STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155335	A. BUILDING 00 B. WING	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OSSIAN HEALTH CARE AND REHABILITATION CENTER	215 DAVIS RD OSSIAN, IN 46777

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00385715. Complaint IN00385715 - Substantiated. Federal/state deficiencies related to the allegations are cited at F690. Survey dates: July 27, 2022 Facility number: 000228 Provider number: 155335 AIM number: 100266650 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 5 Medicaid: 46 Other: 38 Total: 89 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 29, 2022	F 0000	b> b=""> b="">	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure assessment and care plan development for urinary incontinence for 1 of 3 residents reviewed (Resident J). Findings include: On 7/27/22 at 11:00 A.M., Resident J's record was reviewed. Diagnoses included, but were not limited to, overactive bladder and need for assistance with personal care.	F 0690	b=""> Plan of Correction: F 690 Bowel/Bladder Incontinence, Catheter, UTI - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident J's admission bowel and	08/14/2022

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	An admission MDS (Minimum Data Set) assessment, dated 5/25/22, indicated the resident had a BIMS (Brief Interview Mental Status) score of 14. This indicated the resident had no cognitive impairment. She had no moods, behaviors, or rejection of care. She required supervision of 1 staff member for bed mobility, transfers, walking in the hallway, locomotion on and off the unit, and eating. She required limited assistance from 1 staff member for walking in her room, dressing, toileting, and personal hygiene and needed physical help of 1 for bathing. She was occasionally incontinent of bladder and a trial toileting program had been completed which resulted in decreased wetness. An ADL Care Area Assessment (CAA), dated 6/1/22, indicated Resident J had recently admitted from assisted living due to incontinence and weakness. Her goal was to return to her home in assisted living. She was at risk for further decline, including but not limited to, ADL's (activities of daily living), falls, and incontinence. She was referred to and was working with PT (physical therapy) and OT (occupational therapy) to return to her prior level of functioning. A Urinary incontinence CAA, dated 6/1/22, indicated the resident was occasionally incontinent and required limited assistance with toileting. Modifiable factors contributed to her incontinence was psychological/psychiatric problems, urinary urgency, depression, restricted mobility, and medications. She was at risk for skin rashes, skin breakdown, falls, isolation, and urinary infection. Care plans indicated the following: -5/18/22: Resident needed assistance with ADL's related to impaired cognition. The goal was that		bladder evaluation was reviewed by Director of Nursing. Resident J's care plan was updated to include type of incontinence, environmental devices in use, psychosocial concerns, promotion of skin integrity, UTI prevention, incontinence products, referral for medical management based on res/family choice and refusal of care. Referral was made for counseling due to refusal of staff assistance for toileting and hygiene with first visit held 8/1/22. - **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.** The deficient practice has the potential to affect residents who are incontinent of urine. The Director of Nursing and IDT nursing team including staff development, MDS nurse, case manager, ADON and wound care nurse will audit every resident's bowel and bladder evaluation. All resident care plans will be reviewed and updated to include interventions that address toileting program based on type of incontinence, environmental or assistive devices, promotion of	

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	her ability to perform ADL's would improve using her care planned interventions which included, but were not limited to, staff to provide assistance with am and pm care; assistance of 1 with toileting and bathing; and supervision with walking, transfers, and eating. -5/18/22 and revised on 5/24/22: Resident was occasionally incontinent related to functional incontinence (decreased mental awareness, mobility or personal unwillingness) due to overactive bladder. The goal was her transient incontinence would be managed through her care planned interventions which were: assist with clothing adjustment, cleansing, and transfers during toileting; encourage/remind resident to wear incontinence products to manage incontinence; follow individualized toileting program which was to assist the resident to toilet upon rising, before and after meals, at bedtime, and as needed; refer to therapy for urinary incontinence interventions; and assist with incontinence care. -5/18/22: Resident was at risk for developing pressure ulcers related to incontinence. Interventions included, but were not limited to, the resident would report redness, tenderness, or changes in her skin; provide incontinence care; and observe skin weekly and as needed. A physician progress note, dated 5/23/22 at 10:51 a.m., indicated the resident was transferred to the nursing home side from assisted living due to increased care needs. The resident had confusion not new for her. Her past medical history indicated she had urinary urgency. Resident J had a diagnosis of dementia without behavioral disturbance. A Bowel and Bladder Evaluation, dated 5/24/22 at 2:31 p.m., indicated the resident was frequently		choice and dignity, psychosocial concerns, skin integrity, UTI prevention, incontinence products, referral for medical management and hydration/nutrition needs as applicable. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** DON/Designee will audit newly completed bowel and bladder evaluations for accuracy and comprehensive care plan development. These audits will be conducted 5 days per week for four weeks, then three days a week for four weeks, then once a week for eight weeks, then randomly thereafter for two months. DON/designee will review the point click care priority report weekly for any new incontinence development for a resident who was previously continent. Bowel and bladder evaluation will be initiated along with care plan development. This audit will be conducted one day per week for six months and then prn thereafter. All audits will be forwarded to QA for monthly review for minimum of	

