

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/30/2024	
NAME OF PROVIDER OR SUPPLIER SWEET GALILEE AT THE WIGWAM		STREET ADDRESS, CITY, STATE, ZIP CODE 1315 JOHN STREET, ANDERSON, , 46016					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00449942, IN00449881, IN00448676, IN00448579, IN00448370, and IN00448394. Complaint IN00449942 - No deficiencies related to the allegations are cited. Complaint IN00449881 - No deficiencies related to the allegations are cited. Complaint IN00448676 - State deficiencies related to the allegations are cited at R0241 and R0243. Complaint IN00448579 - No deficiencies related to the allegations are cited. Complaint IN00448370 - State deficiencies related to the allegations are cited at R0243. Complaint IN00448394 - No deficiencies related to the allegations are cited.	R 0000					

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	Survey dates: December 26, 27, and 30, 2024 Facility number: 014706 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed January 6, 2025.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure physician orders were obtained for provision of care when staff removed a urinary catheter without a physician order. This deficient practice resulted in the resident being sent to the hospital for the inability to urinate for approximately 8 hours.	R 0241	Resident B continues to be a Resident of Sweet Galilee. The Director of Nursing, at the time of this survey, is no longer employed by the facility. All nursing staff will be in-serviced on the policy for Catheter Care. All nurses will be in-serviced on the policy for physician orders. The DON/Designee will audit the community to ensure Residents with catheters are able to care for their own catheter that requires inserting, irrigating and removing catheter, or have outside provider/HHC	01/17/2025

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Findings include:

The clinical record for Resident B was reviewed on 12/26/24 at 10:50 a.m. Diagnoses included obstructive and reflux uropathy, hydronephrosis with renal and urethral obstruction, history of malignant neoplasm of the bladder, retention of urine, and acute kidney failure.

An Initial Assessment, dated 10/16/24, indicated Resident B did not receive home health care and was not incontinent. The document had an area for catheter information , which was left blank.

Discharge documents from the nursing home were provided by the DON on 12/26/24 at 1:19 p.m. Medications included dutasteride (5-alpha reductase inhibitor- used to block natural substance that enlarges the prostate) 0.5 mg to be given once daily on Mondays, Wednesdays and Fridays for related diagnosis of history of malignant neoplasm of the bladder and furosemide (diuretic) 20 mg to be given twice daily related to diagnosis of acute pulmonary edema. The documents included resident care goals of urinary catheter to be managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma.

provide these treatments per the policy.

The DON/Designee will monitor all new orders for catheters daily for the next 4 weeks then monthly thereafter. Any variances will be corrected at the time of finding and will be reported to the Executive Director and the Resident's Physician. In addition, the variances will be reported to the QAPI committee for review.

The Executive Director is responsible for the continued compliance of the regulations.

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Admission orders indicated Resident B admitted to the facility on 11/29/24 and lacked instructions or orders for a urinary catheter.

During an interview on 12/26/24 at 11:44 a.m., the DON indicated she performed an initial assessment for admission for Resident B while he was still at the nursing home. The DON indicated she did see the catheter, but did not document it because the nursing home told her it would be removed prior to the resident being discharged to her facility. The DON indicated she told the nursing home they could not take a resident with a catheter since the facility could not provide catheter care. After the resident was admitted to the facility, the catheter was removed because he arrived with no catheter care orders. The DON indicated she contacted the nursing home to ask about catheter care orders but never received them. She did not follow-up with the physician to attempt to obtain orders. The catheter was just removed. This was not documented in the clinical record. On 12/5/24, the resident complained of shortness of breath and said he had been unable to urinate since the day before. The resident was sent to the hospital and returned with a urinary catheter. The resident was able to get home health

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care to provide the needed catheter care.

Review of previous nursing home documents, provided by the nursing home on 12/30/24 at 2:17 p.m. indicated the following: A progress noted dated 11/29/24 at 11:51 a.m. indicated Resident B was discharged, a report was called to the assisted living facility, and medication order with a complete discharge packet were sent with the resident. A discharge summary, dated 11/29/24, indicated the resident was to discharge home (assisted living apartment) with home health care. The summary indicated the resident had an indwelling catheter and was frequently incontinent of bowel. The summary listed medical equipment as an anchored catheter to be changed every month, and change bag and tubing weekly. Diagnoses listed in the summary included urinary retention, history of malignant neoplasm of the bladder and obstructive and reflux uropathy.

