STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 00 B. WING	09/13/2022

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ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00388046 and IN00389138. Complaint IN00388046 -Unsubstantiated. Complaint IN00389138 - Substantiated. Federal/State deficiencies related to the allegations are cited at F 686. Survey dates: September 7, 8, 9, 12, and 13, 2022 Facility number: 000498 Provider number: 155654 AIM number: 100266110 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 2 Medicaid: 40 Other: 7 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 14, 2022	F 0000	The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUESTS A DESK REVIEW FOR PAPER COMPLIANCE IN LIEU OF A POST SURVEY REVIEW on or after October 20, 2022.	
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.			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 interview, and record review, the facility failed to ensure wound care and assessments for pressure wounds were completed as ordered for 1 of 2 residents reviewed. (Resident T) Resident T's record was reviewed on 9/8/22 10:49 AM. Diagnoses included paraplegia, unspecified, pressure ulcer of right buttock, stage 4, pressure ulcer of sacral region, stage 4, pressure ulcer of left buttock, stage 3, unspecified injury at C1 level of cervical spinal cord, subsequent encounter, need for assistance with personal care, muscle weakness, generalized. Resident T's Quarterly Minimum Data Set Assessment, dated 6/24/22, indicated a brief interview for mental status score of 13 (cognitively intact). Activity of daily living section indicated the resident required extensive assistance with bed mobility, locomotion on and off unit, toileting, and personal hygiene. Resident T required total assistance with transfers and bathing, had an indwelling catheter and was always incontinent of bowel. Resident T had a pressure ulcer and was at risk of developing a pressure ulcer. Resident T had unhealed pressure	F 0686	**F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Wound assessments and wound care reviewed for Res T. Wound assessments completed. **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?** A Look back audit over the past 3 weeks was completed for residents with pressure areas. Wound care and wound assessments to be completed as	10/20/2022

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	ulcers, 3- stage 3 pressure ulcers and did not exhibit behavior to reject evaluation or care. An active order, dated 6/23/22, indicated resident was to be referred to an outside wound clinic related to wounds. An active order, dated 7/25/22, indicated to document drainage amount from the left buttock stage 3 (bed sore that had gone through all layers of skin into the fat tissue but has not reached muscle or bone), the right buttock stage 4 (deep wound that reaches the muscles, ligaments, or bones), the sacral region stage 4 pressure ulcer pressure ulcer (bedsore), every shift, document pain with/without treatment every shift, document periwound (area around wound) skin appearance of the areas every shift, document if the physician was notified of each area's status every shift and to document drainage amount from pressure ulcer (bedsore) every shift. An active order, dated 8/1/22, indicated wound care was to be completed every shift to the pressure ulcer on the left buttock stage 3: apply vasche (prescribed liquid) moistened gauze to wound cover with dry gauze, cover with mepilex border (foam dressing). Apply sure prep around wound bed. An active order, dated 8/1/22, indicated wound care was to be completed every shift to pressure ulcer of right buttock stage 4: apply vasche moistened gauze to wound cover with dry gauze, cover with mepilex border (foam dressing). Apply sure prep around wound bed. An active order, dated 8/1/22, indicated wound care was to be completed every shift to pressure ulcer of sacral region stage 4: apply vasche		ordered. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Wound care nurse received 1:1 training from WCC nurse on: PCC Wound Documentation Protocol. Staff members with missing documentation received 1:1 written education. Nurses educated on PCC Wound Documentation Protocol. WCC/designee will complete an audit daily during clinical meeting X8 weeks, then weekly X4, then monthly X3 to ensure wound care and assessments for pressure wounds are completed as ordered. **4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and	

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	moistened gauze to wound cover with dry gauze, cover with mepilex border (foam dressing). Apply sure prep around wound bed. An active order, dated 8/1/22, indicated the resident was to be up in a wheelchair no longer than 4 hours as ordered by the wound doctor. Activity was to be documented in the progress note, every shift, when the resident refused to get into bed. A current care plan, dated 2/21/22, indicated the resident was at risk for developing pressure ulcers related to a change in mobility. The goal was risk would be minimized through care plan interventions by no skin breakdown. Interventions included: resident would report any redness, tenderness, or changes in skin, resident would rest on a special support surface such as low air loss, alternating air mattress, mosaic/roho mattress, etc., staff would observe resident's skin weekly and as needed, staff would remind resident to turn and reposition when resident chose not to. A current care plan, dated 7/25/22, indicated the resident had a pressure ulcer stage 4 to right buttock, a pressure ulcer stage 4 sacral region, and a pressure ulcer stage 3 left buttock. Goals included Resident T's wounds would progress towards closing. Resident T's stage 3 wound would continue to progress towards closing even though the resident did not always follow care plan interventions. Interventions included: dietary supplements as indicated, the resident frequently refused the wound doctor to see wounds during routine wound rounds, at times refused for staff to perform scheduled treatments, at times chose to sit up in electric wheelchair for prolonged periods of time, staff continued to educate the resident on the importance of above with possible risk of		duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. **5. By what date will the systematic changes be completed?** 10/20/2022	