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	incontinent of bladder with modifiable factors of psychiatric problems, caffeine use, and excess fluid intake. Medications prescribed to the resident that could contribute to her incontinence were sedative/hypnotics, anti-depressants, and calcium channel blockers. Environmental contributing factors were restricted mobility, use of pads/briefs and urgency. The MDS nor CAA's indicated the resident had impaired cognition, dementia, decreased mental awareness, or personal unwillingness/behaviors related to her incontinence. The care plans did not indicate the resident had behaviors or refusals to shower or change her incontinence briefs. The care plans did not indicate the resident was at risk for urinary tract infections nor were there interventions to prevent their occurrence. On 7/27/22 at 11:23 A.M., Resident J's family member was interviewed. The family member had several concerns related to the resident's care. She indicated the facility notified family the resident required more assistance than could be provided in assisted living and recommended she be moved over to the nursing home for a "probation" period where therapies and nursing staff would work with the resident's incontinence and mobility with the goal of returning to assisted living. She indicated the resident had a leaky bladder, wasn't aware when she was wet and was in the early stages of dementia. The family member indicated they were told shortly after she came over to the nursing home that she would have to stay and could no longer live safely in assisted living. Since being in the nursing home, the resident had continued with incontinence, had several refusals of incontinence care and showers which the family were not always notified of. The resident developed a urinary tract infection and a severe		6 months, until 100% compliance noted for two consecutive months, then quarterly X 2or until QAPI committee deems compliance. Plan of Correction for deficient practice will be 8/14/2022. As a consideration of the survey results of the facility respectfully requests a paper review of the plan of correction. -	

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	yeast infection. The family member indicated she had contacted the facility on 4 different occasions and had spoken with a male nurse about her concerns of a urinary tract infection due to her mother having symptoms of past infections. She indicated nothing was done about her concerns until a week after she had called. Family members took the resident to a walk in clinic on because of the severe red rash she had across her pelvis and between her legs. The resident needed to have her showers completed 2 times per week and incontinence care completed timely so the resident wasn't sitting in wet briefs to prevent infections. She and her other family members were willing to be present during showers and had been coming to the facility on Mondays and Thursday (her scheduled shower days). The family member believed the resident received more thorough care in assisted living and expressed concern with the residents hygiene/incontinence care. Progress notes indicated the following: -6/3/22 at 11:11 p.m., resident was refusing to get up to use the bathroom and would rather be changed in bed. Encouraged to get up but refused so was changed in bed. -6/16/22 at 1:36 p.m., resident medications were reviewed and new order given to discontinue sleeping medication. Daughter was notified of change and reported the resident had some confusion during a visit on 6/11/22 and on 6/13/22, the resident had blood on the toilet paper when being assisted to toilet. The resident was noted to have a foul urine odor due to incontinence. 3:11 p.m., resident's family requested that a urinalysis be done due to symptoms of urinary tract infection. The Nurse Practitioner (NP) was notified and new order given for urine sample.			