A hospital discharge instruction document, dated 12/5/24 and provided by the DON on 12/27/24 at 3:16 p.m., indicated Resident B had been seen for urinary tract infection and urinary retention. The resident had an appointment for a bladder biopsy on 1/6/25.

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Emergency department notes were unavailable during the survey.

During an interview on 12/27/24 at 3:09 p.m., the Administrator indicated the facility could admit residents with catheters and assist with cleaning them, but the facility could not remove or insert them.

During an interview on 12/30/24 at 11:36 a.m., the Nursing Home DON indicated Resident B had a urinary catheter placed for obstructive and reflux uropathy. There were no orders to discontinue the urinary catheter. The assisted living facility did not indicate they could not take a resident with a urinary catheter. The resident was on isolation for COVID-19 infection and they still took him.

During an interview on 12/30/24 at 2:24 p.m., the Operational Specialist indicated the facility did take residents with catheters as long as the resident was able to perform their own care, had family to provide care, or had home health services. The facility would set up skilled nursing once a month or as needed to change the catheter. The Operational Specialist indicated a catheter should never be removed without a physician's order. If staff had a concern for the reason for the catheter, they should have

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contacted the physician for clarification.

During an interview on 12/30/24 at 1:29 p.m., the facility Nurse Practitioner indicated they never received a call related to removing the resident's catheter.

A current policy, dated 6/2024 and titled "Catheter Care" was provided by the Administrator on 12/27/24 at 3:09 p.m. The policy indicated the following:

".... Policy: It is the policy of this community to provide assistance with catheter care including education, monitoring, hygiene assistance as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance.

Responsibility:

A. It is the responsibility of the licensed nursing staff to secure a Provider's order for catheter.

B. It is the responsibility of the nursing staff to cleanse and care for the catheter.

C. It is the responsibility of the nursing staff to empty the resident's catheter bag if the resident is unable to complete

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the task themselves.

D. It is the responsibility of the nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visits for change of catheter...."

This citation relates to Complaint IN00448676.

Based on record review and interview, the facility failed to ensure physician orders were obtained for provision of care when staff removed a urinary catheter without a physician order. This deficient practice resulted in the resident being sent to the hospital for the inability to urinate for approximately 8 hours.

Findings include:

The clinical record for Resident B was reviewed on 12/26/24 at 10:50 a.m. Diagnoses included obstructive and reflux uropathy, hydronephrosis with renal and urethral obstruction, history of malignant neoplasm of the bladder, retention of urine, and acute kidney failure.

An Initial Assessment, dated 10/16/24, indicated Resident B did not receive home health care and was not incontinent. The document had an area for catheter information , which was left blank.

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Discharge documents from the nursing home were provided by the DON on 12/26/24 at 1:19 p.m. Medications included dutasteride (5-alpha reductase inhibitor- used to block natural substance that enlarges the prostate) 0.5 mg to be given once daily on Mondays, Wednesdays and Fridays for related diagnosis of history of malignant neoplasm of the bladder and furosemide (diuretic) 20 mg to be given twice daily related to diagnosis of acute pulmonary edema. The documents included resident care goals of urinary catheter to be managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma.

Admission orders indicated Resident B admitted to the facility on 11/29/24 and lacked instructions or orders for a urinary catheter.

During an interview on 12/26/24 at 11:44 a.m., the DON indicated she performed an initial assessment for admission for Resident B while he was still at the nursing home. The DON indicated she did see the catheter, but did not document it because the nursing home told her it would be removed prior to the resident being discharged to her facility. The DON indicated she told the nursing home they could not take a resident with a

catheter since the facility could not provide catheter care. After the resident was admitted to the facility, the catheter was removed because he arrived with no catheter care orders. The DON indicated she contacted the nursing home to ask about catheter care orders but never received them. She did not follow-up with the physician to attempt to obtain orders. The catheter was just removed. This was not documented in the clinical record. On 12/5/24, the resident complained of shortness of breath and said he had been unable to urinate since the day before. The resident was sent to the hospital and returned with a urinary catheter. The resident was able to get home health care to provide the needed catheter care.

