STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155857	A. BUILDING 00 B. WING	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANQUILITY NURSING AND REHAB	3640 N CENTRAL AVENUE INDIANAPOLIS, IN 46205

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F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00363933. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00363933- Substantiated. Federal/State deficiencies related to the allegations are cited at F622, F684 and F690. Survey dates: October 4 and 5, 2021 Facility number: 014265 Provider number: 155857 AIM number: 300029339 Census Bed Type: SNF/NF: 26 Total: 26 Census Payor Type: Medicare: 1 Medicaid: 23 Other: 2 Total: 26 These deficiencies reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 14, 2021	F 0000		
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-			

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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	(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances			

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	specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			

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	Based on interview and record review, the facility failed to communicate appropriate information to the hospital for 1 of 4 residents reviewed for catheters. (Resident B) Findings include: The clinical record for Resident B was reviewed on 10/4/21 at 11:57 a.m. The diagnoses included, but were not limited to: traumatic brain injury, anoxic brain damage, and neuromuscular dysfunction of bladder. The 9/30/21, 7:50 a.m., nurse's note indicated Resident B had been sent to the hospital. There was no information in the clinical record indicating what information had been sent with the resident to the hospital or given to them afterwards. The 9/30/21, 4:25 a.m., emergency room department note read, "...presents via EMS [emergency medical services] from ECF [extended care facility] found unresponsive. EMS states no ECF staff was able to give further history...History is limited due to the available resources." The 9/30/21, 6:24 a.m., emergency room social services note read, "Writer first attempted to call [name and phone number of facility] to get more information on the process of taking care of the patient and possible barriers. Writer called 3 x [times] and continued to be met with the voicemail." An interview was conducted with the DON (Director of Nursing) on 10/4/21 at 3:30 p.m. She indicated when a resident was transferred to the hospital, transfer discharge paperwork went with	F 0622	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective October 29, 2021 to the state findings of the Complaint with a COVID-19 Focused Infection Control survey conducted on October 5, 2021. F - 622 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B no longer resides at the facility. The LPN identified as LPN 7 who was responsible for transferring resident B to the hospital has been counseled regarding their responsibilities in providing appropriate information to the receiving facility per facility policy to ensure that the continuity of care can be provided. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents who require hospitalization have the potential to be affected by this deficient practice. An audit of all hospital	10/29/2021

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	them. It was printed from the computer, and nursing left a copy under her door and she would scan it into the ehr (electronic health record.) They hadn't been scanning it in lately, but she would look for Resident B's 9/30/21 hospital transfer paperwork. An interview was conducted with the DON on 10/4/21 at 3:43 p.m. She indicated she didn't see any documentation of what paperwork was sent to the hospital for Resident B. LPN (Licensed Practical Nurse) 7, who sent Resident B to the hospital on 9/30/21, had to give the ambulance something for them to take him, but she didn't make a copy of it. LPN 7 was unavailable for interview. An interview was conducted with the ED on 10/5/21 at 3:30 p.m. He indicated he spoke to the hospital the morning of 9/30/21, as they were requesting paperwork for Resident B. He sent them Resident B's MAR (medication administration record), because they said that's all they needed. The Discharge Documentation policy was provided by the ED on 10/6/21 at 1:56 p.m. It read, "It is the facility policy that to ensure continuity of care the facility will prepare all necessary documents at the time of transfer/discharge so that the receiving facility will have all the necessary information to continue the resident's plan of care...To Hospital: ...7. Complete a Skilled Nursing Assessment in [name of ehr.] 8. Complete Transfer/Discharge Record (new) which is under the clinical reports in the ADT profiles. Print this completed form out and give to the resident. 9. Complete the State required Notice of Transfer/Discharge Form with the facility bed hold		transfers/discharges that have occurred in the past thirty days has been completed to ensure all required information has been provided to the receiving facility. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility policy related to transfer/discharge of a resident. The in-service included a review of the required documents that are to be provided at the time of transfer/discharge to the receiving facility to ensure continuity of care. The in-service also reminded the nurses that copies of all documents provided to the receiving facility are to be made so that that information can be scanned into the electronic clinical record. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the documentation provided to any receiving facility at the time of a resident’s transfer/discharge. The tool will monitor to ensure that all required documents per facility policy have been provided to the receiving facility as well as a copy of said documents have been scanned into the resident’s electronic clinical record. This tool will be	

