

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Focused Care at Pasadena		STREET ADDRESS, CITY, STATE, ZIP CODE 3434 Watters Rd Pasadena, TX 77504	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215</p> <p>Based on interview, and record review, the facility failed to immediately consult with the physician and notify the resident representative when the resident experienced significant change in the resident's physical status (a deterioration in health status either life-threatening conditions or clinical complications) for 1 of 6 residents (Resident #5) reviewed for a change of condition, in that:</p> <p>-The facility failed to notify the doctor when there was a change of condition with Resident #5's urine which had turned purple.</p> <p>-On 9/30/2024, Resident #5 was diagnosed with a urinary tract infection. Resident #5's change of condition was recognized by the nurses at the facility, on 10/5/2024. Resident #5 was not given antibiotics to treat her UTI until 10/8/2024. She was not sent to the hospital until 10/9/2024. The doctor was never notified of her change of condition until 10/8/2024 and on 10/8/2024 she was diagnosed with purple urine syndrome (a rare condition that causes the urine collection bag to turn purple or blue due to a urinary tract infection (UTI) and long-term catheter use).</p> <p>This failure could affect residents with urinary catheters and other medical conditions and could place them at untimely interventions, exacerbated symptoms, and hospitalization .</p> <p>Findings included:</p> <p>Record review of Resident #5's face sheet revealed she was an [AGE] year-old female who was admitted into the facility on [DATE]. She was diagnosed on [DATE] with, chronic kidney disease (long standing disease of the kidneys leading to renal failure. The kidneys filter waste and excess fluid from the blood. As kidneys fail, waste builds up), cognitive communication deficit (difficulty with communication caused by a disruption in cognitive process), neuromuscular dysfunction of bladder (a condition that occurs when the nerves and muscles of the bladder don't work together properly), and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>On 9/30/24 she was diagnosed with urinary tract infection. For about a month, the resident had been having blue and purple urine. Her change of condition had not been reported to the doctor until 10/8/24. On 10/8/2024 she was diagnosed with purple urine syndrome (a rare condition that causes the urine collection bag to turn purple or blue due to a urinary tract infection (UTI) and long-term catheter use).</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's Comprehensive MDS dated [DATE] revealed she had a BIMs score of 0 out of 15 which indicated she was severely cognitively impaired. She required substantial/maximal assistance with eating and oral hygiene. Resident #5 was dependent for toileting hygiene, shower/bath self, upper body dressing, lower body dressing, and personal hygiene. She was dependent when needed to roll left and right and sit to lying. Resident #5 had an indwelling catheter.</p> <p>Record review of Resident #5's undated comprehensive care plan revealed the following, Toilet use: She is not toileted. Toilet use: She is totally dependent on (1-2) staff for incontinent care.</p> <p>Record review of Resident #5's base line care plan completed until 4/9/24 revealed the following, [Resident #5] Indwelling Foley Catheter and is at Risk for Increased Urinary Tract Infections: Pressure Ulcer sacral Urinary Catheter 20FR,10 CC. Diagnosis: Urinary Retention.</p> <p>Record review of Resident #5's Progress Notes dated 9/16/24 at 6:43 p.m., entered by the ADON, reflected in part, . Foley catheter noted not to be in place and urine was coming out, using aseptic technique, foley catheter replaced with 18fr, 10ml balloon. Resident tolerated procedure and shows no s/s of pain or discomfort at this time</p> <p>Record review of Resident #5's Progress Notes dated 9/29/24 at 11:48 p.m., entered by the LVN C, reflected in part, .16 French, 10cc balloon foley catheter inserted into the urethra without resistance, sterile technique maintained throughout the process, perineal area cleaned with antiseptic solution, new sterile gloves donned (to put on PPE properly to achieve the intended protection and minimize the risk of exposure), clear yellow urine noted in drainage bag, balloon inflated with 10cc of sterile water, catheter secured to thigh with securing tape, resident tolerated the procedure well, no signs of pain after the procedure noted, will continue to monitor urine output .