STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF DEMING PARK	3300 POPLAR ST TERRE HAUTE, IN 47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00429213 and IN00429806. This visit resulted in an Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00429806 - Federal/State deficiencies related to the allegations are cited at F0690 Complaint IN00429213 - Federal/State deficiencies related to the allegations are cited at F0689. Survey dates: March 5, 6, 7, and 8, 2024 Facility number: 000249 Provider number: 155358 AIM number: 100267640 Census Bed Type: SNF: 11 NF: 50 Total: 61 Census Payor Type: Medicare: 11 Medicaid: 47 Other: 3 Total: 61 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 19, 2024.	F 0000	The plan of correction is to serve as Majestic Care of Deming Park's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Majestic Care of Deming Park or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents.			

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

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	The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review the facility failed to follow policy and procedure for safe mechanical lift transfer for 1 of 2 residents observed for transfers (Resident K). Findings Include: On 3/5/24 at 11:14 a.m., during observation and interview with Resident K, the resident was sitting up in wheelchair and she was alert and oriented. She recalled an event which occurred about a week prior. She indicated Certified Nurse Aide (CNA) 5 placed her in a lift pad and attached the pad to the mechanical lift. CNA 5 left the room and did not return. The resident indicated CNA 5 was the only staff person in the room at the time. She was unsure of the time she remained in the pad. She was asleep when the therapist came in to check on her. She indicated she was told by the staff it had not been very long. She indicated at times there was only one CNA available to get her up in the mechanical lift and at other times there were two staff members to help. On 3/5/24 at 11:30 a.m., clinical record was reviewed for Resident K. Diagnoses include but were not limited to acute chronic congestive heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs), muscle weakness, and unsteadiness on feet.	F 0689	The plan of correction is to serve as Majestic Care of Deming Park's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Majestic Care of Deming Park or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. **F 689 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident K's care plan and CNA sheet verified and updated for transfer status.	03/29/2024

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	Physician orders lacked documentation of an order to use mechanical lift for transfers. The medical record lacked evidence of a care plan for use of mechanical lift. A quarterly Minimum Data Set, (MDS) (a standardized assessment tool that measures health status in nursing home residents), dated 2/6/24 indicated the resident was cognitively intact, she had an indwelling foley catheter and was dependent for transfers. During an interview on 3/5/24 at 11:54 a.m., Licensed Practical Nurse (LPN) 4 acknowledged she was called to the resident's room to assist the Occupational Therapist (OT) 3 to transfer the resident into her wheelchair. When she entered the resident's room she observed Resident K, lying asleep in a lift pad which was attached to a mechanical lift. Resident K was in the lift pad and the lift was attached to the mechanical device, ready to be lifted and transported. The transfer was completed by the therapist and LPN 4. The resident was assessed for any injuries. No injuries were indicated but the resident complained of some minor leg pain. She acknowledged CNA 5, had assisted the resident, left the room, and assisted other residents. CNA 5 did not return to the resident's room to complete the transfer. The timeline was determined to be around 15 minutes and she acknowledged the resident was left un-attended during that time. LPN 4 indicated if the resident was a two person assist the staff member would prepare the resident to be transferred into the mechanical lift. If a second person was not available they would find another staff person to assist with the transfer.		**II. The facility will identify other residents that may potentially be affected by the practice.** All residents utilizing mechanical lifts could be affected and were audited to verify care plan and CNA sheet are correct for transfer status. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** All staff who participate in resident transfers educated on mechanical lift policy and skills validation utilizing assist of 2 with return demonstration. Nursing management staff educated on need for care plan and CNA sheet to contain resident's transfer status and should be updated with any change of status. **IV. The facility will monitor the corrective action by implementing the following measures.** DNS or designee will observe 5 mechanical lift transfers to ensure compliance with policy and skills validation weekly x4, bi-weekly x4 and Monthly x4 or until a 100% threshold is obtained.	

