| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455510 | A. Building<br>B. Wing | 05/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Castle Hills Rehabilitation and Care Center | 8020 Blanco Rd<br>San Antonio, TX 78216 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person- centered care of the residents that meets professional standards of quality of care within 48 hours of a resident's admission for one (Resident #1, of five residents reviewed for baseline care plans, in that:<br><br>The facility failed to implement Resident #1's baseline care plan and failed to include Resident #1's current urinary tract infection and antibiotic use in the baseline care plan resulting in Resident #1's hospitilization with a diagnosis of sepsis.<br><br>This deficient practice could place residents at risk of not having their individual care needs met in a timely manner or diminished quality of life, infection, and hospitalization.<br><br>An IJ was identified on 04/29/25. The IJ template was provided to the facility on [DATE] at 9:37 pm. While the IJ was removed on 05/02/25, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>Findings Included:<br><br>Review of Resident #1's face sheet reflected a [AGE] year old man who was admitted to the facility on [DATE] and discharged from the facility on 03/12/25 with diagnoses of Hemiplegia and hemiparesis (hemiplegia refers to complete paralysis on one side of the body, while hemiparesis refers to partial weakness on one side) following cerebral infarction (a condition where a blood clot or blockage in a blood vessel prevents oxygen and blood from reaching a part of the brain, causing brain tissue to die), and Wernicke's encephalopathy (a serious, acute neurological emergency cause by a deficiency of thiamine (vitamin B1) most often due to chronic alcohol use).<br><br>Review of Resident #1's care plan reflected a focus dated 03/10/25 of impaired communication due to: and intervention dated 03/10/25 of use simple and direct communication to promote understanding. Care plan focus dated 03/10/25 of alteration in elimination of bowel and bladder with a goal dated 03/10/25 of will be free from signs and symptoms of incontinence through next review date and interventions dated 03/10/25 of if catheter in place, secure per protocol, cath q shift per protocol, monitor for drainage, out, s/s of UTI: changes in color, odor, or consistency of urine, dysuria (painful or burning urination) frequency, fever, pain and provide assistance to toilet as needed.<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 |
|---|---|---|

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's MDS, dated [DATE], did not reflect he had an indwelling catheter.<br><br>Review of Resident #1's MDS BIMS dated 03/11/25 reflected a score of three suggesting severe cognitive impairment.<br><br>Review of Resident #1's rehabilitation hospital discharge records dated 03/20/25 reflected Resident #1 was discharged with a foley catheter (a thin flexible tube inserted into the bladder to drain urine) with instructions, The most important thing you want to do is prevent infection. Discharge records reflected cognitive status A&O X2 (a person is alert and aware of their person and place), other comments reflected, confused.<br><br>Review of Comprehensive Skilled assessment dated [DATE] signed by LVN B reflected wound care indwelling catheter (including suprapubic catheter (a medical device, a tube inserted into the bladder through a small incision in the lower abdomen, used to drain urine) and nephrostomy tube (a thin, flexible catheter inserted through the back into the kidney to drain urine when normal urine flow is blocked) and summary of head to toe assessment findings included a description of any progress toward goals or decline note reflected confusion noted.<br><br>Review of Resident #1's orders did not reflect physician orders for an indwelling catheter or the care and monitoring of an indwelling catheter.<br><br>Review of Resident #1's progress notes reflected 3 (three) notes referencing Resident #1 foley catheter<br><br>1.<br><br>Skin/wound progress note dated 03/11/25 foley catheter in place<br><br>2.<br><br>Skin/wound progress note dated 03/12/25 foley catheter<br><br>3.<br><br>Note physician history and physical dated 03/12/25 foley catheter in place<br><br>Review of Resident #1's EMR reflected no nurses' notes regarding skilled nurse assessments or urine output measurements for Resident #1's foley catheter.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/10/25 at 8:21 pm, late entry, reflected Resident #1 continued with antibiotics for UTI.<br><br>Review of Resident #1 Nurses Note (identity of nurse unknown) dated 03/10/25 at 8:49 pm, late entry, reflected confusion noted.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of admission & Baseline care plan/summary dated 03/10/25 signed by LVN B reflected GI/Bowel abdomen soft, non-tender, non-distended, urine normal color/consistency, catheter/nephrostomy tube indwelling catheter/suprapubic/nephrostomy, bowel and bladder care plan focus alteration of elimination of bowel and bladder, goal will be free from s/s of UTI or complications related to incontinence through next review dated, interventions call light within reach and remind to use call light as needed, intervention if catheter in place, secure per protocol, cath care q shift per protocol, monitor for drainage, output, s/s of infection and follow up with physician as needed, monitor and report s/s of UTI: changes in color, odor, or consistency of urine, dysuria, frequency, fever pain. Comments: Resident #1 continues with antibiotics for UTI, confusion noted.<br><br>Review of Resident #1's Comprehensive Skilled assessment dated [DATE] signed by LPN C reflected behavior problems verbal, other behaviors (socially inappropriate), rejects evaluation or cares, indwelling catheter, summary of Head-to-Toe<br><br>Assessment/Findings including a description of any progress toward goals or decline noted - confusion noted.<br><br>Review of Resident #1's Elopement Risk Assessment Tool dated 03/11/25, unsigned by staff, reflected Resident #1 had a diagnosis of Dementia, OBS (a condition characterized by cognitive impairment and behavioral changes caused by underlying brain damage), Alzheimer's, Intellectual/Developmental Disability, Hallucinations, Anxiety Disorder, Depression, Bipolar, and/or Schizophrenia, Resident #1 cognitively impaired with poor decision making skills (example disorientation, cognitive deficits, disorganized thinking).<br><br>Review of Resident #1's Trauma Abbreviated PCL-C dated 03/11/25 signed by LPN C reflected, unable to obtain answers from resident due to impaired cognition/communication and representative is unable to answer.<br><br>Review of Resident #1's Infection Surveillance Form dated 03/11/25, unsigned, reflected, confusion note.<br><br>Review of Resident #1's Skin/Wound Progress Noted note dated 03/11/25 by LVN A wound care nurse, reflected Resident, Pt. arrived at facility with . Foley Catheter in place ., MD, DON and RP at bedside.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 reflected, resident was alert and oriented X1. Resident was not able to voice needs. MD notified of admission, orders verified, admission assessment completed, call button within reach will continue to monitor, resident came into facility with peg tube.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 at 5:43 am reflected redirected resident multiple times this shift, observed attempting to get out of bed, re-educated resident to call light, assigned CNA instructed to monitor resident frequently throughout shift, every effort made in making resident as comfortable as possible, as needed Tylenol administered as ordered for nonverbal indicator of discomfort, will monitor through the remainder of this shift<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 reflected witnessed fall resident observed crawling out of bed onto floor by floor mat, he stated he wanted to stand up.