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	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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 Complaint IN00362091, IN00362579, IN00364917, and IN00365025. Complaint IN00362091 - Substantiated. Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00362579 - Substantiated. Federal/state deficiencies related to the allegations are cited at F757, F842, and F880. Complaint IN00364917 - Substantiated. Federal/state deficiencies related to the allegations are cited at F686. Complaint IN00365025 - Unsubstantiated due to lack of evidence. Unrelated deficiencies are cited. Survey dates: October 18, 19, 20, and 21, 2021 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 13 Medicaid: 54 Other: 35 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	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 11-12-2021 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

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F 0677 SS=E Bldg. 00	Quality review completed on October 28, 2021 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 observation, interview and record review, the facility failed to assist dependent residents with showers for 4 of 7 residents reviewed for Activities of Daily Living (ADL) assistance. (Resident M, E, K, and N) Findings include: 1. Resident M's record was reviewed on 10/20/21 at 2:30 p.m. and indicated she had diagnoses that included, but were not limited to, weakness on non-dominant side following a cerebral infarction, difficulty in walking, and generalized muscle weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 9/16/21, indicated Resident M was cognitively intact, speech was clear and she makes herself understood, understands others, required extensive assistance of one for ADL's, had impairment on one side of upper and lower extremities in functional limitation in range of motion, and used a walker and a wheelchair. A care plan, dated 11/4/19, indicated a focus for: "[Resident M's] preferences for daily care include: Showers: 2x/ weekly Showering time of day: Evenings Get up time: No preference Bed time: No preference	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) M,E, K, and N 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 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.	11/12/2021

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	Goal: Personal preferences will be honored through next review. Interventions: Attempt and ensure that resident's preferences are honored daily. Showers on Wednesday and Saturday evening." A care plan, dated 10/29/19, indicated a focus for: "[Resident M] needs assistance with activities of daily living. Goal: [Resident M] will have care needs met daily with assistance of staff. Interventions...PERSONAL HYGIENE: Staff assistance of one to assist resident with her personal hygiene...ADL - Bathing...." Review of shower documentation indicated Resident M received showers on the following days in September, 2021: 9/14, 9/15, 9/22, 9/24, and 9/30/21. Review of shower documentation for October, 2021, indicated Resident M received showers on the following days: 10/6 and 10/13/21. On 10/21/21 at 9:25 a.m., a family member indicated Resident M has had 3 showers this month and she finally got a shower yesterday. On 10/21/21 at 12:55 p.m., Resident M said she isn't getting showers and she has "had 2 showers here lately". On 10/21/21 at 12:34 p.m., the Regional Nurse Consultant indicated they don't know a shower has been given if there is no documentation. 2. During an observation, on 10/19/2021 at 1:22 p.m., Resident E had unkempt hair with small tangles on the back of the head and a noticeable smell of urine in the room. During an observation, on 10/20/2021 at 10:32		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 three times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure shower preferences and showers are 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 substantial compliance has been determined.	

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	a.m., there was a noticeable smell of urine in the room. A moderate amount of urine was on the top sheet and bed pad. CNA 7 provided incontinence care and linen change. The clinical record for Resident E was reviewed, on 10/20/2021 at 2:21 p.m. The record indicated Resident E had diagnoses that included, but were not limited to, unsteadiness on feet, dementia in other disease classified elsewhere with behavioral disturbance, and weakness. The Minimum Data Set (MDS) assessment for Resident E, dated 8/7/2021, indicated the resident was moderately cognitively impaired and was dependent with the assist of one for bathing tasks. The care plan, for Resident E, dated 8/16/2021, indicated "...will have care needs met daily with assistance of staff. Showers per preference Tuesday and Fri day shift." The shower documentation for Resident E indicated resident had not received a shower form 9/3/2021 to 9/18/2021. In total, the resident had 4 bed baths and no showers in the month of September 2021. 3. During an interview, on 10/19/2021 at 1:41 p.m., Resident K indicated he doesn't get showered as often as he should and said he should be showered twice a week. During an observation, on 10/19/2021 at 1:41 p.m., Resident K's skin appeared dry and he had long nails. Resident K indicated his last shower was over 2 week ago.			