Review of previous nursing home documents, provided by the nursing home on 12/30/24 at 2:17 p.m. indicated the following: A progress noted dated 11/29/24 at 11:51 a.m. indicated Resident B was discharged, a report was called to the assisted living facility, and medication order with a complete discharge packet were sent with the resident. A discharge summary, dated 11/29/24, indicated the resident was to discharge home (assisted living apartment) with home health care. The summary

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indicated the resident had an indwelling catheter and was frequently incontinent of bowel. The summary listed medical equipment as an anchored catheter to be changed every month, and change bag and tubing weekly. Diagnoses listed in the summary included urinary retention, history of malignant neoplasm of the bladder and obstructive and reflux uropathy.

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During an interview on 12/30/24 at 2:24 p.m., the Operational Specialist indicated the facility did take residents with catheters as long as the resident was able to perform their own care, had family to provide care, or had home health services. The facility would set up skilled nursing once a month or as needed to change the catheter. The Operational Specialist indicated a catheter should never be removed without a physician's order. If staff had a concern for the reason for the catheter, they should have contacted the physician for clarification.

During an interview on 12/30/24 at 1:29 p.m., the facility Nurse Practitioner indicated they never received a call related to removing the resident's catheter.

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".... Policy: It is the policy of this community to provide assistance with catheter care including education, monitoring,

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	hygiene assistance as well as maintenance of urological appliances and system. Catheter care will be provided in such a manner to promote cleanliness, comfort and to minimize risk associated with use of an intermittent or indwelling urological appliance. Responsibility: A. It is the responsibility of the licensed nursing staff to secure a Provider's order for catheter. B. It is the responsibility of the nursing staff to cleanse and care for the catheter. C. It is the responsibility of the nursing staff to empty the resident's catheter bag if the resident is unable to complete the task themselves. D. It is the responsibility of the nursing staff to change the collective device. Licensed nursing staff to coordinate transportation and office visits for change of catheter...." This citation relates to Complaint IN00448676.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s	R 0243	No Residents have been adversely affected by this deficient practice.	01/17/2025

medication and treatment records that indicate the:

(A) time;

(B) name of medication or treatment;

(C) dosage (if applicable); and

(D) name or initials of the person administering the drug or treatment.

Based on record review and interview, the facility failed to administer and document the administration of medication for 1 of 3 residents reviewed for medication administration.

Findings include:

The clinical record for Resident B was reviewed on 12/26/24 at 10:50 a.m. Diagnoses included obstructive and reflux uropathy, hydronephrosis with renal and urethral obstruction, history of malignant neoplasm of the bladder, retention of urine, and acute kidney failure.

Review of the Medication Administration Record (MAR) for 12/1/24 through 12/27/24 indicated the following medications were not administered and/or lacked explanation or rationale on the missed dates listed:

a. amiodarone (antiarrhythmic) 200 mg once daily 8:00 a.m.:

The Director of Nursing/Designee will in-service all nursing staff (LPN/QMA) on the Medication Administration policy.

The Director of Nursing/Designee will audit the community's medication administration software dashboard weekly for 4 weeks and monthly for 3 months. Variances will be corrected at the time of finding and will be reported to the Executive Director and the Physician. In addition, variances will be reported to the QAPI committee for review.

The Executive Director is responsible for the continued compliance of the regulation.

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12/9 and 12/22/2024.

b. atorvastatin (reduce blood cholesterol) 40 mg at bedtime 8:00 p.m.: 12/2, 12/18 and 12/19/2024.

c. cetirizine (antihistamine) 10 mg at bedtime 8:00 p.m.: 12/2, 12/18 and 12/20/2024.

d. clopidogrel (antiplatelet) 75 mg once daily 8:00 a.m.: 12/9 and 12/11/2024.

e. dutasteride (treats enlarged prostate) 0.5 mg every Monday, Wednesday and Friday 8:01 a.m.: 12/9 and 12/11/2024.

f. Eliquis (anticoagulant) 5 mg twice daily 8:00 a.m.: 12/9 and 12/11/2024.