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 late entry reflected resident had behaviors; resident had restlessness and anxiety noted<br><br>Review of Resident #1's Skilled Status Note 2 (identity of nurse unknown) dated 03/12/25 reflected confusion noted stable no new concerns.<br><br>Review of Resident #1's Skilled Status Note 2 (identity of nurse unknown) dated 03/12/25 reflected resident on antibiotic for UTI for 5 days, call light was in reach, staff continued to monitor resident.<br><br>Review of Resident #1's Skin and Wound Nurses Note (identity of nurse unknown) dated 03/12/25 reflected GU: urinary incontinence, foley catheter.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/12/25 at 1:40 pm reflected resident found on floor by physical therapy, resident confused and unable to express what happened, nurse conducted physical assessment, neurological checks, resident complained of generalized pain and was confused, but normal for baseline, continued to monitor.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/12/25 reflected DON and CNA made nurse aware that resident was on the floor, resident was complaining of pain to left wrist 3/10 (0 = no pain, and 10 = worst imaginable pain). Nurse assessed resident, resident was able to move right upper extremity, x-ray ordered to the left hand, pain medication given and was not effective, nurse monitored and updated provider with any changes.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/12/25 reflected resident was sent out to hospital for pain to left wrist, resident showing signs of restlessness and anxiety, medications were in place, resident was a fall risk, resident continued with antibiotics for UTI, no new concerns.<br><br>Review of IDT Event Review progress note dated 03/12/25 witnessed fall from bed, no injuries noted, root cause analysis for event new admission, anxiety, impulsivity, diagnosis of UTI, dementia, difficulty expressing self, hepatic encephalopathy (a neuropsychiatric syndrome caused by impaired brain function due to liver disease, specifically when the liver fails to remove toxins from the blood), CVA (Cerebrovascular Accident), call light in reach, psych evaluation and treatment anxiety and restlessness.<br><br>Review of Resident #1's Pain assessment - Post Incident dated 03/12/25 signed by LVN B reflected pain behavior - resistiveness to cares, restlessness, repetitive verbalizations or movements, verbal expression of distress/crying, sad, pained, worried facial expressions. Resident's current level of pain on a numeric scale of 1-10 (0 = no pain, and 10 = worst imaginable pain) 3.<br><br>Review of Resident #1's Anxiolytic (medications, also called anti-anxiety agents, used to treat or prevent anxiety) Medication Informed Consent dated 03/12/25 signed by LVN B reflected anxiolytic medication & indication for use Xanax (treats anxiety) anxiety, potential contributing factors previously addressed - pain and infection or other change in condition, target behavior symptoms Resident #1 was showing [NAME] of anxiety and restlessness and came moving to the edge of bed and rolling off the bed.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Change of Condition Evaluation dated 03/12/25 signed by LVN B reflected, the change in condition, symptoms, or signs LVN B was calling about is/are: Falls, pain (uncontrolled), Behavioral symptoms (e.g. agitation, psychosis) started on: 03/12/25<br><br>Change of Condition Evaluation dated 03/12/25 signed by LVN B reflected:<br><br>Since the change in condition occurred have the symptoms or signs gotten worse - medication given was not effective<br><br>This condition, symptom or sign had occurred before: No.<br><br>Other relevant information: Resident has had a past history of left wrist pain with no fractures noted.<br><br>Summarize your observations, evaluation, and recommendations: Left wrist with pain noted. Pain scale is 5/10 (0 = no pain, and 10 = worst imaginable pain). No swelling. X-ray administered. Resident sent to the hospital per family request.<br><br>Describe mental status of changes (compared to baseline; check all that you observe: increased confusion (e.g. disorientation), abrupt significant change in cognitive function form usual, with or without altered level of consciousness.<br><br>Functional status evaluation: describe functions status changes - fall.<br><br>Recommendation of primary clinician - send to the hospital, testing x-ray, interventions - new or change in medications<br><br>Behavioral status evaluation - describe behavioral changes: resident is having signs and symptoms of anxiety and restlessness and symptoms or signs of pain.<br><br>Is an abdominal/GI assessment relevant to the change in condition being reported - not clinically applicable to the change in condition being reported (distended abdomen box not checked)<br><br>Genitourinary (refers to the urinary and genital organs, also known as the urogenital system. It encompasses both the reproductive organs and the urinary tract) Status Evaluation: not clinically applicable to the change in condition being reported.<br><br>Pain Status Evaluation - is pain assessment relevant to the change in condition been reported: yes<br><br>Does the resident/patient have pain: yes<br><br>Is the resident/patient cognitively able to rate their pain scale: - No<br><br>Negative vocalization: troubled - repeated trouble calling out, loud moaning or groaning, crying, facial expression - sad/frightened/frown<br><br>Body language: tense, distressed pacing, fidgeting,<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Consolability: distracted or reassured by voice or touch<br><br>Is the pain: acute<br><br>Pain location: not applicable/not assessed<br><br>Specify exact location of pain: left hand (palm) complaining of left hand with pain scale of 5/10 (0 = no pain, and 10 = worst imaginable pain) Tylenol given<br><br>X-ray results: -no fracture noted.<br><br>Review of Resident #1's Comprehensive Skilled assessment dated [DATE] signed by LVN B reflected evidenced of an acute change in mental status from the resident's baseline behavioral problems of verbal behavior (screaming, cursing, etc.), other behaviors (social inappropriate), and rejects evaluation or cares, indwelling catheter, [Resident #1] was sent out to [hospital] for pain to left wrist, falls . Resident showing signs of restlessness and anxiety. Medications are in place. Resident is a fall risk. Resident continues with abt's for UTI.<br><br>Review of Resident #1's Skilled Nursing Facility Records to Hospital Transfer Form dated 03/12/25 reflected ADLs totally dependent, bladder function incontinent, last know bowel movement 03/12/25, urinary catheter in place left blank. Unusual mental status/cognition function before the change in condition - alert, disoriented but cannot follow simple instructions. Medications on antibiotics - Cephalexin oral capsule 500 MG for UTI treatment duration 03/16/25, treatment started 03/11/25. Devices - bladder (Foley) catheter - left blank. Risk alerts agitation with risk to harm self or others and high fall risk. Resident was showing signs and symptoms of anxiety and restlessness. Redirection given.<br><br>Review of Resident #1 hospital history of present illness records dated 03/13/25 reflected male with history of CVA with outlet obstruction chronic foley (a persistent blockage in the urinary tract, preventing the bladder from emptying properly) presented to the ER with recurrent falls. Resident #1 had been complaining of left sided hip pain, left wrist pain, back pain, lower back pain, left lower quadrant pain, and left femur pain.