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	During an interview on 3/5/24 at 11:56 a.m. with the Director of Rehabilitation Services and Therapist 3, Therapist 3 indicated he went to Resident K's room to take her to therapy. The resident was lying in the mechanical lift pad and was asleep. The pad was attached to the lift. He asked LPN 4 to assist him to transfer the resident. The resident told him she had been in the pad for a while but was not sure of how long it was because she fell asleep. Both, the Director of Rehabilitation Services and Therapist 3, indicated any resident being transferred with a mechanical lift must have two persons to assist. During an interview on 3/5/24 at 12:05 p.m., the Director of Nursing Services (DNS) indicated the mechanical lift procedure was a two persons to assist, but it depended on the resident. Ideally they wanted two persons the entire process, but once the resident was lifted up in the air they must have two persons to assist. She was not sure what the current mechanical lift policy stated. During an interview on 3/6/24 at 9:45 a.m., Licensed Practical Nurse (LPN) 9 indicated the staff would place a lift pad under the resident. They did not attach the pad until there was a second person available to begin the lift. On 3/6/24 at 9:47 a.m., during an interview with LPN 8, she indicated the care plans were updated as a condition changes or a new intervention was needed. Any resident who required assistance to transfer by mechanical lift would have a care plan in place. On 3/7/24 at 10:12 a.m., during interview with Certified Nurse Aide (CNA) 12, the CNA indicated she had provided mechanical lift transfers with two staff persons. She would ask for assistance		DNS or designee will audit care plan and CNA sheet for 5 residents who use mechanical lifts to ensure transfer status correct and updated with change of status weekly x4, bi-weekly x4, and monthly x4 or until 100% threshold is obtained. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance 3/29/24 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	first and would use two persons to help place the pad under the resident. She would attach the lift pad to the mechanical lift. She acknowledged she would not place a resident in a lift pad and attach it to the lift before a second person was there to assist and she would not leave the resident unattended once they were in the pad because it was not safe, and anything could happen. On 3/6/24 at 9:15 a.m., the DNS provided a document titled, "Lifting machine, using a mechanical," dated July 2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...General guidelines ...2. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility ...Steps in the procedure ...10. Place the sling under the resident ...11. Lower the sling bar closer to the resident ...12. Attach sling straps to sling bar according to manufacturer's instructions ...." On 3/6/24 at 9:15 a.m., the DNS provided an undated document titled, "Comprehensive Care Plans," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy ...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ...1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the residents personal and cultural preferences in developing goals of care ...a. the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive assessment and quarterly MDS assessment ...6. Alternative interventions will be			

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	documented, as needed ...." On 3/6/24 at 9:41 a.m., the DNS provided a document, titled, "Lifting machine, using a mechanical," dated July 2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...General guidelines ...1. At least two (2) nursing assistants/nurse are needed to safely move a resident with a mechanical lift ...." This citation relates to Complaint IN00429213. 3.1-45(a)			
F 0690 SS=J 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			

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	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 assess and treat a resident's urinary catheter and follow-up on continued hematuria resulting in immediate jeopardy when the resident with a history of UTI and septic shock did not have a follow-up with a Urologist for continued hematuria and blood clots, had a change in condition with his urinary catheter, and was sent to the hospital several hours later in septic shock and respiratory failure for 1 of 5 residents reviewed for change in condition (Resident B). The immediate jeopardy began on 2/27/24 when Resident B, with a history of urinary catheter, severe sepsis with septic shock, and urinary tract infection (UTI) on 11/13/23, had a distended abdomen and low urine output in the foley drain bag on 2/27/24 at 10:19 p.m. The catheter was changed, and bloody urine was returned. The physician was not notified, and no assessment or vital signs were obtained. On 2/28/24 at 4:30 a.m. Resident B had black emesis, blood clots from the catheter, and bloody urine. The resident's vital signs were blood pressure of 68/49, pulse of 107, and temperature of 96.9. Resident B was sent to the hospital at 5:10 a.m. At the hospital Resident B was diagnosed with septic shock, respiratory failure, UTI, bladder hemorrhage with probable cystitis, pneumonia, and anemia. Resident B had	F 0690	**F690 BOWEL/BLADDER INCONTINENCE, CATHETER, UTI** **The facility plans to dispute this citation. Narrative and supporting documentation to come under separate cover.** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The resident affected no longer resides in the facility. . **II. The facility will identify other residents that may potentially be affected by the practice.** . Other residents who have an indwelling foley catheter or require catheterization have the potential to be affected and were audited to ensure all ordered urology follow-up appointments are made and a complete urinary	03/29/2024