</p> <p>Record review of Resident #5's Progress Notes dated 9/30/24 at 10:45 p.m., entered by the LVN D, reflected in part, .16 French, 10cc balloon foley catheter inserted into the urethra without resistance, sterile technique maintained throughout the process, perineal area cleaned with antiseptic solution, new sterile gloves donned, clear yellow urine noted in drainage bag, balloon inflated with 10cc of sterile water, catheter secured to thigh with securing tape, resident tolerated the procedure well, no signs of pain after the procedure noted, will continue to monitor urine output .</p> <p>Record review of Resident #5's Order Summary dated 9/30/24 revealed she had a diagnosis of urinary tract infection.</p> <p>Record review of Resident #5's Progress Notes dated 10/05/24 at 12:40a.m., entered by RN A, reflected in part, .Per family request, resident will be sent out to the hospital. The U/A lab results were reviewed and concluded client is positive with Gram negative and positive bacterium. HCP was contacted by documenting nurse with most recent lab results. Requesting how to move forward. No response considering its late hours of the night. After reviewing family concerns of client having blood tinge fluid in her catheter and reviewing medical docs. This nurse is honoring the request of the client's family and sending Resident #5 out .</p> <p>Record review of Resident #5's Progress Notes dated 10/05/24 at 7:56 a.m., entered by the DON, reflected in part, .This writer was made aware that resident RP is requesting her to be send to the hospital and stated [Resident #5] has UTI, [Physician A] made aware and have orders for 0.9%ns @60ml/hr x 2L, Encourage po fluids. Rp called x 2 no response .</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's Progress Notes dated 10/05/24 at 5:29 p.m., entered by RN C, reflected in part, . cancelled transportation to hospital per DON. resident alert foley bag exhibits about 10cc of urine. new order for normal saline for hydration 2000 ml per iv. 22g to left wrist patent and no s/s infection. continue to monitor. once started, urine began to flow from catheter dark red urine again. family wanted patient to go to hospital but now they are allowing [resident] to stay at the facility at this time .</p> <p>Record review of Resident #5's Progress Notes dated 10/8/24 at 7:15p.m., entered by RN D, reflected in part, .Doxycycline Monohydrate, Oral Capsule 100MG, give 1 capsule by mouth two times a day for Prophylaxis for 10 days .</p> <p>Record review of Resident #5's Order summary Report dated 10/8/24, reflected in part, .Doxycycline Monohydrate (used to treat a wide variety of bacterial infections, including those that cause acne), Oral Capsule 100MG, give 1 capsule by mouth two times a day for Prophylaxis for 10 days . Start date: 10/9/24.</p> <p>Record review of Resident #5's hospital records dated 10/10/24 on page 5/16, revealed, altered mental status, unspecified altered mental status type: 2/2 UTI, UTI (urinary tract infection due to urinary indwelling foley catheter (CMS/HCC) (HCC).</p> <p>Observation on 10/8/24 at 1:35p.m. with Resident #5, revealed her lying asleep in bed. She had a fluid IV bag that was almost empty. She was covered up with a blanket. RN B removed the cover from Resident #5's catheter bag and it revealed that her urine was purple. RN B said Resident #5's urine had been a purple color for the past three days. She said she was not sure if it was blood or not.</p> <p>Interview on 10/8/2024 at 2:21p.m. RN A said Resident #5 had a medical diagnosis of a urinary tract infection on 9/30/2024. On 4/9/2024 Resident #5 was initiated for the catheter. RN A said Resident #5 was care planned for dehydration on, 4/11/2024 7/17/2024, 10/5/2024 and 10/8/2024. She said Resident #5 was not drinking or eating very well. She said Resident #5's family provided a bottle of water for them to give to her. She said sometimes she would take it and sometimes she would not. She said Resident #5 had a change of condition with her urine on 10/5/2024 and it was GI related. Physician A was contacted and put in an order for an IV.</p> <p>Interview on 10/8/24 at 2:36p.m., the NP said he assumed Resident #5 had a catheter to help her wounds heal faster. He said he first saw Resident #5 when she arrived at the facility from the hospital, upon admission, she had a foley catheter. He most of the time, nurses were to change the catheter in 30 days or if there was a malfunction. He said if Resident #5's urine changed color, he would not be able to explain why it happened. He said he would monitor Resident #5. He said he did not see a purple color in the catheter. He said staff should have notified him if there was a change of condition with the resident.