| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155272 | A. BUILDING 00<br>B. WING | 10/21/2021 |

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| ALLISON POINTE HEALTHCARE CENTER | 5226 E 82ND ST<br>INDIANAPOLIS, IN 46250 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00364264.<br><br>Complaint IN00364264 - Substantiated. Federal/State deficiencies related to the allegations are cited at F550, F656, F684, F686, and F690.<br><br>Survey dates: October 19, 20, and 21, 2021<br><br>Facility number: 000172<br>Provider number: 155272<br>AIM number: 100267130<br><br>Census bed type:<br>SNF/NF: 123<br>Total: 123<br><br>Census payor type:<br>Medicare: 5<br>Medicaid: 97<br>Other: 21<br>Total: 123<br><br>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on October 26, 2021 | F 0000 | Acknowledged. | |
| F 0550<br>SS=D<br>Bldg. 00 | 483.10(a)(1)(2)(b)(1)(2)<br>Resident Rights/Exercise of Rights<br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, | | | |

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

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| | including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br><br>Based on interview and record review, the facility failed to treat a resident with dignity | F 0550 | 1) Resident B is at psychosocial baseline. Social services followed up with resident | 11/11/2021 |

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| | during a care plan meeting for 1 of 1 resident reviewed for dignity (Resident B).<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 10/19/21 at 11:45 a.m. The Resident's diagnosis included, but were not limited to, respiratory failure, tracheostomy, and anxiety. She was admitted to the facility on 9/10/21.<br><br>An Admission MDS (Minimum Data Set) Assessment, completed 9/17/21, indicated she was cognitively intact. She could make her needs known and understand what was being said to her.<br><br>A care plan, dated 9/13/21, indicated she had a communication problem related to her tracheostomy with a goal of maintaining or improving current level of communication function. The approaches included, but were not limited to, allow her adequate time to respond, do not rush her, ask yes and no questions as appropriate, and to observe for physical and nonverbal indicators of distress and follow-up as needed.<br><br>A care plan, revised on 9/23/21, indicated that she used anti- anxiety medications due to her anxiety disorder with a goal that she would have decrease in episodes of anxiety. The approaches included, but were not limited to, encouraging her to voice her feelings and to provide a calm environment and limit over stimulation.<br><br>During an interview on 10/19/21 at 2:11 p.m., FM (Family Member) 5 indicated that a care plan meeting had been held with the Ombudsman. During the meeting things became heated and she | | with no distress noted.<br>2) All residents have the potential to be affected. An audit of residents who had care plans held within the last 30 days was completed. Those residents were interviewed to identify if they had any concerns or allegations related to how staff interacted with them during the care plan.<br>3) IDT team were educated on the facilities Resident Rights policy.<br>4) ED and DON will sit in on 3 care plans per week x 1 month, then 2 care plans per week x 1 month, then 1 care plan per week x 1 month to ensure that resident rights policy is enforced and executed and that residents experience no psychosocial distress. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

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| | was trying to just keep the peace.<br><br>During an interview on 10/19/21 at 2:49 p.m., FM 4 and Resident B indicated that they had attended a care plan meeting on 10/5/21 with the facility staff and the Ombudsman. They felt as though the facility staff had used harsh tones and had not listened when she talked. They were deflective when asked questions about her care. They had been rude to her husband and talked down to him in front of her, which upset her a lot. She had not been able to speak due to everyone talking over each other. She had become frustrated and tearful during the meeting and did not feel as she had been heard. She was observed to become tearful when talking about the meeting.<br><br>During an interview on 10/19/21 at 2:42 p.m., the Ombudsman indicated that she had attended a care plan meeting on 10/5/21. She did not feel good about how the meeting was handled by the facility staff. The staff had harsh tones while speaking to her and her family during the meeting. Resident B was overwhelmed by the meeting. She was crying throughout the meeting and was exhausted from trying to talk and everyone was talking over each other. The meeting environment was confrontational and not respectful of the resident or her family.<br><br>During an interview on 10/20/21 at 3:30 p.m., the DNS (Director of Nursing Services) indicated that she had attended the care plan meeting on 10/5/21. There had been some push back from the family members about what they were hearing in the meeting. The family had not liked being told that she refused care. She had not noticed any tension or anxiety during the meeting. She did not recall the Resident B | | | |

