PRINTED: 11/07/2022

DEPARTMENT	T OF HEALTH AND HUN	MAN SERVICES				FOI	RM APPROVED	
CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUIL	DING	00	COMPL	ETED		
155807			B. WING	<u> </u>		10/07/	2022	
NAME OF P	PROVIDER OR SUPPLIER	<u>. </u>			DDRESS, CITY, STATE, ZIP COD	<u> </u>		
RURAL H	HEALTH CARE CEN	NTER			APOLIS, IN 46218			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00								
		Post Survey Revisit (PSR) to	F 000	0				
		and State Licensure Survey						
		st 26, 2022. This survey was						
		nction with the Complaint						
	IN00391995 survey.							
	Complaint IN00391	995-Unsubstantiated due to						
	lack of evidence.							
	Survey dates: Octob	per 6 and 7, 2022						
	Facility number: 00	0388						
	Provider number: 1:	55807						
	AIM number: 1004:	54140						
	Census Bed Type:							
	SNF/NF: 40							
	Total: 40							
	Census Payor Type	:						
	Medicaid: 40							
	Total: 40							
	These deficiencies i	reflect State Findings cited in						
	accordance with 410	_						
	Quality review com	apleted on October 19, 2022						

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

F 0609

SS=D

Bldg. 00

483.12(c)(1)(4)

the facility must:

Reporting of Alleged Violations

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment,

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including

(X6) DATE

TITLE

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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	ſ ′	JILDING	00	COMPI	
		155807	B. W			10/07	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			RURAL ST		
RURAL H	IEALTH CARE CEI	NTER			IAPOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	injuries of unknow						
		of resident property, are					
		tely, but not later than 2					
		egation is made, if the					
		the allegation involve abuse					
		s bodily injury, or not later ne events that cause the					
		nvolve abuse and do not					
	result in serious b						
		ne facility and to other					
		to the State Survey					
	, ,	protective services where					
		s for jurisdiction in long-term					
	•	accordance with State law					
	through establishe						
	§483.12(c)(4) Rep	oort the results of all					
	- ,,,,	he administrator or his or					
	_	presentative and to other					
	officials in accorda	ance with State law,					
	including to the St	tate Survey Agency, within					
	5 working days of	the incident, and if the					
	alleged violation is	s verified appropriate					
	corrective action r						
		and record review, the facility	F 0	609	what corrective action(s) will be	oe	11/04/2022
		ort an allegation of physical			accomplished for those reside	ents	
		sidents reviewed for abuse.			found to have been affected b	y the	
	(Residents 37 and 1	9)			deficient practice;		
	Findings include:				Resident 37 and 19 incident	:	
					has been reported to ISDH.		
		for Resident 37 was reviewed					
		a.m. Resident 37's diagnoses					
	· ·	mited to, schizoaffective					
		lementia, seizures, and			how other residents ha	-	
	encephalopathy.				the potential to be affected by		
	D: 14 27!	IMPC (Minimum D + C +)			same deficient practice will be		
		al MDS (Minimum Data Set)			identified and what corrective		
		ated, Resident 37 was severely			action(s) will be taken;		
	cognitively impaire	ca.	1		All Resident's have the		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/07/2022 155807 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1747 N RURAL ST RURAL HEALTH CARE CENTER INDIANAPOLIS, IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE potential to be affected by this A behavior note dated 9/24/22 at 10:50 p.m. alleged deficient practice. The indicated, Resident 37 "has had no further Administrator completed a 1 behaviors this shift, continues on 15 minutes month audit to identify any checks..." incidents reported late, no new concerns identified. A nursing note dated 9/24/22 at 12:47 p.m. indicated, Resident 37 was involved in a witnessed altercation with another male resident. Resident 37 was sitting in the dining room, when what measures will be put he stood up from his wheelchair and assaulted into place and what systemic another male resident by hitting him in his face. changes will be made to ensure that the deficient practice does not A social services note dated 9/26/22 at 12:54 p.m. indicated, "Resident had an incident with another resident." The Administrator was The clinical record for Resident 19 was reviewed in-serviced by the RDO on on 10/7/22 at 10:22 a.m. Resident 19's diagnoses 10/25/22 regarding the state included, but not limited to, cerebrovascular requirements for reporting disease affecting left side, hypertensive allegations and follow up of encephalopathy, and hemiplegia. potential abuse. Resident 19's annual MDS dated 8/9/22 indicated. Resident 19 was cognitively intact. how the corrective action(s) A Facility incident report was received on 10/6/22 will be monitored to ensure the at 1:30 p.m. from the ED (Executive Director). The deficient practice will not recur, incident report indicated, on 9/24/22 at 12:30 p.m., i.e., what quality assurance Resident 37 had hit Resident 19. While the program will be put into place; and incident between Resident 37 and 19 occurred on The RDO/Designee will visit or 9/24/22, the facility had not reported the incident call the facility daily (M-F) to until 9/26/22. review with the Administrator or Designee, any potential An interview with ED conducted on 10/7/22 at occurrences of abuse that have 11:04 a.m. indicated, the incident between been identified via the daily Residents 37 and 19 had occurred over a weekend review of the facility behavior and the manager on duty had informed her of the and nurse's notes and/or were