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	policy. Make a copy for the clinical record and give the original to the resident...10. Send a copy of the most recent lab test results. 11. Send a copy of the resident's immunization record. 12. Send a copy of the most recent H&P (history and physical.) 13. Send a copy of the resident's Code Status form." This Federal tag relates to Complaint IN00363933. 3.1-12(a)(3)		completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, interview, and record review, the facility failed to ensure a resident's wound dressing was changed as ordered. (Resident C) Findings include: The clinical record for Resident C was reviewed on 10/4/21 at 2:30 p.m. The diagnosis for Resident C included, but was not limited to, dependence of ventilator. A physician order for Resident C dated 9/29/21 indicated the staff was to "Cleanse skin tear to left forearm with wound cleanser, pat dry, then apply collagen sheet, cover with foam q [every] 3 days	F 0684	F - 684 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident C is now receiving their wound treatment in accordance with their physician's orders. The skin tear is continuing to heal without complications. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents with skin impairments have the potential to be affected	10/29/2021

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	and prn [as needed] soilage..." The October 2021 Treatment Administration Record (TAR) indicated Resident C's wound dressing for her skin tear was changed on 10/3/21. An observation was made of Resident C on 10/4/21 at 4:26 p.m. A soiled wound dressing was observed on her left forearm dated, 10/1/21. There was a red and yellow substance bleeding through the top portion of the dressing. An interview was conducted with Resident C on 10/4/21 at 4:30 p.m. She indicated she had a skin tear on her arm, and the dressing was suppose to be changed every few days. The staff had not changed the dressing in awhile. An observation was made of Resident C on 10/5/21 at 9:30 a.m. A soiled wound dressing dated 10/1/21, was observed on her left forearm. The dressing was stained with a yellow substance around the edges and lifting away from her skin. A red substance was bleeding through the top portion of the dressing. The resident indicated at that time no one had changed the wound dressing. An interview was conducted with License Practical Nurse (LPN) 6 on 10/5/21 at 9:38 p.m. She indicated she had not been working in the last couple of days, so she was unable to determine why the TAR was signed off the wound dressing for Resident C had been completed on 10/3/21, and the wound dressing was dated 10/1/21. She would change the dressing. This Federal Tag relates to complaint IN00363933. 3.1-37(a)		by this deficient practice. A housewide audit has been conducted on all residents with any type of wound treatments. All residents with an order for a wound treatment are now receiving that treatment in accordance with their physician's orders. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses on the facility's policy related to following the plan of care. All nurses were reminded that it is their responsibility to follow all physician's orders including wound treatments. The nurses were also reminded that it is against facility policy to falsify any documentation in the clinical record. Failure to follow physician's orders or the falsification of a clinical record will be subject to the facility's disciplinary process. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the provision of following physician's orders in accordance with the resident's plan of care. The tool will monitor to ensure that all medications/treatments are being provided as ordered by the physician. This tool will be completed by the Director of	

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			Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§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 adequately address a resident's UTI (urinary tract infection) resulting in a hospitalization for sepsis and ensuring catheter care was provided for 3 of 4 residents reviewed for catheters, (Resident B, G and H) Findings include: 1. The clinical record for Resident B was reviewed on 10/4/21 at 11:57 a.m. The diagnoses included, but were not limited to: traumatic brain injury, anoxic brain damage, and neuromuscular dysfunction of bladder. The 9/22/21 catheter care plan indicated the goal was for him to be free from catheter related trauma and or infection. An intervention was to "Observe/record/report to MD for s/sx (signs/symptoms) UTI: pain, burning, blood tinged urine, cloudiness, no output, foul smelling urine, altered mental status." The 9/16/21 NP (Nurse Practitioner) note, written by NP 9, read, "...being seen for review of UA [urinalysis.] On Sept [September] 12 a Stat [immediately] UA was done for dark amber urine with sediment. Nurse stated that it has not cleared even after flushing. UA was done and culture was indicated but have not received the results of culture as of this note. Resident is in a persistent vegetative state so he is a poor historian. He has been afebrile and vs [vital	F 0690	F - 690 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident B no longer resides at the facility. The LPNs identified as resident LPN 7 and LPN 8 have been re-educated on facility policies related to catheter care and the required documentation related to assessment of the resident's condition. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident H has had the physician's orders related to their supra pubic catheter reviewed and clarified as warranted. Resident H is now having their urinary output measured each shift and documented in the clinical record. Resident H is also now having catheter care provided in accordance with facility policy each shift and documented in the clinical record. *3.) The corrective action taken for those residents found to have*	10/29/2021