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	to be intubated to protect the airway due to massive amount of projectile vomiting. Resident B expired on 3/1/24 at 1:15 a.m. The Executive Director (ED) and the Director of Nursing were notified of the immediate jeopardy at 1:20 p.m. on 3/6/24. The immediate jeopardy was removed on 3/7/24, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: On 3/5/23 at 3:00 p.m., Resident B's medical record review was reviewed. Resident B was admitted to the facility on 3/10/23. Diagnoses included but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems) added 3/10/23, breakdown (mechanical) of other urinary catheter (a thin, flexible catheter used especially to drain urine from the bladder) added on 11/13/23, severe sepsis with septic shock (a serious condition in which the body responds improperly to an infection causing a dramatic drop in blood pressure that can damage the lungs, kidneys, liver, and other organs) added on 11/13/23, neuromuscular dysfunction of bladder unspecified (issues with urinating are referred to as bladder and bowel dysfunction), 3/10/23, hematuria (blood in the urine) added on 11/13/23, and urinary tract infection (infection of the bladder) added on 11/13/23. An annual Minimum Data Set (MDS) assessment, dated 2/12/24, indicated Resident B was cognitively intact and had an indwelling urinary catheter. Physician orders, dated 11/15/23, ordered Flomax		assessment was completed with full set of vitals with any abnormal findings resulting in immediate notification to the provider. Orders entered for all residents requiring catheterization to have urine characteristics and volume assessed every shift and prn if change in characteristics of baseline occurs. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** All direct care team members educated on reporting abnormal urine characteristics to nurse immediately, reporting to provider if change in urinary characteristics is identified, urinary system physical assessment, importance of early assessment and identification of change of condition for residents with urinary catheter. Skills validations completed for all direct care team members for catheter care and emptying and measuring urinary output with return demonstration. **IV. The facility will monitor the corrective action by implementing the following measures.** DNS or designee will audit 5	

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	0.4 milligrams (mg) 1 capsule daily for urinary retention. Physician orders, dated 11/14/23, ordered anticoagulant medication staff to observe discolored urine and black tarry stools. Foley catheters care every shift and may change foley catheter PRN (as needed) for dislodgement/occlusion as needed for foley catheter. May irrigate Foley Catheter with 10 ml sterile H20 (water) or normal saline as needed. Physician orders, dated 1/26/24, ordered aspirin low dose 81 milligrams (mg) tablet chewable 1 tablet daily for anticoagulant (blood thinner). Physician orders, dated 1/25/24, ordered Eliquis oral tablet 2.5 mg 1 tablet two times per day for A-Fib (irregular heart rate) and history of CVA, (Cerebral vascular accident, stroke). Physician orders, dated 2/19/24, change foley catheter once monthly with 30 ml (milliliters)/20 Fr (French) (indicates the size of the catheter) Foley urinary catheter (a thin, flexible catheter used especially to drain urine from the bladder), every night shift every 30 day(s) for urinary retention, A care plan, dated 3/13/23, indicated the resident was at risk for complications related to indwelling catheter, intervention included but was not limited to notifying Medical Doctor (MD) of abnormal findings. A care plan, dated 3/14/23, indicated the resident was at risk for abnormal bleeding secondary to anticoagulant therapy. Interventions included but were not limited to, observing for signs of abnormal bleeding, coffee ground emesis, blood tinged or frank blood in urine. The care plan		residents to assess changes in urinary characteristics and for changes in baseline conditions weekly x4, bi-weekly x4 and Monthly x4 or until a 100% threshold is obtained. DNS or designee will observe 5 staff members perform urinary catheter care and drainage to ensure compliance with policy and skills validation weekly x4, bi-weekly x4 and Monthly x4 or until a 100% threshold is obtained. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance 3/29/24 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	interventions were revised on 3/4/24 to include document abnormal findings and notify MD (Medical Doctor). A care plan, dated 4/13/23, indicated the resident had a urinary tract infection, resolved 4/27/23. A care plan, dated 11/14/23, indicated the resident had a urinary tract infection and was in isolation for Klebsiella Oxytoca which was resolved 2/1/23. A care plan, dated 1/10/24, indicated the resident had a urinary tract infection that was resolved on 3/4/24. On 3/8/24 at 9:15 a.m., the DNS provided a copy of the urinary output record for February 1-28, 2024, for Resident B. The record indicated the total daily 24 hr. output for Resident B was the following: 2/1 - 1100 milliliters (ml) 2/2 - 750 ml. No output was recorded for the night shift. 2/3 - 650 ml. No output was recorded for the night shift. 2/4 - 970 ml 2/5 - 700 ml. No output was recorded for the night shift. 2/6 - 650 ml 2/7 - 1290 ml 2/8 - 1150 ml 2/9 - 1150 ml 2/10 - 1000 ml 2/11 - 750 ml. No output was recorded for the night shift. 2/12 - 750 ml. No output was recorded for the night shift. 2/13 - 840 ml 2/14 - 250 ml. No output was recorded for the night shift. 2/15 - 2300 ml			

