STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155053	A. BUILDING 00 B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

(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 Bldg. 00	This visit was for the Investigation of Complaints IN00399411 and IN00400387. Complaint IN00399411 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550, F580, F684 and F690. Complaint IN00400387 - Substantiated. Federal/state deficiencies related to the allegations are cited at F550, F580, F684, and F690. Survey dates: January 31 and February 1, 2023 Facility number: 000018 Provider number: 155053 AIM number: 100273930 Census Bed Type: SNF/NF: 38 SNF: 05 Total: 43 Census Payor Type: Medicare: 14 Medicaid: 18 Other: 11 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 3, 2023	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is: February 22, 2023. **The Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amber Busald	Administrator	02/17/2023

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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	existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §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. §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. §483.10(b) Exercise of Rights. 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. §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. §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.	F 0550	**F-550**	02/22/2023

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	Based on observation, interview, and record review, the facility failed to promote dignity for one resident when he was not toileted timely and left soiled (Resident B), and failed to promote dignity for two residents when their urinary drainage bags were not covered (Residents B and C). This affected 2 of 3 residents reviewed for dignity. Findings include: 1. On 1/31/23, at 11:33 a.m., a family member of Resident B's was interviewed and indicated on Monday, January 16, 2023, Resident B had a bowel movement in his brief, and the aide wouldn't help him because she didn't have any gloves. The aide helped him back to his chair, and there was blood and feces all over the commode, his back, and his peritoneal area but she took him back to his chair and left him like that. The family member indicated it was over an hour before he was cleaned up. Resident B's record was reviewed, on 1/31/23, at 12:10 p.m., and indicated diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, urinary retention, neuromuscular dysfunction of bladder, muscle wasting and atrophy of right and left upper arm, generalized muscle weakness, and gait and mobility abnormalities. An Admission Minimum Data Set assessment (MDS), dated 11/18/22, indicated Resident B had minimal difficulty hearing, did not wear a hearing aid, speech was clear, makes self understood and understands others, he was cognitively intact, required extensive assist of two for bed mobility,		It is the policy of the facility to ensure residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Residents who reside in the facility have the potential to be affected by this finding. 1. A staff in-service was held on 02/03/2023 reviewing customer service regarding resident's rights and dignity both in and outside the facility including but not limited to call light response timeliness, and meeting resident's needs, along with catheter care, and incontinence care policies. 2. A 100% audit was completed on all residents with a urinary drainage bag to ensure drainage bag was covered to promote resident dignity and to ensure drainage bag was not touching the floor. 3. A 100% audit was completed to ensure gloves needed were available in all resident rooms and care areas. Director of Nursing/Designee will monitor the following: covering of urinary drainage bags and placement of catheter bag, call light timeliness, gloves present in rooms, and interview residents to ensure incontinence care is being	

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	transfers, dressing, toilet use, and personal hygiene, was totally dependent on two for bathing, did not walk, used a wheelchair, had no impairment in upper or lower extremities for functional limitation in range of motion, had an indwelling catheter, was always incontinent of bowels. Current physician's orders indicated an order for "Catheter care every shift and ensure catheter drainage bag is below the waist and covered, do not have tension on catheter", dated 1/20/2023. Resident B had a care plan, dated 12/14/22, that indicated: "CATHETER: I require the use of a catheter for Neurogenic Bladder, urinary retention. Goal: My catheter will be maintained per plan of care daily and I will remain free from catheter related complications daily such as leakage or infection. Interventions: 12/14/22: Assess for cause of leakage such as irritation due to large balloon, excessive catheter diameter, fecal impaction, and or improper catheter position...12/14/22: Catheter care each shift 12/14/22: Document any catheter related complications in EMR [electronic medical records] and update physician as needed...12/14/22: Establish frequency of drainage bag changes and keep bag covered...." On 1/31/23, at 12:37 p.m., Resident B was observed seated in his recliner beside his bed in his room. His urinary drainage bag was hooked on the side of the waste paper basket, facing the open door, and was not covered, and the bottom of the bag touched the floor. Resident B indicated a couple of weeks ago, a staff member walked him to the bathroom and didn't help him clean up. She told him to go back to his chair and sit down.		done timely using audit tool “A” 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, then 1 x weekly x 4 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of resident rights/exercise of rights will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. Facility's date of alleged compliance is: February 22, 2023.	

