STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Trace of Fishers	11851 Cumberland Rd Fishers, IN 46037

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. Based on interview and record review, the facility failed to ensure a resident with a urinary catheter was provided with catheter care, monitoring, and documenting of urine outputs for 1 of 3 residents reviewed for catheters. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/30/24 at 2:00 p.m. The diagnoses for Resident B included, but were not limited to, central cord syndrome (spinal cord injury causing weakness without being paralyzed.) and neuromuscular dysfunction of bladder (loss of bladder control). A physician's order, dated 12/20/25, indicated the staff were to bladder scan Resident B for urine retention every shift. If the resident's urine totals in the bladder were greater than 200 milliliters the medical provider was to be contacted. A physician's order, dated 12/29/25, indicated the staff was to remove Resident B's urinary catheter. The January 2026 Medication/Treatment Record (MAR/TAR) indicated on 12/20/25 in the evening shift, the resident's urine residual in his bladder was 855 milliliters. A physician's note, dated 12/20/25, indicated the nursing staff reported that day (12/20/25) Resident B was having urinary retention of 855 milliliters with abdomen firmness. The plan of treatment was to anchor a indwelling catheter and monitor the resident's urine output. The catheter was to be clamped if the resident's urine output was greater than 600 milliliters. Do not remove the indwelling catheter until the resident had been seen by the physician. A nursing note, dated 12/21/25, indicated an order had been given by the on-call provider to anchor the resident's indwelling catheter. The staff were to monitor the resident's urine output and clamp the catheter; if the output was greater than 600 milliliters. The indwelling catheter had been anchored, and Resident B reported he was doing a lot better. The indwelling catheter was not to be removed until the resident was seen by the physician. Resident B's clinical record did not include a physician's order as described in the physician's note, for the resident to have a indwelling catheter, treatment orders for the care of a catheter, or monitoring of urine output. An interview was conducted with the Director of Nursing (DON) on 1/30/26 at 2:16 p.m. He indicated he was unable to locate a physician's order for a indwelling catheter for Resident B. The on-call physician gave the order to the staff during the phone call. The staff was to anchor the indwelling catheter on 12/20/25. The staff did not record urine output amounts unless ordered by the physician to do so. The DON was unaware of the physician's 12/20/25 note indicating the staff were to monitor the resident's urine out. Catheter Care should be provided and documented every shift for residents that have an indwelling catheter. This citation is related to Intake 2711740. 3.1-41(a)(2)

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