** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. Resident(s) D and E were identified during the time of observation. All Nurses and CNAs have been educated on Residents and Dignity specific to catheter covers.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. A campus wide review was completed to ensure all Residents utilizing a catheter have appropriate covers in place.3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure catheter covers are in place. The plan will be revised, as warranted.4. How the corrective action(s) will be monitored to ensure the deficient	01/17/2022

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	9/28/2021, indicated that Resident E was cognitively impaired, needed extensive to total assistance for all activities of daily living, and had an indwelling catheter. It was observed on 12/20/2021 at 2:34 p.m. that Resident E was in bed. A urinary catheter collection bag was hanging off the frame of his bed at the foot with a large amount of yellow urine visible. An interview with LPN 1 on 12/20/2021 at 2:40 p.m. indicated that residents should have urinary collection bag covers on to maintain their privacy. She was unaware that both residents did not have covers. No policy addressing urinary catheter covers was produced. 3.1-3(t)		practice will not recur, i.e., what quality assurance program will be put into place.1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;			

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	(D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical			

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	record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to ensure the appropriate information was communicated to the receiving provider to assist with providing continuity of care for a resident transferred to the hospital for	F 0622	**F 622: Transfer and Discharge Requirements** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	01/17/2022

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	2 of 3 residents reviewed for hospitalization. (Resident B and C) Findings include: 1. The clinical record for Resident B was reviewed on 12/17/21 at 1:35 p.m. The diagnoses for Resident B included, but were not limited to, retention of urine and obstructive and reflux uropathy (blockage in urinary tract). A nursing progress note dated 12/5/21 indicated Resident B had a fever and was transferred to the hospital for evaluation. The clinical record did not indicate a written transfer form was completed; that would include the care needs of Resident B, nor a verbal report was provided at the time of transfer with Emergency Medical Services (EMS) or to the hospital personnel. The Hospital Record dated 12/5/21 indicated Resident B "...presents emergency department for evaluation. Patient arrives by EMS states that they did not receive report from nursing staff at ECF [Extended Care Facility]. They state the only information I received was that the patient had a fever of 105 [degrees Fahrenheit] today and received Tylenol. They report that the patient is COVID positive but unknown onset of symptoms or date of testing positive. Attempted to receive report from nursing staff at ECF multiple times..." An interview was conducted with Resident B's Representative on 12/17/21 at 4:04 p.m. She indicated the facility staff did not send paperwork with Resident B when she was transferred to the hospital.		practice.1. Resident(s) B and C were identified during the time of observation. All Nurses have been educated on transfer and discharge assessment and documentation.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.1. All Residents have the potential to be affected by this practice.2. A campus wide review was completed to ensure all Residents within the last 30 days that have transferred or discharged have appropriate documentation as warranted,3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly x4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure catheter covers are in place. The plan will be revised, as warranted.4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.For quality assurance, the DHS or designee will review any findings	

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	An interview was conducted with the Director of Nursing (DON) and the Clinical Regional Support (CRS) on 12/20/21 at 3:37 p.m. The CRS indicated a transfer form should be filled out and sent with a resident that was to be transferred to the hospital. The nursing staff had not completed the transfer form for Resident B. The DON indicated she had received a call by the hospital staff that day indicating they were having trouble getting report about Resident B from the facility nursing staff. She indicated she had notified the facility and had addressed with nursing. 2. A health status note dated 11/30/21 at 8:05 a.m. indicated, Resident C was unable to move her right arm or turn her head that morning. Resident C's speech was "different than her usual" and was responding only with one-word answers even when asked an open-ended question. An order was received to send Resident C to the ER (emergency room) for evaluation and treatment. A health status note dated 11/30/21 at 8:12 a.m. indicated, EMS (emergency medical services) arrived to transport Resident C to the ER. The clinical record for Resident C was reviewed on 12/20/21. Resident C's clinical record contained an eINTERACT transfer form. The transfer form did not contain the current list of medications to include when administered last. The clinical record did not indicate if the medication list to include when last administered was sent with Resident C when she went to the ER. An interview with CRS (Clinical Regional Support) was conducted on 12/20/21 at 3:47			

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p.m. CRS indicated; a medication list should be sent along with the resident when being transferred out of the facility.