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	Resident B said there was blood and bowel movement on himself, the commode, the floor, and his chair. He said he had to wait an hour and a half altogether, from the time he needed help to get to the bathroom, until he was cleaned up. A girl, he thought was a CNA, said she couldn't help him because she didn't have any gloves, and he said there were two boxes of gloves in the room. He said she had to wear special gloves but he didn't know that at the time. When they got him back out of his chair, the chair pad was covered with blood and bowel movement. His depends had blood and he said he had some diarrhea. He said he didn't like sitting there like that and he was upset about it at that time. During an interview, on 2/1/2023 at 1:24 p.m., CNA 3 indicated on January 16, 2023, Resident B used his call light, and he never uses his light, but it was on and she knew this was unusual for him. Resident B indicated a "nurse" came in and was helping him to the bathroom but had left him dirty and bloody. Resident B said [the nurse] assisted him to the bathroom and he was able to clean his front, but couldn't clean the back so he asked her to help. He was told to pull up his brief and "stuff" because this nurse didn't have gloves. When CNA 3 went to change him he was pretty soiled. The brief was completely soiled with bowel movement and blood, he needed a new one, and the bed pad was soaked and his pants were soaked with blood. The area on the bed pad was about the size of a cantaloupe, and the pants were "soaked through". The male nurse came in and helped her clean the resident up. During an interview, on 2/1/23, 1:33 p.m., LPN 4 indicated she has worked with Resident B, and on January 16th, she came in at 2:30 p.m. At 3:00 p.m., she was told he was bleeding around his catheter,			

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	and he did have blood around his catheter. It was dislodged and she re-anchored it, but it wasn't draining at this time. So she took the catheter out and changed it fully at this time. At this time it, when she anchored it was an instantly a blood return. She reassessed during that time. It had amber, then cloudy, then clear urine. He didn't have further bleeding. He did have some pain and discomfort at the catheter, but this changed it cleared up. He thanked me for cleaning him. There was blood in the recliner and blood in his brief, she changed all of that. There was a pad. There were not external open areas. She hasn't worked with him after the 16th. He was upset because he was on a toilet longer than necessary. She didn't call the physician after this event since he was doing better. On 2/1/23, at 2:43 p.m., the Director of Nursing indicated all trained staff: aides, nurses, QMAs, and clinical staff are responsible to ensure catheter tubing and catheter bags are off the floor and the catheter bag is covered. The Director of Nursing said a resident should be given care when found incontinent, and not left soiled with a bowel movement or blood, and they try to answer the call light within 10 minutes. The QMA who answered the light had to go get different gloves due to an allergy, and she had told someone else he needed attention. 2. On 1/31/23, at 12:25 p.m., Resident C was observed as he sat in his room in his recliner. His catheter bag was hooked to his waste paper basket beside his recliner, on the door side of his bed, and the uncovered bag sat on the floor. He was dressed in street clothes. He said he has had problems with his catheter, it cut his penis and it gets sore. He said it is ok right now.			

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	Resident C's record was reviewed on 2/1/23 at 10:00 a.m. The record indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus, dementia, congestive heart failure, benign prostatic hyperplasia with lower urinary tract symptoms, and weakness. A care plan, dated 1/31/23, included, but was not limited to, Resident C had an enlarged prostate with urinary obstruction with need for a Foley catheter. The goals were no signs and symptoms of infection daily, and had interventions for catheter care every shift and prn, document urine output every shift, encourage fluids, and position tubing to facilitate tube draining during positioning and as needed. Physician's orders indicated an order for catheter care every shift and ensure the catheter drainage bag is below the waist and covered, with a start date of 1/24/23. A policy for "Indwelling Urinary Catheterization for Male Resident" was provided by the Director of Nursing on 2/1/23 at 2:43 p.m. and included, but was not limited to: "...Catheter care should be done eery shift for residents with catheters...Catheter bag will be changed monthly...." This Federal tag relates to Complaints IN00399411 and IN00400387. 3.1-3(t)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the			

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	resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A			