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	The clinical record for Resident K was reviewed, on 10/20/2021 at 12:06 p.m. The record indicated Resident K had diagnoses that included, but were not limited to, repeated falls, weakness, and difficulty walking. The Quarterly MDS assessment for Resident K, dated 9/18/2021, indicated the resident was mildly cognitively impaired and needed assistance for physical help in bathing by one staff member. The care plan for Resident K, dated 8/6/2021, indicated "preferences for daily care and care planning include: Showering: Showers 2x Weekly Bathing Time of Day: nights-before bed." The electronic shower documentation indicated one shower given 9/10/2021. Documents entitled "BATHTIME SKIN ANATOMY DIAGRAM" were provided on 10/20/2021 at 1:33 p.m. by Regional Nurse Consultant (RNC) dated 9/6/2021 and indicated resident K refused bathing. Additional "BATHTIME SKIN ANATOMY DIAGRAM" documents were provided for dates 9/13/2021, 9/16/2021, and 9/30/2021 without indication of type of bathing provided, if any. The electronic shower documentation showed no showers given from 10/2/2021 until 10/19/2021. No paper documentation was provided for this time frame. 4. During an interview, on 10/21/2021 at 10:03 a.m., Resident N indicated she is not getting a shower regularly. She indicated and was observed to have greasy hair and appear somewhat unkempt. The clinical record for Resident N was reviewed, on 10/21/2021 at 10:22 a.m.. The record indicated			

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	Resident N had diagnoses that included, but were not limited to, type 2 diabetes mellitus, unsteadiness on feet, and muscle weakness (generalized). A Significant Change MDS assessment for Resident N, dated 9/16/2021, indicated the resident was mildly cognitively impaired and dependent on assistance of one for bathing tasks. The care plan for Resident N, dated 10/21/2021, indicated "preferences for daily care and care planning include: Showering: Showers 2x Weekly Bathing Time of Day:Morning." The shower documentation from Resident N, indicated no bathing care was provided from 10/7/2021 until 10/14/2021 and from 10/15/2021 until 10/21/2021. A policy entitled, "Bath, Shower/Tub", provided by RNC on 10/21/2021 at 10:35 a.m.. The policy indicated, but was not limited to, "The date and time the shower/tub bath was performed...All assessment data." An interview with CNA 7, on 10/20/2021 at 11:07 a.m., indicated that it is the expectation that CNA charting, including shower documentation, is completed every shift. An interview with LPN 9, on 10/20/2021 at 1:31 p.m., indicated that is the expectation for CNAs to document every shift and report refusals of care to the nurse for further assessment if needed. An interview with RNC, on 10/21/2021 at 10:35 a.m., indicated that if showers were completed, they would be documented in the electronic record or on the "BATHTIME SKIN ANATOMY			

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	DIAGRAM". This Federal tag relates to Complaint IN00362091. 3.1-38(a)(2)(A) 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(b)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to obtain a physician's order for the indication and care for a Foley Catheter (indwelling urinary catheter) for 1 of 1 resident reviewed for Foley Catheter care. (Resident J) Findings include: During an observation, on 10/20/2021 at 2:41 p.m., Resident J was in bed, and her Foley Catheter bag was laying on the floor. CNA 8 was notified and hung the Foley Catheter bag on the bed frame to keep the bag and tubing free from contact with the floor. The clinical record for Resident J was reviewed,	F 0684	**F 684: Quality of Care** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. 1. Resident(s) J were identified during the time of observation. All care team members have been educated physician orders, catheter care, and bowel/bladder polices. 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.	11/12/2021

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	on 10/20/2021 at 4:02 p.m., and indicated diagnoses that included, but were not limited to, displaced trimalleolar fracture of the right lower leg and type 2 diabetes mellitus without complication. There was no Minimum Data Set assessment finalized at this time due to the resident being a new admission. There was no care plan on record in regard to Foley Catheter care or placement for Resident J. There were no physician's orders for the Foley Catheter, indication for use, or catheter care for Resident J. Skilled nursing documentation from 10/10/2021 indicated "indwelling/suprapubic catheter" present. On 10/20/21, at 2:43 p.m., CNA 8 indicated that Foley Catheter care is completed every shift as part of Resident J's care. CNA 8 stated Resident J had a catheter because Resident J was unable to get up. In an interview with Regional Clinical Support (RNC), on 10/21/2021 at 11:35 a.m., indicated that no order for the Foley Catheter, indication for its use, or Foley Catheter care could be located. It is the expectation that Foley Catheter care is provided every shift. A policy entitled "Bowel and Bladder Program", last revised July 2020, was provided by RNC, on 10/20/2021 at 3:43 p.m. The policy included, but was not limited to, "...Resident who have an indwelling urinary catheter will be assess upon admission...Assessment will include diagnosis		1. All Residents with a catheter have the potential to be affected by this practice. 2. A campus wide review was completed to ensure all Residents with a catheter are accompanied with a physician order, care plan and diagnosis. 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 three times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all catheters are managed as ordered. 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.	

