| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146146 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Foxes Sr Living & Rehab | 609 South Marshall<br>McLeansboro, IL 62859 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician of a change in condition timely for 1 (R1) of 3 residents reviewed for change in condition in the sample of 4.Findings Include:R1's admission Record documented that R1 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Unspecified Dementia, aortic valve stenosis, dysphagia, retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, cognitive communication deficit, and pain.R1's MDS (Minimum Data Set) quarterly assessment with an Assessment Reference Date of December 12, 2025, documented a Brief Interview for Mental Status (BIMS) score of 06 indicating R1 had severe cognitive impairment. R1's Care Plan with an initiation date of 09/12/2025 has a Focus Area of I have an indwelling catheter due to diagnosis of urinary retention, and benign prostatic hyperplasia with lower urinary tract symptoms. Interventions listed include monitor and document intake and output as per facility policy, monitor/record/report to medical doctor signs and symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns.R1's Treatment Administration Record (TAR) with a date range from 12/01/2025 - 12/31/2025 documented under urinary output, R1 had 0 urinary output from 10 P.M. on 12/25/2025 to 6 A.M. on 12/26/2025. R1's TAR also documented on 12/25/2025 R1's oral intake for day shift was 10 milliliters, evening shift was 240 milliliters and night shift was 0. Under the section titled Amount Eaten for 12/25/2025 it is documented 0 for all three meals.R1's Progress Note dated 12/25/2025 at 7:26 A.M. authored by V9 (Licensed Practical Nurse) documented when CNA went to get R1 out of bed for breakfast, dried emesis of undigested food in bed and R1 was incontinent of a large bowel movement. Taken to shower and laid down. Afebrile. R1 clinches teeth when staff tried to assist with feeding or when medications are attempted. Negative for COVID.R1's Progress Note dated 12/25/2025 at 1:00 P.M. authored by V9 documented R1 was up for lunch in wheelchair. Staff attempted to feed and resident clinches teeth together.R1's Progress Note dated 12/26/2025 at 11:00 A.M. authored by V5 (Licensed Practical Nurse) documented call placed to V8 (Medical Doctor) office due to resident has had no urine output from indwelling catheter. Resident lethargic and lower abdomen is distended and rigid. New order from V8 to send R1 to local hospital emergency department for evaluation and treatment.R1's Emergency Department (ED) Provider Notes dated 12/26/25 from the local hospital documents R1 presents to ED with c/o (complaints of) lethargy and urinary retention with current foley catheter. On arrival patient is responsive to painful stimuli and groans when moved. R1's bladder distended with no drainage in bag. Bladder scan shows >1570ml. 18 fr coude removed and replaced with 18 fr straight tip foley cath (catheter) placed. When foley bulb was deflated, brown urine started flowing out around the catheter. R1 had 1850ml out of bladder, very malodorous, nearly brown in color with large amount of sediment present.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146146 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Foxes Sr Living & Rehab | 609 South Marshall<br>McLeansboro, IL 62859 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Photos of R1's urine in the hospital records dated 12/26/25 shows three graduated cylinders with dark brown, cloudy urine with large amounts of sediment visible.On 01/02/2026 at 1:35P.M. V2 (Director of Nursing / Registered Nurse) stated she was the nurse for R1 the night before he was sent to the hospital. V2 stated she came in on 12/25/2025 at 7:00 P.M .and worked until 06:00 A.M. on 12/26/2025. V2 stated R1 was in bed when she came on shift. V2 stated she had received in report that R1 had been sick all day and had not eaten or drank anything. V2 stated R1 had vomited earlier that day and the wife felt like it was because R1 had eaten too much when he was out with family on 12/24/2025. V2 stated she had not notified the physician because she thought he was sick from overeating the day before.On 01/02/2026 at 3:15 P.M. V7 (Licensed Practical Nurse) stated she was there to pass the medications on 12/26/2025 from 6:00-10:00 A.M. V7 sated it was reported that R1 had been sick, had emesis and loose stools. V7 stated that R1 did not eat or drink that morning. V7 stated she obtained vital signs and must not have charted them. V7 stated she did not notify the physician of R1's condition. V7 stated she does not remember being told that R1 had no urine output. V7 stated she provided no care for the foley catheter on 12/26/2025.On 01/07/2026 at 10:10 A.M. V8 (Medical Doctor) stated 8 hours is a reasonable amount of time for R1 to go without urine out put before the physician was notified. V8 stated R1's catheter was flushed with no issues or return output. V8 stated he felt like there was an issue with the catheter and that is why R1 was sent to the emergency department. V8 stated he feels that the catheter had to have some type of obstruction causing the urine to not flow. V8 stated R1 had been having issues with the indwelling catheter and had been following with the urologist in the weeks prior. V8 was shown the pictures of R1's urine from the hospital