g. Eliquis 5 mg twice daily 8:00 p.m.: 12/18/2024.

h. Entresto (angiotensin receptor inhibitor) 24 mg - 25 mg twice daily 8:00 a.m.: 12/9/2024

j. Entresto 24 mg - 25 mg twice daily 8:00 p.m.: 12/4/2024.

k. Entresto 49 mg - 51 mg twice daily 8:00 p.m.: 12/18/2024.

l. folic Acid (supplement) 1 mg once daily 8:00 a.m.: 12/9 and 12/11/2024.

m. furosemide (diuretic) 20 mg twice daily 8:00 a.m.: 12/9 and

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12/11/2024.

n. furosemide 20 mg twice daily
4:00 p.m.: 12/18/2024.

o. metformin (antidiabetic) 500
mg at bedtime 8:00 p.m.: 12/2,
12/9, 12/11, 12/18 and
12/20/2024.

p. metformin 500 mg 1/2 tablet
in the morning with breakfast
8:00 a.m.: 12/1, 12/9, and
12/11/2024.

q. metoprolol (antihypertensive)
100 mg once daily 8:00 a.m.:
12/9 and 12/11/2024.

r. pantoprazole (proton-pump
inhibitors-works to reduce
stomach acid) 40 mg once daily
8:00 a.m.: 12/9 and 12/11/2024.

s. potassium CL ER
(supplement) 10 mEq once daily
8:00 a.m.: 12/9 and 12/11/2024.

t. pregabalin (anticonvulsant) 50
mg twice daily 8:00 a.m.: 12/9
and 12/11/2024.

u. pregabalin 50 mg twice daily
4:00 p.m.: 12/4 and 12/18/2024.

v. quetiapine (atypical
antipsychotic) 100 mg at
bedtime 8: p.m.: 12/2, 12/4,
12/18 and 12/20/2024.

w. roflumilast (used to decrease
chronic obstructive pulmonary
disease exacerbations) 500 mcg
once daily 8:00 a.m.: 12/9 and

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12/11/2024.

x. spironolactone (potassium sparing diuretic) 25 mg 1/2 tablet once daily 8:00 a.m.: 12/9 and 12/11/2024.

y. Trelegy Ellipta (anticholinergic) 100-62.5-25 inhale one puff once daily: 12/9 and 12/11/2024.

z. vitamin D3 (supplement) 10 mcg once daily 8:00 a.m.: 12/9 and 12/11/2024.

During an interview on 12/26/2024 at 1:42 p.m., LPN 1 indicated the facility had to use a lot of agency staff who might not always document medications administered. Medications should have been documented in the electronic chart when they were given.

During an interview on 12/27/24 at 9:10 a.m., LPN 2 indicated medications administered should have been documented in the electronic chart by using the facility smart phones. If a medication was not given there should have been a note saying why.

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A current policy dated 1/2024 and titled "Medication Management, Administration, & Storage (Indiana and Ohio Only)" was provided by the Administrator on 12/27/24 at 3:09 p.m. The policy indicated the following:

" Policy:

B. Medication Administration:
Medication administration will be administered as ordered by the resident's provider and will be administered by a licensed nurse or a QMA.

4. Documentation: At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication)or treatment) administration record that includes the following:

- a. Resident name
- b. Name of Medication or Treatment
- c. Date, Time
- d. Route
- e. Dosage (if applicable)
- f. Name or initials of the person administering the drug or treatment

g. Response to medication for all PRN's and if indicated.

7. Resident Unavailable: in the event a resident is not available, for any reason, at the time of medication administration is attempted, the licensed nurse or QMA will make two additional attempts to administer the medication(s) within the acceptable window of time (one hour before the scheduled dose or one hour after the scheduled dose), prior to documenting that a resident was unavailable for the medication administration."

This citation relates to Complaint IN00448370 and IN00448676.

Based on record review and interview, the facility failed to administer and document the administration of medication for 1 of 3 residents reviewed for medication administration.

Findings include:

The clinical record for Resident B was reviewed on 12/26/24 at 10:50 a.m. Diagnoses included obstructive and reflux uropathy, hydronephrosis with renal and urethral obstruction, history of malignant neoplasm of the bladder, retention of urine, and acute kidney failure.