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/8/2024 at 3:38p.m., the DON said she cancelled the transportation for the Resident #5 going to the hospital on 10/5/2024 because she was able to get Physician A to order IV fluids after he reviewed Resident #5's lab results. She said Physician A gave an order for 2 liters of IV fluid and that if Resident #5 was not drinking any fluids, then her urine was going to be dark. She said she first notified Physician A of the discoloration of dark, yellow urine on 10/5/2024. The DON said when Physician A sent the order for IV fluids, she contacted Resident #5's family and the family agreed to not send Resident #5 to the hospital as they had requested. The DON then said she was first notified about Resident #5 change of condition when a nurse told her about Physician A wanting to prescribe antibiotics for a UTI. She said it happened a week ago.</p> <p>Interview on 10/8/2024 at 3:35p.m., RN B said the first time she saw discoloration in Resident #5's urine was on 10/7/24. She said she had been working on Resident #5's hall for 3 months. She said she changed her catheter every month. She said she last changed her catheter a month ago and her urine was clear. She said Resident #5's UA came back negative. She said she communicated with the RP that her urine came back negative on 10/1/24. She showed documentation that the lab results revealed, UTI Panel: Enterococcus Faecalis- Gram-positive, Escherichia Coli- Gram-negative, and Proteus Mirabilis- Gram-negative. [Physician A] ordered Doxycycline Monohydrate Oral Capsule 100MG, give 1 capsule by mouth two times a day for prophylaxis UTI for 10 days.</p> <p>Interview on 10/8/24 at 3:48p.m., Physician A said he was first notified on 10/5/2024 about Resident #5's dark urine because she was not drinking enough water. He said if the lab was negative, they would normally start with a fluid and for Resident #5 started on Saturday, 10/5/2024. He said Resident #5 came into the facility with a Foley catheter. He said he had not seen Resident #5 in 3 weeks. He said he had been going off what the facility was telling him about Resident #5. He said he was scheduled to go to the facility on ce a week. He said he was on a monthly schedule to see the residents. He said a nurse at the facility should have informed him that Resident #5 needed to be seen. He said the nurse should have told NP A to see Resident #5 while he was at the facility. He said he had an order for fluids. He said he can give an order over the phone.</p> <p>Observation and interview on 10/8/2024 at 5:06p.m. with Resident #5, the DON, RN B and CNA A revealed Resident #5 lying awake in bed and could hardly speak. The DON grabbed the catheter bag and observed the purple urine. She said the color of the urine was a problem because Resident #5 could have an infection. She said the urine looked purple . CNA A said Resident #5's urine looked like a brownish purple color. She said the color of Resident #5's urine was not a normal color. She said yellow urine would be a normal color. RN B said Resident #5's urine looked like a brownish color, and it was not a normal color. She said it could be due to an infection or the intake of her juice. She said Resident #5 did not drink cranberry juice. The DON said it was her first time seeing Resident #5's catheter filled with purple urine. She said yesterday it was a dark colored urine but not purple.</p> <p>Interview on 10/8/24 at 5:15p.m., Physician A said he was told on 10/5/2024 by a staff member that Resident #5's urine was dark, and they requested fluids. He said staff changed their minds about sending Resident #5 out to the hospital after the order of the fluids and he said he was told the family was okay with the that. He said he did not know the family had requested for Resident #5 to be sent to the hospital and was adamant about her going. He said someone at the facility was supposed to inform him first. Physician A said he did not give orders to send the Resident #5 out to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/8/2024 at 5:22p.m., the DON, said the nurses changed Resident #5's Foley catheter a few times in the past weeks because of the family's request. She said Resident #5's family wanted it done.</p> <p>Interview on 10/8/2024 at 5:30p.m., CNA A said Resident #5's urine was a brownish, a purple color due to dehydration.