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| | crying at the meeting.<br><br>During an interview on 10/20/21 at 3:41 p.m., the SSD (Social Services Director) indicated that she had attended the care plan meeting on 10/5/21. There had been some tension between herself and a family member. He was unhappy with some of the information given to him. She had tried to explain her role in the discharge process to the family and they had become upset. Resident B did become tearful during the meeting, but she was frequently tearful due to her anxiety.<br><br>On 10/21/21 at 11:00 a.m., the DNS provided the Resident Rights Policy, reviewed 5/30/2019, which read "... Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority of care. The purpose of this policy is to guide employees in the general principles of dignity and respect of caring for residents...Care for residents will be provided in a safe and respectful manner that includes care in a private setting, as appropriate. Residents have a choice and a voice in how they will be treated..."<br><br>This Federal tag relates to Complaint IN00364264.<br><br>3.1-3(a) | | | |
| F 0656 SS=D Bldg. 00 | 483.21(b)(1)<br>Develop/Implement Comprehensive Care Plan<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered | | | |

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| | care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph | | | |

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| | (c) of this section.<br>Based on interview and record review, the facility failed to have care plans to address a resident's pressure ulcer and another resident's skin condition and catheter use for 2 of 5 residents whose care plans were reviewed. (Residents B and G)<br><br>Findings include:<br><br>1. The clinical record for Resident G was reviewed on 10/20/21 at 2:54 p.m. The diagnoses included, but were not limited to, arthritis and obesity.<br><br>The 9/10/21, 9/13/21, 9/21/21, 10/8/21, and 10/19/21 wound care evaluations indicated a stage 3 pressure ulcer to her right posterior thigh.<br><br>The 7/5/21 skin integrity care plan indicated she was at risk for altered skin integrity due to immobility, but it did not reference any actual pressure ulcers or other skin impairments.<br><br>An interview was conducted with the DNS (Director of Nursing) on 10/20/21 at 4:30 p.m. She reviewed Resident G's care plans and indicated she did not see a care plan addressing her pressure ulcer. They either needed to create a new pressure ulcer care plan or address her pressure ulcer under the at risk for altered skin integrity care plan.<br>2. The clinical record for Resident B was reviewed on 10/19/21 at 11:45 a.m. The Resident's diagnosis included, but were not limited to, respiratory failure, tracheostomy, and anxiety. She was admitted to the facility on 9/10/21. | F 0656 | 1) Residents B and G were not harmed from the alleged deficient practice. Residents B care plan has been reviewed for accuracy and has been updated with all appropriate diagnoses and identified problems. Residents G care plan has been reviewed for accuracy and has been updated with all appropriate diagnoses and identified problems.<br>2) All residents with skin conditions and catheters have the potential to be affected. An audit was completed of all residents with catheters and skin issues to ensure that their care plans reflect an accurate picture of th3e resident and updated accordingly.<br>3) Licensed nurses and IDT team, including MDS, were educated on facilities Care plan overview policy, with an emphasis on ensuring care plan reflects an accurate plan of care for residents, including catheters and skin conditions.<br>4) MDS or designee will review 5 care plans weekly x 1 month, then 3 care plans weekly x 1 month, then 1 care plan weekly x 1 month to ensure accuracy and completion of care plan including skin conditions and catheters if applicable. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a | 11/11/2021 |

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| | An Admission MDS (Minimum Data Set) Assessment, completed 9/17/21, indicated she was cognitively intact. She required extensive assistance with bed mobility and toilet use. She was incontinent of bladder and did not have a urinary catheter in place.<br><br>The Admission Initial Evaluation, dated 9/10/21, indicated that she had an unstageable pressure ulcer on her sacrum (tail bone) which was being treated per the physician's orders. She had no other skin conditions present at that time.<br><br>A Wound Evaluation note, dated 9/21/21, indicated that she had developed a new fungal rash on her right and left buttocks and that Nystatin (antifungal medication) was being used twice a day.<br><br>A physician's order, dated 9/28/21, indicated that a foley (indwelling) catheter to be placed for urinary retention.<br><br>The clinical record did not contain a comprehensive care plan addressing the fungal rash or the indwelling foley catheter.<br><br>During an interview on 10/20/21 at 3:30 p.m., the DNS (Director of Nursing Services) indicated that the indwelling catheter should have been included in the care plan.<br><br>On 10/21/21 at 11:00 a.m., the DNS provided the Plan of Care Overview Policy, reviewed 5/30/2019, which read "...The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provisions of services to enable the resident to | | minimum of 6 months then randomly thereafter for further recommendation. | |