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	facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to promptly notify the physician after a change in a resident's condition when the resident had bleeding around or in his urinary catheter tubing. This affected 1 of 3 residents reviewed for notification. (Resident B) Findings include: On 1/31/23, at 11:33 a.m., a family member of Resident B's was interviewed and indicated on Monday, January 16, 2023, Resident B had a bowel movement in his brief, and the aide wouldn't help him because she didn't have any gloves. The aide helped him back to his chair, and there was blood and feces all over the commode, his back, his peri area but she took him back to his chair and left him like that. The family member indicated it was over an hour before he was cleaned up. Resident B's record was reviewed, on 1/31/23, at 12:10 p.m., and indicated diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, urinary retention, neuromuscular dysfunction of bladder, muscle wasting and atrophy of right and left upper arm, generalized muscle weakness, and gait and mobility abnormalities.	F 0580	F-580 It is the policy of the facility to ensure the physician is promptly notified after a resident experiences a change in condition. Residents who reside in the facility have the potential to be affected by this finding. 1. An in-service was held on 02/03/2023 regarding physician notification related to a change of condition using our policy. 2. A 100% audit will be completed on assessments completed in the previous 30 days to ensure residents physician was notified promptly following a change in condition. Director of Nursing/Designee will monitor all residents for documented changes in condition and ensure physician was notified. Completed assessments will be audited regarding physician notification using audit tool “B” 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, then 1 x weekly x 4	02/22/2023

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	An Admission Minimum Data Set assessment (MDS), dated 11/18/22, indicated Resident B had minimal difficulty hearing, did not wear a hearing aid, speech was clear, makes self understood and understands others, he was cognitively intact, required extensive assist of two for bed mobility, transfers, dressing, toilet use, and personal hygiene, was totally dependent on two for bathing, did not walk, used a wheelchair, had no impairment in upper or lower extremities for functional limitation in range of motion, had an indwelling catheter, was always incontinent of bowels. Resident B had a care plan, dated 12/14/22, that indicated: "CATHETER: I require the use of a catheter for Neurogenic Bladder, urinary retention. Goal: My catheter will be maintained per plan of care daily and I will remain free from catheter related complications daily such as leakage or infection. Interventions: 12/14/22: Assess for cause of leakage such as irritation due to large balloon, excessive catheter diameter, fecal impaction, and or improper catheter position. 1/20/23: Cath changes by urologist ONLY 12/14/22: Catheter care each shift 12/14/22: Document any catheter related complications in EMR and update physician as needed 12/14/23: Encourage fluid intake and record outputs each shift on output record 12/14/22: Establish frequency of drainage bag changes and keep bag covered. 12/14/22: Follow physician specific order for size and frequency of changing 12/14/22: Maintain the urinary drainage bag below bladder level to facilitate flow of urine. 12/14/22: Monitor for changes in LOC		months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring completed by the Director of Nursing/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. Facility's date of alleged compliance is: February 22, 2023.	

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	12/14/22: Provide measures to prevent excessive pulling/tension on catheter tubing- secure to leg, gather catheter bag prior to any transfer, etc...." Progress notes indicated: 1/16/2023 at 1:36 p.m. "Communication of new or changed plan of care/orders ...Replace foley catheter today...catheter blockage...Indicate who will carry out this task (RN, LPN, CNA, x-ray tech, lab tech, Practitioner etc):: nursing" 1/16/2023 at 2:46 p.m. "Residents foley was replaced this shift. Resident tolerated well. A 16 fr (size of catheter) was anchored with 5 cc (cubic centimeters) bulb. 100 ccs urine was immediate return. The urine was blood tinged. Will continue to monitor." 1/16/2023 at 5:19 p.m. "Late Entry: Residents catheter dislodged after ambulating from bathroom, blood tinged urine noted in urinary bag, 16 french catheter and urinary bag replaced and urine was returned upon insertion, resident tolerated well, will continue to monitor." On 1/31/23, at 12:37 p.m., Resident B was observed seated in his recliner beside his bed in his room. His urinary drainage bag was hooked on the side of the waste paper basket, facing the open door, and was not covered. Resident B indicated a couple of weeks ago, a staff member walked him to the bathroom and didn't help him clean up. She told him to go back to his chair and sit down. Resident B said there was blood and bowel movement on himself, the commode, the floor, and his chair. He said he had to wait an hour and a half altogether, from the time he needed help to get to the bathroom, until he was cleaned up. A girl, he thought was a CNA, said she couldn't help him because she didn't have any gloves, and he			