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	declines with wounds, the resident had a catheter, the catheter care plan was initiated, the resident would receive treatments as ordered, the resident would use assistive devices to assist with turning and repositioning as needed, staff would assist the resident with incontinence care and apply barrier cream as needed, staff would assist the resident with turning and repositioning every two hours and more frequently as needed. An outpatient burn/wound center document, titled Therapy Plan of Care, dated 8/15/22, was received from the DON on 9/13/22 8:32AM. The document indicated Resident T's lower left buttock pressure ulcer stage 3 measured 4.5cm x 3.6cm x 2.5cm, had undermining (wound edges erode resulting in a pocket beneath the skin at the edge of the ulcer) 1.0cm from 9 to 12 o'clock. The Therapist comments indicated the resident returned to the clinic with no dressing in place, stated nursing had left off the dressing today, typed orders were sent with the resident for the nursing home, the resident was educated the dressing needed to be changed 3 times a day, the resident verbalized understanding of instructions. Resident T's sacral region pressure ulcer stage 4 measured 6.5cm x 6.5cm x1.5cm, had undermining 4cm from 5 to 11 o'clock. The Therapist comments indicated the resident returned to the clinic with no dressing in place. Resident T's right ischium pressure ulcer stage 4 measured 3.0cm x 4.5cm x 2.3cm. The Therapist comments indicated the resident returned to the clinic with no dressing in place. Clinician comments indicated typed orders were sent with resident to the nursing facility, DON was to be called about the need to change dressings tid (3 times per day) and the resident was to return to clinic with dressings intact. A document titled, Physician Testing Orders,			

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	dated 8/24/22 was received from the DON on 9/13/22 8:32 AM. The document indicated moist to dry dressings with vasche were to be continued 3 times per day, the resident was to return in 2 weeks, the resident was to use a trapeze bar for turning and keeping pressure off of wounds, and a wound clinic appointment was scheduled on 9/7/22 1:30PM, arrive 1:00PM. A Physician's Progress Note, dated 9/7/22, was received from the DON on 9/13/22 8:32AM. The progress note indicated physician comment, the ulcer was improving, progress might be attributed to better off loading. The treatment plan would remain the same. Resident T's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated August 2022, were reviewed. No documentation was found for the Resident's left buttock pressure ulcer drainage amount, drainage type, dressing change, pain with/without treatment, peri wound skin, and doctor notification on night shift for 8/2, 8/5, 8/8, 8/12, 8/16, 8/19, 8/23, 8/26, and 8/30, evening shift 8/4, 8/18, 8/20, 8/26, and 8/27, and day shift 8/3 and 8/13. No documentation was found to indicate the Resident's left buttock pressure ulcer care, apply vasche moistened gauze to the wound, cover with dry gauze, cover with mepilex border (foam dressing) and apply sure prep around wound bed was completed on night shift 8/1, 8/2, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/16, 8/19, 8/23, 8/26, and 8/30, evening shift 8/13, 8/18, 8/20, 8/26, and 8/27, and day shift 8/3 and 8/13. No documentation was found for the Resident's right buttock pressure ulcer drainage amount,			

