| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 0000<br><br>Bldg. 00 | This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on August 26, 2022. This survey was completed in conjunction with the Complaint IN00391995 survey.<br><br>Complaint IN00391995-Unsubstantiated due to lack of evidence.<br><br>Survey dates: October 6 and 7, 2022<br><br>Facility number: 000388<br>Provider number: 155807<br>AIM number: 100454140<br><br>Census Bed Type:<br>SNF/NF: 40<br>Total: 40<br><br>Census Payor Type:<br>Medicaid: 40<br>Total: 40<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on October 19, 2022 | F 0000 | | |
| F 0609<br>SS=D<br>Bldg. 00 | 483.12(c)(1)(4)<br>Reporting of Alleged Violations<br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including | | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to timely report an allegation of physical abuse for 2 of 5 residents reviewed for abuse. (Residents 37 and 19)<br><br>Findings include:<br><br>The clinical record for Resident 37 was reviewed on 10/7/22 at 10:08 a.m. Resident 37's diagnoses included, but not limited to, schizoaffective disorder, vascular dementia, seizures, and encephalopathy.<br><br>Resident 37's annual MDS (Minimum Data Set) dated, 8/1/22 indicated, Resident 37 was severely cognitively impaired. | F 0609 | what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br><br>**Resident 37 and 19 incident has been reported to ISDH.**<br><br>· 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;<br>**All Resident's have the** | 11/04/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | A behavior note dated 9/24/22 at 10:50 p.m. indicated, Resident 37 "has had no further behaviors this shift, continues on 15 minutes checks..."<br><br>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 he stood up from his wheelchair and assaulted another male resident by hitting him in his face.<br><br>A social services note dated 9/26/22 at 12:54 p.m. indicated, "Resident had an incident with another resident."<br><br>The clinical record for Resident 19 was reviewed on 10/7/22 at 10:22 a.m. Resident 19's diagnoses included, but not limited to, cerebrovascular disease affecting left side, hypertensive encephalopathy, and hemiplegia.<br><br>Resident 19's annual MDS dated 8/9/22 indicated, Resident 19 was cognitively intact.<br><br>A Facility incident report was received on 10/6/22 at 1:30 p.m. from the ED (Executive Director). The incident report indicated, on 9/24/22 at 12:30 p.m., Resident 37 had hit Resident 19. While the incident between Resident 37 and 19 occurred on 9/24/22, the facility had not reported the incident until 9/26/22.<br><br>An interview with ED conducted on 10/7/22 at 11:04 a.m. indicated, the incident between Residents 37 and 19 had occurred over a weekend and the manager on duty had informed her of the incident when it happened, but had not reported the incident until 9/26/22 when she knew the full | | **potential to be affected by this alleged deficient practice. The Administrator completed a 1 month audit to identify any incidents reported late, no new concerns identified.**<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br><br>**The Administrator was in-serviced by the RDO on 10/25/22 regarding the state requirements for reporting allegations and follow up of potential abuse.**<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The RDO/Designee will visit or call the facility daily (M-F) to review with the Administrator or Designee, any potential occurrences of abuse that have been identified via the daily review of the facility behavior and nurse's notes and/or were directly reported to the Administrator. The RDO is** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | details of the event. She indicated, the incident should have been reported sooner since it involved resident to resident abuse.<br><br>An Abuse & Neglect policy was received on 10/6/22 at 1:30 p.m. from ED. The policy indicated, "Physical Abuse includes hitting, slapping, pinching, and kicking...Reporting/Response...The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse...are reported immediately to the administrator of the facility. Alleged violations will be reported to the appropriate state agency and to other officials in accordance with Federal and State law."<br><br>3.1-28(c) | | **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. The RDO will correct any non-compliance noted, immediately with the Administrator/Designee x 6 months. The RDO will report findings to the QAPI meeting monthly.**<br><br>· by what date the systemic changes for each deficiency will be completed.<br>11/4/22 | |