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	said there were two boxes of gloves in the room. He said she had to wear special gloves but he didn't know that at the time. When they got him back out of his chair, the chair pad was covered with blood and bowel movement. His depends had blood and he said he had some diarrhea. He said he didn't like sitting there like that and he was upset about it at that time. On 2/1/23 at 12:20 p.m., QMA 2 indicated Resident B had a small bowel movement in his brief and he was trying to take it off before he got on the toilet, so she assisted him to the toilet and told him to ring the call bell when he was done. He pushed the call light and stood up from the toilet and walked over to the chair. He tried to take the soiled brief off before getting to the recliner and the recliner didn't have a pad on it, so she told him to pull up the brief soiled with bowel movement until she got some gloves and a pad for the chair. Then she went to the nursing station and let the other staff at the nursing station know that he needed help. Her relief came and she had to count narcotics with them. She didn't know which staff ended up helping him or when he was assisted. She had reported to LPN 4, CNA 3 and QMA 5. QMA 2 indicated Resident B had a little stool and tiny bit of blood in the brief, the catheter bag had "quite a bit of blood in the bag". She said she was more concerned about the outside of the catheter insertion site having blood around it, as there was a lot of blood at the insertion site. During an interview, on 2/1/2023 at 1:24 p.m., CNA 3 indicated on January 16, 2023, Resident B used his call light, and he never uses his light, but it was on and she knew this was unusual for him. Resident B indicated a "nurse" came in and was helping him to the bathroom but had left him dirty and bloody. Resident B said she [the nurse]			

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	155053	A. BUILDING 00 B. WING	02/01/2023

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	assisted him to the bathroom and he was able to clean his front, but couldn't clean the back so he asked her to help. He was told to pull up his brief and "stuff" because this nurse didn't have gloves. When CNA 3 went to change him he was pretty soiled. The brief was completely soiled with bowel movement and blood, he needed a new one, and the bed pad was soaked and his pants were soaked with blood. The area on the bed pad was about the size of a cantaloupe, and the pants were "soaked through". She did look at his catheter, he was having a lot of bleeding on his penis. The catheter was clogged with blood clots. She reported it to the Administrator on January 16th. The night of January 16th he was dripping blood from his penis, but he wasn't bleeding on January 17th when she cared for him. The male nurse came in and helped her clean the resident up. She didn't know where exactly he was bleeding from. During an interview, on 2/1/23, 1:33 p.m., LPN 4 indicated she has worked with Resident B, and on January 16th, she came in at 2:30 p.m. At 3:00 p.m., she was told he was bleeding around his catheter, and he did have blood around his catheter. It was dislodged and she re-anchored it, but it wasn't draining at this time. So she took this out and changed it fully at this time. At this time it, when she anchored it was an instantly a blood return. She reassessed during that time. It had amber, then cloudy, then clear urine. He didn't have further bleeding. He did have some pain and discomfort at the catheter, but this changed it cleared up. He thanked me for cleaning him. There was blood in the recliner and blood in his brief, she changed all of that. There was a pad. There were not external open areas. She hasn't worked with him after the 16th. He was upset because he was on a toilet longer than necessary. She didn't call the physician after this event since he was			