incident when it happened, but had not reported

the incident until 9/26/22 when she knew the full

directly reported to the

Administrator. The RDO is

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	OF HEALTH AND HU MEDICARE & MEDIC						RM APPROVED B NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155807		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/07/2022	
NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER				1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST IAPOLIS, IN 46218			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	should have been reinvolved resident to An Abuse & Negle 10/6/22 at 1:30 p.m. "Physical Abuse in pinching, and kicki facility will ensure involving mistreatr reported immediate facility. Alleged viappropriate state ag	She indicated, the incident eported sooner since it oresident abuse. In the policy was received on the from ED. The policy indicated, cludes hitting, slapping, angReporting/ResponseThe that all alleged violations ment, neglect, or abuseare the slap to the administrator of the iolations will be reported to the gency and to other officials in orderal and State law."			setup to receive emails verifying reportable information has been sent to the ISDH. The RDO will view the Gateway portal if an allegation has been identified and verify reporting done timely and follow up completed timely as well. Th RDO will correct any non-compliance noted, immediately with the Administrator/Designee x 6 months. The RDO will repor findings to the QAPI meeting monthly. - by what date the system changes for each deficiency w be completed. 11/4/22	d ne t		
F 0610 SS=D Bldg. 00	§483.12(c) In resp	nt/Correct Alleged Violation conse to allegations of xploitation, or mistreatment,						

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§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while

the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other

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CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES				OMB NO. 0938-039
		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULT A. BUILE B. WING	PLE CONSTRUCTION ING <u>00</u>	COI	TE SURVEY MPLETED 07/2022
	PROVIDER OR SUPPLIE HEALTH CARE CE		1	REET ADDRESS, CITY, 747 N RURAL ST IDIANAPOLIS, IN 4	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		FIX (EACH CORRE	ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE LENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	including to the S 5 working days of alleged violation is corrective action. Based on interview failed to have evide investigation of an for 2 of 5 residents 37 and 19). Findings include: The clinical record on 10/7/22 at 10:08 included, but not list disorder, vascular cencephalopathy. Resident 37's annudated, 8/1/22 indicated, 8/1/22 indicated, Resident behaviors this shift checks" A nursing note data indicated, Resident witnessed altercation Resident 37 was since the stood up from hanother male resided.	and record review, the facility ence of a thorough allegation of physical abuse reviewed for abuse (Residents for Resident 37 was reviewed a.m. Resident 37's diagnoses mited to, schizoaffective dementia, seizures, and al MDS (Minimum Data Set) ated, Resident 37 was severely	F 0610	will be accoresidents for affected by On 10/25/22 Director was incident invand process. Resident in completed • how the potential same deficited are action(s) will the Social completed month of restores interviews new finding. • what into place a changes will	Services Director an audit of last 1 eportable incidents staff and resident were completed, no	11/04/2022

resident."