| F 0610 SS=D Bldg. 00 | 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>Based on interview and record review, the facility failed to have evidence of a thorough investigation of an allegation of physical abuse for 2 of 5 residents reviewed for abuse (Residents 37 and 19).<br><br>Findings include:<br><br>The clinical record for Resident 37 was reviewed on 10/7/22 at 10:08 a.m. Resident 37's diagnoses included, but not limited to, schizoaffective disorder, vascular dementia, seizures, and encephalopathy.<br><br>Resident 37's annual MDS (Minimum Data Set) dated, 8/1/22 indicated, Resident 37 was severely cognitively impaired.<br><br>A behavior note dated 9/24/22 at 10:50 p.m. indicated, Resident 37 "has had no further behaviors this shift, continues on 15 minutes checks..."<br><br>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 he stood up from his wheelchair and assaulted another male resident by hitting him in his face.<br><br>A social services note dated 9/26/22 at 12:54 p.m. indicated, "Resident had an incident with another resident."<br><br>The clinical record for Resident 19 was reviewed | F 0610 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>**On 10/25/22 the Social Services Director was educated on the incident investigation policy and procedure. The staff and Resident interviews were completed for the incident.**<br><br>· 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;<br>**The Social Services Director completed an audit of last 1 month of reportable incidents to ensure staff and resident interviews were completed, no new findings.**<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>**The Social Services director or designee will review weekly the reportable incident binder** | 11/04/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | on 10/7/22 at 10:22 a.m. Resident 19's diagnoses included, but not limited to, cerebrovascular disease affecting left side, hypertensive encephalopathy, and hemiplegia.<br><br>Resident 19's annual MDS dated 8/9/22 indicated, Resident 19 was cognitively intact.<br><br>A Facility incident report was received on 10/6/22 at 1:30 p.m. from the ED (Executive Director). The incident report indicated, on 9/24/22 at 12:30 p.m., Resident 37 had hit Resident 19.<br><br>An interview with Resident 19 was conducted on 10/7/22 at 11:24 a.m. indicated, he and Resident 37 were in the dining room and Resident 37 was "going with his mouth" and he had told him to stop it and that was when Resident 37 stood up and punched him with a closed fist on the right jaw. Resident 19 further indicated, Resident 25 was in the dining room as well and saw the incident.<br><br>An interview with Resident 25 was conducted on 10/7/22 at 11:30 a.m. He indicated, he was seated at the table next to where the incident occurred and he had witnessed Resident 37 hit Resident 19 with a fist. He further indicated, after Resident 37 struck Resident 19, he lost his balance and then fell backwards onto the floor. Resident 25 indicated, a lot of other residents were in the dining room at the time that incident occurred.<br><br>An interview with SS (social services) was conducted on 10/7/22 at 10:27 a.m. SS indicated, two of the nurses on duty on 9/24/22, at the time of the incident, had witnessed the incident between Residents 37 and 19. She stated, after that weekend, both of those nurses quit working at the facility. She further indicated, she had not | | **to ensure completion of Resident and staff interviews for all incidents.**<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and **The Administrator or designee will complete a weekly compliance audit to ensure all reported incidents include Resident and staff interviews. The Administrator will report any findings to QAPI monthly x 6 months.**<br><br>· by what date the systemic changes for each deficiency will be completed.<br><br>11/4/22 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | attempted to contact either of the two nurses in an attempt to get a statement from them regarding what they had witnessed.<br><br>An interview with MOD (Manager on Duty) was conducted on 10/7/22 at 10:27 a.m. MOD indicated, the two nurses on duty at the time of the incident on 9/24/22, had come to her office and informed her of the incident between Resident 37 and 19. She indicated, she had not attempted to get a witness statement from either of them, but had informed them to write a nursing note. She further indicated, she did not obtain statements from the residents involved in the incident or any other potential witnesses.<br><br>An interview with ED conducted on 10/7/22 at 11:04 a.m. indicated, the incident between Residents 37 and 19 occurred over a weekend and was informed by MOD the same day. ED indicated, she had SS conduct the investigation into the 9/24/22 incident.<br><br>The investigation file for the incident involving Resident 37 and 19 was received from ED on 10/6/22 at 1:30 p.m. The file contained, but not limited to, a copy of the nursing note for Resident 37 dated 9/24/22 at 12:47 p.m.; copy of the incident report, the policy report file number, an interview from the manager on duty dated 9/24/22; a one on one schedule for Resident 37; a copy of Resident 37's updated care plan; and several resident interviews about witnessing abuse. The investigation file did not contain witness statements from the two nurses present when incident occurred, a statement from Resident 37, or a statement from Resident 19.