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	and/or rational for the use of the catheter...If it is determined an indwelling catheter IS medically necessary, obtain a physician's order with the size of catheter, frequency of changing, and the diagnosis or condition to support use...It is recommended that catheter care be performed every shift or as indicated per physician order." 3.1-37(a)		2. Findings will be reported at the QA meeting monthly or until substantial compliance has been determined.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to provide a treatment and dressing change for pressures ulcers and failed to implement an air mattress as ordered by the physician for a resident with pressure ulcers for 1 of 3 resident's reviewed for pressure ulcers (Resident H). Finding include: During an interview and observation with	F 0686	**F 686: Treatment Services to Prevent** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. Resident(s) H were identified during the time of observation. All Nurses have been educated on wound care, treatment services, and orders. Resident H was immediately	11/12/2021

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	Resident H on 10/19/21 at 12:00 p.m., indicated she had pressure ulcers on her back side and the treatment and dressings were not always completed. The resident indicated this happened frequently and they were not changed yesterday (10/18/21). The resident was observed laying in bed on a regular mattress. During an observation on 10/19/21 at 12:10 a.m., RN 2 completed Resident H's pressure ulcer treatment and dressing change on the following pressure ulcers: #1 on her left gluteal fold stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer) the area was quarter size and pink, there was no dressing on this pressure ulcer, #2 a stage two pressure ulcer on the right buttock that was quarter size and pink, with a dressing dated 10/17/21 with LPN 3's initials, #3 a stage two pressure ulcer on the right buttock that was dime size and pink, there was no dressing on this pressure ulcer, #4 a stage two pressure ulcer that was dime size and pink on the coccyx, the dressing had a date of 10/17/21 with LPN 3's initials, #5 stage two pressure ulcer on the right buttock dime size and pink, the pressure ulcer did not have a dressing on it. RN 2 verified that the resident had on two dressings dated 10/17/21 with LPN 3's initials and that three areas did not have a pressure ulcer dressing in place. Review of the nursing schedule provided by the Scheduler on 10/18/21 at 4:00 p.m., indicated LPN 3 worked on 10/17/21 and LPN 1 had worked on 10/18/21. During an interview with LPN 1 on 10/21/21 at 11:39 a.m., indicated she was Resident H's nurse on 10/18/21. LPN 1 indicated she was not aware the resident had pressure ulcers until later in her		assessed with dressings changed.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 with wounds have the potential to be affected by this practice.2. A campus wide skin review was completed to ensure all Residents with a wound(s) have treatment services, wound care plan, and active treatment orders.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 three times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure wound treatment and services are provided as ordered. 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 substantial compliance has been determined.	

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	shift. LPN 1 indicated she did sign of on the Treatment Administration Record (TAR) that she had completed the resident's treatment and dressing change, but did not complete them. LPN 1 indicated she got busy and ran out of time to complete them. LPN 1 indicated during shift report at 6:30 p.m., she did report to the oncoming nurse that she had signed off the treatment and dressing changes for Resident H, but was unable to complete them. LPN 1 indicated the oncoming nurse told she would complete them for her. Review of the record Resident H on 10/21/21 at 11:55 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, muscle spasm of the back, restless leg syndrome, fracture of right femur, diabetes, major depression disorder, muscle weakness, cutaneous abscess of abdominal wall, morbid obesity and surgical aftercare following surgery on the skin and subcutaneous tissue. The Significant Change Minimum Data Set (MDS) assessment for Resident H dated, 9/20/21, indicated the resident was cognitively intact. Decision making was consistent and reasonable. The resident was admitted to the facility on 7/22/21. The braden scale for predicting pressure sore risk for Resident H, dated 9/13/21, the resident's score was 11 indicating the resident was at high risk for developing pressure ulcers. The physician recapitulation for Resident H, dated October 2021, indicated the resident was ordered the following: an air mattress for prevention of skin breakdown (original order date 8/13/21), cleanse pressure wound to right upper buttocks and gluteal cleft and coccyx with normal saline,			

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	apply xerofoam and cover ever day for wound care. The pressure ulcer assessment for Resident H, dated 10/20/21 11:22 a.m., indicated the resident was admitted with a stage two pressure ulcer on the right buttock that had pink wound bed with granulation tissue, the pressure ulcer measured 1.0 centimeters (cm) by 0.5 cm by 0.1 cm. The pressure ulcer assessment for Resident H, dated 10/20/21 at 11:38 a.m., indicated the resident was admitted with a stage two pressure ulcer on the right buttock with pink wound bed, the pressure ulcer measured 1.0 cm by 3.0 cm by 0.1 cm. The pressure ulcer assessment for Resident H, dated 10/20/21 at 11:43 a.m., indicated the resident was admitted with a stage two pressure ulcer on the right buttock with pink wound bed, the pressure ulcer measured 1.8 cm by 2.0 cm by 0.1 cm. The pressure ulcer assessment for Resident H, dated 10/20/21 at 11:56 a.m., indicated the resident was admitted with a stage two pressure ulcer on the left gluteal fold with pink wound bed and granulation tissue, the pressure ulcer measured 3.0 cm by 1.0 cm by 0.1 cm. The pressure ulcer assessment for Resident H, dated 10/20/21 at 11:56 a.m., indicated the resident was admitted with a stage two pressure ulcer on the coccyx that with pink wound bed, the pressure ulcer measured 0.5 cm by 1.0 cm by 0.1 cm. During an observation and interview with Resident H on 10/21/21 at 1:04 p.m., the resident did not have an air mattress. Resident H indicated			