<br><br>Review of Resident #1's hospital X-ray of chest, abdomen and pelvis dated 03/13/25 reflected foley catheter was present within the urinary bladder. The bladder remained distended and recommended correlation for catheter dysfunction (mechanical issues like kinking, catheter malposition, or thrombotic complications such as intracatheter thrombosis and fibrin sheath formation).<br><br>Review of Resident #1's hospital records dated 03/13/25 reflected Resident #1's general appearance, chronically ill appearing, confused .<br><br>Review of Resident #1's hospital Diagnosis Assessment Plan dated 03/13/25 reflected UTI/Sepsis, change foley catheter - done in the ER.<br><br>Interview on 04/29/25 with a family member by phone at 1:59 pm revealed Resident #1 had a foley catheter and the hospital told her it was placed wrong, pulled, or neglected and Resident #1 got sepsis.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/30/25 with LVN B at 2:20 pm revealed she looked at care plans and care plans were the blueprint of the residents' care including what the resident needed, residents' goals, and how to take care of the resident. She said the negative effects of not following the catheter care plan were the resident could get a UTI or become septic if catheter care was not properly care planned and followed through for the resident.<br><br>Interview on 04/30/25 with LVN F at 1:44 pm revealed everything about a resident should be care planned and of course the catheter care should be care planned. She revealed the negative effects of not having a resident centered care plan in place was that you don't have a plan in place to care for the resident and if you don't carry out catheter care planning, it means that the needs of the resident were not being meet. She said that all the nurses, not just the admitting nurse, were responsible to make that it was made known that Resident #1 had a foley catheter and to make sure it was care planned and the residents' catheter care needs were meet.<br><br>Interview on 04/30/25 with the Administrator at 12:24 pm revealed the nurse who admits the resident into the facility can open the care plan. There was a care plan for the resident, but it was not specific to the information from the hospital discharge information.<br><br>Resident #1 had a UTI, and he was on an antibiotic and that was not included in his care plan. The negative effect of not having a care plan that addressed the individual resident needs was that it was not resident centered and there was the opportunity for error in for the care or service to be provided to that resident. The Administrator said a care plan provided body of knowledge to be able to carry out the services or elements of the needs of the resident and was the template that allowed you and your staff meet the welfare of the resident. The administrator said the care plan was the responsibility admitting nurse because Resident #1 was at the facility less than 72 hour and the admitting nurse should have done the admitting orders for the foley catheter care. The negative effects of not having the order entered was the failure of not having Resident #1's needs meet. He stated if you don't take care of a catheter a resident could get an infection. He said he was not a nurse, but he did not feel like catheter care was carried out for this resident.<br><br>Interview on 04/30/25 with the DON at 8:47 am revealed a care plan contained all the residents' information gathering in one central area for anything that is important to the residents' care, and it should be resident specific. She revealed the catheter care plan should be specific to the catheter size and include the reason the catheter was present, and the reason would be different from resident to resident. The care plan should include everything that should be included in a catheter order including monitoring urine output. She said the IDT team was responsible for the care plan, but it was a whole facility approach. She said the nurse who signed the baseline care plan should make sure that that all the information was in the care plan. She stated this was the responsibility of the previous DON. The current DON said the negative effect of not having a person-centered care plan was that you don't really know how to care for the resident, and everyone was different, so their care was different. She said she thought the care plan had everything that it needed to have for the care of Resident #1's catheter needs but based on the progress notes there was no indication that they carried out catheter care. She said she hoped that they carried out Resident #1's catheter care plan but the documentation was poor. She stated she subscribed to the idea that if care was not charted it did not happen.<br><br>Review of facility Care Plans, Comprehensive Person-Centered dated 2022 reflected:<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Policy statement<br><br>Measurable objectives and at timetables to meet the residence physical, psychosocial and functional needs is developed and implemented for each resident.<br><br>Policy Interpretation and Implementation<br><br>The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person centered plan for each resident.<br><br>The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.<br><br>The ADM was notified on 04/29/25 at 9:37 pm that an IJ had been identified and an IJ template was provided. An amended IJ template was provided on 04/30/25 at (I have to find the time).<br><br>The following POR was approved on 04/30/25 at 4:36 pm:<br><br>The POR included the following:<br><br>CARE PLAN TAG F656<br><br>PLAN OF REMOVAL<br><br>FOR<br><br>IMMEDIATE JEOPARDY<br><br>To Whom it May Concern,<br><br>Summary of details which leads to outcomes.<br><br>On April 29, 2025, an investigation was initiated at the Rehabilitation and Care Center. At approximately 9:37 p.m. on April 29, 2025, a surveyor provided verbal notification that Texas Health and Human Services had determined the conditions at Rehabilitation and Care Center constitute immediate jeopardy to resident health and safety. The Immediate Jeopardy findings were identified in the following areas:<br><br>F656 - The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs.<br><br>The facility failed to write a care plan for Resident #1's catheter care.<br><br>Immediate Corrections Implemented for Removal of Immediate Jeopardy.<br><br>Resident #1 no longer resides at facility<br><br>(continued on next page) |

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|---|---|
| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On April 29, 2025, at approximately 10:00pm the following actions were taken;<br><br>Action:<br><br>Director of nursing/Designee validated all residents with urinary catheters have comprehensive care plans with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in place for each identified resident. All identified residents with urinary catheters were validated to have comprehensive, person-centered care plans to incorporate care of catheter and identified risk factors associated with catheters.<br><br>The DON was trained by Corporate Clinical Support.<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible: Director of Nursing/Designee<br><br>Action: Ad Hoc QAPI with Administrator, Director of Nursing, and Medical Director was conducted to review citations and Plan of Correction for removal<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible: Administrator and Director of Nursing<br><br>IDENTIFICATION OF OTHER AFFECTED:<br><br>All residents with urinary catheters have the potential to be affected.<br><br>Action:<br><br>Director of Nursing/designee completed a sweep of all residents to identify any resident with urinary catheter, and to validate residents with catheters have comprehensive plans of care in place addressing the following: Catheter care, monitoring and identification of signs and symptoms of infection, pain, monitoring of output urine, monitoring for appropriate drainage, and for signs of change of condition.<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible: Director of Nursing/Designee<br><br>SYSTEMIC CHANGES AND/OR MEASURES:<br><br>Action:<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Director of Nursing/Designee completed education with all licensed nursing staff on the requirement and facility policy to ensure completion of comprehensive plan of care with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in place for each resident. Education included the need to ensure all residents with urinary catheters have comprehensive, person-centered care plans to incorporate care of catheters and identified risk factors associated with catheters.<br><br>Start Date: 4/29/2025<br><br>Completion Date: Ongoing until all licensed staff have received education prior to their next scheduled shift.<br><br>Responsible Party: Director of nursing/designee<br><br>Action: Director of Nursing/designee will review all residents with foley catheters upon admission. Director of Nursing and/or designee will ensure monitoring orders and care plans are immediately updated upon admission and identification of resident admitted with a foley catheter. All residents with foley catheters will be added to facilities daily internal tracking tool and reviewed daily, Monday through Friday, by interdisciplinary team for compliance with facility policy and procedure related to foley catheter care and care planning requirements.<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible Party: Director of Nursing/Designee<br><br>Tracking and Monitoring<br><br>Director of nursing/designee will monitor all resident with new orders for catheters, or newly admitted with catheters, daily Monday through Friday, x 4 weeks, then weekly x 4 weeks, to include review of any new admissions from weekend on Mondays, to validate all residents with urinary catheters have comprehensive care plan with measurable objectives and timetables to ensure they have comprehensive, person-centered care plan to incorporate care of catheter and identified risk factors associated with catheter, including s/s of infection, cares of catheter, output, pain, drainage, and change in condition. Results will be supplied to the Quality Assurance Committee.<br><br>Any trends or concerns were/will be addressed with Quality Assurance Performance Committee and continue until a lessor frequency deemed appropriate through QAPI review<br><br>Monitoring:<br><br>Review on 05/01/25 of nurses note that Resident #1 was discharged to the hospital, review of skilled nursing facility to hospital form transferring Resident #1 to the hospital. A review of PCC reflected Resident #1 was discharged from the facility to the hospital on [DATE] and he is no longer a resident at the facility.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review on 05/01/25 of statement from the DON that she performed a sweep of all residents by pulling the order listing report to identify any resident with a urinary catheter, and to validate residents with catheters have comprehensive plans of care in place to address catheter monitoring and care, monitoring and identifying signs and symptoms of infections, pain, monitoring output of urine, monitoring for appropriate drainage and for signs of change in condition.<br><br>Review on 05/01/25 of the care plans for the three (3) residents in the facility with urinary catheters reflected comprehensive, person-centered care plans that incorporated the care of catheters and identified risk factors associated with catheters.<br><br>Record review of statement on 05/01/25 from DON that as of 04/29/25 the facility had no new admissions of residents with foley catheters.<br><br>Interview on 05/01/25 with the CNO at 4:08 pm revealed she in-serviced the DON on comprehensive care plans and discussed the importance of comprehensive care plans specific to catheters that on admission residents who have urinary catheters have comprehensive care plan with measurable objectives and timetables to ensure they have comprehensive, person-centered care plan to incorporate care of catheter and identified risk factors associated with catheter, including s/s of infection, cares of catheter, output, pain, drainage, and change in condition.<br><br>Interview on 05/01/25 with the DON at 1:47 pm revealed she reviewed the facility care plan policy with the CNO and was in-serviced to make sure resident care plans are accurate and resident care plans will be audited. She was further in-serviced by the CNO regarding comprehensive care plans specific to catheters that on admission residents who have urinary catheters have comprehensive care plan with measurable objectives and timetables to ensure they have comprehensive, person-centered care plan to incorporate care of catheter and identified risk factors associated with catheter, including s/s of infection, cares of catheter, output, pain, drainage, and change in condition.<br><br>Record review on 05/01/25 of Ad Hoc QAPI with Administrator, Director of Nursing, and Medical Director dated 04/29/25.<br><br>Record review completed on 05/01/25 of log used to complete training for staff, indicated who was trained over the phone or in person. 100 percent of the nursing staff was in-serviced, this included PRN staff.<br><br>During interviews on 05/01/25 from 10:15 am - 2:29 pm 2 RNs, 1 LPN, and 9 LVNs from different shifts all stated they were in-serviced before working their shift on the requirements and facility policy to ensure completion of comprehensive plan of care with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs in place for each resident. The in-service included the need to ensure all residents with urinary catheters have comprehensive, person-centered care plans to incorporate care of catheters and identified risk factors associated with catheters.<br><br>While the IJ was removed on 05/02/25 at 12:11 pm, the facility remained out of compliance at a level of no actual harm at a scope of isolated because the facility's need to evaluate the effectiveness of the corrective systems. |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<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** Based on interview and record review the facility failed to ensure that residents with indwelling catheters received appropriate treatment and services for one (Resident #1) of three residents reviewed for indwelling urinary catheters, in that:<br><br>The facility failed to manage Resident #1's foley catheter by not having orders for catheter care, monitoring for signs/symptoms of infection, or monitoring the input/output, subsequently leading to hospitalization on 03/12/25 and a diagnosis of sepsis.<br><br>These failures could place Residents with indwelling urinary catheters at risk of discomfort, infections, and a decreased quality of life, and hospitalization.