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	2/16 - 500 ml. No output was recorded for the night shift. 2/17 - 800 ml. No output was recorded for the night shift. 2/18 - 1400 ml. No output was recorded for the night shift. 2/19 - 850 ml 2/20 - 200 ml. No output was recorded for the night shift. 2/21 - 1360 ml 2/22 - 500 ml. No output was recorded for the night shift. 2/23 - 1800 ml 2/24 - 940 ml 2/25 - 250 ml. No output was recorded for the night shift. 2/26 - 1650 ml 2/27 - 950 ml. No output was recorded for the night shift. 2/28 - 240 ml On 2/27/24 at 10:19 p.m., the Nurse Progress Note indicated Resident B's abdomen was distended over the bladder. Resident B complained of some pain when touched, very little output in foley drain bag (the urine that drains through the catheter is connected to a bag). The nurse attempted to adjust the catheter and attempted to irrigate the catheter with no success. Documentation indicated the nurse removed the catheter and inserted and anchored a new catheter. The new catheter returned 650 ml of bloody urine. Resident B stated he "felt better." Documentation lacked a complete assessment of the resident's condition including vital signs, abdominal assessment, or pain assessment. The physician was not notified of the difficulty with catheter irrigation, and increased blood in the urine.			

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	On 2/27/24 at 10:43 p.m., a Nurse Progress note lacked any follow up note regarding blood in urine or notification of the physician. The note indicated Resident B was resting in bed with no complaints, call light within reach. Documentation lacked follow-up assessments of the resident's condition including vital signs assessment, abdominal distention, or pain assessments. On 2/28/24 at 4:30 a.m., a Nurses' Note Summary Report was initiated. Resident B's vital signs included blood pressure of 68/49, pulse of 107 regular, respirations 16 breaths per minute, temperature 96.9, pulse oximetry 92% (indicates the oxygen levels in the blood). Blood was in the resident's urine and blood clots were coming from around penis and in the catheter tubing. The resident was vomiting dark brown, black emesis. The primary care provider was notified (the nurse practitioner), and an order received for the resident to be sent to ER (emergency room) for evaluation. On 2/28/24 at 6:22 a.m., a Nurse Progress Note indicated the Foley urinary catheter had been draining bloody urine. A large amount of blood clots noted in catheter tubing. The resident was vomiting brown, black emesis. Blood pressure was 68/49, faint pulse was 107 beats per minute, respirations 16 breaths per minute, and oxygen saturation 92%. Resident was pale and drowsy, and somewhat lethargic. Ambulance service was called, and the nurse was instructed to call 911 for transportation. The resident was transferred to the hospital at 5:10 a.m. The documentation indicated the resident had an acute change of condition at 10:19 p.m., on 2/27/24. The physician was not notified until 4:30 a.m., on 2/28/24, 5 hours 11 minutes after the			

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	155358	A. BUILDING 00 B. WING	03/08/2024

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	change in condition was identified. After the order to send to the ER was obtained, the resident was not sent to the ER for 40 minutes. Review of Resident B's medical record the record lacked documentation of communication between the facility and the urologist or the urology office, regarding the increased blood in the urine or a request to have the urologist change the catheter. The record lacked documentation of Resident B being followed by a Urologist for the blood in his urine. The nurse's progress note record lacked documentation of the NP visit and examination of the resident on 2/27/24. A hospital consultation report, dated 2/28/24, indicated a computed tomography (CT) scan of the abdomen showed urinary bladder hemorrhage with inflammation of the bladder and bilateral pneumonia likely from aspiration. A hospital discharge note, dated 2/29/24, indicated Resident B presented to the ER with hypotension and hypoxia. The urinary analysis (UA) suggested a UTI. Resident B had dark brown, or coffee ground emesis and hematuria Resident B was put on oxygen per nasal cannula but had "massive amount of projectile vomiting and required intubation to protect his airway" and was put on a ventilator in the ER and moved to the intensive care unit. He was placed on intravenous vasopressin to increase blood pressure. The POA was informed of poor prognosis and Resident B was moved to comfort care. Resident B expired on 3/1/24 at 1:15 a.m. During an interview on 3/6/24 at 11:47 a.m., LPN 10 indicated Resident B had an indwelling foley catheter and was recently admitted to the hospital due to sepsis infection and respiratory issue.			