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	-6/19/22 at 2:50 p.m., resident had been continent on this day but went to the bathroom frequently and changed her underwear if she dribbled or had an accident. -6/20/22 at 2:17 p.m., resident's urinalysis sample was sent for culture. -6/22/22 at 8:35 a.m., urine culture returned with large growth of bacteria. A new order was given for an antibiotic 2 times per day for 7 days. 3:58 p.m., urine was clear yellow but with odor. -6/23/22 at 4:06 a.m., resident refused to allow brief to be changed earlier in the shift and currently. Her brief was clearly soaked. She had also refused her early morning shower. -6/24/22 at at 7:18 a.m., urine in commode and in brief had strong odor and was dark amber in color. Resident had been resistant to getting up to void on commode but finally agreed. -6/28/22 at 4:32 p.m., resident voiding yellow urine without odor; is occasionally incontinent of bladder. -7/14/22 at 5:51 p.m., the resident was observed with redness to both sides of her groin area. The NP was notified and new orders received for antifungal powder. -7/15/22 at 4:57 a.m., the resident refused care from the nurse aid when attempted 3 times. The resident had told the aid to get out of her room. The nurse was notified and approached the resident who at first ignored the nurse but then agreed to be assisted with care. 3:44 p.m., the resident arrived back to the facility with her family. Her family brought in 2 tubes of antifungal cream from a local pharmacy and gave it to the nurse for the resident's yeast infection for 7 days. Family requested that the resident be showered daily and if refused, continue to encourage her and family would follow up to ensure the task was completed. -7/21/22 at 2:39 p.m., the resident refused her			

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	shower on 1st shift. She had been re-approached several times but still refused. Her family was notified of the refusals. -7/23/22 at 6:06 a.m., resident refused assistance with her ADL's and told staff to leave her alone and let her sleep. 2:04 p.m., resident was observed to fall in her room and landed on her buttocks. -7/24/22 at 1:55 a.m., staff attempted to change the resident's brief as it was moderately saturated. The resident yelled at staff and told them to get out of her room. Staff re-approached but resident refused assistance. 5:25 a.m., different staff members tried to change the resident but she continued to yell for staff to get away from her. -7/25/22 at 2:02 a.m., the nurse aid went into resident's room to change her brief. The resident told the aid "don't even start with me". She refused care. -7/27/22 at 5:33 a.m., staff attempted to assist resident with her ADL's but she refused and attempted to hit staff to get them away from her as she yelled for them to get out. She was agitated and yelled at the nurse stating "you are always waking me up and then I can't get back to sleep". Resident was told that she needed to let staff help her because "her family request it". She yelled at the nurse and refused assistance. A review of the resident's OT evaluation and discharge plan indicated on 5/19/22, Resident B was referred for therapy. She'd been a resident in assisted living, had declined in her abilities with self care and was unable to manage her incontinence. She received 4 days of therapy and was discharged on 5/27/22 with recommendation to continue to complete toileting on a regular basis to assist with decreasing episodes of incontinence. She had progressed well with			

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	treatment and met her goals. She was managing her incontinence and had decreased her episodes of incontinence by increasing her frequency of going to the toilet. In interviews on 7/27/22, the following was indicated -At 1:42 P.M., CNA 5 (Certified Nurse Assistant) indicated she had worked with Resident J for the past 2 months. The resident was resistant at times to being assisted with incontinence care and showers according to her mood. At times she was open to assistance. At other times would refuse and could not be talked into it. -1:48 P.M., the Social Services Director (SSD) indicated Resident J had been brought over to the nursing home to work with therapy to try and do incontinence training, establish a routine the resident could follow to decrease her incontinence and allow for her to stay in assisted living. She indicated the resident could be resistant to care but was not on a behavior plan nor were there specific behavioral interventions care planned. -2:03 P.M., the Director of Nurses (DON) indicated the facility was trying to assist the resident to go back to assisted living and were trying to determine if her urinary incontinence was a functional issue. The resident had an overactive bladder but hadn't had any further follow up to determine if there were other interventions to be done. The physician progress notes had not indicated the type of incontinence the resident had or if she had received prior treatment. She indicated the resident had some cognition issues and behaviors of refusing to be assisted with incontinence care and hygiene. -2:20 P.M., Certified Occupational Therapy Assistant (COTA) 6 indicated she had worked with the resident previously while in assisted			

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	living and while in the nursing home. She indicated the resident had contributing issues to her inability to care for her incontinence. These were cognition/confusion, her schedule, and her lack of recognition for hygiene needs. The resident liked to attend activities and didn't want to be bothered for toileting. -2:39 P.M., the Administrator and MDS nurse were interviewed. The MDS nurse indicated some time during the resident's stay at assisted living, her family had taken her to appointments with the urologist who had administered Botox injections for the incontinence although she was not aware if the family still did this. The resident had a recent UTI but it was not care planned. The Administrator indicated the resident was resistant to care due to interruption of her activities. Her toileting plan was to toilet in the morning, before bed, before and after meals and as needed. The plan did not address the resident's activities and coordination with planned toileting. This Federal tag relates to Complaint IN00385715. 3.1-41(a)(2)			