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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335684	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Nursing and Rehab at Goshen	46 Harriman Drive Goshen, NY 10924

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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49372

Based on record review and interviews during an abbreviated survey (NY00362632) the facility did not ensure that a resident who entered the facility with an indwelling catheter was assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrated that catheterization was necessary for 2(Resident #1,#2) out of 3 residents reviewed for indwelling catheters. Specifically, (1) Resident #1 was admitted to the facility on [DATE] with a Foley catheter in place, and they were never assessed or trialed for the Foley catheter removal, as per the facility policy. (2) Resident #2 was admitted to the facility on [DATE] with a Foley catheter in place, and they were never assessed or trialed for the Foley catheter removal, as per the facility policy.

The findings are:

The facility Catheter Care, Urinary policy dated 2/1/2017 and last revised 11/1/2019 documented the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Catheter Evaluation included review and document the clinical indications for catheter use, nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place, use a standardized tool for documenting clinical indications for catheter use and remove the catheter as soon as it is no longer needed.

1)Resident #1 was admitted with diagnoses including but not limited to Sepsis, Malignant Neoplasm of the Prostate and Bacteremia.

A Comprehensive Minimum Data Set (a tool that measures health assessment) dated 10/24/2024 documented the resident had moderate cognitive impairment. The resident had impairment to the upper extremities on both sides and required a walker or a wheelchair for locomotion. The resident required moderate assistance with eating, maxima assistance with bed mobility and was dependent for toileting and transfers. The resident had an indwelling catheter and was always incontinent of bowel.

Review of a urinary incontinence care plan dated 10/23/2024 documented Resident #1 had a potential for urinary incontinence secondary to their foley catheter. Interventions listed included encourage oral fluids, encourage/support resident to use call bell to notify staff of need to void, monitor for signs and symptoms of urinary tract infection and monitor output as needed.