A Transfer or Discharge Documentation policy was provided by the CRS on 12/20/21 at 3:47 p.m. It indicated, "Policy Statement...4.When a resident is transferred or discharged, details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider...When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: a. The basis for the transfer or discharge...b. That an appropriate notice was provided to the resident and/or legal representative c. The date and time of the transfer or discharge; d. The new location of the resident; e. The mode of transportation; f. A summary of the resident's overall medical, physical, and mental condition; g. Disposition of personal effects; h. Disposition of medications...7. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. the basis for the transfer or discharge; (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: a) the specific resident needs that cannot be met; b) this facility's attempt to meet those needs; and c) the receiving facility's service(s) that are available to meet those needs. b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate;

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	f. Comprehensive care plan goals; and g. All other necessary information, including a copy of residents discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care." This Federal tag relates to Complaint IN00368788. 3.1-12(a)(3)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review, and interview, the facility failed to ensure dependent residents received assistance with activities of daily living related to not providing showers or bed baths for 2 of 3 residents reviewed for activities of daily living. (Resident C and Resident E) Findings include: 1. The clinical record for Resident C was reviewed on 12/20/21. Resident C's diagnoses included, but not limited to, fracture of left humerus (arm), dementia with behavioral disturbance, chronic pain syndrome, and major depressive disorder. The admission MDS (minimum data set) dated 11/30/21 indicated, Resident C required physical assistance of one person in part of activity for bathing and extensive assistance of one person for transfers.	F 0677	**F 677: ADL Care for Dependent Residents** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) C and E were identified during the time of observation. All care team members have been educated on Resident rights, shower preferences, and ADL care. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this	01/17/2022

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	Resident C's most recent care plan was provided by DON (Director of Nursing) on 12/20/21 at 3:17 p.m. It indicated, Resident C needed assistance with activities of daily living related to activity intolerance, dementia and fracture of left humerus. Interventions included, but not limited to, staff assistance of 2 persons to assist resident to transfer safely from surface to surface with appropriate equipment; and bathing/showering: nail care on bath day and as necessary. A copy of Resident C's "Bathtime Skin Anatomy Diagram" sheet dated 11/25/21 was provided by CRS (Clinical Regional Support) on 12/21/21 at 11:49 a.m. The sheet only contained a signature of a nurse aide and a nurse otherwise the sheet was left blank. A copy of Resident C's "Bathtime Skin Anatomy Diagram" sheet dated 11/29/21 was provided by CRS (Clinical Regional Support) on 12/21/21 at 11:49 a.m. The sheet only contained a signature of a nurse aide and a nurse otherwise the sheet was left blank. The clinical record for Resident C was reviewed on 12/20/21. In the tasks tab under showers, no documentation was noted which indicated if Resident C received a shower or bed bath, if her hair was washed, or if nail care was performed between 11/23/21 and 11/30/21. An interview with CRS was conducted on 12/20/21 at 11:51 a.m. CRS indicated, the bath time skin anatomy diagram sheets are what the facility uses to record if a shower/bed bath was completed and that usually the aide would write something on the sheet. The bath time skin anatomy sheet did not have a spot to indicate if		practice. 2. A campus wide review was completed to ensure all dependent Residents had documented shower preferences and scheduled days. All Residents were offered showers. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure ADL care is provided and upheld. The plan will be revised, as warranted. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until	

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	shower/bed bath was given/refused, hair was washed, or nail care completed. A Shower/Tub Bath policy was received from CRS on 12/21/21 at 12:12 p.m. It indicated, "Documentation 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data." 2. The clinical record for Resident E was reviewed on 12/20/2021 at 12:55 p.m. The diagnoses include, but are not limited to, flaccid hemiplegia, cerebral infarction (stroke), and narcolepsy. A Significant Change Minimum Data set, dated 9/28/2021, indicated Resident E needed physical assistance of two caregivers for bathing tasks. During an observation of Resident E on 12/20/2021 at 2:34 p.m. it was indicated his hair was unkept, had a noticeable odor, and the fingernails of his right hand were dirty. There was no care plan that addressed bathing/showering. A task (care assignment) indicated Resident E was to receive showers on Sunday and Wednesday night shift.		substantial compliance has been determined.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF CONNERSVILLE	1029 E 5TH STREET CONNERSVILLE, IN 47331

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"BATHTIME SKIN ANATOMY DIAGRAM" sheets provided for Resident E indicated he was receiving complete bed baths on 11/27/2021, 12/1/2021, 12/5/2021, and 12/8/2021, not showers as indicated in his care assignment. No additional baths/showers were documented either on paper or in the electronic record since 11/20/2021.