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| | live with dignity and supports the resident's goals, choices, and preferences..."<br><br>This Federal tag relates to Complaint IN00364264.<br><br>3.1-35(b)(1) | | | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br>§ 483.25 Quality of care<br>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.<br><br>Based on interview and record review, the facility failed to obtain a treatment order for a skin condition timely for 1 of 3 residents reviewed for pressure ulcers and skin conditions (Resident B).<br><br>Findings include:<br><br>The clinical record for Resident B was reviewed on 10/19/21 at 11:45 a.m. The Resident's diagnosis included, but were not limited to, respiratory failure, tracheostomy, and anxiety. She was admitted to the facility on 9/10/21.<br><br>An Admission MDS (Minimum Data Set) Assessment, completed 9/17/21, indicated she was cognitively intact. She required extensive assistance with bed mobility and toilet use. She could make her needs known and understand what | F 0684 | 1) Resident B was not harmed by the alleged deficient practice. Resident B had a head to toe skin assessment and treatment orders updated. MD was notified of any findings and orders were transcribed per recommendation.<br>2) All residents with skin conditions have the potential to be affected. A full house skin sweep was performed to identify any skin conditions without treatment orders. Any identified areas that did not have orders were reported to the MD and family and treatment orders were obtained and transcribed and care plans were updated to reflect skin condition.<br>3) Licensed nurses were | 11/11/2021 |

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| | was being said to her.<br><br>The Admission Initial Evaluation, dated 9/10/21, indicated that she had an unstageable pressure ulcer on her sacrum (tail bone) which was being treated per the physician's orders. She had no other skin conditions present at that time.<br><br>During an interview on 10/19/21 at 2:49 p.m., FM (Family Member) 4 and Resident B indicated her incontinent briefs had not been changed and she had not been repositioned as often as necessary. She had developed a rash in her perineal area about a week or two after she had been admitted. They felt the rash had been caused by her not being changed as often as she should have been.<br><br>The Wound Evaluation notes, dated 9/21/21, indicated that she had developed a new fungal rash on her right and left buttocks and that Nystatin (antifungal medication) was being used twice a day. The areas were to be left open to air.<br><br>The Wound Evaluation notes, dated 10/8/21, indicated the fungal rashes on her left and right buttocks continued to be present and there was MASD (Moisture Associated Skin Damage) with a superimposed yeast infection present bilaterally on her groin. The areas were being treated with Nystatin twice daily.<br><br>The clinical record did not contain a physician's order to treat her right or left buttock with nystatin cream until 10/8/21.<br><br>During an interview on 10/20/21 at 3:30 p.m., the DNS (Director of Nursing Services) indicated that a treatment order for the fungal rash should have been obtained when it was | | educated on facilities policy Skin Care and Wound Management Overview, with an emphasis on obtaining and transcribing treatment orders timely.<br>4) DON/wound nurse/designee will review all new skin conditions in the clinical morning meeting and validate that treatment orders were obtained, transcribed, and initiated timely. This is an ongoing facility practice. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

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| | discovered on 9/21/21.<br><br>On 10/20/21 at 4:36 p.m., the DNS provided the Skin Care and Wound Management Policy, revised 10/5/21, which read "...The facility staff strive to prevent resident/ patient skin impairment and to promote the healing of existing wounds...Treatments 1. Select and complete the appropriate form...2. Review and select the appropriate treatment for the identified skin impairment. 3. Obtain a physician's order. 4. Document the treatment on the Treatment Administration Record..."<br><br>This Federal tag relates to Complaint IN00364264.<br><br>3.1-37 | | | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>Based on observation, interview, and record review, the facility failed to monitor a resident's pressure ulcer daily and perform dressing | F 0686 | 1) Resident G was not harmed by the alleged deficient practice. The wound care team has | 11/11/2021 |