<br><br>An IJ was identified on 04/29/25. The IJ template was provided to the facility on [DATE] at 9:37 pm. While the IJ was removed on 05/02/25, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>Findings Included:<br><br>Review of Resident #1's face sheet reflected a [AGE] year old man who was admitted to the facility on [DATE] and discharged from the facility on 03/12/25 with diagnoses of Hemiplegia and hemiparesis (hemiplegia refers to complete paralysis on one side of the body, while hemiparesis refers to partial weakness on one side) following cerebral infarction (a condition where a blood clot or blockage in a blood vessel prevents oxygen and blood from reaching a part of the brain, causing brain tissue to die), and Wernicke's encephalopathy (a serious, acute neurological emergency cause by a deficiency of thiamine (vitamin B1) most often due to chronic alcohol use).<br><br>Review of Resident #1's care plan reflected a focus dated 03/10/25 of impaired communication due to: and intervention dated 03/10/25 of use simple and direct communication to promote understanding. Care plan focus dated 03/10/25 of alteration in elimination of bowel and bladder with a goal dated 03/10/25 of will be free from signs and symptoms of incontinence through next review date and interventions dated 03/10/25 of if catheter in place, secure per protocol, cath q shift per protocol, monitor for drainage, out, s/s of UTI: changes in color, odor, or consistency of urine, dysuria (painful or burning urination) frequency, fever, pain and provide assistance to toilet as needed.<br><br>Review of Resident #1's MDS, dated [DATE], did not reflect he had an indwelling catheter.<br><br>Review of Resident #1's MDS BIMS dated 03/11/25 reflected a score of three suggesting severe cognitive impairment.<br><br>Review of Resident #1's rehabilitation hospital discharge records dated 03/20/25 reflected Resident #1 was discharged with a foley catheter (a thin flexible tube inserted into the bladder to drain urine) with instructions, The most important thing you want to do is prevent infection. Discharge records reflected cognitive status A&O X2 (a person is alert and aware of their person and place), other comments reflected, confused.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Comprehensive Skilled assessment dated [DATE] signed by LVN B reflected wound care indwelling catheter (including suprapubic catheter (a medical device, a tube inserted into the bladder through a small incision in the lower abdomen, used to drain urine) and nephrostomy tube (a thin, flexible catheter inserted through the back into the kidney to drain urine when normal urine flow is blocked) and summary of head to toe assessment findings included a description of any progress toward goals or decline note reflected confusion noted.<br><br>Review of Resident #1's orders did not reflect physician orders for an indwelling catheter or the care and monitoring of an indwelling catheter.<br><br>Review of Resident #1's progress notes reflected 3 (three) notes referencing Resident #1 foley catheter<br><br>1.<br><br>Skin/wound progress note dated 03/11/25 foley catheter in place<br><br>2.<br><br>Skin/wound progress note dated 03/12/25 foley catheter<br><br>3.<br><br>Note physician history and physical dated 03/12/25 foley catheter in place<br><br>Review of Resident #1's EMR reflected no nurses' notes regarding skilled nurse assessments or urine output measurements for Resident #1's foley catheter.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/10/25 at 8:21 pm, late entry, reflected Resident #1 continued with antibiotics for UTI.<br><br>Review of Resident #1 Nurses Note (identity of nurse unknown) dated 03/10/25 at 8:49 pm, late entry, reflected confusion noted.<br><br>Review of admission & Baseline care plan/summary dated 03/10/25 signed by LVN B reflected GI/Bowel abdomen soft, non-tender, non-distended, urine normal color/consistency, catheter/nephrostomy tube indwelling catheter/suprapubic/nephrostomy, bowel and bladder care plan focus alteration of elimination of bowel and bladder, goal will be free from s/s of UTI or complications related to incontinence through next review dated, interventions call light within reach and remind to use call light as needed, intervention if catheter in place, secure per protocol, cath care q shift per protocol, monitor for drainage, output, s/s of infection and follow up with physician as needed, monitor and report s/s of UTI: changes in color, odor, or consistency of urine, dysuria, frequency, fever pain. Comments: Resident #1 continues with antibiotics for UTI, confusion noted.<br><br>Review of Resident #1's Comprehensive Skilled assessment dated [DATE] signed by LPN C reflected behavior problems verbal, other behaviors (socially inappropriate), rejects evaluation or cares, indwelling catheter, summary of Head-to-Toe Assessment/Findings including a description of any progress toward goals or decline noted - confusion noted.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Elopement Risk Assessment Tool dated 03/11/25, unsigned by staff, reflected Resident #1 had a diagnosis of Dementia, OBS (a condition characterized by cognitive impairment and behavioral changes caused by underlying brain damage), Alzheimer's, Intellectual/Developmental Disability, Hallucinations, Anxiety Disorder, Depression, Bipolar, and/or Schizophrenia, Resident #1 cognitively impaired with poor decision making skills (example disorientation, cognitive deficits, disorganized thinking).<br><br>Review of Resident #1's Trauma Abbreviated PCL-C dated 03/11/25 signed by LPN C reflected, unable to obtain answers from resident due to impaired cognition/communication and representative is unable to answer.<br><br>Review of Resident #1's Infection Surveillance Form dated 03/11/25, unsigned, reflected, confusion note.<br><br>Review of Resident #1's Skin/Wound Progress Noted note dated 03/11/25 by LVN A wound care nurse, reflected Resident, Pt. arrived at facility with . Foley Catheter in place ., MD, DON and RP at bedside.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 reflected, resident was alert and oriented X1.<br><br>Resident was not able to voice needs. MD notified of admission, orders verified, admission assessment completed, call button within reach will continue to monitor, resident came into facility with peg tube.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 at 5:43 am reflected redirected resident multiple times this shift, observed attempting to get out of bed, re-educated resident to call light, assigned CNA instructed to monitor resident frequently throughout shift, every effort made in making resident as comfortable as possible, as needed Tylenol administered as ordered for nonverbal indicator of discomfort, will monitor through the remainder of this shift<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 reflected witnessed fall resident observed crawling out of bed onto floor by floor mat, he stated he wanted to stand up<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/11/25 late entry reflected resident had behaviors; resident had restlessness and anxiety noted.<br><br>Review of Resident #1's Skilled Status Note 2 (identity of nurse unknown) dated 03/12/25 reflected confusion noted stable no new concerns.<br><br>Review of Resident #1's Skilled Status Note 2 (identity of nurse unknown) dated 03/12/25 reflected resident on antibiotic for UTI for 5 days, call light was in reach, staff continued to monitor resident.<br><br>Review of Resident #1's Skin and Wound Nurses Note (identity of nurse unknown) dated 03/12/25 reflected GU: urinary incontinence, foley catheter.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/12/25 at 1:40 pm reflected resident found on floor by physical therapy, resident confused and unable to express what happened, nurse conducted physical assessment, neurological checks, resident complained of generalized pain and was confused, but normal for baseline, continued to monitor.