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	drainage type, dressing change, pain with/without treatment, peri wound skin, and doctor notification on night shift 8/2, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/16, 8/19, 8/23, 8/26, and 8/30, evening shift 8/4, 8/13, 8/18, 8/20, 8/26, and 8/27, and day shift 8/3 and 8/13. No documentation was found to indicate the Resident's right buttock pressure ulcer care, apply vasche moistened gauze to the wound, cover with dry gauze, cover with mepilex border (foam dressing) and apply sure prep around wound bed was completed on night shift 8/1, 8/2, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/16, 8/19, 8/23, 8/26, and 8/30, evening shift 8/13, 8/18, 8/20, 8/26, and 8/27, and day shift 8/3 and 8/13. No documentation was found for the Resident's sacral pressure ulcer drainage amount, drainage type, dressing change, pain with/without treatment, peri wound skin, and doctor notification on night shift 8/2, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/16, 8/19, 8/23, 8/26, and 8/30, evening shift 8/4, 8/13, 8/18, 8/20, 8/26, and 8/27, and day shift 8/3 and 8/13. No documentation was found to indicate the Resident's sacral pressure ulcer care, apply vasche moistened gauze to the wound, cover with dry gauze, cover with mepilex border (foam dressing) and apply sure prep around wound bed was completed on night shift 8/1, 8/2, 8/5, 8/6, 8/8, 8/10, 8/12, 8/13, 8/16, 8/19, 8/23, 8/26, and 8/30, evening shift 8/13, 8/18, 8/26, and 8/27, and day shift 8/3 and 8/13. Resident T's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated September 2022, were reviewed. No documentation was found for the Resident's left			

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	buttock pressure ulcer drainage amount, drainage type, dressing change, pain with/without treatment, peri wound skin, and doctor notification on night shift 9/2, 9/6, and 9/9, evening shift 9/1, 9/3, and 9/13, and day shift 9/13. No documentation was found to indicate the Resident's left buttock pressure ulcer care, apply vasche moistened gauze to the wound, cover with dry gauze, cover with mepilex border (foam dressing) and apply sure prep around wound bed was completed on night shift 9/2, 9/6, 9/9, evening shift 9/1 and 9/3, and day shift 9/12. No documentation was found for the Resident's right buttock pressure ulcer drainage amount, drainage type, dressing change, pain with/without treatment, peri wound skin, and doctor notification on night shift 9/2,9/6, and 9/9, evening shift 9/1, 9/3, and 9/12, and day shift 9/12. No documentation was found to indicate the Resident's right buttock pressure ulcer care, apply vasche moistened gauze to the wound, cover with dry gauze, cover with mepilex border (foam dressing) and apply sure prep around wound bed was completed on night shift 9/2, 9/6, 9/9, evening shift 9/1 and 9/3, and day shift 9/12. No documentation was found for the Resident's sacral pressure ulcer drainage amount, drainage type, dressing change, pain with/without treatment, peri wound skin, and doctor notification on night shift 9/2, 9/6, and 9/9, evening shift 9/1, 9/3, and 9/12, and day shift 9/12. No documentation was found to indicate the Resident's sacral pressure ulcer care, apply vasche moistened gauze to the wound, cover with dry gauze, cover with mepilex border (foam			

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dressing) and apply sure prep around wound bed was completed on night shift 9/2, 9/6, 9/9, evening shift 9/1 and 9/3, and day shift 9/12.

A nurse note, dated 8/1/22 11:52, indicated resident returned from wound clinic with orders to continue vashe wet/dry to wound 3 times per day, apply sure prep around wound bed prior to treatment.

A nurse note, dated 8/15/22 11:02 AM indicated the resident returned from the appointment with the wound doctor, to continue vashe moistened gauze with mepilex border 3 times per day.

The physician narrative progress note, dated 8/15/22, indicated to follow up with the pressure ulcers and labs. Resident T was seen in the wound clinic, wounds reported as worsening. The resident was noncompliant with off loading, was up in wheelchair over 8 hours per day, and refused to go back to bed. No documentation was found regarding the resident refusing wound care.

The Nurse Practitioner's progress note, dated 8/20/22, indicated the resident was noncompliant with only being up for 4-hour increments and not wanting to take prostat. The note did not indicate the resident refused wound care.

A nurse note, dated 8/24/22 16:03, indicated the resident returned from the wound doctor appointment with orders to continue 3 times per day moist to dry dressing with vashe.

The physician narrative progress note, dated 9/1/22, indicated the wounds worsening, wound clinic had discussed with resident. Resident continued to be noncompliant with keeping pressure off area, noncompliant with only being

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up for 4-hour increments, normally in his chair in the morning and did not want to be put back in bed until bedtime. No documentation was found regarding resident refusing wound care.