Additional "BATHTIME SKIN ANATOMY DIAGRAM" sheets were provided for Resident E dated 11/25/2021, 12/12/2021, 12/15/2021, and 12/19/2021. These did not indicate what kind, if any, bathing/shower care was provided. No documentation was provided for 11/20/2021 to 11/25/2021.

An interview with CNA 3 on 12/21/2021 at 1:15 p.m., indicated that staff were to document the care they provide, including the type of bath, nail care, shaving, and/or hair care on the BATHTIME SKIN ANATOMY DIAGRAM and then have the nurse sign off.

A policy, entitled "Bath, Shower/Tub", was provided by the Clinical Regional Support on 12/21/2021 at 11:31 a.m. The policy indicated documentation should include the date/time the care was provided as well as documentation of any refusals.

This Federal tag related to Complaint IN00369109.

3.1-38(a)(2)(A)
3.1-38(a)(3)(A)
3.1-38(a)(3)(B)
3.1-38(b)(2)

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §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 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (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 (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. §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.			
	Based on interview and record review, the facility failed to ensure staff monitored and	F 0690	**F 690: Bowel/Bladder incontinence, Catheter, UTI** 1. What corrective action(s)	01/17/2022

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	recorded urinary output for a resident with a catheter, follow up on an ordered a urinalysis (UA), follow up on lab results resulting in a delay of treatment of a urinary tract infection, and ensure urinary catheter bag remained off the floor for 2 of 3 residents review for indwelling catheter care and 1 of 3 residents reviewed for urinary tract infections. (Resident B, D, and F) Findings include: 1a. The clinical record for Resident B was reviewed on 12/17/21 at 1:35 p.m. The diagnoses for Resident B included, but were not limited to, retention of urine and obstructive and reflux uropathy (blockage in urinary tract). The Annual MDS (Minimum Data Set) Assessment dated 7/30/21, indicated Resident B had an indwelling catheter. A "Readmission Evaluation" dated 11/18/21 indicated Resident had an indwelling catheter. A care plan dated 9/15/21 indicated "[Resident B] is at risk for infection/complications related to Indwelling Catheter d/t [due to] urinary retention, obstructive and reflux uropathy...Interventions...document catheter output every shift..." An interview was conducted with the Clinical Regional Support (CRS) on 12/21/21 at 2:59 p.m. She indicated she was unable to provide recorded urine output amounts for Resident B. 1b. A nursing progress note dated 10/28/21 indicated an order was placed to obtain a urine sample, due to Resident B had an increase in her temperature.		will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) B, D, and F were identified during the time of observation. All Nurses have been educated on Catheter care, urinary output and lab services. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all Residents with a catheter have appropriate diagnosis, labs, and urinary output. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure catheter care is provided as ordered by the physician.	

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	A physician order dated 10/31/21 indicated the staff was to obtain a urine sample from Resident B. A Urinalysis lab report date collected on 10/28/21 and reported on 11/1/21, indicated abnormal findings of Resident B's urine sample. The urine was amber in color and cloudy. The UA reported the urine sample pH was elevated, and contained abnormal findings of glucose, bilirubin, protein, leukocytes, white blood cells, epithelial cell, bacteria, triple phosphate crystal, amorphous and mucus. It indicated, "...Greater than or equal to 3 organisms isolated. Probable contaminant. Contact the laboratory within 48 hours if identification is clinically indicated..." The clinical record did not have documentation the staff had followed up on the resident's UA. An interview was conducted with Resident B's Representative on 12/17/21 at 4:04 p.m. She indicated Resident B had a fever and was transferred to the hospital by request. The resident was diagnosed with a urinary tract infection. The Hospital Record dated 12/5/21 indicated Resident B "...presents emergency department for evaluation. Patient arrives by EMS [Emergency Medical Services]...They state the only information I received was that the patient had a fever of 105 [degrees Fahrenheit] today and received Tylenol. They report that the patient is COVID positive but unknown onset of symptoms or date of testing positive..." During the hospitalization, Resident B was diagnosed and treated for Urinary Tract Infection.		4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	

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An interview was conducted with the CRS on 12/21/21 at 10:47 a.m. she indicated another urine sample should have been obtained, and the UA should have been redone.