<br><br>An Abuse & Neglect policy was received on 10/6/22 at 1:30 p.m. from ED. The policy indicated, | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | "Investigation...The investigator will review relevant documentation, including relevant parts of the medical records, and interview witnesses. The facility will document the findings of the investigation on an investigation form developed by the facility unless a different form is required by stated law. The documentation will include the identity of the staff members responsible for the initial reporting, investigation of alleged violations, and reporting of results to the proper authorities."<br><br>3.1-28(d) | | | |
| F 0690<br>SS=D<br>Bldg. 00 | 483.25(e)(1)-(3)<br>Bowel/Bladder Incontinence, Catheter, UTI<br>§483.25(e) Incontinence.<br>§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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(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<br>(iii) A resident who is incontinent of bladder | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§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.<br>Based on interview and record review, the facility failed to provide appropriate treatment and services to a resident with an indwelling urinary catheter for 1 of 2 residents reviewed for urinary catheter care. (Resident 38)<br><br>Findings include:<br><br>The clinical record for Resident 38 was reviewed on 10/6/22 at 12:21 a.m. Resident 38's diagnoses included, but not limited to, major depressive disorder, anxiety disorder, and disorder of the kidney and ureter.<br><br>Resident 38's annual MDS (Minimum data set) dated 8/1/22 indicated, he was cognitively intact and required extensive assistance of one person for personal hygiene.<br><br>A physician's order dated 9/26/22 indicated, to change the Foley catheter bulb monthly starting on the 26th and then monthly.<br><br>A physician's order dated 9/29/22 indicated, the nurse was to check Foley catheter placement every shift.<br><br>Resident 38's physician orders did not contain an order to provide Foley catheter care. | F 0690 | · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>**An order for foley catheter care for Resident 38 was entered on 10/7/22. Resident 38 catheter care was performed, and catheter checked for placement. His indwelling urinary catheter was changed per his orders. His care plan has been updated to reflect an indwelling foley catheter. Resident 38 now receives catheter care, catheter placement checks, catheter changes and medication as ordered.**<br><br>· 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;<br>**On 10/25/22 the MDS** | 11/04/2022 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Resident 38's September and October MARs (Medication Administration Record) did not indicate Foley catheter care was provided at all. It further indicated, Foley catheter placement checks were not provided on 9/29/22 for the evening and night shifts and on 9/30/22, the day, evening, and night shifts.<br><br>Resident 38's care plan dated 8/25/22 indicated, he was a risk for urinary tract infections related to having an indwelling catheter. The interventions included, but not limited to, catheter care to be completed as ordered and check around the catheter entry site for signs/symptoms of irritation, redness, tenderness, swelling, or drainage.<br><br>An interview with DON (Director of Nursing) was conducted on 10/6/22 at 2:27 p.m. DON indicated, she was unable to locate a physician's order for Foley catheter care for Resident 38. She indicated, 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.<br><br>3.1-41(a)(2) | | **coordinator completed an audit to ensure any other Residents that have an indwelling catheter order were being provided care as ordered. No other Residents identified.**<br><br>· what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;<br>**All licensed nursing staff to be educated by the Director of nursing by 11/4/22 on catheter care. The MDS coordinator or designee will complete a daily audit Monday -Friday x 6 months to identify any Resident catheter care concerns.**<br><br>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and<br>**The MDSC/Designee will audit the Mar/Tar for each resident with an indwelling urinary catheter daily x 1 month, then 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** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155807 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RURAL HEALTH CARE CENTER | 1747 N RURAL ST<br>INDIANAPOLIS, IN 46218 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | **action as needed. Findings will be reported by the MDSC/ designee at the monthly QAPI meetings.**<br><br>· by what date the systemic changes for each deficiency will be completed.<br><br>**11/4/22** | |