STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155687	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brickyard Healthcare - Muncie Care Center	2701 Lyn-Mar Dr Muncie, IN 47304

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 Level of Harm - Minimal harm or potential for actual harm 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. 42685 Based on observation, interview, and record review, the facility failed to provide consistent interventions to maintain urinary drainage devices for 2 of 3 residents reviewed for urinary catheters. (Residents B and C). Findings include: 1. Resident B's clinical record was reviewed on 7/9/24 at 3:04 p.m. Diagnoses included, paraplegia, obstructive and reflux uropathy, malignant neoplasm of the bladder, and Methicillin-resistant Staphylococcus aureus (MRSA - bacteria resistant to treatment) infection. A current physician order, dated 7/3/24, included Bactrim (antibiotic) Double Strength (DS) - give 1 tablet by mouth twice daily related to a MRSA infection for 10 days. A current physician order, dated 3/9/23, included monitor urostomy site for signs/symptoms of infection every shift for urostomy monitoring. A current physician order, dated 3/9/23, included record urostomy output every shift for output monitoring. A current physician order, dated 3/9/23, included observe for signs/symptoms of urinary tract infection such as leaking or abdominal cramps every shift and notify the physician. A current physician order, dated 4/8/24, included gown and gloves for all interactions with the resident every shift. A quarterly Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was cognitively intact. He was dependent on staff assistance for toileting and transfers and used a wheelchair for mobility. He required a urostomy and had frequent bowel incontinence. A current care plan, dated 3/9/23, indicated the resident had a urostomy related to obstructive uropathy. Interventions included the following: observe for complications and the document findings if noted (3/9/23), monitor output from the urostomy (5/19/23), and document output as per facility policy (1/24/23). (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the residents Treatment Administration Record, from 6/1/24 to 6/11/24, indicated the resident lacked urostomy output monitoring on the following dates and shifts: a. 6/2/24 - second shift b. 6/14/24 - second shift c. 6/19/24 - second shift d. 6/28/24 - second shift e. 7/2/24 - third shift f. 7/3/24 - third shift The resident failed to have his urostomy urinary drainage bag emptied until it was completely full on the following dates, shifts, and output amounts: a. 6/7/24 - third shift - 2000 milliliters (ml) b. 6/16/24 - third shift - 2000 ml c. 6/21/24 - second shift - 2000 ml d. 7/2/24 - first shift - 2600 ml e. 7/10/24 - first shift - 3050 ml During an observation on 7/10/24 at 10:00 a.m., LPN 8 delivered medication to Resident B's roommate. Resident B's urinary drainage bag was hung on the right side of his bed and excessively expanded, much like a balloon, and the tubing was full of clear yellow urine. LPN 8 exited the resident's room. The resident's catheter was not emptied at this time. During an observation on 7/10/24 at 11:32 a.m., LPN 8 used a graduated measuring container to empty the resident's over-full and expanded urinary drainage bag. The nurse had to make three separate trips with the graduated measuring container to empty the urinary drainage bag entirely. During an interview on 7/10/24 at 11:35 a.m., LPN 8 indicated the aides were not supposed to allow the urinary drainage bags get full and were responsible for emptying the urinary drainage bags every shift. She indicated a total of 3050 milliliters (ml) was in the resident's urinary collection bag when she emptied it during the observation. She thought the resident's urinary drainage bag was severely over-full and she was afraid it might burst when she touched it to empty it. During an interview on 7/10/24 at 3:57 p.m., Resident B indicated, approximately two or three times a week, staff had failed to empty his urinary drainage bag for an entire shift in the last month. He was dependent on staff to empty his urinary collection bag as he was unable to do it himself. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an interview on 7/09/24 at 11:33 a.m., Resident C was in his bed with his urinary drainage bag hung on the resident's left side of the bed frame. The urinary drainage bag contained 900 ml of clear yellow urine. Wet, yellow residue was observed on the floor tiles below the urinary drainage bag the span of 1.5 large tiles in length and 1 large floor tile in width, towards the center of the bed. The yellow residue was wet underneath the urinary drainage bag and dried as it went towards the center of the bed. Resident C indicated the facility staff had been letting the urinary drainage bag get very full before they emptied it. He knew it was very full because they had to use two of the graduated measuring containers to get it emptied. Resident C's clinical record was reviewed on 7/9/24 at 3:14 p.m. Diagnoses included obstructive and reflux uropathy and urine retention. A current physician's order, dated 4/28/24, included monitoring of the suprapubic urinary catheter site for sign or symptoms of infections and document output every shift. A current physician order, dated 4/29/24, included gown and gloves for all interactions with the resident every shift for enhanced precautions. A quarterly MDS assessment, dated 5/3/24, indicated the resident was cognitively intact. The resident was dependent on staff assistance for toileting, lower body dressing, bathing, and transfers. He had an indwelling catheter and was always incontinent of bowel. A current care plan, dated 10/31/22, indicated the resident had a suprapubic urinary catheter. Interventions included the following: change catheter bag as ordered/needed (9/14/22), check catheter tubing for proper drainage and positioning (9/14/22), catheter care every shift and as needed (11/1/22), and observe for signs/symptoms of leaking, burning with urination, increased frequency of urination, cloudy urine, flank pain, fever or abdominal cramps every shift (5/20/23). Review of the resident's Treatment Administration Record from 6/1/24 to 6/11/24 indicated the resident lacked suprapubic catheter output monitoring on the following dates and shifts: a. 6/2/24 - first and second shift b. 6/8/24 - first shift c. 6/14/24 - second shift d. 6/19/24 - second shift e. 6/28/24 - second and third shift f. 7/2/24 - third shift g. 7/3/24- third shift h. 7/10/24 - first shift (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/10/24 at 11:23 a.m., LPN 8 indicated Resident C's urinary drainage bag must have had a hole in it because it had leaked on the floor. During an interview on 7/11/24 at 12:20 p.m., Resident C was in his bed with the urinary catheter hung on the left side of the bed frame. He indicated he had some trouble with night shift emptying his urinary drainage bag for his suprapubic catheter. He was uncertain how long this had been a problem, but he knew they had not emptied it on 7/9/24 and 7/10/24 for night shift because he started writing it down this week. He had requested night shift not to wake him from midnight until 6:00 a.m. unless he pressed his call light, but not the whole shift. During an interview on 7/12/24 at 10:37 a.m., CNA 9 indicated she was familiar with the residents' care and never had any problems with Residents B or C refusing to have their urinary drainage bags emptied. Aides were required to empty the urinary collection bags every shift and report the output and any concerns to the nurse for output documentation in the resident's clinical record. The urinary drainage bags were full when the bag contained 2000 ml. During an interview on 7/12/24 at 12:10 p.m., the DON indicated the urinary drainage bags should have been emptied, at minimum, every shift. A urinary drainage bag should not be entirely full where the urine is backing up the drainage tube. CNAs typically emptied the urinary drainage bags, but all nursing staff were responsible to recognize if a urinary drainage bag was leaking. This information must be reported to the nurse immediately. A current facility policy, undated, titled Catheter Care, provided by the DON on 7/12/24 at 2:15 p.m., indicated the following: .Policy: It is the policy of this facility to ensure that resident with indwelling catheters receive appropriate catheter care . when indwelling catheters are in use. Policy Explanation: Empty drainage bags when bag is half-full or every 3 to 6 hours . 24. Document care and report any concerns noted to the nurse on duty This citation relates to complaint IN00436684. 3.1-41(a)(2)