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	signs] reviewed. At this time will initiate ABT [antibiotic] therapy due to large protein count. Will need to change ABT pending C&S [culture and sensitivity] result....Will continue to monitor and re-eval [re-evaluate] as needed....Genitourinary: Foley catheter draining thick with sediment, amber urine....Problems Urinary tract infection...Plan Note 1. Bactrim DS, one tab via G-tube BID [twice daily] for 10 days. 2. CBC [complete blood count,] BMP [basic metabolic panel,] A1C [glycated hemoglobin] 3. Will need to Chang ABT if C&S indicates." The 9/24/21 NP note, written by NP 9, read, "...being seen for follow-up UTI. He continues to be on ABT therapy. Labs reviewed. NS [normal saline] irrigation had been ordered for Foley over the phone. Urine continues to be amber but with significant less sediment....Genitourinary: Foley catheter draining amber urine with sediment....Problems Urinary tract infection...Plan Note 1. Continue with current ABT therapy 2. Flush Foley catheter with NS 60 ml BID and PRN [as needed.] The note did not reference follow up to the pending C&S results referenced in the 9/16/21 NP note. There were no C&S results in Resident B's clinical record, and the DON was unable to provide them. An interview was conducted with the DON on 10/5/21 at 4:18 p.m. She indicated there was were no C&S results, and hadn't followed up with labs to see what the hold up was. Without them, there was no way to determine if the Bactrim antibiotic Resident B was receiving would be effective in treating his UTI. The September, 2021 MAR (medication administration record) indicated he completed the		*been affected by the deficient practice is that* the resident identified as resident G is now receiving catheter care each shift in accordance with facility policy. Resident G's urinary output is also being documented in the clinical record at the end of each shift, per facility policy. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents who have any type of urinary catheter are at potential risk related to this deficient practice. A housewide audit of all residents with a urinary catheter has been conducted to ensure that appropriate catheter care orders are in place. All residents with urinary catheters are now receiving catheter care each shift and more often if deemed necessary. All residents with urinary catheters are also having their urinary output documented in the clinical record each shift. In addition, the facility has developed and implemented a lab tracking tool to ensure that all lab orders are being processed in a timely manner, including receipt of lab results and reporting of lab results to the physician. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff	

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	10 days of Bactrim DS antibiotic on 9/26/21; that his Foley catheter was irrigated on 9/26/21; and continued to receive Foley catheter care twice daily from 9/24/21 through 9/29/21. The progress note last referencing his catheter was on 9/27/21 at 4:43 p.m. and read, "...Foley catheter site cleansed and tube is patent." The 9/30/21, 2:50 a.m. therapy progress note read, "Checked resident's Sp02 [oxygen saturation] and it was 76%, HR [heart rate] = 155. Turned flowmeter up to 11 L [liters,] and went to notify the nurse. Returned to room and cleared vent circuit of thin, tan secretions. Then replaced the HME [heat and moisture exchanger] filter, again for same secretions. Suctioned resident's trach for scant amount of secretions. Color was very pale. His Sp02 was up to 87%. After clearing secretions and checking inner cannula, Sp02 was up to 90%. His color did improve to looking flushed in the cheeks. RR [respiratory rate] 34-38 EMT [emergency medical technicians] was called." The 9/30/21, 4:25 a.m. emergency department note read, "...presents via EMS from ECF [extended care facility] found unresponsive. EMS states no ECF staff was able to give further history, pt [patient] was 85% on room air on their arrival, pt has a trach and PEG, opens eyes, does not follow any commands, no spontaneous movement of extremities. Trach [Tracheostomy] was suctioned on scene and EMS bagged pt en route. On arrival is hot to the touch with frank pus in Foley bag and leaking around catheter....GU [Genitourinary:] Foley in place with frank pus in bag leaking around tubing...Medical Decision Making Pt placed on ventilator on arrival, minimal secretions from trach, hot to touch, tachycardic, normotensive. Large volume pus in Foley bag and		on the facility's policies related to the care of urinary catheters. The in-service included a review of catheter care, documentation of urinary assessments, documentation of intake and output, and the monitoring for signs and symptoms of urinary tract infections/complications. In addition, the licensed nurses were in-serviced on the new lab tracking tool and their responsibility to ensure that all lab orders are processed in a timely manner including receipt of lab results and timely reporting of lab results to the physicians. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the care of urinary catheters. This tool will monitor to ensure that catheter care is being provided each shift, urinary output is being documented at the end of each shift and that the resident is being monitored for any signs and symptoms of urinary tract infections/complication. The tool will also monitor to ensure that lab tests are being processed in a timely manner. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be	