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	doing better. There was no documentation in the Progress Notes that the resident had the large amount of bleeding that the CNA and LPN had described, and no documentation the Physician had been notified of the bleeding. On 2/1/23 at 2:43 p.m., the Director of Nursing indicated she had not been told it was a lot of bleeding, just blood tinged urine in the catheter. She had not been given the description that it was a lot of bleeding, and it was not reported to her as the same amount of bleeding that the staff had told the surveyors. A policy for "Change in Resident's Condition or Status" was provided by the Director of Nursing on 2/1/23 at 2:43 p.m. and included, but was not limited to: "Policy: It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status. Procedure: 1. The nurse will notify the resident's attending physician when...There is a significant change in the resident's physical, mental or psychological status...6. The nurse will record in the resident's medical record any changes in the resident's medical condition or status." 3.1-5(a)(2) This Federal tag relates to Complaints IN00399411 and IN00400387.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure complete assessments were done after a resident had bleeding in or around his catheter. This affected 1 of 3 residents reviewed for assessments. (Resident B) Findings include: Resident B's record was reviewed, on 1/31/23, at 12:10 p.m., and indicated diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, urinary retention, neuromuscular dysfunction of bladder, muscle wasting and atrophy of right and left upper arm, generalized muscle weakness, and gait and mobility abnormalities. An Admission Minimum Data Set assessment (MDS), dated 11/18/22, indicated Resident B had minimal difficulty hearing, did not wear a hearing aid, speech was clear, makes self understood and understands others, he was cognitively intact, required extensive assist of two for bed mobility, transfers, dressing, toilet use, and personal hygiene, was totally dependent on two for bathing, did not walk, used a wheelchair, had no impairment in upper or lower extremities for functional limitation in range of motion, had an indwelling catheter, was always incontinent of	F 0684	**F-684** It is the policy of the facility to ensure an assessment is completed when a resident has a change in condition. Residents who reside in the facility have the potential to be affected by this finding. 1. An in-service was held on 02/03/2023 regarding completion of assessments related to change of condition. Director of Nursing/Designee will monitor all residents for documented changes in condition and ensure assessments were completed. Completed assessments will be audited regarding change of condition using audit tool “B” 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, then 1 x weekly x 4 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. Any staff who fail to comply with the points of the in-service will be further educated and or	02/22/2023

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	bowels. Resident B had a care plan, dated 12/14/22, that indicated: "CATHETER: I require the use of a catheter for Neurogenic Bladder, urinary retention. Goal: My catheter will be maintained per plan of care daily and I will remain free from catheter related complications daily such as leakage or infection. Interventions: 12/14/22: Assess for cause of leakage such as irritation due to large balloon, excessive catheter diameter, fecal impaction, and or improper catheter position...12/14/22: Catheter care each shift. 12/14/22: Document any catheter related complications in EMR (Electronic Medical Record) and update physician as needed...12/14/22: Provide measures to prevent excessive pulling/tension on catheter tubing-secure to leg, gather catheter bag prior to any transfer, etc...." Physician's orders included: Apixaban (blood thinner) tablet, give 5 milligrams two times a day for deep vein thrombosis and pulmonary embolism. started 11/15/22. Progress notes indicated: 1/16/2023 at 1:36 p.m. "Communication of new or changed plan of care/orders List New/changed order(s) or plan of care : Replace foley catheter today Reason for change: catheter blockage...." 1/16/2023 at 2:46 p.m. "Residents foley was replaced this shift. Resident tolerated well. A 16 fr (size of catheter) was anchored with 5 cc (cubic centimeters or one teaspoon) bulb. 100 ccs (3.3 ounces) urine was immediate return. The urine was blood tinged. Will continue to monitor."		progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring completed by the Director of Nursing/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. Facility's date of alleged compliance is: February 22, 2023.	

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	1/16/2023 at 5:19 p.m. "Late Entry: Residents catheter dislodged after ambulating from bathroom, blood tinged urine noted in urinary bag, 16 french catheter and urinary bag replaced and urine was returned upon insertion, resident tolerated well, will continue to monitor." 1/17/2023 at 1:45 p.m. "Daily Skilled Nursing Note: Note Text: Resident up to recliner this [with no complaints of] pain this shift. urinary catheter patent and draining yellow urine. Good p.o. (by mouth) intake this shift. Resident able to make needs known." 1/17/2023 at 6:26 p.m. "Incident Note: Note Text: Resident up to recliner per usual this shift. Resident also worked with therapy this afternoon. No c/o (complaints) voiced to this nurse at this time. Will continue to monitor." On 1/31/23, at 12:37 p.m., Resident B was observed seated in his recliner beside his bed in his room. Resident B indicated a couple of weeks ago, a staff member walked him to the bathroom and didn't help him clean up. She told him to go back to his chair and sit down. Resident B said there was blood and bowel movement on himself, the commode, the floor, and his chair. He said he had to wait an hour and a half altogether, from the time he needed help to get to the bathroom, until he was cleaned up. A girl, he thought was a CNA, said she couldn't help him because she didn't have any gloves, and he said there were two boxes of gloves in the room. He said she had to wear special gloves but he didn't know that at the time. When they got him back out of his chair, the chair pad was covered with blood and bowel movement. His depends had blood and he said he had some diarrhea. He said he didn't like sitting there like that and he was upset about it at that			