The physician narrative progress note, dated 9/2/22, indicated to follow up labs and chest x-ray from 9/1/22. The resident was noncompliant with medical treatment and regimen, noncompliant with orders from the wound clinic to be only up in wheelchair for 4-hour increments. The plan indicated the resident was going to think what times he wanted to be up and would write up a schedule that he would adhere to, continue to encourage compliance to aid in wound healing. No documentation was found regarding resident refusing wound care.

The physician narrative progress note, dated 9/5/22, indicated the resident continued to be noncompliant with keeping pressure off the areas, the resident was agreeable to plan a schedule to be in bed and be more compliant. No documentation was found regarding resident refusing wound care.

A nurse note, dated 9/7/22 at 9:30 PM, indicated the nurse attempted x 3 to change Resident's coccyx and buttock wound dressings. The resident refused repeatedly, was educated on importance of wound care. The resident verbalized understanding but continued to refuse dressing changes.

A nurse note, dated 9/11/22 at 7:39 PM, indicated the resident did not want to lay down after supper, would lay down after watching the game, encouraged to lay down, but the resident refused.

A nurse note, dated 9/12/22 at 6:27 AM, indicated

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	the resident refused to allow treatments to be done, sitting in the wheelchair and would not allow himself to be moved out of the chair to accommodate treatment needs. In an interview on 9/12/22 at 9:36 AM, the Wound Nurse indicated wound care was done by the hall nurse. The Wound Doctor measured the wounds, documented wound measurements and characteristics. The Wound Nurse indicated she documented in the progress notes after the Wound Doctor rounded and she did the wound assessments on new admits. The initial wound assessments were done by the nurse, wound care was documented in the MAR, daily wound documentation was in assessments. The DON was present during the interview and indicated that Resident T did not want the surveyor to observe his wound care or catheter care. In an interview on 9/12/22 at 10:08 AM, the DON indicated when a resident went to an outside wound clinic, the wounds were monitored by the clinic, measurements were done at the clinic. The floor nurses did wound care and documented in the MAR, daily wound assessments. Wounds were to be measured every week by a facility nurse when a resident did not go to the wound clinic weekly. Measurements were documented in a progress note under assessments. In an interview on 9/12/22 2:05 PM, LPN 4 indicated wound care was documented in the TAR when care was completed. The TAR prompted documentation to be completed regarding odor, drainage, peri wound area, pain, any changes noted. When changes in the wound was noted, the nurse notified the Wound Nurse and NP. Measurements were done by the Wound Doctor on weekly rounds, nurses did not measure.			

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	In an interview on 9/13/22 10:42 AM, the DON indicated Resident T was initially seen by the in house Wound Doctor. The resident's wounds were not healing so the resident elected to be seen by an outpatient wound doctor. No documentation of wound measurements done by the facility nursing staff or Wound nurse were found. No documentation of a wound assessment by the Wound Nurse was found in Resident T's chart. A current policy titled PCC Wound Documentation Protocol, dated 6/21, was received from the DON on 9/13/22 9:10 AM. The policy indicated " ... 4. The wound nurse/designee will document weekly, no later than every 7 days, on the areas using the skin and wound application. 5, Daily wound documentation to be completed by the staff nurse or wound nurse for any pressure ulcers, diabetic ulcers, vascular or arterial ulcers, and any other wound that required a daily assessment or a dressing. This was not an optional tool. ...13. The wound nurse or licensed nurse would complete weekly assessments of the skin condition using the skin and wound application ...14 Measurements of the wound would be completed using the head-to-toe method. The application would measure the length, width, and calculate the area using the photograph of the injury. The nurse would measure depth, undermining and tunneling and document as it applied for pressure injuries and other wounds ...16. Weekly assessments of wounds and skin conditions will be documented weekly, no later than every 7 days, in the electronic record ...20. Physician ordered treatments would be documented on the TAR after each administration 21. A daily observation			

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	155654	A. BUILDING 00 B. WING	09/13/2022

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	of the wound would be completed by a licensed nurse for any open wound or skin condition requiring a dressing change. A policy titled Wound Documentation Guidelines, dated 6/21, was received from the DON on 9/13/22 9:10AM. The policy indicated when charting a description of a pressure injury, the following components should be part of the weekly charting. 1.Location 2. Stage ...3. Dimensions ...4. Undermining/tunneling ...5. Wound Base Description ...6. Drainage ...7. Wound edges ...8. Odor ...9. Pain ... 10. Progress. This Federal Citation is related to Complaint IN00389138. The state reference 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. 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 interview and record review the facility failed to ensure fall risk assessments were completed timely on 2 of 2 residents reviewed. (Resident 14 and Resident 151). Findings include: 1) Resident 14's record review began on 9/7/22 at 10:32 AM. Diagnosis included encephalopathy,	F 0689	**F689 Free of Accident Hazards/Supervision/Devices** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	10/20/2022