and stated that looks infected. V8 stated looking over the facts R1 could have been sent out and hour or two earlier but it would not have changed the fact that R1 was declining in health.On 01/07/2026 at 11:57 A.M. V12 (Urology Nurse) stated with R1's diagnosis, previous issues with his indwelling catheter and decreasing urine output, something should have been done immediately and before he had no urine output.On 01/07/2026 at 11:57 A.M., V10 (Urologist) was unavailable for a phone call. V12 took down this surveyors' questions for V10. On 01/07/2026 at 12:08 P.M., V12 stated V10's opinion was when it was noticed R1 had no urine out put something should have been done at that point, not waiting additional hours. On 01/08/2026 at 10:18 A.M. V1 (Administrator) stated it is her expectation for staff to follow the change in condition policy.The facility policy titled Change in a Resident's Condition or Status with a revision date of October 2010, documented Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical /mental condition and or status.The facility policy titled Catheter Care, Urinary with a revision date of September 2014, under Input/Output documents 1. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor. Under Complications documents I. Observe the resident for complications associated with urinary catheters. e. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146146 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Foxes Sr Living & Rehab | 609 South Marshall<br>McLeansboro, IL 62859 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide appropriate treatment and services to prevent urinary tract infections (UTI) for 1 (R1) of 3 residents reviewed for indwelling catheters in the sample of 4. This failure resulted in R1 being sent to a local hospital emergency department, flown to an out of state hospital and admitted with diagnoses including Sepsis and Complicated UTI.Findings Include:R1's admission Record documented that R1 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Unspecified Dementia, aortic valve stenosis, dysphagia, retention of urine, benign prostatic hyperplasia with lower urinary tract symptoms, cognitive communication deficit, and pain.R1's MDS (Minimum Data Set) quarterly assessment with an Assessment Reference Date of December 12, 2025, documented a Brief Interview for Mental Status (BIMS) score of 06 indicating R1 had severe cognitive impairment. R1's Care Plan with an initiation date of 09/12/2025 has a Focus Area of I have an indwelling catheter due to diagnosis of urinary retention, and benign prostatic hyperplasia with lower urinary tract symptoms. Interventions listed include monitor and document intake and output as per facility policy, monitor/record/report to medical doctor signs and symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns.R1's Order Summary Report with a print date of 01/07/2026 documented that R1 had the following orders: Urinary catheter, irrigate with 30 milliliters of normal saline for blockage as needed with an order date of 9/12/25, urinary output every shift related to retention of urine dated 9/12/25, and urinary catheter 18 fr (French) coude with 10 cc (cubic centimeter) balloon, change every 30 days on night shift with an order date of 09/12/2025.R1's Treatment Administration Record with a date range of 12/01/2025 - 12/31/2025 documented that R1 did not have an indwelling catheter change during that time frame. The same TAR documents that R1's urinary catheter was irrigated with 30 cc of Normal Saline on 12/26/25 and documents R1's daily urinary output as:12/19/2025 -1150 milliliters,12/20/2025 - 1150 milliliters,12/21/2025 - 900 milliliters12/22/2025 - 925 milliliters12/23/2025 - 650 milliliters12/24/2025 - 700 milliliters12/25/2025 - 200 milliliters12/26/2025 - No urine output documentedR1's Progress Note dated 12/08/2025 authored by V13 (Registered Nurse) documented the resident is experiencing a change in condition. The change in condition the resident is currently experiencing is Urine dark amber in color with white sediment in catheter tubing No distress noted. No c/o voiced. Afebrile. Fluids encouraged. Message to D.O.N. (Director of Nursing).R1's Progress Note dated 12/09/2025 authored by V13 documented Resting in bed. No distress noted. No complaints voiced. Urine a dark yellow at this time, improved in color.R1's Progress Note dated 12/16/2025 authored by V6 (Licensed Practical Nurse) documented return from doctor visit. Catheter wasn't changed. New order to change monthly.R1's Progress Note dated 12/19/2025 authored by V2 (Director of Nursing) documented new order received today from V10 (Urologist) to change catheter order to an 18Fr. coude with 10cc balloon change monthly. May change when catheter supplies are received. A January 7th appointment was made in case catheter needs changed in office.R1's Progress Note dated 12/25/2025 at 7:26 A.M. authored by V9 (Licensed Practical Nurse) documented when CNA went to get R1 out of bed for breakfast, dried emesis of undigested food in bed and R1 was incontinent of a large bowel movement. Taken to shower and laid down. Afebrile. R1 clinches teeth when staff tried to assist with feeding or when medications are attempted. Negative for COVID.R1's Progress Note dated 12/25/2025 at 1:00 P.M. authored by V9 documented R1 was up for lunch in wheelchair. Staff attempted<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146146 