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	time. On 2/1/23 at 12:20 p.m., QMA 2 indicated Resident B had a small bowel movement in his brief and he was trying to take it off before he got on the toilet, so she assisted him to the toilet and told him to ring the call bell when he was done. He pushed the call light and stood up from the toilet and walked over to the chair. He tried to take the soiled brief off before getting to the recliner and the recliner didn't have a pad on it, so she told him to pull up the brief soiled with bowel movement until she got some gloves and a pad for the chair. Then she went to the nursing station and let the other staff at the nursing station know that he needed help. Her relief came and she had to count narcotics with them. She didn't know which staff ended up helping him or when he was assisted. She had reported to LPN 4, CNA 3 and QMA 5. QMA 2 indicated Resident B had a little stool and tiny bit of blood in the brief, the catheter bag had "quite a bit of blood in the bag". She said she was more concerned about the outside of the catheter insertion site having blood around it, as there was a lot of blood at the insertion site. During an interview, on 2/1/2023 at 1:24 p.m., CNA 3 indicated on January 16, 2023, Resident B used his call light, and he never uses his light, but it was on and she knew this was unusual for him. Resident B indicated a "nurse" came in and was helping him to the bathroom but had left him dirty and bloody. Resident B said she [the nurse] assisted him to the bathroom and he was able to clean his front, but couldn't clean the back so he asked her to help. He was told to pull up his brief and "stuff" because this nurse didn't have gloves. When CNA 3 went to change him he was pretty soiled. The brief was completely soiled with bowel movement and blood, he needed a new one, and			

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	the bed pad was soaked and his pants were soaked with blood. The area on the bed pad was about the size of a cantaloupe, and the pants were "soaked through". She did look at his catheter, he was having a lot of bleeding on his penis. The catheter was clogged with blood clots. She reported it to the Administrator on January 16th. The night of January 16th he was dripping blood from his penis, but he wasn't bleeding on January 17th when she cared for him. The male nurse came in and helped her clean the resident up. She didn't know where exactly he was bleeding from. During an interview, on 2/1/23, 1:33 p.m., LPN 4 indicated she has worked with Resident B, and on January 16th, she came in at 2:30 p.m. At 3:00 p.m., she was told he was bleeding around his catheter, and he did have blood around his catheter. It was dislodged and she re-anchored it, but it wasn't draining at this time. So she took this out and changed it fully at this time. At this time it, when she anchored it was an instantly a blood return. She reassessed during that time. It had amber, then cloudy, then clear urine. He didn't have further bleeding. He did have some pain and discomfort at the catheter, but this changed it cleared up. He thanked me for cleaning him. There was blood in the recliner and blood in his brief, she changed all of that. There was a pad. There were not external open areas. She hasn't worked with him after the 16th. He was upset because he was on a toilet longer than necessary. She didn't call the physician after this event since he was doing better. There was no documentation in the Progress Notes or assessments that the resident had the amount of bleeding that the Resident, QMA, CNA and LPN had described.			

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	On 2/1/23 at 2:43 p.m., the Director of Nursing indicated she had not been told it was a lot of bleeding, just blood tinged urine in the catheter. She had not been given the description that it was a lot of bleeding, and it was not reported to her as the same amount of bleeding that the staff had told the surveyors. She did not find any further assessments in the resident's record of the bleeding or the condition Resident B was described as being in on January 16, 2023. A policy for "Change in Resident's Condition or Status" was provided by the Director of Nursing on 2/1/23 at 2:43 p.m. and included, but was not limited to: "Procedure: 6. The nurse will record in the resident's medical record any changes in the resident's medical condition or status." 3.1-37(a) This Federal tag relates to Complaints IN00399411 and IN00400387.			
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. §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			