An interview was conducted by License Practical Nurse (LPN) 2 on 12/21/21 at 11:20 a.m. She indicated she had spoken to the lab, and they had reported the facility staff should have requested for a sensitivity to be sent with UA for Resident B.

2. The clinical record for Resident D was reviewed on 12/20/2021 at 12:01 p.m. The diagnoses included, but were not limited to, dependence on respirator, stage 3 pressure area, stage 4 pressure area, and history of urinary tract infection.

An Admission Minimum Date Set, dated 9/2/2021, indicated Resident D had impaired cognition, needed extensive to total assistance for all activities of daily living, and had an indwelling urinary catheter in place.

An indwelling catheter care plan dated 9/16/2021 indicated that Resident D was at risk for infection due to his indwelling catheter with an intervention to notify MD of abnormal findings and to observe for symptoms of urinary tract infection including change in color or smell of urine.

Resident D utilized as needed midodrine for low blood pressure. In the month of November, he utilized this medication 7 times in 30 days. For the month of December, he had utilized this 11 times in 20 days.

CNA documentation reviewed for Resident D indicated the volume of urine emptied out of bag

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	every shift was usually documented, but did not indicate color, odor, or clarity. A physician order dated 12/7/2021 for urinalysis (UA) with culture if indicated for increased sediment in Resident D's urine. A nursing note dated 12/7/2021 indicated the UA was obtained and sent with the outside lab. This note also indicated Resident D had thick white sediment in his urine. A laboratory report, finalized on 12/10/2021 from UA collected on 12/7/2021, indicated Resident D had equal to or greater than 3 organisms in his sample and for staff to contact lab within 48 hours if identification is indicated. The urine on this sample was noted to the amber (dark) and turbid (cloudy). It was positive for white blood cells and bacteria, indicative of potential infection. A nursing note dated 12/12/2021, indicated UA results stated possible contamination and to contact lab within 48 hours but was not followed up on within 48 hours. Attending practitioner gave an order to repeat UA. A nursing note dated 12/12/2021, indicated UA was obtained. The urine in this sample was straw colored with sediment present. A nursing note dated 12/15/2021, indicated the nurse attempted to follow up on the second UA, but lab was not able to complete their request for culture and to have the day shift nurse complete. A laboratory report, finalized on 12/15/2021 from UA collected on 12/12/2021, indicated Resident D had greater than or equal to 3			

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organisms in his sample and for staff to contact lab within 48 hours if identification is indicated. The urine on this sample was noted to be yellow and cloudy. It was positive for white blood cells and bacteria, indicative of a potential infection.

No further nursing note was made until 12/17/2021.

A nursing note dated 12/17/2021 a, indicated Resident D was found unresponsive at 9:45 p.m. and sent to the Emergency Room (ER).

An ER Physician Note, dated 12/17/2021, indicated that Resident D had his urinary catheter change and UA obtained at the ER that indicated positive bacteria and white blood cells. Resident D was started on Macrobid (antibiotic) pending culture due to the positive UA and recurrent urinary tract infections (UTI).

A nursing note on 12/19/2021 indicated that Macrobid was not effective for all organisms present in Resident D's UA that was obtained during his ER visit on 12/17/2021. The attending practitioner was contacted to change antibiotic treatment. Resident D had previous antibiotic order discontinued then was started on oral and intravenous antibiotics at that time. This note indicated Resident D also had a fever that was treated with as needed antipyretics.

An interview with LPN 1 on 12/20/2021 at 2:37 p.m., indicated that lab faxes a UA report within 48 hours. The nurse taking care of the resident should be following up on this every shift and passing it on during report.

An interview with the Clinical Regional Support on 12/20/2021 at 3:31 p.m., indicated that UA

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should be followed up on every shift by the floor nurse. The expected time from collection to start of treatment if indicated should be 3-4 days.

A policy entitled, "Culture Results", was provided by the Director of Nursing on 12/20/2021 at 2:48 p.m. The policy indicated, "Should the Attending Physician order cultures, they shall be obtained and completed as soon as practical. All test results shall be reported to the physician as soon as the results are obtained."

A policy entitled, "Catheter Care, Urinary", was provided by the Director of Nursing on 12/20/2021 at 2:48 p.m. The policy indicated for staff to observe for complications of urinary catheters including checking the urine for unusual appearance such as color, blood, etc. The policy further indicated the characteristic of urine such as color, clarity, and odor should be documented.