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Foxes Sr Living & Rehab | 609 South Marshall<br>McLeansboro, IL 62859 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | to feed and resident clinches teeth together.R1's Progress Note dated 12/26/2025 at 11:00 A.M. authored by V5 (Licensed Practical Nurse) documented call placed to V8 (Medical Doctor) office due to resident has had no urine output from indwelling catheter. Resident lethargic and lower abdomen is distended and rigid. New order from V8 to send R1 to local hospital emergency department for evaluation and treatment.R1's Emergency Department (ED) Provider Notes dated 12/26/25 from the local hospital documents R1 presents to ED with c/o (complaints of) lethargy and urinary retention with current foley catheter. On arrival patient is responsive to painful stimuli and groans when moved. R1's bladder distended with no drainage in bag. Bladder scan shows >1570ml. 18 fr coude removed and replaced with 18 fr straight tip foley cath (catheter) placed. When foley bulb was deflated, brown urine started flowing out around the catheter. R1 had 1850ml out of bladder, very malodorous, nearly brown in color with large amount of sediment present. R1's abdomen no longer distended. R1's ED Progress Notes document a clinical impression of hypotensive episode, hydronephrosis with ureteropelvic junction obstruction, sepsis with acute renal failure and septic shock, and unspecified acute renal failure type and documents that R1 was accepted at an out of state hospital. Photos of R1's urine in the hospital records dated 12/26/25 shows three graduated cylinders with dark brown, cloudy urine with large amounts of sediment visibleR1's out of state hospital records document that R1 was admitted on [DATE] and discharged on 12/31/25 with admitting and discharge diagnoses including Sepsis, complicated UTI, chronic indwelling catheter, and AKI (Acute Kidney Injury) on CKDIIIB (Chronic Kidney Disease Stage 3B). The hospital records further document that R1 was seen in the ICU (Intensive Care Unit) and R1's family elected comfort care and was discharged to a hospice facility.On 01/02/2026 at 1:35P.M. V2 (Director of Nursing / Registered Nurse) stated she was the nurse for R1 the night before he was sent to the hospital. V2 stated she came in on 12/25/2025 at 7:00 P.M .and worked until 06:00 A.M. on 12/26/2025. V2 stated R1 was in bed when she came on shift. V2 stated she had received in report that R1 had been sick all day and had not eaten or drank anything. V2 stated R1 had vomited earlier that day and the wife felt like it was because R1 had eaten too much when he was out with family on 12/24/2025. V2 stated she had not notified the physician because she thought he was sick from overeating the day before. V2 stated she had been told in report that day shift had flushed / irrigated R1's indwelling catheter without any issue so she did not attempt to. V2 stated she let the day shift nurse that came on 12/26/2025 know R1 had not had any urine out put all night and keep an eye on him.On 01/02/2026 at 3:09 P.M., V5 (Licensed Practical Nurse) stated she was the nurse for R1 on 12/26/2025 for about 30 minutes. V5 stated she took report from V7 (Licensed Practical Nurse) around 10:00 A.M. V5 stated when she got report she went in an assessed R1 and sent him to the hospital. On 01/07/2026 at 9:58 A.M. V5 (Licensed Practical Nurse) stated on 12/25/2025 she assumed care of R1 around 10:00 A.M. V5 stated V7 let her know in report that R1 had not taken his medications, had no urine output, and had not eaten. V5 stated she went in and assessed R1. V5 stated she attempted to flush / irrigate R1's indwelling catheter but had no success. V5 stated she then notified the physician, and R1 was sent to the local hospital. V5 stated R1 was lethargic, had a distended abdomen and had not taken his medication that helped keep his blood pressure up. V5 stated R1's baseline was alert and oriented at times.On 01/02/2026 at 3:15 P.M., V7 (Licensed Practical Nurse) stated she was here to pass the medications on 12/26/2025 from 0600-1000 A.M. V7 sated it was reported that R1 had been sick, had emesis and loose stools. V7 stated that R1 did not eat or drink that morning. V7 stated she obtained vital signs and must not have charted them. V7 stated she did not notify the physician of R1's condition. V7 stated she does not remember being told that R1 had no urine output. V7 stated she provided no care for the foley catheter on 12/26/2025. On 01/02/2026 at 10:34 A.M., V3 (Registered<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146146 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Foxes Sr Living & Rehab | 609 South Marshall<br>McLeansboro, IL 62859 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Nurse at local hospital) stated she was the nurse working the day R1 came into the emergency department. V3 stated she was told the facility had tried to irrigate R1's catheter because he was not having any output. V3 stated R1 was hypotensive upon arriving to the emergency department with blood pressures averaging 80's over 40's. V3 stated that R1's indwelling catheter balloon was deflated and dark foul urine started to immediately pour out around the catheter. V3 stated she had done a bladder scan on R1, and the outcome was R1 had greater than 1500 Milliliters (ML) of urine in the bladder. V3 stated she took R1's indwelling catheter out and