Review of the Medication Administration Record (MAR)

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for 12/1/24 though 12/27/24 indicated the following medications were not administered and/or lacked explanation or rationale on the missed dates listed:

a. amiodarone (antiarrhythmic) 200 mg once daily 8:00 a.m.: 12/9 and 12/22/2024.

b. atorvastatin (reduce blood cholesterol) 40 mg at bedtime 8:00 p.m.: 12/2, 12/18 and 12/19/2024.

c. cetirizine (antihistamine) 10 mg at bedtime 8:00 p.m.: 12/2, 12/18 and 12/20/2024.

d. clopidogrel (antiplatelet) 75 mg once daily 8:00 a.m.: 12/9 and 12/11/2024.

e. dutasteride (treats enlarged prostate) 0.5 mg every Monday, Wednesday and Friday 8:01 a.m.: 12/9 and 12/11/2024.

f. Eliquis (anticoagulant) 5 mg twice daily 8:00 a.m.: 12/9 and 12/11/2024.

g. Eliquis 5 mg twice daily 8:00 p.m.: 12/18/2024.

h. Entresto (angiotensin receptor inhibitor) 24 mg - 25 mg twice daily 8:00 a.m.: 12/9/2024

j. Entresto 24 mg - 25 mg twice daily 8:00 p.m.: 12/4/2024.

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k. Entresto 49 mg - 51 mg twice daily 8:00 p.m.: 12/18/2024.

l. folic Acid (supplement) 1 mg once daily 8:00 a.m.: 12/9 and 12/11/2024.

m. furosemide (diuretic) 20 mg twice daily 8:00 a.m.: 12/9 and 12/11/2024.

n. furosemide 20 mg twice daily 4:00 p.m.: 12/18/2024.

o. metformin (antidiabetic) 500 mg at bedtime 8:00 p.m.: 12/2, 12/9, 12/11, 12/18 and 12/20/2024.

p. metformin 500 mg 1/2 tablet in the morning with breakfast 8:00 a.m.: 12/1, 12/9, and 12/11/2024.

q. metoprolol (antihypertensive) 100 mg once daily 8:00 a.m.: 12/9 and 12/11/2024.

r. pantoprazole (proton-pump inhibitors-works to reduce stomach acid) 40 mg once daily 8:00 a.m.: 12/9 and 12/11/2024.

s. potassium CL ER (supplement) 10 mEq once daily 8:00 a.m.: 12/9 and 12/11/2024.

t. pregabalin (anticonvulsant) 50 mg twice daily 8:00 a.m.: 12/9 and 12/11/2024.

u. pregabalin 50 mg twice daily 4:00 p.m.: 12/4 and 12/18/2024.

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v. quetiapine (atypical antipsychotic) 100 mg at bedtime 8: p.m.: 12/2, 12/4, 12/18 and 12/20/2024.

w. roflumilast (used to decrease chronic obstructive pulmonary disease exacerbations) 500 mcg once daily 8:00 a.m.: 12/9 and 12/11/2024.

x. spironolactone (potassium sparing diuretic) 25 mg 1/2 tablet once daily 8:00 a.m.: 12/9 and 12/11/2024.

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During an interview on 12/26/2024 at 1:42 p.m., LPN 1 indicated the facility had to use a lot of agency staff who might not always document medications administered. Medications should have been documented in the electronic chart when they were given.

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4. Documentation: At the time of administration, the licensed nurse or QMA administering the medication will document the administration in the medication)or treatment) administration record that includes the following:

a. Resident name

b. Name of Medication or Treatment

c. Date, Time

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FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

d. Route

e. Dosage (if applicable)

f. Name or initials of the person
administering the drug or
treatmentg. Response to medication for
all PRN's and if indicated.

7. Resident Unavailable: in the event a resident is not available, for any reason, at the time of medication administration is attempted, the licensed nurse or QMA will make two additional attempts to administer the medication(s) within the acceptable window of time (one hour before the scheduled dose or one hour after the scheduled dose), prior to documenting that a resident was unavailable for the medication administration."

This citation relates to
Complaint IN00448370 and
IN00448676.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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

TITLE

(X6) DATE