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| | changes daily for 1 of 3 residents reviewed for pressure ulcers and skin conditions. (Resident G)<br><br>Findings include:<br><br>The clinical record for Resident G was reviewed on 10/20/21 at 2:54 p.m. The diagnoses included, but were not limited to, arthritis and obesity.<br><br>The 7/5/21 skin integrity care plan indicated she was at risk for altered skin integrity due to immobility.<br><br>The 9/10/21 wound care evaluation indicated she had a stage 3 pressure ulcer on her right posterior thigh that was present on admission. The measurements in centimeters were 1.01 x 1.41 x 0.10. It read, "Dressing Change Frequency Daily. Cleanse Wound With Wound Cleanser...Dressings Collagen. Secondary Dressing Bordered Foam."<br><br>The 9/13/21 wound care evaluation indicated the pressure ulcer on her right posterior thigh now measured in centimeters 1.11 x 1.47 x 0.10. It read, "Dressing Change Frequency Daily. Cleanse Wound With Wound Cleanser...Dressings Collagen. Secondary Dressing Bordered Foam."<br><br>The 9/21/21 wound care evaluation indicated a measurement in centimeters of 2.81 x 0.99 x 0.10 and a change in treatment to twice weekly with normal saline, PolyMem foam, and cover with tegaderm.<br><br>The physician's orders and September, 2021 MAR (medication administration record) | | assessed the wound and appropriate orders were initiated for daily wound monitoring and appropriate dressing change orders were updated as needed. ‘<br>2) All residents with pressure ulcers have the potential to be affected. An audit was conducted on all residents with pressure ulcers to ensure they have daily wound monitoring on their EMAR and that dressing changes were being performed daily. Any resident identified as not having dressing changes done daily or daily wound monitoring had the physician notified, orders obtained and transcribed, and care plan updated accordingly.<br>3) Licensed nurses were educated on facilities policies Skin Care and Wound Management Overview and Physician Orders, with an emphasis on ensuring residents with pressure ulcers have daily wound monitoring on EMAR and that dressing changes are performed per physician order.<br>4) DON/wound nurse/designee will review ETAR to ensure that daily wound monitoring and treatment orders are being performed and documented appropriately. This is an ongoing facility practice. DON/wound nurse/designee will observe 3 treatments weekly x 1 month, then 2 treatments weekly x 1 month, then 1 treatment weekly x 1 month | |

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| | 155272 | A. BUILDING 00<br>B. WING | 10/21/2021 |

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| ALLISON POINTE HEALTHCARE CENTER | 5226 E 82ND ST<br>INDIANAPOLIS, IN 46250 |

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| | indicated no dressing changes to her pressure ulcer until 9/24/21 and no daily assessment of her pressure ulcer until 9/25/21.<br><br>An observation and interview with Resident G was conducted on 10/21/21 at 11:05 a.m. She was sitting up in bed. She indicated a dressing change to the pressure ulcer on her right posterior thigh had only occurred twice weekly.<br><br>An interview was conducted with the DNS (Director of Nursing Services) on 10/20/21 at 4:30 p.m. She reviewed Resident G's September, 2021 MAR and indicated the daily dressing changes were not completed, but should have been.<br><br>The Skin Care & Wound Management policy was provided by the DNS on 10/20/21 at 4:36 p.m. It read, "Skin care and wound management program includes, but is not limited to: ...Daily monitoring of existing wounds....Treatment: >..3. Obtain a physician's order. 4. Communicate interventions to the caregiving team. 5. Document treatment on the Treatment Administration Record (TAR.) 6. Monitor and document progress."<br><br>This Federal tag relates to Complaint IN00364264.<br><br>3.1-40(a)(2) | | to ensure completion of treatment. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation | |
| F 0690 SS=D 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 | | | |