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	she use to have an air mattress a long time ago at the hospital that rotated and it was nice, but she did not recall having an air mattress at the facility. During an observation and interview with RN 2 on 10/21/21 at 1:15 p.m., RN 2 verified Resident H did not have an air mattress on her bed. RN 2 indicated she does not ever remember the resident having an air mattress since she had been at the facility. The wound care policy provided by the Administrator on 11/18/21 at 2:48 p.m., indicated the purpose was to provide guidelines for the care of wounds to promote healing. The guidelines included, but were not limited to, nurse was to verify the physicians order for the treatment, dress the wound, mark tape with initials, time and date. This Federal tag relates to Complaint IN00364917. 3.1-40			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, interview, and record review, the facility failed to ensure monitoring for adverse reactions was completed, and failed to obtain routine labs for medication dosage, for 1 of 3 residents reviewed for anticoagulation monitoring. (Resident G) Findings include: The clinical record for Resident G was reviewed, on 10/20/2021 at 9:55 a.m., and indicated the resident's diagnoses included, but were not limited to, chronic atrial fibrillation, hypertension, hemiplegia, and hemiparesis following cerebral infarction (stroke) affecting left non-dominate side. The Quarterly Minimum Data Set (MDS) assessment, dated 9/20/21, indicated Resident G was cognitively intact and received anticoagulation medications. The care plan, dated 6/7/2021, indicated "[Resident G] is at risk for abnormal bleeding/bruising r/t [related to] ASA [aspirin] and Coumadin [blood thinner] therapy...observe for signs of abnormal bleeding such as increased frequently of bruising, increased size of bruising, bleeding gums, dark or tarry stools, coffee ground	F 0757	**F 757: Drug Regimen is free of unnecessary drugs** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. Resident(s) G were identified during the time of observation. All Nurses have been educated on parameters regarding Coumadin administration and treatment. Resident G was immediately assessed for any adverse effects related to failed monitoring.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 receiving Coumadin have the potential to be affected by this practice.2. A campus wide review was completed to ensure all Residents receiving Coumadin have appropriate orders and routine parameters in place as ordered by the physician.3. What measures will be put into place and what systemic changes	11/12/2021

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	emesis, nosebleeds. Document abnormal findings and notify MD [Medical Doctor]." A physician order for coumadin, dated 7/2/2021, indicated coumadin 5 mg (milligrams) by mouth every day for the diagnosis of atrial fibrillation. This order was discontinued on 7/16/2021. An order for "ANTICOAGULANT MEDICATION - OBSERVE FOR DISCOLORED URINE, BLACK TARRY STOOLS, SUDDEN SEVERE HEADACHE, N&V, DIARRHEA, MUSCLE JOINT PAIN, LETHARGY, BRUISING, SUDDEN CHANGES IN MENTAL STATUS AND/ OR V/S, SOB (shortness of breath), NOSE BLEEDS..." was dated 10/11/2021. No anticoagulation monitoring was indicated on the medication or treatment administration records for July, August, September, or October 1-10th of 2021. A lab result for Resident G indicated a PT/INR (Prothrombin Time and International Normalized Ratio) from 7/16/2021 at a level of 1.8 seconds. Therapeutic range is 2.0-3.0 seconds. A nursing note from 7/16/2021 for Resident G addressing PT/INR results indicated, "New order to change coumadin...recheck PT/INR [Prothrombin Time and International Normalized Ratio] in one week..." A physician's order for coumadin, dated 7/17/2021, indicated coumadin 5 mg (milligrams) by mouth every Tuesday, Thursday, Saturday, and Sunday for the indication of atrial fibrillation. This order was discontinued on 8/8/2021. A physician's order for coumadin, dated		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 three times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all orders and services are provided as ordered. 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 substantial compliance has been determined.	

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	7/17/2021, indicated coumadin 6 mg by mouth every Monday, Wednesday, and Friday for the indicated of atrial fibrillation. This order was discontinued on 8/8/2021. No nursing notes were in the record for a PT/INR on 7/23/2021 for Resident G. No lab result for a PT/INR was in the record for 7/23/2021 for Resident G. A lab result for Resident G indicated PT/INR from 7/30/2021 present at a level of 3.1 seconds. A new physician's order for Resident G indicated to decrease the dose x 1, then resume the regular order and recheck the PT/INR level in one week, 8/6/2021. An interview, with the Regional Nurse Consultant (RNC), on 10/21/2021 at 11:35 a.m., indicated that there was no lab result for Resident G's PT/INR on 7/23/2021. A policy entitled "Coumadin Monitoring Policy and Tracking Log", dated January 2020 was provided by RNC on 10/20/2021 at 3:43 p.m. Policy indicated, but was not limited to, "...Prior to administering the Coumadin/Warfarin dose the licensed nurse should verify the most current PT/INR." This Federal tag relates to Complaint IN00362579. 3.1-48(a)(3)			
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			

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	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, 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.			

