Printed: 02/11/2025
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 |
|---|---|---|---|
| | 365461 | A. Building<br>B. Wing | 11/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Muskingum Skilled Nursing & Rehabilitation | 501 Pinecrest Drive<br>Beverly, OH 45715 |

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<br>(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** 32801<br><br>Based on closed record review and interviews the facility failed to ensure residents received adequate indwelling catheter care, failed to ensure residents received adequate indwelling catheter education upon discharge, failed to ensure urine was obtained per orders, and failed to ensure bladder assessment was accurate on admission. This affected two (Resident #44 and Resident #45) of three reviewed for bladder impairments.<br><br>Findings included:<br><br>1. Closed record review revealed Resident #44 was admitted to the facility on [DATE] and discharged on [DATE]. The residents' diagnoses included metabolic encephalopathy, pneumonia, severe protein-calorie malnutrition, bladder neck obstruction, hydronephrosis, generalized anxiety, malignant neoplasm of prostate, and depression. He had a history of dysphagia, edema, and heart disease.<br><br>Review of Resident #44's discharge hospital notes dated [DATE] revealed a foley catheter was placed and would need a chronic foley catheter as he was a poor surgical candidate. The resident was alert and oriented. His diagnoses included hydronephrosis, acute retention of urine, bladder outlet obstruction, and malignant tumor of prostate.<br><br>Review of Resident #44's care plan initiated [DATE] revealed to provide catheter care every shift and as needed.<br><br>a. Review of Resident #44's admission assessment dated [DATE] revealed the resident was continent of bladder, had no complaints, and did not have a urinary foley catheter.<br><br>Review of Resident #44's five-day MDS dated [DATE] revealed the resident had cognition impairment. Resident #44 had an indwelling catheter and was frequently incontinent of bowel.<br><br>Interview on [DATE] at 9:46 A.M., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the admission assessment was inaccurate due to the resident had an indwelling foley catheter on admission.<br><br>b. Review of Resident #44's orders dated [DATE] revealed to collect a urine for culture and sensitivity due to his urine being tea colored and having an odor to start on [DATE].<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: 365461 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/04/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Muskingum Skilled Nursing & Rehabilitation | 501 Pinecrest Drive Beverly, OH 45715 |

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 | Review of Resident #44's laboratory results dated [DATE] to [DATE] revealed no evidence a urine was collected on [DATE].<br><br>Interview on [DATE] at 9:46 A.M., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the urine sample was no collected on [DATE] per orders.<br><br>c. Review of Resident #44's medical record (paper and electronic) revealed no evidence indwelling catheter care was performed from [DATE] to [DATE].<br><br>Review of Resident #44's orders dated ,d+[DATE] revealed on [DATE] to monitor urine for color, consistency and odor every shift, change catheter drainage bag weekly and as needed, and may irrigate with 30 milliliters of normal saline (NS) as needed for blockage, and on [DATE] an order was entered for catheter care every shift.<br><br>Interview on [DATE] at 9:46 A.M., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed there was no documented evidence that indwelling foley care had been provided to Resident #44 from [DATE] to [DATE]. The ADON confirmed the resident did not have orders until [DATE] to monitor urine for color, consistency and odor every shift, change catheter drainage bag weekly and as needed, and may irrigate with 30 milliliters of normal saline (NS) as needed for blockage and on [DATE] an order was entered for catheter care every shift. The ADON reported catheter care should be performed daily on each shift. The facility process was to enter orders into the electronic medical record and the nurses would sign off on the treatment administration record that the care was provided on each shift.<br><br>Interview on [DATE] at 10:52 A.M. with Resident #44's family confirmed Resident #44 had a revolting smell of yeast and was raw from the catheter.<br><br>d. Review of Resident #44's discharge initiated [DATE] and was still currently opened revealed to change the foley bag and tubing weekly and foley catheter care with soap and water daily.<br><br>Further review of Resident #44's medical record (paper and electronic) revealed no evidence the resident nor the family were provided education regarding how to change the foley bag and tubing or catheter care.<br><br>Interview on [DATE] at 10:52 A.M. with Resident #44's family confirmed Resident #44 they were not provided education on how to change the foley bag, tubing or provide catheter care.<br><br>Interview on [DATE] at 11:27 A.M., with the ADON confirmed she was unable to locate documented evidence that either resident or family were provided education on changing the foley bag, tubing, or catheter care per the discharge instructions. The ADON reported she had tried reaching out to the nurse that did the discharge but was unable to reach him at this time.<br><br>2. Closed record review revealed Resident #45 was admitted to the facility on [DATE] and requested to discharge home on [DATE]. The residents' diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms. The resident was admitted with an indwelling foley catheter.<br><br>a. Review of Resident #45 orders dated ,d+[DATE] revealed no evidence of orders for indwelling catheter care.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365461 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/04/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Muskingum Skilled Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 501 Pinecrest Drive Beverly, OH 45715 | |

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 | Review of the resident medical record (paper and electronic) revealed no evidence indwelling foley catheter care was performed during the resident stay from [DATE] to [DATE].<br><br>Interview on [DATE] at 9:46 A.M., with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed there was no documented evidence that indwelling foley care had been provided to Resident #45 from [DATE] to [DATE].<br><br>b. Review of Resident #45's discharge instruction initiated on [DATE] and closed on [DATE] revealed catheter care instructions were provided.<br><br>Further review of Resident #45's medical record (paper and electronic) revealed no evidence Resident #45, or the family was provided education on how to perform catheter care. There was no documented evidence of what education or instructions were provided.<br><br>Interview on [DATE] at 10:30 A.M., with Resident #45's wife revealed the resident had since expired. Resident #45's could not recall if they were provided education on how to perform foley care or what the care included.<br><br>Interview on [DATE] at 11:27 A.M., with the ADON confirmed she was unable to locate documented evidence what education or instructions were provided to the resident/family. The ADON reported she had tried reaching out to the nurse that did the discharge but was unable to reach him at this time.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00159212. |