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	coming out around catheter tubing. Exchanged Foley, started empiric antibiotics and fluids....Will admit to ICU [intensive care unit] for further care....Assessment/Plan: ...2. Sepsis...3. UTI...has purulent material out of his Foley. He appears to generally (sic) poorly cared for unfortunately. He is tachypneic and tachycardic with copious secretions. He was given broad spectrum abx [antibiotics] and IVF [intravenous fluids] and will be admit for sepsis. Social work was contacted to file with APS [adult protective services] given his presentation. ED Critical Care Time Spent: The high probability of sudden, clinically significant deterioration in the patient's condition required the highest level of my preparedness to intervene urgently. The services I provide to this patient were to treat and/or prevent clinically significant deterioration that could result in: septic shock and death." An interview was conducted with the DON (Director of Nursing) on 10/5/21 at 2:35 p.m. She indicated if catheter care was performed on the same shift he was sent to the hospital, there shouldn't have been pus in the Foley bag upon admission to the hospital, because that would have been recognized and addressed during catheter care. LPN (Licensed Practical Nurse) 7, who signed off as having performed catheter care on the 9/29/21, 7:00 p.m. to 7:00 a.m. shift, was unavailable for interview. LPN 8, who signed off as having performed catheter care on the 9/29/21, 7:00 a.m. to 7:00 p.m. shift, was interviewed via telephone on 10/5/21 at 3:00 p.m. in the presence of the DON. He indicated when he came to work the morning of 9/29/21, he was informed Resident B's catheter		reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	had just been changed, but he didn't know why. Urine was flowing, but there was trauma around the catheter site and a "little blood" in the catheter bag. He informed the DON, but couldn't' remember what he was told to do about it. He thought he'd spoken with the physician, but couldn't remember. He didn't consider what he saw as a sign of infection. An interview was conducted with NP 9 on 10/5/21 at 3:09 p.m. in the presence of the DON. She indicated she last saw Resident B on 9/24/21 and his urine had improved from the previous week. There was sediment, but wouldn't say pus, but there was a white fluffy substance present. She did not place an order to change Resident B's catheter the day before going out to the hospital, as LPN 8 indicated had been done. No one had notified her Resident B had any signs or symptoms of infection in the days leading up to his 9/30/21 discharge. An interview was conducted with the DON on 9/29/21 at 3:25 p.m. after LPN 8's interview. She indicated LPN 8 did not document any of the information he'd just communicated in his interview. An interview was conducted with the ED (Executive Director) on 10/5/21 at 3:30 p.m. He indicated the antibiotic Resident B completed on 9/26/21 must not have worked. An interview was conducted with NP 9 on 10/5/21 at 4:37 p.m. She indicated there were no C&S results and was never able to determine if the Bactrim would be effective in treating his UTI. When she saw the C&S was pending, she didn't' realize how much time had passed and that he only had 2 days left of his antibiotic treatment.			

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	She didn't follow up and look for the C&S results. She did not believe nursing performed catheter care, as ordered, on Resident B, as the facility had a history of not performing catheter care as she'd ordered. 2. The clinical record for Resident H was reviewed on 10/4/21 at 3:00 p.m. The diagnoses for Resident H included, but were not limited to, neuromuscular dysfunction of bladder, calculus of kidney and stage 1 through stage 4 hypertensive chronic kidney disease. A Quarterly MDS assessment, dated 9/9/21, indicated Resident H was severely impaired. A care plan dated 7/14/21 indicated "The resident [H] has SP [Suprapubic] catheter due to Neurogenic bladder that he was admitted with...Monitor/record/report to MD [medical provider] for s/sx [signs and symptoms] UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observe and document intake and output as per facility policy..." A physician order dated 1/10/20 indicated to "Cleanse supra pubic site and place sponge on" There was no frequency on the order nor was this order showing up on the Treatment Administration Record (TAR). A physician order dated 2/9/20 indicated to "Change supra cath [catheter] on the 9th of month or for dislodgement; 18fr [french]..." A physician order date 5/26/20 indicated to			

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"Apply to super pubic site topically every morning and at bedtime for redness at super pubic site with pain at touch."

A physician order dated 3/13/20 indicated staff was to flush Resident H's catheter with 60 milliliters of normal saline every night shift.

A physician order dated 9/13/21 indicated staff was to monitor urine output.