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	§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 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 document accurate information on the Medication Administration Records (MARs) for 3 of 7 residents reviewed for medications (Residents B, L, and E), monitored a resident for a urinary tract infection while they were receiving an antibiotic for a wound infection, (Resident L) and documented a resident was receiving a wound treatment that had been discontinued. (Resident L) Findings include:	F 0842	**F 842: Resident Records** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.1. Resident(s) B, L, and E were identified during the time of observation. All Nurses have been educated on Medication Administration and documentation. Resident(s) B, L, and E were immediately assessed for any adverse effects.2. How other residents having the	11/12/2021

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	1. Resident B's record was reviewed, on 10/19/21, at 11:30 a.m. The record indicated Resident B had diagnoses that included, but were not limited to, congestive heart failure, hypothyroidism, fractured wrist, unsteady on feet, and generalized muscle weakness. Physician's orders for September, 2021 included, but were not limited to, the following medications: - Keflex Capsule, 500 milligrams (mg), give one capsule by mouth two times a day for cellulitis until 9/24/21. - Metoprolol tartrate tablet, 25 mg, give one tablet by mouth two times a day for congestive heart failure. - Levothyroxine sodium tablet, 50 micrograms by mouth one time a day for hypothyroidism. - Spironolactone tablet 100 mg, give one tablet by mouth one time a day for congestive heart failure. The Medication Treatment Records (MARs) for September, 2021 indicated these medications had no documentation that they had been given, or why they were not given: - Keflex: 9/22 at 9:00 a.m., 9/23 at 9:00 p.m., and 9:24 at 9:00 a.m. - Metoprolol: 9/22 at 9:00 a.m., 9/23 at 9:00 p.m., 9/24 at 9:00 a.m., and 9/26 at 9:00 a.m. - Levothyroxine: 9/24 at 6:00 a.m. and 9/26 at 6:00 a.m. - Spironolactone: 9/22 at 12:00 p.m., 9/24 at 12:00 p.m., and 9/26 at 12:00 p.m. On 10/20//2021, at 1:31 p.m., LPN 9 indicated that medications and treatments are to be signed off the MARs at the time of administration and/or application. 2. The clinical record for Resident E was reviewed, on 10/20/2021 at 2:21 p.m. The record indicated Resident E had diagnoses that included, but were		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 MAR audit was completed to ensure all Residents are receiving medications as prescribed by the physician.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 three times weekly X 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then monthly ongoing to ensure all orders and services are provided as ordered. 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 substantial compliance has been determined.	

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	not limited to, dementia in other disease classified elsewhere with behavioral disturbances, type 2 diabetes mellitus, general anxiety disorder, hypertension, major depressive disorder, bipolar disorder, chronic obstructive pulmonary disease, and muscle weakness The Quarterly Minimum Data Set (MDS) assessment for Resident E, dated 8/7/2021, indicated the resident was moderately cognitively impaired and receiving high risk medications: insulin, antipsychotic, hypnotic, anticoagulant, and diuretic, and had one unstageable pressure area. A nurse's note, dated 5/11/2021, indicated an unstageable pressure area to her left heel. Physician's orders for Resident E, in August, September, and October of 2021 included, but were not limited to, the following medications: - Atorvastatin Calcium Tablet 40 MG Give 1 tablet by mouth at bedtime for hyperlipidemia - cloZAPine Tablet 50 MG Give 3 tablet by mouth at bedtime for mania associated with bipolar disorder. - Ramelteon Tablet 8 MG Give 1 tablet by mouth at bedtime for difficulty falling asleep - Semglee Solution 100 units/ml (milliliter) - Inject 20 units subcutaneously at bedtime for type 2 diabetes mellitus. - Apixaban Tablet 5 MG Give 1 tablet by mouth two times a day for anticoagulant - Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth two times a day for supplement. - Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth two times a day for HTN (Hypertension-high blood pressure) - Primidone Tablet 50 MG Give 75 mg by mouth two times a day for tremors			

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	- Senna Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth two times a day for constipation - Symbicort Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate) 2 puff inhale orally two times a day for Shortness of Breath - Divalproex Sodium Capsule Delayed Release Sprinkle 125 MG Give 4 capsule by mouth every 8 hours for manic-depression - NovoLog Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units Call MD for >400, subcutaneously before meals and at bedtime for DM (Diabetes Mellitus) type 2 - Sure prep to left heel daily one time a day for red heel - Lithium Carbonate Capsule 150 MG Give 1 capsule by mouth two times a day for bipolar depression - Potassium Chloride Packet 20 MEQ (milliequivalent) Give 1 packet by mouth two times a day for supplement take with a meal Review of Resident E's MAR (Medication Administration Record) for August, September, and October of 2021, indicated these medications had no documentation that they had been given, or why they were not given: -Atorvastatin Calcium Tablet 40 mg PO (by mouth) on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Clozapine tab 50 mg PO on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Ramelteon tab 8 mg PO on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Semglee Solution 100 units/ml - Inject 20 units subcutaneously on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Apixaban tab 5 mg PO on 8/6/2021 at 2100 and 8/14/2021 at 2100.			