The clinical record for Resident 19 was reviewed

The Social Services director or designee will review weekly

the reportable incident binder

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/07/2022
	NAME OF PROVIDER OR SUPPLIER RURAL HEALTH CARE CENTER			ET ADDRESS, CITY, STATE, ZIP COD 'N RURAL ST ANAPOLIS, IN 46218	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	included, but not lin	a.m. Resident 19's diagnoses nited to, cerebrovascular ft side, hypertensive d hemiplegia.		to ensure completion of Resident and staff intervi for all incidents.	iews
	Resident 19 was con A Facility incident at 1:30 p.m. from the incident report indices Resident 37 had hit. An interview with Facility 10/7/22 at 11:24 a.r. were in the dining regoing with his most stop it and that was and punched him we jaw. Resident 19 furnished.	report was received on 10/6/22 are ED (Executive Director). The cated, on 9/24/22 at 12:30 p.m.,		how the corrective a will be monitored to ensure deficient practice will not ri.e., what quality assurance program will be put into play the Administrator or deswill complete a weekly compliance audit to ensure ported incidents include Resident and staff intervent The Administrator will reany findings to QAPI mone 6 months.	e the ecur, ee ace; and signee ure all de iews. port
	An interview with I 10/7/22 at 11:30 a.r at the table next to and he had witnesse with a fist. He furth struck Resident 19, fell backwards onto indicated, a lot of o dining room at the table. An interview with Sconducted on 10/7/2 two of the nurses of of the incident, had between Residents that weekend, both	Resident 25 was conducted on m. He indicated, he was seated where the incident occurred and Resident 37 hit Resident 19 mer indicated, after Resident 37 he lost his balance and then the floor. Resident 25 ther residents were in the ime that incident occurred. SS (social services) was 22 at 10:27 a.m. SS indicated, in duty on 9/24/22, at the time witnessed the incident 37 and 19. She stated, after of those nurses quit working further indicated, she had not		by what date the sy changes for each deficient be completed. 11/4/22	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		A. BU	A. BUILDING <u>00</u>			COMPLETED		
155807			B. W	ING		10/07/	2022	
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					RURAL ST			
RURAL H	HEALTH CARE CEN	NTER			APOLIS, IN 46218			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		t either of the two nurses in an						
		ement from them regarding						
	what they had witne	essed.						
	An interview with N	MOD (Manager on Duty) was						
		22 at 10:27 a.m. MOD						
		urses on duty at the time of						
		/22, had come to her office and						
		incident between Resident 37						
	and 19. She indicat	ed, she had not attempted to						
	get a witness statem	ent from either of them, but						
	had informed them	to write a nursing note. She						
		ne did not obtain statements						
		nvolved in the incident or any						
	other potential with	esses.						
	An interview with F	ED conducted on 10/7/22 at						
		d, the incident between						
		occurred over a weekend and						
		OD the same day. ED						
	1	S conduct the investigation						
	into the 9/24/22 inc	_						
	_	le for the incident involving						
		was received from ED on						
		. The file contained, but not f the nursing note for Resident						
		12:47 p.m.; copy of the incident						
		port file number, an interview						
		n duty dated 9/24/22; a one on						
	_	esident 37; a copy of Resident						
		an; and several resident						
	interviews about wi							
		d not contain witness						
	statements from the	two nurses present when						
		statement from Resident 37,						
	or a statement from	Resident 19.						
	A A lang - 0- NI - 1	ot malion magaine 4						
		ct policy was received on						
	10/0/22 at 1:30 p.m	. from ED. The policy indicated,						

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	r í	LDING	INSTRUCTION 00	(X3) DATE COMPL 10/07	LETED
	PROVIDER OR SUPPLIEF			1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 0690 SS=D Bldg. 00	"InvestigationThe relevant documenta of the medical reco The facility will do investigation on an by the facility unles by stated law. The identity of the staff initial reporting, inviolations, and reporting authorities." 3.1-28(d) 483.25(e)(1)-(3) Bowel/Bladder Inc §483.25(e) Incont §483.25(e) Incont §483.25(e)(1) The resident who is composed by the composition of the clinical contract continence is §483.25(e)(2)For incontinence, bas comprehensive as ensure that- (i) A resident who an indwelling catheter essary; (ii) A resident who indwelling catheter essary; (iii) A resident who indwelling catheter essary; (iiii) A resident who indwelling catheter essary; (ii	e investigator will review ution, including relevant parts rds, and interview witnesses. cument the findings of the investigation form developed as a different form is required documentation will include the members responsible for the vestigation of alleged orting of results to the proper					