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	secondary Parkinsonism, Alzheimer's disease, muscle weakness, and stroke. Falls were documented as occurring on 6/18/22, 7/11/22, 7/12/22, 8/4/22, 8/17/22, 8/28/22, 8/29/22, 8/30/22, and 9/9/22. A fall risk assessment was completed on 3/1/22. There were no other documented fall risk evaluations. In an interview on 9/9/2022 at 2:45 PM, the DON (Director of Nursing) indicated she was unable to show any further documentation of fall risk assessment. The most recent care plan for Resident 14 included a focus of being at risk for falls initiated on 3/1/22. The most recent intervention update was 8/30/22. 2) An interview with Resident 151's POA (Power of Attorney) on 9/9/22 at 11:46 AM indicated Resident 151 fell in the facility on 8/18/22 and required medical care. Resident 151's record review began on 9/9/22 at 2:47 PM, and indicated diagnoses included dementia, seizure disorder, stroke, and history of falls. Resident 151's most current MDS (Minimum Data Set) assessment indicated their BIMS (Brief Interview for Mental Status) indicated she had moderate cognitive difficulties thus the need for a POA. Resident 151's progress note dated 8/18/22 at 10:23 PM indicated they were found on the floor. An ambulance was called, and Resident 151 was taken to the hospital.		**practice?** Fall Risk Assessments were completed for Resident 14 and Resident 151. **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?** Fall Risk Assessments were reviewed and completed for all residents. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Fall Assessments completed and up to date for residents. 1:1 education shared with nurses found to be in error Nurses educated on Fall Investigation and Risk Evaluation Policy. DON/designee to complete audit daily during clinical meeting X 8 weeks, then weekly X 4, then monthly X 3 to ensure fall risk assessments are completed timely. **4. How will the corrective action(s) be monitored to**	

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	A fall risk assessment was not documented on admission or readmission from the hospital. The most recent care plan for Resident 151 included a focus on risk for falls was initiated on 8/19/22. The interventions for falls were last updated 9/1/22. An interview with DON on 9/12/22 at 12:04 PM indicated a fall risk assessment was done upon admission and quarterly thereafter for all residents. A policy titled, "Fall Investigation and Risk Evaluation" dated 6/2012 with most recent revision on 6/2022, indicated .... Complete risk evaluations on each resident on admission, quarterly, and with a significant change in the resident that may change their risk for falls .... 3.1-45(a)		**ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. **5. By what date will the systematic changes be completed?** 10/20/2022	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on record review and interview, the facility failed to ensure catheter care was completed on every shift for 1 of 1 resident reviewed. (Resident 19) Resident 19's record was reviewed on 9/8/22 10:49 AM. Diagnoses included paraplegia, unspecified, neuromuscular dysfunction of bladder, unspecified, pressure ulcer of right buttock, stage 4, pressure ulcer of sacral region, stage 4, pressure ulcer of left buttock, stage 3, unspecified injury at	F 0690	**F690 Bowel/Bladder Incontinence, Catheter, UTI** **Plan of Correction** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident T's catheter care	10/20/2022