replaced it. V3 stated there was greater than 1800 ml of urine with a lot of sediment in it. V3 stated R1's urine was very brown in appearance and had a foul odor. V3 stated that R1 was septic and had to be placed on intravenous vasopressors for his blood pressure. V3 stated R1 was flown via helicopter to an out of state hospital. V3 stated when she spoke to R1's wife, she was told that on 12/24/2025, R1 went home for Christmas dinner. R1 must have eaten too much because he ended up vomiting. V3 stated that on 12/25/2025 when the wife came to visit, R1 was not acting like himself. On 01/07/2026 at 10:49 A.M., V9 (Licensed Practical Nurse) stated she was the nurse caring for R1 on 12/25/2025. V9 stated she was made aware early that morning that R1 had vomited. V9 stated they got R1 up, gave him a shower and laid him back in bed. V9 stated she notified R1's wife and was told that he had overeaten while out of the facility on 12/24/2025 and she was not surprised that he threw up. V9 stated R1 was out of bed for lunch but did not eat. V9 stated R1 took his medications with water but refused eating and drinking. V9 stated his vitals were with in normal range for her and she was not concerned about R1 at that time. V9 stated there was a small amount of urine in R1's catheter bag and the urine in the drainage tube was amber in color. V9 stated there were times that R1's urine would get darker, and the staff would encourage fluids. V9 stated her shift ended around 4:00 P.M. and R1 had a low-grade temperature of 99.5. V9 stated at that time R1 was given Tylenol. V9 stated she did a COVID test on R1 when he vomited, and it was negative. V9 stated besides vomiting and having loose stools there was nothing that she was concerned about and contributed the vomiting to R1 overeating while out with family.On 01/07/2026 at 10:10 A.M., V8 (Medical Doctor) stated he reviewed the medical records for R1 and doesn't see anything bad, the staff called after he went greater than 8 hours without urine output. V8 stated 8 hours is a reasonable amount of time for R1 to go without urine output before the physician was notified. V8 stated R1's catheter was flushed with no issues or return output. V8 stated he felt like there was an issue with the catheter and that is why R1 was sent to the emergency department. V8 stated he feels that the catheter had to have some type of obstruction causing the urine to not flow. V8 stated R1 had been declining for a period of time before this happened. V8 stated R1 had been having issues with the indwelling catheter and had been following with the urologist in the weeks prior. V8 stated R1 is on hospice now and he honestly was not surprised. V8 stated with 100 out on the prior two shifts and vital signs stable the entire day waiting until there was no urine output was acceptable. V8 was shown the pictures of R1's urine from the hospital records and stated that looks infected. V8 stated looking over the facts, R1 could have been sent out and hour or two earlier but it would not have changed the fact that R1 was declining in health. On 01/08/2026 at 2:26 P.M., V1 (Administrator) stated she expects the nursing staff to provide the proper care required for all residents and to document the care that was provided. V1 stated it is also her expectation for the nurses to follow the physician orders.On 01/07/2026 at 11:57 A.M. V12 (Urology Nurse) stated with R1's diagnosis, previous issues with his indwelling catheter and decreasing urine output, something should have been done immediately and before he had no urine output. V12 stated R1 had to feel miserable with that much urine in his bladder. V12 stated they nurse should have attempted something at the point they knew there<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146146 | A. Building<br>B. Wing | 01/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Silver Foxes Sr Living & Rehab | 609 South Marshall<br>McLeansboro, IL 62859 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0690<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | was no urine and not wait another 4 hours.On 01/07/2026 at 11:57 A.M., V10 (Urologist) was unavailable for a phone call. V12 took down this surveyors' questions for V10. On 01/07/2026 at 12:08 P.M., V12 stated in V10's professional opinion was when it was noticed R1 had no urine out put something should have been done at that point, not waiting additional hours. With R1's diagnosis, decrease in urine output, having an indwelling catheter, the facility should have attempted to change the catheter or flush it at the time there was no urine output observed. V12 stated that V10 said with the decrease in urine out put it should have been flushed or changed before there was no urine output.The facility policy titled Output, Measuring and Recording with a revision date of October 2010 documented Purpose: the purpose of this procedure is to accurately determine the amount of urine that a resident excretes in a 24-hour period. The policy goes on to document Reporting: 3. Report to the primary care physician abnormal output within 24 hours.The facility policy titled Catheter Care, Urinary with a revision date of September 2014, under Input/Output documents 1. Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor. Under Complications documents I. Observe the resident for complications associated with urinary catheters. e. Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. |