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	-Ascorbic Acid tab 500 MG PO on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Metoprolol Tartrate tablet 25 mg PO on 8/6/2021 at 2100 and 8/14/2021 at 2100 -Primidone tablet 50 mg PO on 8/6/2021 at 2100, 8/14/2021 at 2100, and 8/28/2021. -Senna tablet 8/6 mg PO on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Symbicort Aerosol 160-4.5 MCG/ACT - 2 puffs inhaled on 8/6/2021 at 2100 and 8/14/2021 at 2100. -Divalproex Sodium Capsule Delayed Release Sprinkle 125 MG- give 4 capsules PO on 8/6/2021 at 2100, 8/7/2021 at 0500, 8/14/2021 at 2100 , 8/15/2021 at 0500, and 8/22/2021 at 0500. -Novolog 100units/ml - give sliding scale dose on 8/3/2021 at 0500, 8/4/2021 at 0500, 8/5/2021 at 0500, 8/6/2021 at 0500, 8/7/2021 at 0500, 8/9/2021 at 1700, 8/10/2021 at 0500, 8/11/2021 at 0500, 8/12/2021 at 0500, 8/13/2021 at 0500, 8/14/2021 at 2100, 8/15/2021 at 0500 and 1700, 8/16/2021 at 0500 and 1700, 8/17/2021 at 1700, 8/18/2021 at 0500, 8/20/2021 at 0500, 8/22/2021 at 0500, 8/23/2021 at 0500, 8/24/2021 at 0500, 8/25/2021 at 0500, 8/28/2021 at 0500, 9/24/2021 at 1700, and 10/4/2021 at 1100 and 1700. -Sure prep to left heel daily on 8/2/2021 at 1700, 8/9/2021 at 1700, 8/12/2021 at 1700, 8/13/2021 at 1700, 8//15/2021 at 1700, 8/16/2021 at 1700, 8/17/2021 at 1700, 8/20/2021 at 1700, 8/23/2021 at 1700, 8/25/2021 at 1700, 8/27/2021 at 1700, 8/30/2021 at 1700, 9/4/2021 at 1700, 9/5/2021 at 1700, 9/10/2021 at 1700, 9/12/2021 at 1700, 9/19/2021 at 1700, 9/24/2021 at 1700, 10/4/2021 at 1700, 10/7/2021 at 1700, and 10/14/2021 at 1700 -Lithium Carbonate Capsule 150 mg PO on 9/24/2021 at 1700. -Potassium Chloride 10 mEq PO on 9/24/2021 at 1700. Behavioral care plans, dated 8/6/2021, indicated			

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	"[Resident E] exhibits behavior symptoms of disrobing...physical aggression towards staff...sitting self on floor...taking items from various places...verbal aggression towards staff...Administer medications as ordered." A care plan for Resident E for difficulty sleeping, dated 8/6/2021, indicated the intervention of "administer medication as order". A care plan for Resident E for the risk for impaired cardiac output related to hyperlipidemia, hypertension, dated 8/6/2021, indicated the intervention of "Administer Medications as ordered". A care plan for Resident E for the risk for bruising related to use of apixaban, dated 8/6/2021, indicated an intervention of "Administer medication as ordered." A care plan for Resident E for the "Diagnosis of Diabetes, Receiving blood glucose lowering medications", dated 8/6/2021, with the interventions of "Diabetes medications as ordered by doctor...Blood Sugars as ordered by doctor." A wound care plan for Resident E's unstageable pressure injury to her left heel, dated 8/6/2021, indicated intervention of "wound treatment as ordered". An interview with LPN 9, on 10/20//2021 at 1:31 p.m., indicated that medications and treatments are to be signed off the MARs at the time of administration and/or application. An interview with the ADON (assistant director of nursing), on 10/21/2021 at 10:33 a.m., indicated that the wound to the left heel was improving at			

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	155491	A. BUILDING 00 B. WING	10/21/2021

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	this time and review of current treatments appeared effective. A policy entitled, "Documentation of Medication Administration" was provided by RCN, on 10/20/2021 at 4:25 p.m. The policy indicated, but was not limited to, "A Nurse or Certified Medication Aide (where applicable) shall document all mediations administered to each resident on the resident's medication administration record [MAR]. Administration of medication must be documented immediately after (never before) it is given...." 3. An interview with Resident L was completed on 10/20/2021 at 10:15 a.m. and indicated the dressing to her heel was being changed every other day. The staff stopped changing it daily about a month ago when her order changed. Resident L indicated she was on antibiotic for an infection in her wound at this time. The clinical record for Resident L was reviewed on 10/20/2021, at 12:44 p.m. The record indicated that Resident L had diagnoses that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus without complications, and difficulty walking. A Minimum Data Set assessment, dated 7/23/2021, indicated that Resident L was cognitively intact, at risk for pressure areas, had an unstageable deep tissue injury, and moisture acquired skin deterioration. A nursing note, dated 5/12/2021, indicated an unstageable deep tissue injury to Resident L's left heel.			