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	Resident B was sent to the hospital on 2/28/24. She indicated the resident had been seeing a urologist due to blood in his urine. If a resident had blood in urine, she would notify the physician. She would assess the resident and obtain vital signs and if there was a Registered Nurse (RN) available she would ask the RN to assess the resident as well. During an interview on 3/6/24 at 12:50 p.m., the DNS indicated the nurse called her late on the night of 2/28/24. She did not get the call because she was asleep. She did not find out about the condition of Resident B until the next morning. The resident was sent to the hospital due to excess bleeding around the catheter and vomiting black emesis. She indicated it was not unusual for him to have blood in his urine. She did not know why the nurse did not call the doctor the evening before. She indicated the NP had seen the resident on 2/27/24 and had noted he had blood in the urine. If the issue was the same, it would not be a change of condition and they would not necessarily call the doctor. On 3/6/24 at 1:00 p.m., the DNS provided a copy of the NP notes with a service date of 2/27/24. Documentation on the note indicated it was electronically signed by the NP on 3/5/24 and uploaded into the medical record on 3/6/24. The NP indicated she saw the resident due to hematuria (blood in urine) and dysuria (painful urination). She indicated the resident had been seen by a urologist and the catheter is normally changed by him monthly. She indicated the catheter was irrigating fine, but the resident was having penile pain and passing lots of clots through the catheter as well as around the catheter and out the urethra (the tube through which urine leaves the body). The NP Progress			

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	Note indicated Resident B had been sent to the ER on 11/8/23 for catheter complications and per the ER notes the nursing home facility was unable to remove the Foley catheter, was bleeding from the catheter site and having severe pain. Resident B was diagnosed with sepsis and released from the hospital on 11/13/23. On 1/5/24 the NP saw Resident B and sent him to the hospital to see Urologist 18 to change his catheter. On 1/16/24 the patient was seen by the NP and the note indicated Resident B was going to be seen by Urologist 18 for a catheter change on 1/19/24. She indicated the staff were trying to reach the urology office to see if Urologist 18 would like to see the resident to change the catheter. Resident B's medical record lacked documentation Urologist 18's office was contacted and lacked a response from the urologist's office. Documentation from Resident B's urologist appointments was requested from the DNS on 3/7/24 at 1:45 p.m. During a phone interview on 3/6/24 at 3:23 p.m., LPN 13 indicated she provided care to Resident B on 2/27/24 through the morning of 2/28/24. She indicated she had assessed the resident and obtained vital signs. She did not notify the physician because this was nothing new. She indicated she assessed the resident through the night. The resident was alert and talking until she sent him to the hospital. On 3/7/24 at 11:06 a.m., LPN 13's a written statement, dated 3/6/24 at 2:45 p.m., was provided and indicated LPN 13 called the nursing manager on-call to alert of event, then she called NP 17 who told LPN 13 that due to Resident B's Do Not Resuscitate (DNR) status to ask if the family wanted to send Resident B to the hospital, and if			

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	they family requested it LPN 13 could send him to the hospital. LPN 13 was unable to reach family after a few attempts, so she called the nursing manager back. LPN 13, the nurse manager, and Resident B, who was alert and coherent, determined the resident would like to go to (Name of Hospital) for evaluation. LPN 13 then attempted to set transportation through the non-emergent transportation, but they were not available. So, LPN 13 sent Resident B via 911 to the hospital. Transfer paperwork including the out hospital DNR. During an interview on 3/6/24 at 11:50 a.m., Certified Nurse Aide (CNA) 11 explained how she emptied and measured the catheter output. CNA 11 indicated she dried the end of the drain tube which the urine was emptied from the drain bag the tip with a paper towel. She did not clean off the tube with anything else and did not clean with alcohol swab. She completed catheter care if the resident had a bowel movement. And she would provide catheter care for the resident before she leaves for the day. During an interview on 3/6/24 at 12:05 p.m., Resident A indicated the staff did not provide catheter care routinely. On 3/7/24 at 10:12 a.m., during an interview with Certified Nurse Aide (CNA) 12, the CNA indicated she provided catheter care every two hours for a resident when she changed the resident's incontinent brief or after personal care as needed. She indicated she emptied the Foley drain bag as needed. She unclipped the drain tube, which was attached to the drain bag, emptied the urine from the bag and wiped the drain tubing with a paper towel. She indicated she did not clean the tube with anything else. She clipped the tube closed			