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| | 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 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><br>Based on observation, interview, and record review, the facility failed to assess for need, have physician's orders for care, and provide care appropriately to reduce the risk of urinary tract infection for a resident with an indwelling urinary catheter for 1 of 1 resident reviewed for urinary catheters (Resident B).<br><br>Findings include: | F 0690 | 1) Resident B was not harmed by the deficient practice.<br>Physician was notified and orders obtained for catheter care. C.N.A 3 was immediately provided an inservice on providing catheter care appropriately with return demonstration.<br>2) All residents that have foley catheters have the potential to be | 11/11/2021 |

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| | The clinical record for Resident B was reviewed on 10/19/21 at 11:45 a.m. The Resident's diagnosis included, but were not limited to, respiratory failure, tracheostomy, and anxiety. She was admitted to the facility on 9/10/21.<br><br>An Admission MDS (Minimum Data Set) Assessment, completed 9/17/21, indicated she was cognitively intact. She required extensive assistance with bed mobility and toilet use. She was incontinent of bladder and did not have a urinary catheter in place.<br><br>A physician's order, dated 9/28/21, indicated that a foley (indwelling) catheter to be placed for urinary retention.<br><br>During an interview on 10/19/21 at 2:49 p.m., FM (Family Member) 4 indicated that the catheter was put in place about 2 to 3 weeks ago. She had been told it would be in place for a couple of days, but it had not been removed yet. She was unsure why the catheter was placed.<br><br>The clinical record did not contain an assessment indicating why the catheter was placed, physician's orders for the size of catheter to use, how often to change the catheter, or to provide catheter care. There was no documentation of what sized indwelling catheter had been placed or how she tolerated the procedure.<br><br>On 10/20/21 at 2:15 p.m., CNA (Certified Nursing Assistant) 3 was observed providing catheter care. She donned a pair of disposable gloves and lowered the incontinent brief. She then obtained an incontinence wipe and wiped the catheter tubing from the from the end of the tubing toward the resident. She obtained a new | | affected. An audit was performed on all residents with foley catheters to ensure that they had appropriate orders for catheter care.<br>3) All licensed nurses, qualified medication aides, and C.N.A's had a competency performed on "Catheter Care". All licensed nurses were educated on the facilities policy "Catheter Care" with an emphasis on obtaining orders for catheter care.<br>4) DON /designee will review all new foley catheters in the clinical morning meeting and validate that catheter care orders were obtained, transcribed, and initiated timely. This is an ongoing facility practice. DON/designee will perform 3 foley cath care observations weekly x 1 month, then 2 foley cath care observations weekly x 1 month, then 1 foley cath care observation weekly x 1 month to ensure proper catheter care completion. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. | |

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| | incontinence wipe and cleansed the resident's perineum, wiping front to back, then turned the wipe inside out and wiped the perineum again. She then assisted the resident to turn and placed a new incontinent brief on the resident. She indicated that this was how she normally performed catheter care.<br><br>On 10/21/21 at 10:06 a.m., the DNS (Director of Nursing Services) provided the Catheter Care Policy, reviewed 4/20/2017, which read "...Policy: It is the policy of this facility to provide residents care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Catheter Care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place...Procedure...Catheter care...b. Perform hand hygiene c. Don gloves d. expose front genital area only, observing for dignity and warmth e. obtain clean, wet washcloth with warm soap and water f. Securely grasp the catheter tubing nearest the meatal opening to prevent movement or accidental dislodgement g. Clean around catheter just above entrance to meatus. i. wipe the catheter from meatus downward approximately 6 inches..."<br><br>On 10/21/21 at 11:32 a.m., the DNS provided the Female Indwelling Catheterization Procedure, reviewed 6/03/2021, which read "... Policy...Indwelling catheters may be inserted for specific needs under the direct order of a physician, and usually are for short duration unless extenuating circumstances are documented including palliative care, wound management or disease management. The resident / resident representative will be notified of the need for the catheter and expected duration. Procedure: I. Review physician's | | | |

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| | order for the type, size, drainage bag type and diagnosis...i. Document in progress notes, procedure, size, and type of catheter, amount of urine obtained, appearance and any other abnormalities..."<br><br>This Federal tag relates to Complaint IN00364264.<br><br>3.1-41(a)(1) | | | |