</p> <p>Interview on 10/8/2024 at 6:02p.m., the NP said he had not assessed Resident #5 since 4/7/2024. He said he was at the facility on 10/8/2024, but the nurse said everything was okay with Resident #5. He said he saw her lying in bed, but he did not go into her room to physically see her. He said one of the nurses told him about another resident but never mentioned Resident #5 to him.</p> <p>Interview on 10/9/2024 at 12:27p.m., Family member A said they did not change their minds about sending Resident #5 to the hospital. She said they were waiting at home on 10/5/2024, when they received a call from a staff member at the facility, and they told her they were going to leave Resident #5 at the facility. She said the family did not approve it. She said a staff member called yesterday on 10/8/2024 and asked if they wanted to send Resident #5 to the hospital. She said she told them that she wanted to wait and see how Resident #5 was going to do with the new orders. Family member B said she gave permission to staff to send Resident#5 to the hospital on 10/5/2024. She said as of 10/9/2024 she wanted staff to start the antibiotics for the infection. She said she told them to wait to see what her reaction would be to the medication, and they would decide if they wanted to send Resident #5 to the hospital. She said the nurses took the catheter out of Resident #5. She said Physician A told staff to take out the catheter. She said one nurse came in the room looking for the Foley catheter and did not know that it was gone. She said a nurse on 10/4/2024 told her that Resident #5 had an infection.</p> <p>Interview on 10/9/24 at 12:42p.m., Physician A said Resident #5 was diagnosed with a stage 4 ulcer when she was transferred from the hospital, and she received a Foley catheter. He said Resident #5 failed a trial removal of the Foley catheter and had urinary tract retention. He said it failed once and she had a diagnosis of urinary tract infection. He said the facility did not talk about changing</p> <p>Resident #5's Foley catheter on 9/16/2024 or 9/29/2024. He said he never given staff permission to use a different order or talked to staff about using a different Foley catheter against the initial order. Physician A said on 10/8/20024, he gave an order to remove Resident #5's Foley catheter to see if she could pass urine without it. He said it was a trial removal and her Foley catheter was leaking. Physician A said Resident #5's wound reopened, and he was just informed about it. He said it could be due to nutrition. He said Resident #5 had a bad wound when she first entered the facility.</p> <p>Follow-up interview on 10/9/24 at 2:55p.m., with CNA A, said she told nurses and RN B about Resident #5's purple urine a month ago. She said Resident #5's family was concerned about her urine. She said the nurse said it could be from dehydration. CNA A said she was concerned because the color of the urine was yellow in her catheter a month ago. She said she tries to accommodate residents as best she can.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/10/24 at 9:27a.m., the Administrator said she had been working at the facility since 3/11/24. She said she would report change of conditions by following protocol. She said when Resident #5 had a change of condition she should have been a part of the conversation with the DON, but she was not notified about it. She said she was notified about Resident #5's purple urine during an end of day meeting, on 10/8/24. The Administrator said she was not aware that the size of Resident #5's Foley catheter that had been inserted by the nurses on 9/16/24 and 9/29/24 and was different from the physician orders. She said the IV was discussed during the morning meeting on 10/7/24. She said there was a problem with honoring the family's request to send Resident #5 to the hospital, providing education to staff and documentation. She said there was not a lot of documentation on what was going on with Resident #5. She said moving forward she would work on implementing staffing changes, removing people from their roles, providing training, and taking accountability. She said she would start contacting her for everything. She said she would set up a new template for clinical meetings and take advantage of quality monitoring resources that was made available to them.</p> <p>Interview on 10/10/24 at 11:27a.m., with the ADON said she had been working at the facility for over a year. She said she believed the communication between her, and staff had been going well. She said the family requested that Resident #5 be sent out to the hospital. She said the doctor was called and he gave an order for an IV due to possible dehydration and not eating well. She said she did not know there was an issue with Resident #5. She said she was not aware that Resident #5's urine was purple. She said no one mentioned anything to her about Resident #5's purple urine.