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	and inserted it into the bag holder. During an interview on 3/7/24 at 11:06 a.m., the Regional Nurse for the facility indicated Resident B had hematuria since December. She indicated the facility had called the urologist several times. The resident was sent out to the hospital for the Urologist to change Resident B's catheter in the past. During an interview on 3/7/24 at 11:06 a.m., the NP indicated Urologist 18 changed Resident B's catheter if there were issues with the facility staff changing it. The NP indicated when she saw Resident B on 2/27/24 she had reached out to Urologist 18's office to see if the urologist wanted to change Resident B's catheter. She was unsure if there was a response from the urologist's office. The NP indicated she also contacted Resident B's physicians at the local veteran's hospital regarding the anticoagulant while having hematuria but did not receive a response. During a phone interview on 3/7/24 at 1:38 p.m., Urologist 18 indicated Resident B was not his patient. He only had his catheter changed by them 2 times. Once when the resident was at another local hospital his catheter was stuck and could not be removed. The other hospital transferred Resident B to the local hospital Urologist 18 worked. Urologist 18 saw Resident B in the ER and changed his catheter. Resident B came to the office to have catheter changed on 1/19/24 after the nursing facility and Resident B asked the office to change the catheter for them. Resident B was never his patient. Urologist 18 was not his physician, he was not familiar with Resident B's care, did not oversee Resident B's conditions, and had only seen him twice to have the catheter changed.			

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	On 3/8/24 at 9:35 a.m., during an interview, the DNS indicated Resident B was admitted to the facility with an indwelling foley catheter for neurogenic bladder. The primary care physician was following the resident for management of the catheter. When he was admitted from another nursing facility his discharge records indicated he was to be followed by Urologist 20. When she called the number for Urologist 20, she was told the resident was to see Urologist 18. She assumed Urologist 18 had taken over the practice for Urologist 20. She indicated the resident was a patient of Urologist 18. She acknowledged he had been seen by Urologist 18 at the hospital when he had been in the ER. There were no urologist notes for Resident B besides the hospital ER notes. On 3/5/2024 at 1:00 p.m., the DNS provided a document, titled, "Change of condition," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose: to ensure timely interventions for a change in a resident's condition ...2. Acute change in condition ...a. Any sudden or serious change in a resident's condition will be communicated to the physician ...3. Non-urgent change in condition ...a all symptoms and unusual signs will be documented in the medical chart and communicated to the attending physician/NP. Non-urgent changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening ...b. The charge nurse is responsible for notification of physician ...prior to the end of the shift ...." On 3/5/2024 at 1:00 p.m., the DNS provided an undated document, titled, "Catheter Care," and indicated it was the policy currently being used			

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	by the facility. The policy indicated, "...Policy ...It is the policy if this facility to ensure that residents with indwelling catheters receive appropriate catheter care ...1. Catheter care will be performed every shift and as needed by nursing personnel...." On 3/7/2024 at 9:58 a.m., the DNS provided a document, titled, "Emptying a urinary drainage bag," dated October 2010, and indicated it was the policy currently being used by the facility. The policy indicated, "...Purpose ...The purpose of this procedure are to prevent drainage bag from becoming full and allowing urine to flow back into the bladder, to measure output, and to obtain a sterile specimen ...Steps in the procedure ...6. Remove the drain tube from its holder ...7. Open the drainage bag and let the urine flow into the measuring container ...8. After the drainage bag has emptied, close the drain ...9. Wipe the drain with an alcohol sponge or swab ...replace the drain tube back into its holder...." The immediate jeopardy that began on 2/27/24 was removed on 3/7/24 when the facility assessed all residents with urinary catheters for signs and symptoms of infection, nursing staff were in-serviced on catheter care and urinary tract infections, staff were educated on assessment and change of condition with urinary catheters. The noncompliance remained at the lower scope and severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring. This citation relates to Complaint IN00429806. 3.1-41(a)(1) 3.1-41(a)(2)			

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