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/12/25 reflected DON and CNA made nurse aware that resident was on the floor, resident was complaining of pain to left wrist 3/10 (0 = no pain, and 10 = worst imaginable pain). Nurse assessed resident, resident was able to move right upper extremity, x-ray ordered to the left hand, pain medication given and was not effective, nurse monitored and updated provider with any changes.<br><br>Review of Resident #1's Nurses Note (identity of nurse unknown) dated 03/12/25 reflected resident was sent out to hospital for pain to left wrist, resident showing signs of restlessness and anxiety, medications were in place, resident was a fall risk, resident continued with antibiotics for UTI, no new concerns.<br><br>Review of IDT Event Review progress note dated 03/12/25 witnessed fall from bed, no injuries noted, root cause analysis for event new admission, anxiety, impulsivity, diagnosis of UTI, dementia, difficulty expressing self, hepatic encephalopathy (a neuropsychiatric syndrome caused by impaired brain function due to liver disease, specifically when the liver fails to remove toxins from the blood), CVA (Cerebrovascular Accident), call light in reach, psych evaluation and treatment anxiety and restlessness.<br><br>Review of Resident #1's Pain assessment - Post Incident dated 03/12/25 signed by LVN B reflected pain behavior - resistiveness to cares, restlessness, repetitive verbalizations or movements, verbal expression of distress/crying, sad, pained, worried facial expressions. Resident's current level of pain on a numeric scale of 1-10 (0 = no pain, and 10 = worst imaginable pain) 3.<br><br>Review of Resident #1's Anxiolytic (medications, also called anti-anxiety agents, used to treat or prevent anxiety) Medication Informed Consent dated 03/12/25 signed by LVN B reflected anxiolytic medication & indication for use Xanax (treats anxiety) anxiety, potential contributing factors previously addressed - pain and infection or other change in condition, target behavior symptoms Resident #1 was showing [NAME] of anxiety and restlessness and came moving to the edge of bed and rolling off the bed.<br><br>Review of Resident #1's Change of Condition Evaluation dated 03/12/25 signed by LVN B reflected, the change in condition, symptoms, or signs LVN B was calling about is/are: Falls, pain (uncontrolled), Behavioral symptoms (e.g. agitation, psychosis) started on: 03/12/25<br><br>Change of Condition Evaluation dated 03/12/25 signed by LVN B reflected:<br><br>Since the change in condition occurred have the symptoms or signs gotten worse - medication given was not effective<br><br>This condition, symptom or sign had occurred before: No.<br><br>Other relevant information: Resident has had a past history of left wrist pain with no fractures noted.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Summarize your observations, evaluation, and recommendations: Left wrist with pain noted. Pain scale is 5/10 (0 = no pain, and 10 = worst imaginable pain). No swelling. X-ray administered. Resident sent to the hospital per family request.<br><br>Describe mental status of changes (compared to baseline; check all that you observe: increased confusion (e.g. disorientation), abrupt significant change in cognitive function form usual, with or without altered level of consciousness.<br><br>Functional status evaluation: describe functions status changes - fall.<br><br>Recommendation of primary clinician - send to the hospital, testing x-ray, interventions - new or change in medications<br><br>Behavioral status evaluation - describe behavioral changes: resident is having signs and symptoms of anxiety and restlessness and symptoms or signs of pain.<br><br>Is an abdominal/GI assessment relevant to the change in condition being reported - not clinically applicable to the change in condition being reported (distended abdomen box not checked)<br><br>Genitourinary (refers to the urinary and genital organs, also known as the urogenital system. It encompasses both the reproductive organs and the urinary tract) Status Evaluation: not clinically applicable to the change in condition being reported.<br><br>Pain Status Evaluation - is pain assessment relevant to the change in condition been reported: yes<br><br>Does the resident/patient have pain: yes<br><br>Is the resident/patient cognitively able to rate their pain scale: No<br><br>Negative vocalization: troubled - repeated trouble calling out, loud moaning or groaning, crying, facial expression - sad/frightened/frown<br><br>Body language: tense, distressed pacing, fidgeting,<br><br>Consolability: distracted or reassured by voice or touch<br><br>Is the pain: acute<br><br>Pain location: not applicable/not assessed<br><br>Specify exact location of pain: left hand (palm) complaining of left hand with pain scale of 5/10 (0 = no pain, and 10 = worst imaginable pain) Tylenol given<br><br>X-ray results: -no fracture noted.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Comprehensive Skilled assessment dated [DATE] signed by LVN B reflected evidenced of an acute change in mental status from the resident's baseline behavioral problems of verbal behavior (screaming, cursing, etc.), other behaviors (social inappropriate), and rejects evaluation or cares, indwelling catheter, [Resident #1] was sent out to [hospital] for pain to left wrist, falls . Resident showing signs of restlessness and anxiety. Medications are in place. Resident is a fall risk.<br><br>Resident continues with abt's for UTI.<br><br>Review of Resident #1's Skilled Nursing Facility Records to Hospital Transfer Form dated 03/12/25 reflected ADLs totally dependent, bladder function incontinent, last know bowel movement 03/12/25, urinary catheter in place left blank. Unusual mental status/cognition function before the change in condition - alert, disoriented but cannot follow simple instructions. Medications on antibiotics - Cephalexin oral capsule 500 MG for UTI treatment duration 03/16/25, treatment started 03/11/25. Devices - bladder (Foley) catheter - left blank. Risk alerts agitation with risk to harm self or others and high fall risk. Resident was showing signs and symptoms of anxiety and restlessness. Redirection given.<br><br>Review of Resident #1 hospital history of present illness records dated 03/13/25 reflected male with history of CVA with outlet obstruction chronic foley (a persistent blockage in the urinary tract, preventing the bladder from emptying properly) presented to the ER with recurrent falls. Resident #1 had been complaining of left sided hip pain, left wrist pain, back pain, lower back pain, left lower quadrant pain, and left femur pain.<br><br>Review of Resident #1's hospital X-ray of chest, abdomen and pelvis dated 03/13/25 reflected foley catheter was present within the urinary bladder. The bladder remained distended and recommended correlation for catheter dysfunction (mechanical issues like kinking, catheter malposition, or thrombotic complications such as intracatheter thrombosis and fibrin sheath formation).<br><br>Review of Resident #1's hospital records dated 03/13/25 reflected Resident #1's general appearance, chronically ill appearing, confused .<br><br>Review of Resident #1's hospital Diagnosis Assessment Plan dated 03/13/25 reflected UTI/Sepsis, change foley catheter - done in the ER.<br><br>Interview on 04/29/25 with a family member by phone at 1:59 pm revealed Resident #1 had a foley catheter and the hospital told her it was placed wrong, pulled, or neglected and Resident #1 got sepsis.<br><br>Interview on 04/29/25 with CNA D by phone at 2:33 revealed he had worked at the facility for about a year. CNA D said he was responsible for emptying out the urine in catheters and measuring the amount of urine and telling the nurse the amount, but he said he did not remember Resident #1 except that his name was familiar. He said if the urine was not emptied from the catheter bag, it could go back into the bladder and cause an infection.