The September 2021 TAR indicated the following days and shifts the urine output was not obtained:
9/17/21 - 6:00 a.m., 9/18/21 - 6:00 a.m., 9/23/21 -6:00 a.m., 9/25/21 - 6:00 a.m., and 9/27/21 - 6:00 p.m.

The September 2021 and October 2021 TAR did not indicate catheter care was provided, but did indicate flu.

A progress note dated 9/5/21 indicated the supra pubic catheter was patent and draining amber urine per gravity and irrigated at night as ordered.

A progress note dated 9/5/21 indicated the supra pubic catheter had been changed due to leaking and resistance to irrigation. The urine characteristics was gold in color, sediment and mucus appearance.

A progress not dated 9/9/21 indicated the resident's catheter was changed on 9/5/21 and draining yellow urine.

A progress note dated 9/24/21 indicated super pubic catheter was cleaned and draining yellow urine.

A progress note dated 9/25/21 indicated super

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	pubic catheter was patent draining yellow cloudy urine. A progress note dated 9/26/21 indicated the catheter was draining yellow urine. A progress note dated 9/27/21 indicated the catheter care was cleaned and yellow urine with a scant of sediment. The progress notes did not include documentation catheter care was provided after 9/27/21, and the doctor was notified of changes in appearance of Resident H's urine. An observation was made of Resident H on 10/5/21 at 12:20 p.m. Resident H's catheter tubing was observed to be stained a dark gold-brownish color. The neck of the tubing that went into the collection bag had a brown substance collected at the end of the tubing and amber colored urine was collected in the bag. An interview was conducted with Certified Nursing Assistant (CNA) 5 on 10/5/21 at 3:25 p.m. She indicated she had been working in the facility for 4 months, and Resident H's urine "always" looked orange-brown in color with brown "grudge." An interview was conducted with the Director of Nursing on 10/5/21 at 5:02 p.m. She indicated Resident H was noncompliant with care at times. The order on 9/27/21, regarding the catheter care was needing the frequency of care times. The staff know if a resident has a catheter to provide catheter care. The staff should be documenting if the care was provided, and the appearance of the urine. If he had refused the care the staff should also document that he refused as well. At that			

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time, Resident H was refusing for the DON to assess his catheter. She would reattempt to assess, and change the collection bag. The DON indicated she would notify the doctor.

An interview was conducted with the Nurse Practitioner 9 on 10/6/21 at 11:44 a.m. She indicated Resident H's appearance of his urine does go back and forth clear yellow at times and amber brown in color at other times. She "always" would like to be notified when the resident's urine appearance was not clear and yellow. The staff did notify her yesterday about the appearance of his urine, and she has ordered a UA (urinalysis).

3. The clinical record for Resident G was reviewed on 10/4/21 at 2:00 p.m. The diagnosis for Resident G included, but was not limited to, neuromuscular dysfunction of bladder.

A Quarterly MDS (Minimum Data Set) assessment, dated 8/14/21, indicated Resident G was cognitively intact.

A physician order dated 7/28/21 indicated staff was to obtain Resident G's catheter output every day and night shift.

A physician order dated 7/14/21 indicated staff was to provide catheter care every shift.

The September 2021 Treatment Administration Record (TAR) indicated the collection of the catheter output was duplicated on both the catheter output, and the catheter care section on the TAR. The following dates and shifts did not have any documentation catheter care was provided nor catheter output was collected: 9/17/21 - 7:00 p.m. - 7:00 a.m. shift, 9/22/21 - 7:00 p.m. - 7:00 a.m., 9/27/21 - 7:00 a.m. - 7:00 p.m., and

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7:00 p.m. - 7:00 a.m.

The October 2021 TAR indicated the duplication of the collection of the catheter output was completed on the catheter output, and the catheter care. It did not indicate catheter care was completed.

An interview was conducted with Resident G on 10/5/21 at 12:04 p.m. She indicated the staff provided catheter care when she was provided a full bed bath which was once a day, and if she had leakage. The staff did not provide catheter care twice a day.

An observation was made of catheter care to Resident G with License Practical Nurse (LPN) 6 on 10/5/21 at 3:27 p.m. LPN 6 was observed removing a brief from Resident G prior to providing treatment. The brief had a scant amount of urine on it. LPN 6 indicated Resident G does at times have bladder spasms. She then using wash cloths with soap and water cleansed the urinary catheter and peri area of the resident. After, she closed the brief up and covered the resident. LPN 6 was not observed during the observation, emptying the urine from the collection bag to obtain the output.