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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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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/07/2022
	PROVIDER OR SUPPLIEI		1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST JAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	receives appropriato prevent urinary restore continence. §483.25(e)(3) For incontinence, bas comprehensive as ensure that a resibowel receives appropriate to restore function as possible Based on interview failed to provide appropriate to a resider catheter for 1 of 2 reatheter care. (Resident and record on 10/6/22 at 12:21 included, but not lind disorder, anxiety diskidney and ureter. Resident 38's annual dated 8/1/22 indicated and required extens for personal hygien. A physician's order change the Foley can on the 26th and the	ate treatment and services tract infections and to e to the extent possible. The a resident with fecal ed on the resident's essessment, the facility must dent who is incontinent of expropriate treatment and expressive as much normal bowel oble. The and record review, the facility expropriate treatment and expressive treatment and expressive treatment and expressive treatment and expressive and industry expressive for urinary exident 38) The analysis of the expressive sorder, and disorder of the expressive sorder, and disorder of the expressive expressi	F 0690	what corrective action(s will be accomplished for those residents found to have been affected by the deficient pract An order for foley catheter of for Resident 38 was entered 10/7/22. Resident 38 cathete care was performed, and catheter checked for placement. His indwelling urinary catheter was change per his orders. His care plan has been updated to reflect indwelling foley catheter. Resident 38 now receives catheter care, catheter placement checks, catheter changes and medication as ordered.	11/04/2022 s) ice; are on r
	nurse was to check every shift.	dated 9/29/22 indicated, the Foley catheter placement cian orders did not contain an		 how other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken; 	the

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order to provide Foley catheter care.

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On 10/25/22 the MDS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/07/2022 155807 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1747 N RURAL ST RURAL HEALTH CARE CENTER INDIANAPOLIS, IN 46218 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE coordinator completed an audit Resident 38's September and October MARs to ensure any other Residents (Medication Administration Record) did not that have an indwelling indicate Foley catheter care was provided at all. It catheter order were being further indicated, Foley catheter placement checks provided care as ordered. No were not provided on 9/29/22 for the evening and other Residents identified. night shifts and on 9/30/22, the day, evening, and night shifts. Resident 38's care plan dated 8/25/22 indicated, he what measures will be put was a risk for urinary tract infections related to into place and what systemic having an indwelling catheter. The interventions changes will be made to ensure included, but not limited to, catheter care to be that the deficient practice does not completed as ordered and check around the catheter entry site for signs/symptoms of All licensed nursing staff to be irritation, redness, tenderness, swelling, or educated by the Director of drainage. nursing by 11/4/22 on catheter care. The MDS coordinator or An interview with DON (Director of Nursing) was designee will complete a daily conducted on 10/6/22 at 2:27 p.m. DON indicated, audit Monday -Friday x 6 she was unable to locate a physician's order for months to identify any Resident Foley catheter care for Resident 38. She indicated, catheter care concerns. Resident 38 should have had an order for Foley catheter care and that the documentation on his MAR for checking its placement did not constitute catheter care occurred. how the corrective action(s) will be monitored to ensure the 3.1-41(a)(2) deficient practice will not recur, i.e., what quality assurance program will be put into place; and The MDSC/Designee will audit the Mar/Tar for each resident with an indwelling urinary catheter daily x 1 month, then

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weekly x 1 month and then monthly x 4 months to ensure care is being provided as ordered. Non-compliance will be addressed with further education and/or disciplinary

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155807	· ′	LDING	onstruction 00	(X3) DATE COMPI 10/07	
	ROVIDER OR SUPPLIER			1747 N	ADDRESS, CITY, STATE, ZIP COD RURAL ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
					action as needed. Finding be reported by the MDSC/ designee at the monthly Comeetings. - by what date the system changes for each deficiency be completed.	temic	

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