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	C1 level of cervical spinal cord, subsequent encounter, urinary tract infection, site unspecified, need for assistance with personal care. Resident T's Quarterly Minimum Data Set Assessment, dated 6/24/22, indicated the brief interview for mental status score was 13 (cognitively intact). Activity of daily living indicated the resident required extensive assistance with bed mobility, locomotion on and off unit, toileting, and personal hygiene. The resident required total assistance with transfers and bathing, had an indwelling catheter, was always incontinent of bowel, had a pressure ulcer, was at risk of developing a pressure ulcer, and had unhealed pressure ulcers, 3- stage 3 pressure ulcers. The resident did not exhibit behavior to reject evaluation or care. An active order, dated 6/27/22, indicated change foley catheter 16 Fr (French) 10 cc (cubic centimeter) as needed for leakage. An active order, dated 6/13/22, indicated Resident to have a catheter leg strap to assist with pulling/tugging/dislodgement. Check for placement and replace if needed every shift. There was no order for foley catheter care. A current care plan, dated 2/7/2022, indicated the resident needed assistance with ADLs (Activity of Daily Living) related to paraplegia. Goal: the resident would maintain current level using care plan interventions as long as disease process allowed. Interventions included Resident needed assist of 1-2 staff with toileting. A current care plan, dated 2/21/22, indicated the resident had an indwelling catheter related to		documentation was reviewed and catheter care provided. **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?** Catheter care documentation was reviewed and completed for those residents with catheters. **3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur?** Staff members without documentation for completion of catheter care received 1:1 written education. Nursing staff educated on Catheter Use Care Policy. Orders written for nurses to perform catheter care every shift. Requested of Supply QMA to order personal cleansing wipes for use with catheter care. DON/designee will complete daily audits during clinical morning meeting X 8 weeks, then weekly X4, then monthly X3 to ensure catheter care is being provided every shift. **4. How will the corrective action(s) be monitored to**	

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	neurogenic bladder. Goals: The resident's care plan interventions would minimize risk for complications. Interventions included change catheter system when clinically indicated or ordered, extra fluids offered with medication, receive fluid of choice with meals, report and staff observe for changes in the color, consistency, and odor of urine, changes in mental status, changes in amount of urine produced, and pain in lower back or lower abdomen, refer to the registered dietician for fluid recommendations, and have catheter leg strap to assist with pulling/tugging/dislodgement. Foley catheter care was not indicated on the resident's care plan. The Task List: Indwelling Catheters, dated 8/15/22-8/13/22 was reviewed. The task list indicated when catheter care was provided. No documentation regarding completion of catheter care was found for day shift on 8/21, 8/25, 8/29, 9/4, and 9/8, evening shift on 8/15, 8/16, 8/18, 8/19, 8/20, 8/21, 8/22, 8/23, 8/24, 8/25, 8/26, 8/27, 8/28, 8/29, 8/30, 8/31, 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/8, 9/9, 9/10, 9/11, and 9/12, night shift on 8/16, 8/17, 8/18, 8/20, 8/21, 8/23, 8/26, 8/28, 8/29, 8/31, 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/10, and 9/12. No documentation was found to indicate the resident refused catheter care. In an interview on 9/12/22 10:00 AM, C.N.A. 3 indicated catheter care was completed every day and when changing a resident's brief. Catheter care was documented on the form provided by the facility, the information went to administration for review to make sure staff were providing the care they should be providing. When a resident refused care, C.N.A. 3 indicated she would notify the nurse.		**ensure the deficient practice will not recur?** **ie: what QA program will be put into place and by what date will they be completed.** Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. Afer consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. **5. By what date will the systematic changes be completed?** 10/20/2022	

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	In an interview on 9/12/22 2:05 PM, LPN 4 indicated catheter care was completed by C.N.A.s and nurses, mostly the nurses. Catheter care was done every shift, and documented in the TAR. An order to do catheter care was generated when a resident had a catheter. When a resident refused catheter care, LPN 4 indicated she would ask the resident why, document on the task, TAR and progress note, and notify doctor when resident refused after 3 attempts. In an interview on 9/13/22 10:42 AM, the DON indicated an order was not needed for catheter care, it was placed on a task sheet. C.N.A.s did the catheter care. Catheter care was performed when a resident was cleaned up after incontinence episodes, and should be done at least 1 time per shift. When a resident refused care, the C.N.A. reported to the nurse, the nurse would speak to the resident then document on the behavior sheet or progress note. A current policy titled Catheter Use Care Policy, dated 5/22, was received from the DON on 9/13/22 at 8:32 AM. The policy indicated Policy ..."provide proper care while a resident is catheterized including observing for signs of catheter related infections ...." General considerations 1. Catheter care may be completed by licensed nurses or certified nursing assistants. 2 Catheter care will include cleansing the perineal area and external portion of the catheter, draining the collection bag, and placing the tubing and collection bag in the correct position to prevent infection, as well as providing dignity to the resident ... Catheter Care: 1. Perform hand hygiene and put on clean gloves. 2. Cleanse the perineal area from center to the outside. 3. Using a clean washcloth to cleanse the catheter at the insertion site outward about 4 inches. 4. Remove gloves			

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	and perform hand hygiene." The policy did indicate a frequency for catheter care. 3.1-41(a)(1)			