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/29/25 with CNA E at 2:25 pm revealed she worked at facility during the time frame Resident #1 was at the facility but could not recall helping Resident #1, but she did provide foley catheter care to residents. She said if a resident had a foley catheter, CNAs needed to check the bag to see if it needs to be emptied of urine and then do the peri care (cleaning the genitals and anal area to promote hygiene and prevent infections). She said if the catheter bag was full of urine, it hurt the resident. She said she emptied catheter bags of the urine, measured the amount of urine, then told the amount to the nurse.<br><br>Interview on 04/29/25 with LVN B at 6:38 pm revealed she vaguely remembered the resident, but she did not remember him having a catheter. She said nurses were supposed to look at the catheters and chart when they had looked at it and what they saw. She said nurses looked at the residents' catheters to confirm that there was no trauma to the cite, that the color and consistency of the urine was not abnormal, that the output was measured, and there was no blood in the urine. LVN B said this information would have been charted by the nurse. She said if the urine was not emptied from the catheter bag, it could go back into the bladder and cause the bladder to become distended, and the person could get sick, develop sepsis, and possibly die. She did not remember Resident #1 being confused, she said this would have concerned her. She revealed she did not remember him, she said it was a crazy time and it was like a blur because the facility was changing ownership, and they were in-between 2 (two) nurse managers.<br><br>Interview on 04/30/25 with LVN B at 2:20 pm revealed when Resident #1 was at the facility, either the ADON or the DON were putting in the orders in for catheter care. She said she would have taken report from the hospital, and she would do baseline admission and care plan admission assessment. She said the ADON and DON should have looked at the assessments and they were not looking at the assessments. She said catheter care required more immediacy. LVN B said she did not remember the names of any CNAs who would have helped Resident #1 with his catheter care. She said if there was not an order entered for catheter care, the EMR did not prompt for the catheter care needs for a resident who had a catheter. She said if you visually saw a resident had a catheter, and there were no orders for catheter care, you could manually enter the catheter care order into the EMR system to prompt the necessary care. LVN B did not know what happened to cause the catheter care order to be missed and it was a problem that the order was not placed because treatment was missed.<br><br>Interview on 04/29/25 with LVN A by phone at 7:05 pm revealed she no longer worked at the facility, and she did not remember working with Resident #1. She revealed she was the wound care nurse, and the floor nurses did the catheters. Surveyor told LVN A there was a wound care progress note dated 03/11/25 with her name that discussed Resident #1's skin care and the note did not reflect that Resident #1's bladder was distended. LVN A revealed if Resident #1's bladder was distended, she would have reported it to the floor nurse and the floor nurse would have reported it to the MD. She said there were procedures to follow when a resident had a foley catheter. She said a residents' catheter needed to be checked and monitored to make sure everything was in place. She revealed if the foley catheter was not monitored, absolutely things could go wrong with the resident, a resident could go septic. She said it was the responsibility of the floor nurse to check the foley catheter every shift and monitor the output. She said if the monitoring was not charted, then the foley catheter was not monitored.<br><br>(continued on next page) |

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|---|---|---|---|
| | 455510 | A. Building<br>B. Wing | 05/02/2025 |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/29/25 with LVN F at 1:44 pm revealed she remembered Resident #1 but did not remember if he had a catheter. She said she remembered him because he had a lot of falls. She said she did not remember anyone providing catheter care to him. She said she felt like he fell because he was restless, did not want to be at the facility, and he seemed confused. She said if she saw a resident who had a catheter, but did not have catheter orders, she would prompt them to be entered in the system so catheter care would be populated as a resident care task. LVN F said the lack of catheter care could have caused and infection and caused a distended bladder. She said that Resident #1 could have been restless because of the discomfort from the infection caused by the lack of catheter care. She said the admission nurse was responsible for entering the catheter orders. She said the negative effects of not providing catheter care were infection, sepsis, and possibly death. She said all nurses needed to check on the residents even if they were not the admitting nurse and confirm that the necessary catheter orders were in place.<br><br>Interview on 04/30/25 with the previous DON by phone at 11:11 am revealed she recalled Resident #1, and she was aware that he had a catheter, but she did not assist with catheter care. She said the CNAs would have provided catheter care but she did not see anyone provide catheter care but that did not mean it had not been provided. She said if catheter care was done, it was in the nursing notes. She said usually there was an ordered entered for catheter care. She said the nurse who did Resident #1's assessment could have created his order for catheter care and the ADON and DON would have followed up. She said it was part of the nurses skilled notes to document a residents' catheter care.<br><br>Interview on 04/30/25 with the Administrator at 12:24 pm revealed the nurse who admitted Resident #1 was at the facility less than 72 hour and the admitting nurse should have done the admitting orders for the foley catheter care. The negative effects of not having the order entered was the failure of not having Resident #1's needs meet. He stated if you don't take care of a catheter the resident could get an infection. He said he was not a nurse, but he did not feel like catheter care was carried out for this resident.<br><br>Interview on 04/30/25 with the DON at 8:47 am reflected she began working at the facility on 04/10/25. The DON stated Resident #1 should have had standard foley catheter orders in place for measuring urine output, looking for s/s of infection, securing the catheter bag so the catheter bag was below the resident's bladder, Enhanced Barrier Protection (infection control measures that expand standard precautions by incorporating the use of gowns and gloves during high-contact resident care activities), and orders to change the bag once a month. She said all of these measures should have been in the nursing orders. She said the admitting nurse should have entered the orders. The DON said the negative effects of not entering the orders at admission was that if orders were not in place, necessary resident care would get missed. The DON said it was important to assess the catheter to confirm there was no obstruction or urinary retention and make sure catheter was flowing. She said if the catheter was not flowing well and emptied property it could cause bladder distention and pain. She said it was the responsibility of the nursing management team to double check and make sure orders were correctly entered. She said that it is important to trust but verify that orders were not missed and that Resident #1 did not have a catheter because there were no catheter ordered entered. She said the negative effect of not checking if a resident has a catheter and the resident did have a catheter was missing the s/s of infection.