3. The clinical record for Resident F was reviewed on 12/20/2021 at 3:38 p.m. The diagnoses included, but were not limited to, history of urinary tract infection, stage 3 kidney disease, and obstructive and reflux uropathy.

A Quarterly Minimum Date Set, dated 10/6/2021, indicated Resident F was cognitively intact, needed extensive assistance with activities of daily living, and had an indwelling urinary catheter present.

An indwelling catheter care plan indicated Resident F was to have catheter drainage bag and tubing below level of bladder.

An observation on 12/20/2021 at 3:01 p.m. indicated Resident F sitting in his wheelchair

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	with the bottom inch of his catheter drainage bag contacting the floor. An observation on 12/20/2021 at 4:30 p.m. indicated Resident F sitting in his wheelchair with the bottom inch of his catheter drainage bag contacting the floor. An observation on 12/21/2021 at 9:32 a.m. indicated Resident F sitting in his wheelchair with the bottom inch of his catheter drainage bag contacting the floor. An observation on 12/21/2021 at 11:05 a.m. indicated Resident F was sitting in his wheelchair with the bottom inch and half of his catheter drainage bag contacting the floor. An observation on 12/21/2021 at 1:15 p.m. indicated Resident F was sitting in his wheelchair with his catheter drainage bag hanging below his wheelchair, both drainage bag and tubing is free of contact with the floor. A policy, entitled "Catheter Care, Urinary", was provided by the Clinical Regional Support on 12/20/2021 at 2:48 p.m. The policy indicated, "Purpose. The purpose of this procedure is to prevent catheter-associated urinary tract infections...Be sure the catheter tubing and drainage bag are kept off the floor...Steps in the Procedure... Documentation. The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any			

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	problems noted at the catheter-urethral junction during a perineal care such drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and tile of the person recording the data..." This Federal tag relates to Complaint IN00368788. 3.1-41(a)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,			

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	regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission			

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	screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure a resident's medical record was complete and accurate regarding the care of a catheter for 1 of 3 residents reviewed for catheter and failed to document a change in condition timely for a resident who had increased confusion and a change in the ability to communicate for 1 of 3 residents reviewed for hospitalization. (Resident B and Resident C) Findings include: 1. The clinical record for Resident B was reviewed on 12/17/21 at 1:35 p.m. The diagnoses for Resident B included, but were not limited to, retention of urine and obstructive and reflux uropathy (blockage in urinary tract). A physician order dated 10/21/21 indicated the staff was to change Resident B's catheter monthly. A physician order dated 11/22/21 indicated the staff was to provide catheter care every shift. The November 2021 Treatment Administration Record (TAR) indicated Resident B's catheter was changed on 11/20/21 by License Practical Nurse (LPN) 5 and 11/21/21 by LPN 4. LPN 4, LPN 5, and LPN 6 documented catheter care was provided to Resident B on 11/20/21 and 11/21/21.	F 0842	**F842: Resident Records-Identifiable information** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) B and C were identified during the time of observation. All Nurses have been educated on change in condition and Resident assessment. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide review was completed to ensure that all Residents with a change in condition have had appropriate assessment and review. 3. What measures will be put into place and what systemic	01/17/2022

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	The clinical record did not indicate documentation by the nursing staff on the procedure performed of the removal or replacing of the resident's catheter. An interview was conducted with LPN 4 on 12/21/21 at 11:32 a.m. She indicated the previous Director of Nursing (DON) was assisting her with care to the resident that day. She had not changed Resident B's catheter nor provided any care to the catheter on 11/21/21 as documented. An interview was conducted with LPN 5 on 12/21/21 at 11:52 a.m. She indicated she had not changed Resident B's catheter on the night of 11/20/21 nor provided any care to a catheter for the resident as documented. The resident did not have a catheter during her shift. She had received report from the previous shift nurse the resident's 16 French catheter had been removed but had not been replaced. An interview was conducted with LPN 6 on 12/21/21 at 12:03 p.m. She indicated she had worked on 11/20/21 on the day shift. She had not provided catheter care as documented. The resident's catheter had been removed on the previous shift. A Catheter Care policy was provided by the Clinical Regional Support (CRS) on 12/20/21 at 1:00 p.m. It indicated, "Purpose. The purpose of this procedure is to prevent catheter-associated urinary tract infections...Steps in the Procedure...Documentation. The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of		changes will be made to ensure that the deficient practice does not recur. 1. DHS or Designee will complete an audit at varied times on varied shifts five times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all change in conditions have been reviewed and documented as appropriate. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. 1. For quality assurance, the DHS or designee will review any findings daily, with subsequent corrective action and education for identified staff. 2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155491	A. BUILDING 00 B. WING	12/21/2021

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the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction during a perineal care such drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and tile of the person recording the data..."