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	Physician's orders for wound treatment, indicated these orders: a.) 9/15/2021, "Clean left heel with NS (normal saline), pat dry, apply Medical Honey to wound bed, cover with Aquacel AG, secure with border dressing change daily and PRN every night shift for wound." b.) 9/22/2021, "White felt to offload wound to left heel. Apply hydrofera blue to wound bed. Cover as desired. Change every other day and prn. Elevate foot when sitting. every night shift every other day for wound care." c.) 10/11//2021, "Hydrofera Blue Foam Dressing Pad (Wound Dressings) Apply to left heel topically one time a day on odd days for left heel wound white felt to offload wound, hydrofera blue to wound bed, cover as desired then place Circaid compression wrap." A care plan, dated 10/7/2021, indicated Resident L "...has impaired skin integrity-Pressure Ulcer -Unstageable area on L heel...wound treatment as ordered". In review of September and October 2021 treatment administration record, Resident L was indicated to be receiving wound treatments a, b, and c simultaneously to left heel. An observation of Resident L, on 10/20/2021 at 10:15 a.m., indicated that the dressing to her heel was last changed on 10/19/2021. Resident L's left lower extremity was noted to be red and itchy. LPN 8 indicated the redness looked improved and that the area is being treated with hydrofera blue every other day. LPN 8 indicated that the medical honey order was discontinued in September 2021.			

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	An interview with the ADON, on 10/21/2021 at 10:33 a.m., indicated that Resident L was followed by the wound center and the dressing changed from daily changes of medical honey to every other day hydrofera blue in September of 2021. She indicated the wound was showing some improvements with dressing order changes. The Treatment Administration Records (TARs) were reviewed with the ADON and she confirmed that the physician's order from 10/11/2021 (c) is the accurate treatment for Resident L's left heel and that the physician's orders from 9/15/21 and 9/22/21 should have been discontinued. A physician's order for Resident L, dated 10/11/2021, indicated "Cephalexin Tablet 500 MG Give 500 mg by mouth four times a day for left heel wound for 10 Days". A nursing note for Resident L, from 10/12/2021, indicated "Resident continues on ATB [antibiotic] for wound infection. No adverse reactions noted." A nursing note for Resident L, from 10/13/2021, indicated "Note Text: Resident remains on ATB for wound infection...." No nursing notes addressing antibiotic therapy were documented on 10/14/21, 10/15/21, 10/16/21, 10/19/21, nor 10/20/21. A nursing note for Resident L, from 10/17/2021, indicated "Res [Resident continues on ATb [antibiotic] for UTI [Urinary Tract Infection]. Res remain a febrile at this time. Writer notes no s/s [signs or symptoms] of adverse effects r/t [related to] atb therapy. Res denies pain or discomfort at this time. Call light within reach, will continue to observe."			

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Resident L had no order for a new antibiotic, change in antibiotic, or change in indication for antibiotic since Cephalexin started for wound infection on 10/11/2021.

A nursing note for Resident L from 10/18/2021, indicated "Resident alert and verbally responsive without difficulty. Able to make needs known. Remains on antibiotic for UTI. No adverse effects observed or noted."

An interview with LPN 8 on 10/21/2021 at 10:03 a.m. indicated that Resident L was on antibiotic for a wound infection.

A policy entitled, "Medication and Treatment Orders", was provided by the RCN, on 10/20/2021 at 10:35 a.m. The policy indicated, but was not limited to, "Orders for medication and treatments will be consistent with safe and effective order writing...."

A wound care policy provided by the Administrator, on 10/18/21 at 2:48 p.m., indicated the purpose was to provide guidelines for the care of wounds to promote healing. The guidelines included, but were not limited to, nurse was to verify the physicians order for the treatment.

A policy entitled, "Charting and Documentation", was provided by RCN, on 10/20/2021 at 10:35 a.m. The policy indicated, "...Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate...."

This Federal tag relates to Complaint IN00362579.