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	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 observation, interview and record review the facility failed to ensure residents' catheter bags or tubing were not touching the floor to prevent infection for 2 of 2 residents reviewed. (Residents B and C) Findings include: 1. Resident B's record was reviewed, on 1/31/23, at 12:10 p.m., and indicated diagnoses that included, but were not limited to, atrial fibrillation, high blood pressure, benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptoms, urinary retention, neuromuscular dysfunction of bladder, muscle wasting and atrophy of right and left upper arm, generalized muscle weakness, and gait and mobility abnormalities.	F 0690	**F-690** It is the policy of the facility to ensure residents catheter bags and/or tubing are not touching the floor to prevent infection. Residents who reside in the facility with a catheter have the potential to be affected by this finding. A staff in-service was held on 02/03/2023 regarding catheter care including but not limited to catheter tubing not touching the floor to prevent infection using our policy. 1. A 100% audit was	02/22/2023

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	An Admission Minimum Data Set assessment (MDS), dated 11/18/22, indicated Resident B had minimal difficulty hearing, did not wear a hearing aid, speech was clear, makes self understood and understands others, he was cognitively intact, required extensive assist of two for bed mobility, transfers, dressing, toilet use, and personal hygiene, was totally dependent on two for bathing, did not walk, used a wheelchair, had no impairment in upper or lower extremities for functional limitation in range of motion, had an indwelling catheter, was always incontinent of bowels. A care plan, dated 12/14/22, included but was not limited to: "CATHETER: I require the use of a catheter due to neurogenic bladder and urinary retention. My catheter will be maintained per plan of care daily and I will remain free from catheter related complications daily such as leakage or infection. Interventions...Catheter care each shift. 12/14/22: Document any catheter related complications in EMR (electronic medical record) and update physician as needed...12/14/22: Establish frequency of drainage bag changes and keep bag covered...12/14/22: Maintain the urinary drainage bag below bladder level to facilitate flow of urine..." On 1/31/23, at 12:37 p.m., Resident B was observed seated in his recliner beside his bed in his room. His urinary drainage bag was hooked on the side of the waste paper basket, facing the open door, and was not covered, and the bottom of the bag touched the floor. On 2/1/23 at 10:03 a.m., Resident B's catheter tubing was observed lying on the floor between the resident's pant leg and the drainage bag.		completed on all current residents with catheters to ensure tubing was not touching the floor in order to prevent infection. Director of Nursing/Designee will monitor catheter tubing placement for all residents with catheters using audit tool “A” 5 x weekly x 4 weeks, 3 x weekly x 4 weeks, then 1 x weekly x 4 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring completed by the DON/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution. Facility's date of alleged compliance is: February 22, 2023.	

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	When questioned about the catheter tubing making contact with the floor, RN 6 indicated his pant leg was down and moved the catheter tubing up off the floor and secured it to the drainage bag away from the floor. 2. On 1/31/23, at 12:25 p.m., observed Resident C as he sat in his room in his recliner. His catheter bag was hooked to his waste paper basket beside his recliner, on the door side of his bed, and the uncovered bag sat on the floor. Resident C's record was reviewed on 2/1/23 at 10:00 a.m. The record indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus, dementia, congestive heart failure, benign prostatic hyperplasia with lower urinary tract symptoms, and weakness. A care plan, dated 1/31/23, included, but was not limited to, Resident C had an enlarged prostate with urinary obstruction with need for a Foley catheter. The goals were no signs and symptoms of infection daily, and had interventions for catheter care every shift and as needed, document urine output every shift, encourage fluids, and position tubing to facilitate tube draining during positioning and as needed. Physician's orders indicated an order for catheter care every shift and ensure the catheter drainage bag is below the waist and covered, with a start date of 1/24/23. On 2/1/23, at 2:43 p.m., the Director of Nursing indicated all trained staff: aides, nurses, QMAs, and clinical staff are responsible to ensure catheter tubing and catheter bags are off the floor and the catheter bag is covered.			

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	155053	A. BUILDING 00 B. WING	02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF RUSHVILLE SKILLED NURSING FACILITY, THE	612 E 11TH ST RUSHVILLE, IN 46173

(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
	3.1-41(a)(2) This Federal tag relates to Complaints IN00399411 and IN00400387.			