2. The clinical record for Resident C was reviewed on 12/20/21. Resident C's diagnoses included, but not limited to, fracture of left humerus (arm), dementia with behavioral disturbance, chronic pain syndrome, and major depressive disorder.

A nursing note dated 11/24/21 at 4:37 p.m. indicated, Resident C was alert and oriented to person, place, time, and situation.

A physician's note dated 11/27/21 at 6:36 p.m. indicated, Resident C was oriented, followed commands, was pleasant and talkative.

A health status note dated 11/28/21 at 11:39 a.m. indicated, "Daughter called...concerned that mother might be having a UTI [sic, urinary tract infection]. Daughter states that when mother is not able to finish her sentences d/t [sic, due to] increased confusion it is an indicator for her of a UTI." An order for a urine analysis was received.

A physician's order for a urine analysis was placed on 11/29/21 at 1:02 a.m.

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	An interview with LPN (Licensed Practical Nurse) 2 was conducted on 12/21/21 at 10:10 a.m. LPN 2 indicated, she had not assessed Resident C prior to receiving the phone call from Resident C's daughter. She stated, after the phone call with Resident C's daughter, she went to Resident C's room and assessed her. She indicated, Resident C was confused and that she was "understanding some things, but not everything", but she was unfamiliar with Resident C's baseline. LPN 2 did not document a change in condition for Resident C. LPN 2 did not document her assessment and/or findings after she had assessed Resident C and noted her altered mental status. An administration note dated 11/29/21 at 4:01 p.m. indicated, the urine sample for the urine analysis was obtained. An interview with LPN 10 was conducted on 12/20/21 at 2:54 p.m. She indicated; she was the nurse for Resident C on 11/29/21. During her assessment of the resident, she noted Resident C was confused and called the nurse practitioner who indicated they were aware of Resident C's increased confusion and that was why they had ordered a urine analysis (UA) with culture. The direction she received was to "collect the UA and they will look at it". She further stated, she is agency staff, so she gets floated all over the facility and this was her first time caring for Resident C, but she just knew something was "not right" with Resident C and that was why she called the nurse practitioner. LPN 10 did not document a change in condition for Resident C. LPN 10 did not document her assessment and/or findings after she had assessed Resident C and noted her altered mental status.			

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A health status note dated 11/30/21 at 8:05 a.m. indicated, "Resident unable to move her right arm and unable to turn her head to look at me when I'm speaking to her. Resident is speaking but her speech is different than her usual-she is only responding with one word replies even with open ended questioning."

A change in condition note was written on 11/30/21 at 8:07 a.m. It indicated, the change in condition reported was altered mental status, stroke/cerebral vascular accident/transient ischemic attack/new neurological signs.

An interview with DON (Director of Nursing) was conducted on 12/20/21 at 4:14 p.m. DON indicated, a change of condition should be documented in the clinical record on the day in which the change of condition had been identified and the physician notified. She stated, in the regards to an altered mental status change, she would consider it to be an acute change in condition.

A change in condition policy was provided on 12/20/21 at 4:12 p.m. by DON. It indicated, "Procedure:
1. Life Threatening Change in Condition
a. The licensed nurse will initiate appropriate first aide measures until emergency response personnel arrive on the scene.
b. The licensed nurse will inform the attending physician of Medical Director of resident status as soon as possible.
c. The licensed nurse will notify the family/responsible party of resident change of condition and document notification.
d. The charge nurse will notify the Director of Nursing Services or Executive Director, as appropriate.

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2. Acute Change in Condition
a. Any sudden or serious change in a resident's condition will be communicated to the physician.
b. The responsible party will be notified that there has been a change in the resident's condition.

3. Non-Urgent Change in Condition
a. All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician/NP[sic, nurse practitioner]
b. The charge nurse is responsible for notification of physician and family/responsible party prior to end of the shift.
c. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow up."

This Federal tag relates to Complaint IN00368788.

3.1-50(a)(1)
3.1-50(a)(2)