STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415099	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Lake Rehabilitation and Care Center	999 South Main Street Pascoag, RI 02859

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 - Some	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** 21613 Based on record review and staff interview, it has been determined that the facility failed to provide appropriate treatment and services relative to Urinary Tract Infections (UTI) and/or Indwelling catheters (a flexible tube that collects urine from the bladder and leads to a drainage bag), for 3 of 3 residents reviewed, Resident ID #s 1, 2 and 4. Findings are as follows: Review of the facility's undated policy and procedure titled Urinary Incontinence and Indwelling catheter, states in part, .assessment should include the risks and benefits of an indwelling catheter .the potential for removal of the catheter .Documentation must support why the Foley catheter is necessary .With all indwelling catheter (temporary or permanent), the size and type of catheter must be written in the order . Review of the facility's undated policy titled UTI Protocol states, .Check resident for Constipation .Obtain CBC w/dif [Complete Blood Count with differential, a blood test that helps detect a range of disorders and conditions including infections] .Cranberry Tab 1 Tab [tablet] Daily x 7 days .V/S [Vital Signs] x 72 hours . According to Brunner & Suddarth's Textbook of Medical-Surgical Nursing Volume 2, 10th Edition, page 1282 states, For patients with indwelling catheters, the nurse assesses the drainage system to ensure that it provides adequate urinary drainage. The color, odor, and volume of urine are also monitored. An accurate record of fluid intake and urine output provides essential information about the adequacy of renal function and urinary drainage. 1. Review of a community reported complaint submitted to the Rhode Island Department of Health on 3/20/2024 alleges that Resident ID #1 was observed with blood in his/her catheter, and shortly after, s/he went sepsis [a life-threatening response to an infection that can cause organ failure and death]. Record review revealed Resident ID #1 was admitted to the facility in February of 2024 with diagnoses including, but not limited to, status post fall with compression fracture of the lumbar spine (lower back) and the thoracic spine (mid section of spine), Diabetes Mellitus, type 1 (Insulin dependent), and left leg amputation. (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 - Some	Further record review revealed the resident was also admitted with a Foley catheter. Record review of nursing progress notes revealed the following: -3/3/2024 at 6:30 AM: .had slight hematuria [blood in urine] . -3/3/2024 at 4:47 PM: .foul smelling hematuria . -3/4/2024 at 3:33 PM: The resident stated .I feel like I need to pee and can't .frank blood [blood in urine that can be seen with the naked eye] . Record review revealed a physician's order was obtained on 3/4/2024 to initiate the facility's UTI Protocol related to .urinary c/o [complaints] . Record review of a nursing progress note dated 3/7/2024 at 6:23 AM revealed the resident had .Hematuria . Record review failed to reveal evidence that the UTI protocol was implemented in its entirety regarding obtaining vital signs from 3/4-3/7/2024. Review of a nursing progress note dated 3/8/2024 at 4:02 AM indicates the resident was complaining of . Foley catheter discomfort .had light hematuria . Record review revealed a blood draw for a CBC (complete blood count) was completed on 3/8/2024 which revealed the resident's white blood cell count (WBC) was elevated and at 13.7 K/ul (thousand cells per cubic milliliter, high WBC can indicate an infection. A normal WBC range is 4.0-10.0 K/ul). Additional, record review revealed that on 3/8/2024 at 4:57 PM, the physician was notified of the resident's elevated WBC and a new order was provided for Ciprofloxacin (antibiotic) 500 milligrams (mg) once daily for 7 days. Record review revealed a progress note dated 3/8/2024 at 5:18 PM which states in part, .is having urinary pain from [his/her] foley .Foley cath [catheter] intact, drainage hematuria .Resident noted pulling at the tubing . Further review of the progress note revealed .Resident continued with leaning over in [his/her] wheelchair and at times, standing for urinary relief. Resident noted on the floor in front of his/her wheelchair . Record review lacked evidence that the antibiotic was ever administered to the resident in accordance with the physician's order. Further record review revealed that on 3/9/2024 at 6:19 AM, the resident was in his/her wheelchair at 5:30 AM, and at approximately 5:40 AM, the resident was found on the floor on the right side of his/her bed. The resident was noted to have a skin tear to his/her right hand, and was not answering or responding appropriately to questions. Staff called 911 and the resident was transferred to the hospital. Record review of a nursing progress note dated 3/10/2024 revealed the resident was admitted with a diagnosis of sepsis. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan failed to reveal evidence that a care plan was developed relative to the use of a Foley catheter. Further record review revealed the following: -there was no assessment completed relative to the Foley catheter as per the facility's policy -there is no order relative to the size and type of catheter as per the facility's policy upon admission, an order was not obtained until 3/4/2024 -there is no evidence that fluid intake was monitored between 2/24/2024 through 3/8/2024 -urinary output was documented only 4 times between 2/24/2024 through 3/3/2024 -there is no evidence that Foley catheter care was provided between 2/24/2024 through 3/3/2024 During a surveyor interview with the resident's primary care physician on 3/21/2024 at 2:20 PM, she revealed that when she orders the UTI protocol, her expectation is that staff would obtain vital signs every shift for 72 hours and encourage the resident to increase their fluid intake. The primary care physician further revealed that she would expect staff to follow a physician's order and administer the antibiotic as soon as possible and to notify her if the medication is unavailable as to ensure the resident receives the prescribed medication in a timely manner. During a surveyor interview with License Practical Nurse, Staff E, on 3/21/2024 at 2:30 PM, she revealed that Ciprofloxacin is available in the facility's emergency medication kit. Staff E further revealed when a medication is not available and not in the emergency medication kit, they can call the pharmacy for a stat delivery and usually get a delivery of the medication within a couple of hours. During a surveyor interview with the Acting Director of Nursing Services (DNS) on 3/22/2024 at approximately 1:00 PM, she acknowledged that there was not a care plan in place for the resident's Foley catheter. The Acting DNS further indicated that she would have expected the orders for the Foley catheter (size, flushing, changing bag, intake and out put as well as catheter care, etc) to be included in the care plan. Additionally, she revealed that her expectation is that physician orders for the UTI protocol to be implemented, would include a specific order to obtain vital signs every shift for 72 hours, despite this being part of the facility's UTI protocol. Furthermore, the Acting DNS acknowledged that the resident did not receive the prescribed antibiotic and was unable to explain why staff did not administer the medication as ordered when it was available in the facility's emergency medication kit. 2. Record review revealed Resident ID #2 was admitted to the facility in July of 2023 with diagnoses including, but not limited to, cancer, and recurrent urinary tract infections. Record review revealed the resident has a care plan dated 2/14/2024 for .has a UTI . with an intervention including but not limited to .Temp [check temperature] q [every] shift . Review of a nursing progress note dated 3/10/2024 revealed the resident continues to complain of a burning sensation with urination. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a nursing progress note dated 3/16/2024 revealed .Symptom of Urinary Tract Infection .still feeling burn on urination along with feeling pain inside . Further record review revealed new orders were obtained on 3/16/2024 including, but not limited to, Ciprofloxacin 500 mg once a day for 7 days. Record review failed to reveal evidence that his/her temperature was checked every shift as per the resident plan of care (31 out of 114 opportunities between 2/12/2024 through 3/22/2024). During a surveyor interview on 3/22/2024 at 11:16 AM, with the Acting DNS, she acknowledged that the resident's temperature was not checked every shift as per the plan of care. The Acting DNS was unable to provide evidence that the resident's V/S were obtained every shift for 72 hours, as per the facility's UTI Protocol. 3. Record review revealed Resident ID #4 was originally admitted to the facility in November of 2022 with diagnoses including, but not limited to, encephalopathy (damage or disease that affects the brain), and multiple fractures. Record review revealed the resident was transferred to the hospital and was readmitted to the facility on [DATE] with diagnoses of a UTI, sepsis and a Foley catheter. Record review of the physician orders failed to reveal evidence of an order for a Foley catheter until 1/21/2024, despite the Foley catheter being in place since 12/20/2023. Further review of this order revealed that the resident's Foley catheter output was to be measured three times a day. Record review failed to reveal evidence that the resident's urine output was measured three times daily between 2/1/2024 through 3/10/2024 and that an order was not put in place until 3/11/2024 for the foley catheter indicating the size and type of catheter. Further record failed to reveal evidence that a care plan was developed relative to the use and the care of the Foley catheter. During a surveyor interview with the Acting DNS on 3/14/2024 at approximately 3:00 PM, she acknowledged the above findings and was unable to provide an explanation as to why there was not a care plan in place for the Foley catheter.