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

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were maintained, when 5 residents removed ice from an ice chest during random times, for 1 of 4 survey days, (Residents S, O, P, Q, and R), and failed to ensure a catheter drainage bag did not make contact with the floor	F 0880	**F 880: Infection prevention and control (DPOC)** 1. Immediate 1. Residents S,O, P, Q and R were identified in this practice. All Residents have the potential to be effected by this practice.	11/12/2021

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	for 1 of 1 resident. (Resident J) Findings include: 1. On 10/20/21, at 9:50 a.m., Resident S entered the small conference room where an ice chest that was on a rolling cart made of plastic pipe, was stored. He removed ice from the ice chest by scooping his cup into the ice. On 10/20/21, at 10:10 a.m., Resident O entered the room and removed ice from the ice chest by using his cup to scoop the ice, then came back about 10 minutes later and used the ice scoop to put ice in a cup. The ice scoop was in a hold on the shelf under the ice chest. On 10/20/21, at 10:30 a.m., Resident P entered the room and removed ice from the ice chest using the scoop to transfer it to his cup. On 10/20/21, at 10:50 a.m., a CNA entered the room and removed the ice chest by rolling it into the hallway. On 10/20/21, at 10:57 a.m., Resident P removed ice from the ice chest while it sat in the hallway, and used the scoop to transfer ice into his cup. On 10/20/21, at 2:54 p.m., Resident Q removed ice from the ice chest using the scoop and placed the ice in his cup. On 10/20/21, at 4:03 p.m., Resident R removed ice out of the ice chest using the scoop, placed the ice in his cup, then, replaced the ice scoop and closed the lid. On 10/21/21 at 1:15 p.m., the Director of Nursing indicated "No" when queried if residents were		2. All staff members were educated on proper infection control practices, including handwashing and infection control protocol related to ice, water and storage of equipment. 2. Systemic 1. All residents have the potential to be affected by the alleged deficient practice. 2. LTC infection control self-assessment reviewed by QA team including Medical Director, Infection Preventionist Consultant, DHS, ED and Campus Infection Preventionist. 3. DHS/designee will complete daily audits and rounding to ensure all staff are following protocol and guideline. Audits will be conducted five times weekly X 4 weeks, then twice weekly X 4 weeks, then weekly X 4 weeks, then monthly ongoing. 3. Training 1. DHS/designee will conduct an in-service for all staff on infection control practices and protocol including handwashing and infection control protocol related to passing of ice, water and storage of equipment	

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	supposed to get ice out of the ice chest and the Regional Nurse Consultant indicated residents are not supposed to get in the ice chests. A policy for "Ice Machines and Ice Storage Chests" was provided by the Regional Nurse Consultant. The policy included, but was not limited to, "Policy Statement: Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. Policy Interpretation and Implementation: 1. Ice-making machines, ice storage chests/containers, and ice can all become contaminated by: a. Unsanitary manipulation by employees, residents, and visitors...2. To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: a. Limit access to ice machines or ice storage chests/containers to employees only...." 2. During an observation, on 10/20/2021 at 2:41 p.m., Resident J was noted to be in bed with her Foley Catheter bag laying on the floor. CNA 8 was notified and hung the Foley Catheter bag from the bed frame to keep the bag and tubing free from contact with the floor. The clinical record for Resident J was reviewed, on 10/20/2021 at 4:02 p.m., and indicated diagnoses that included, but were not limited to, displaced timbale fracture of the right lower leg and type 2 diabetes mellitus without complication. There was no Minimum Data Set assessment finalized at this time due to the resident being a new admission. There was no care plan in the record in regards to Foley Catheter care or placement for Resident J.		4. Monitoring 1. DHS/designee will complete daily rounding to ensure proper storage, hand hygiene protocol and infection control procedures are communicated effectively, staff have complete understanding of infection control practices including a complete return demonstration with staff as needed and ensure through visual rounding that staff are complying with all infection control measures to encompass all shifts times 6 weeks and until compliance is maintained. 2. DHS/designee will be responsible for the completion of Infection Prevention QA tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed.	

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	There was no physician's order for the Foley Catheter, indication for its use, or catheter care indicated for Resident J. Skilled nursing documentation dated 10/10/2021 indicated "indwelling/supra catheter" present. On 10/20/21, at 2:43 p.m., CNA 8 indicated that Foley Catheter care is completed every shift as part of Resident J's care. CNA 8 stated Resident J had a catheter because Resident J was unable to get up. CNA 8 indicated they did not know why Foley Catheter bags/tubing should be off the floor, but she knew the tubing should be off the floor. An interview with Regional Clinical Support (RNC), on 10/21/2021 at 11:35 a.m., indicated that no order for the Foley Catheter, indication for its use, or Foley Catheter care could be located and it is the expectation that Foley Catheter care is provided every shift. A policy entitled, "Catheter Care, Urinary", last reviewed September 2014, was provided by Regional Nurse Support (RNS) on 10/21/2021 at 1:38 p.m. Policy indicated, "...Be sure the catheter tubing and bag are kept off of the floor." This Federal tag relates to Complaint IN00362579 3.1-18(a)			