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/29/25 with the MD by phone at 5:33 pm revealed if a resident was admitted to the facility with a catheter, the resident would have pre-set orders from the facility to address the necessary catheter care to prevent infection. She said that Resident #1's output should have been monitored, that was basic nursing 101 (refers to the introductory or fundamental level of a subject). She said if there was a change in condition related to the catheter care, she would have been notified, but if they are not monitoring the catheter and there were no skilled nursing notes regarding checking the catheter and notes documenting the urine output, it would be hard to notify of a change of condition of something that was not monitored. She said the facility was changing ownership at that time and staff both quit and walked out and documentation was not very good.<br><br>Review of facility Catheter Care, Urinary dated 2018 reflected<br><br>Input/Output - observe the resident's urine level for noticeable increases or decreases. If the level stays the same or increases rapidly, report it to the physical or supervisor. Maintain as accurate record of the resident's daily output, per facility policy and procedure. Check the resident to be sure he or she is not lying on the catheter and to keep the catheter and be free of kinks. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage back from flowing back into the urinary bladder.<br><br>Documentation - The following information may be recorded in the resident's medical record:<br><br>1.<br><br>The date and time that catheter care was given<br><br>2.<br><br>The name and title of the individual(s) giving the catheter care.<br><br>3.<br><br>Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain<br><br>4.<br><br>Any problems or complaints made by the resident related to the procedure<br><br>5.<br><br>If the resident refused the procedure, the reason(s) why and the intervention taken<br><br>6.<br><br>The signature and title of the person recording the date<br><br>7.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Reporting<br><br>1.<br><br>Notify the supervisor if the resident refuses the procedure.<br><br>2.<br><br>Reporting other information in accordance with facility policy and professional standards of practice.<br><br>The ADM was notified on 04/29/25 at 9:37 pm that an IJ had been identified and an IJ template was provided.<br><br>The following POR was approved on 04/30/25 at 4:36 pm:<br><br>The POR included the following:<br><br>FOLEY CATHETER TAG F690<br><br>PLAN OF REMOVAL<br><br>FOR<br><br>IMMEDIATE JEOPARDY<br><br>To Whom it May Concern,<br><br>Summary of details which leads to outcomes.<br><br>On April 29, 2025, an investigation was initiated at the Rehabilitation and Care Center, At approximately 9:37 p.m. on April 29, 2025, a surveyor provided verbal notification that Texas Health and Human Services had determined the conditions at Rehabilitation and Care Center constitute immediate jeopardy to resident health and safety. The Immediate Jeopardy findings were identified in the following areas:<br><br>F690 - The facility must ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>The facility failed to manage Resident #1's foley catheter by not having orders for catheter care, monitoring for signs/symptoms of infection, or monitoring the input/output, subsequently leading to hospitalization and being diagnosed with sepsis.<br><br>Immediate Corrections Implemented for Removal of Immediate Jeopardy.<br><br>Resident #1 no longer resides at facility<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On April 29, 2025, at approximately 10:00pm the following actions were taken;<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible: Director of Nursing<br><br>Action: All nursing staff were immediately educated on foley catheter care. Education entailed: Appropriate catheter care and documentation of caring out orders on changes of condition, admission or propose of catheter use.<br><br>Director of Nursing and/or designee will ensure monitoring orders and care plans are immediately updated upon admission or change of condition and identification of resident admitted with a foley catheter. The staff will retain if a discrepancy is discovered during review or audit. The current nursing staff has been in-service.<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible: Director of Nursing<br><br>Action: Ad Hoc QAPI with Administrator, Director of Nursing, and Medical Director was conducted to review citations and Plan of Correction for removal<br><br>Record review on 05/01/25<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/2025<br><br>Responsible: Administrator and Director of Nursing<br><br>IDENTIFICATION OF OTHER AFFECTED:<br><br>All residents requiring assistance with incontinent care related to the use of a foley catheter have the potential to be affected.<br><br>SYSTEMIC CHANGES AND/OR MEASURES:<br><br>Action: Orders for all residents with foley catheters will be reviewed upon admission. Director of Nursing and/or designee will ensure monitoring orders and care plans are immediately updated upon admission and identification of resident admitted with a foley catheter. All residents with foley catheters will be added to facility's daily internal tracking tool and reviewed daily, Monday through Friday, by interdisciplinary team for compliance with facility policy and procedure related to foley catheter care.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | This process will be ongoing.<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/25<br><br>Responsible Party: Director of Nursing, Assistant Director of Nursing and/or designee<br><br>Action: Director of nursing/designee completed education with all nursing staff, including PRN employees and agency staff on care and competencies for urinary catheters. Education included review of facility policy on catheter cares, requirement to maintain an accurate record of resident's daily output, monitoring for problems such as drainage, s/s of infection, dysuria, redness, crusting, pain, distention and for any change in condition.<br><br>Start Date: 4/29/2025<br><br>Completion Date: 4/29/25. All new employees will receive education upon hire and prior to start of their shift.<br><br>Education entailed: Appropriate catheter care and documentation of caring out orders on changes of condition, admission or propose of catheter use.<br><br>Director of Nursing and/or designee will ensure monitoring orders and care plans are immediately updated upon admission or change of condition and identification of resident admitted with a foley catheter. The staff will retain if a discrepancy is discovered during review or audit. The current nursing staff has been in-service.<br><br>Responsible Party: Director of Nursing, Assistant Director of Nursing and/or designee<br><br>Tracking and Monitoring<br><br>The Director of Nursing will conduct a weekly audit, for four weeks, of all residents with orders for foley catheters to ensure compliance with facility policy and physician orders. Verification of findings will be documented and submitted to the administrator for tracking and trending. Results will be provided to the Quality Assurance Committee.<br><br>Any trends or concerns were/will be |