The progress notes did not include documentation staff was providing catheter care.

An interview was conducted with Resident G on 10/5/21 12:20 p.m. He indicated he did not receive catheter care on night shift. Resident G had a quarterly MDS assessment dated 8/7/21, indicating he was cognitively intact.

An interview was conducted with the Director of Nursing (DON) and the Assistant Director of

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	Nursing (ADON) on 10/5/21 at 5:02 p.m. They indicated the staff were documenting on the TAR the output on both the catheter output and catheter care which was an error. The Urinary Catheter Care policy was provided by the ED on 10/4/21 at 12:00 p.m. It read, "The purpose of this procedure is to prevent catheter-associated urinary tract infections....Complications 1. Observe the resident for complications associated with urinary catheters....b. Check the urine for unusual appearance (i.e., color, blood, etc). c. Notify the physician or supervisor in the event of bleeding, or if the catheter is accidentally removed....e. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately....Documentation The following information should be recorded in the resident's medical record: 26. Initial the MAR on the date and shift that the catheter care was provided. 27. All assessment data obtained when giving catheter care. 28. Character of urine such as color (straw-colored dark, or red), clarity (cloudy, solid particles, or blood), and odor. 29. Any problems noted at thee catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain." This Federal Tag relates to complaint IN00363933. 3.1-41(a)(2)			
F 9999 Bldg. 00	410 IAC 16.2-5-12 Infection control Authority: IC 16-28-1-7 Affected: IC 4-21.5; IC 16-28-5-1	F 9999	9999 *The corrective action taken for those residents found to have*	10/29/2021

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	Sec. 12. (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on interview, and record review, the facility failed to correctly report 6 of 6 COVID-19 positive residents and staff cases into the Redcap reporting system. (Resident K, L, Qualified Medication Aide (QMA) 1, Social Services 2, Physical Therapist 3, and Housekeeper 4) Findings include: An interview was conducted with the Executive Director (ED) on 10/4/21 at 11:00 a.m. He indicated he had 2 residents currently in the red zone due to positive for COVID-19, and 4 staff members that had tested positive for COVID-19. He had reported all staff and resident cases in the Redcap system. The ED had provided a document with the positive cases of COVID-19 on 10/4/21 at 12:22 p.m. It indicated the following names and dates of the positive cases:		*been affected by the deficient practice is that* the residents identified as resident K and resident L have now been reported in the Redcap system under the Long-Term Care Case Report as being COVID-19 positive. In addition, staff members identified as Social Service 2, QMA 1, Physical Therapist 3 and Housekeeper 4 have also been reported in the Redcap system under the Long-Term Care Case Report as being COVID-19 positive. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents and staff have the potential to be affected by this deficient practice, however no negative outcome has occurred as a result of this error. The Executive Director was mistakenly unaware of a second report in the Redcap system that had to be completed. The Executive Director is now completing all required documents in the Redcap system. *The measures that have been put into place to ensure that the deficient practice does not recur is that* the Executive Director has now been educated on all the required documents that are to be completed in the Redcap system. *The corrective action taken to monitor to ensure the deficient*	

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	Social Services 2 tested positive on 9/13/21, QMA 1 tested positive on 9/15/21, Physical Therapist 3 tested positive on 9/17/21, Resident K had tested positive on 9/19/21, Resident L had tested positive on 9/20/21, and Housekeeper 4 tested positive on 9/21/21. An interview was conducted with the the ED on 10/4/21 at 12:30 p.m. He indicated he had only reported on one form in the Redcap system. The form was called "Covid-19 Point of Care Test Reporting." He was unaware there was any other forms to report in the Redcap system. He had not reported the positive cases on the "Long Term Care Case Report." The 12/22/20 LTC Newsletter indicated, "NOTE: All COVID positive residents, including residents that are positive upon admission should be reported into the Long Term Care COVID-19 Case Report Form-REDCap." The 9/10/21 LTC Newsletter indicated "...Data Submissions Guidelines...The table and chart below outline the various pathways LTC facilities submit COVID-19 related data to the state and federal governments...Long Term Care Case Report. Redcap:..Reporting form for all positive case results and submissions, including staff and residents for all SNF/NF...Within 24 hours of positive result (if false positive not suspected)..."		*practice will not recur is that* the Infection Preventionist will now be reviewing the documentation in the Redcap system weekly to ensure all required documents are being completed. This will be an on-going process as long as this practice is mandated by the State or other governing agencies during the pandemic.	