(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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Foley catheter care plan dated 10/23/2024 documented Resident #1 had altered elimination pattern related to the Foley catheter. The goal was the catheter would be patent and draining every shift. Interventions listed included attempt to remove catheter when appropriate, catheter care every shift, change Foley every 30 days and as needed, ensure urinary drainage bag is covered and monitor for and document signs and symptoms of urinary tract infection. There was no documented evidence of Resident #1's clinical indication for continued catheter use or any assessments by the interdisciplinary team documenting the ongoing need for the Foley catheter in place. There was no evidence of Resident #1 having a voiding trial to evaluate if their Foley catheter could be removed. 2) Resident #2 was admitted with diagnoses including but not limited to Malignant Neoplasm of Bladder, Hyperkalemia and Hypotension. A Comprehensive Minimum Data Set (an assessment tool that measures health status) dated 11/20/2024 documented the resident had moderate cognitive impairment. The resident was dependent for all cares. The resident had an indwelling catheter and was always incontinent of bowel. Review of a urinary incontinence care plan dated 11/14/2024 documented on 11/21/2024 Resident #2 had a Foley. Interventions listed included monitor output as indicated. There was no documented evidence of Resident #2's clinical indication for continued catheter use or any documentation or assessments by the interdisciplinary team regarding the ongoing need for the Foley catheter in place. There was no evidence of Resident #2 having a voiding trial to evaluate if their Foley catheter could be removed. During an interview on 12/5/2024 at 1:48 PM the Director of Nursing stated if a resident comes to the facility with a Foley catheter, and they do not have a Urology consult in place, the physician will review the chart and decide on whether to remove the foley catheter or not. During an interview on 12/6/2024 at 2:14 PM, the Attending Physician #1 stated Resident #1 presented with a history of prostate cancer, sepsis and urinary tract infection and they were on intravenous antibiotics. Attending Physician #1 stated if a resident is admitted to the facility with a catheter, then it is protocol to wait 2 or 3 days to determine if it can be removed. During an interview on 12/6/2024 at 5:00 PM Licensed Practical Nurse #2-unit 2 manager stated generally if a Foley catheter is not for long-term use, then the residents are usually started on Flomax and a voiding trial to try and remove the foley catheter. Licensed Practical Nurse #2-unit 2 manager stated depending on what is happening with the resident, the physician decides when the foley catheter is removed. During the void trials if the resident has not voided in 8 hours or has pain, or distention then the physician is informed, and the Foley catheter may be re-inserted. There was no documented evidence that a voiding trial was initiated for Resident #1. Resident #1 was discharged to the hospital on 11/14/2024 with foley catheter in place. 10NYCRR 415.12(d)(2)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 49372 Based on record review and interviews during an abbreviated survey (NY00362632) the facility did not ensure the physician reviewed the resident's total program of care, including treatments at each visit and a decision about the continued appropriateness of the resident's current medical regimen for 1 out of 3 residents (Resident #1, #2) reviewed for Foley catheter use. Specifically, (1) Resident #1 was admitted to the facility with a Foley catheter on 10/18/2024. Attending Physician #1 did not address Resident #1's Foley catheter when they completed their history and physical. The history and physical documented Resident #1 had stress incontinence and the catheter section documented not applicable. Resident #1 was discharged back to the hospital on 11/14/2024 with the foley catheter still in place. (2) Resident #2 was admitted to the facility with a Foley catheter on 11/16/2024. Attending Physician #1 did not address Resident #2's Foley catheter when they completed their history and physical. The history and physical documented Resident #2 had stress incontinence and the catheter section documented not applicable. Resident #2 still had a foley catheter in place during the onsite visit. The findings are: The facility Physician's Visit policy dated 2/1/2016 and last revised 1/2020 documented the attending physician must make visits in accordance with applicable state and federal regulations. The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation. 1)Resident #1 was admitted with diagnoses including but not limited to Sepsis, Malignant Neoplasm of the Prostate and Bacteremia. A Comprehensive Minimum Data Set (a tool that measures health assessment) dated 10/24/2024 documented the resident had moderate cognitive impairment. The resident had impairment to the upper extremities on both sides and required a walker or a wheelchair for locomotion. The resident required moderate assistance with eating, maximal assistance with bed mobility and was dependent for toileting and transfers. The resident had an indwelling catheter and was always incontinent of bowel. Review of Attending Physician #1's history and physical documentation dated 10/18/2024 revealed Resident #1's Foley catheter use was not documented or addressed for appropriateness of continued use. Resident #1 was documented to have stress incontinence and the catheter status stated not applicable. 2) Resident #2 admitted to the facility admitted to the facility 11/15/2024 with diagnoses including but not limited to Malignant Neoplasm of Bladder, Hyperkalemia and Hypotension. A Comprehensive Minimum Data Set (an assessment tool that measures health status) dated 11/20/2024 documented the resident had moderate cognitive impairment. The resident was dependent for all cares. The resident had a indwelling catheter and was always incontinent of bowel. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Attending Physician #1's history and physical documentation dated 11/16/2024 revealed Resident #2's Foley catheter use was not documented or addressed for appropriateness of continued use. Resident #2 was documented to have stress incontinence and the catheter status stated not applicable. During an interview on 12/5/2024 at 1:48 PM the Director of Nursing stated foley catheters orders for discontinuation are determined by the physician. When the physician comes they review the resident's chart, they complete the history and physical and they also complete monthly assessments including addressing the Foley catheter and document. During an interview on 12/6/2024 at 2:14 PM Attending Physician #1 stated they have been servicing the facility for about a year now. Attending Physician #1 stated the history and physical documentation dated 10/18/2024, regarding Resident #1 having stress incontinence and the catheter being not applicable was a documentation error reflected from the hospital documentation. The provider could not provide a reason why the residents were not offered a void and trial or a discontinuation of foley catheters. 10NYCRR 415.15(b)(2)(iii)