| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155132 | A. Building<br>B. Wing | 05/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Danville Regional Rehabilitation | 255 Meadow Dr<br>Danville, IN 46122 |

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 - Minimal harm or potential for 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** 37981<br><br>Based on observation, interview, and record review, the facility failed to ensure a urinary catheter bag and catheter tubing did not touch the floor resulting in a urinary tract infection (UTI) for 1 of 2 residents observed for catheter acquired urinary tract infection (cauti) (Resident 81), and failed to ensure residents had diagnoses to support the insertion of urinary Foley catheters for 2 of 2 residents reviewed for urinary catheters (Resident 81 and 155).<br><br>Findings include:<br><br>1. On 4/30/24 at 12:15 p.m., Resident 81's urinary Foley bag and catheter tubing were observed on the floor.<br><br>On 5/1/24 at 12:15 p.m., Resident 81's records were reviewed.<br><br>A care plan, dated 4/17/24, indicated Resident 81 required an indwelling urinary catheter related to urinary retention. The goal indicated she would have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection. A nursing approach was to not allow tubing or any part of the drainage system to touch the floor.<br><br>An Infection Control Surveillance document, dated 4/29/24, indicated Resident 81 had a urinary catheter related infection and was on antibiotic therapy until 5/8/24. Her symptoms onset was 4/29/24 with acute change in mental status and suprapubic pain or costovertebral angle pain or tenderness. She was placed on enhanced barrier precautions.<br><br>On 5/2/24 at 10:52 a.m., her record indicated she was scheduled to be given Macrobid (antibiotic) 100 mg every 12 hours for 7 days for a UTI from 5/1/24 to 5/8/24.<br><br>A progress note, dated 4/17/24 at 5:07 p.m., indicated Resident 81 complained of back pain often. Her PVR (post-void residual) was obtained and she was retaining approximately 226 milliliters (mL) of urine. The Nurse Practitioner (NP) was notified and a new order to anchor a foley was received. Resident 81 tolerated it well.<br><br>During an interview, on 4/30/24 at 10:24 a.m., the Moving Forward Unit Manager (MFUM) 5 indicated Resident 81 had a foley catheter due to urinary retention.<br><br>(continued on next page) |



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

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 81's record lacked documentation of a diagnosis of urinary retention.<br><br>2. During an interview, on 4/30/24 at 12:30 p.m., Resident 155's wife indicated he got a new Foley catheter that morning because his abdomen was distended. She indicated the nurse had to clamp it because there was so much urine. The nurse had to empty the catheter bag three times.<br><br>On 5/1/24 at 10:51 a.m., Resident 155 record was reviewed. He was admitted on [DATE]. He had an admission diagnosis of retention of urine.<br><br>A progress note, on 4/30/24 at 1:09 p.m., indicated a PVR was completed as ordered. Resident 155 was retaining approximately 800 mL of urine in his bladder. The NP was notified and a new order to I/O (in and out) catheter every 8 hours as needed (PRN) for abdominal distention and pain due to high PVR. The I/O drained 1400 mL in increments due to his hypotension. The NP was notified of the amount of urine drained and a new order to place a Foley catheter was received.<br><br>A physician's order, dated 4/30/24, indicated to anchor a Foley catheter.<br><br>A care plan, dated 5/1/24, indicated Resident 155 required an indwelling urinary catheter related to urinary retention.<br><br>A care plan, dated 4/26/24, indicated Resident 155 was at risk for pain related to PVD.<br><br>Resident 155's record lacked documentation of a diagnosis of urinary retention.<br><br>A policy, titled, Bowel and Bladder Program, dated 5/2019, was provided by the Regional Nurse Consultant, on 5/3/24 at 12:11 p.m. A review of the policy indicated, .Indwelling Urinary Catheters - Suprapubic or Urethral .Assessment will include reason for indwelling Urinary Catheter<br><br>3.1-41(a)(1)<br><br>3.1-41(a)(2) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>37981<br><br>Based on observation, interview, and record review, the facility failed to ensure 1 of 4 treatment carts remained locked and medication remained inaccessible to residents and visitors (Residents 345, 11, 79, and 63).<br><br>Findings include:<br><br>One 4/30/24 at 9:48 a.m., the Rosewood treatment cart was observed unlocked. Several staff were observed to pass the treatment cart. Prescription medication found inside the treatment cart included:<br><br>a. Resident 345 had SSD cream 1%.<br><br>b. Resident 11 had thera-gel 0.5% shampoo.<br><br>c. Resident 79 had diclofenac sodium 1% gel, one container in drawer one and one container in drawer two.<br><br>d. Resident 63 had diclofenac sodium 1% gel.<br><br>During an interview, on 4/30/24 at 10:03 a.m., Licensed Practical Nurse (LPN) 5 indicated the treatment cart should not be unlocked. She was observed locking it.<br><br>During an interview, on 5/1/24 at 10:21 a.m., the Moving Forward Unit Manager (MFUM) 5 indicated all treatment carts should have been locked because it was a violation of resident's privacy because a resident or visitor could have been curious and looked at or taken medications from the treatment cart.<br><br>On 5/1/24 at 2:58 p.m., the Director of Nursing (DON) indicated Resident 76 and Resident 108 were residents who wandered the building with severe cognitive abilities.<br><br>A policy, titled, Storage and Expiration Dating of Medications, Biologicals, dated 7/21/22, was provided by the Regional Nurse Consultant, on 5/3/24 at 12:15 p.m. A review of the policy indicated, .Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas<br><br>3.1-25(m) |