</p> <p>Interview on 10/14/2024 at 12:31p.m., with a staff member who requested to remain anonymous, said communication with the staff at the facility was not good. She said staff did not respond quickly when a resident needed assistance with care. She said she told the DON about another resident's urine being a dark blue color about a month and a half ago and was told it was that color due to him being on a lot of medications. She said staff did not follow the stop and watch protocol.</p> <p>Interview on 10/14/2024 at 4:32p.m., with the Administrator and Facility Abuse Coordinator revealed when asked how she thought the IJ happened, said ultimately it was communication failure with Resident #5. She said that nursing should have been responsible for the catheter competencies and that they were in the process or reviewing. She said the DON was responsible for infection control tracking, trending and ABT stewardship. She said that they held a monthly QAPI, and that this month had to be rescheduled due to current state investigations and subsequent IJs. She said an Ad Hoc rescheduled QAPI had not been set with a date yet. She said that regarding Resident #5, she had not spoken to the family yet regarding their concerns but that there was a care plan meeting scheduled for 10/15/2024 that she would attend. She said there had been one scheduled last week, but family could not attend at that time and the date they had rescheduled for, the resident was out at the hospital. She said that upon initial hire, nursing was responsible for ensuring all nursing competencies and that nursing was responsible for documentation, but that moving forward she would also have to be oversight and was in the process of hiring a new ADON as well to help.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one of 6 residents (Resident #5) reviewed for urinary catheters.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #5 received treatment without delays for change in condition related to black, purple, and bloody urine in her Foley catheter . 2. The facility failed to follow the doctor's order regarding the size of the catheter that was supposed to be used and the indication for changing the Foley catheter . 3. The facility failed to provide care to Resident #5 in a timely manner after the family repeatedly requested Resident #5 be sent to the emergency room for evaluation of her purple urine and decline which caused a delay in care . <p>These failures could affect residents with urinary catheters and other medical conditions and could place them at risk for physical harm, pain, mental anguish, or emotional distress.</p> <p>Findings included:</p> <p>Record review of Resident #5's face sheet revealed she was an [AGE] year-old female who was admitted into the facility on [DATE]. She was diagnosed on [DATE] with, chronic kidney disease (long standing disease of the kidneys leading to renal failure. The kidneys filter waste and excess fluid from the blood. As kidneys fail, waste builds up), cognitive communication deficit (difficulty with communication caused by a disruption in cognitive process), neuromuscular dysfunction of bladder (a condition that occurs when the nerves and muscles of the bladder don't work together properly), and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>On 9/30/24 she was diagnosed with urinary tract infection. For about a month, the resident had been having blue and purple urine. Her change of condition had not been reported to the doctor until 10/8/24. On 10/8/2024 she was diagnosed with purple urine syndrome (a rare condition that causes the urine collection bag to turn purple or blue due to a urinary tract infection (UTI) and long-term catheter use).</p> <p>Record review of Resident #5's Comprehensive MDS dated [DATE] revealed she had a BIMs score of 0 out of 15 which indicated she was severely cognitively impaired. She required substantial/maximal assistance with eating and oral hygiene. Resident #5 was dependent for toileting hygiene, shower/bath self, upper body dressing, lower body dressing, and personal hygiene. She was dependent when needed to roll left and right and sit to lying. Resident #5 had an indwelling catheter.</p> <p>Record review of Resident #5's undated comprehensive care plan revealed the following, Toilet use: She is not toileted. Toilet use: She is totally dependent on (1-2) staff for incontinent care.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Focused Care at Pasadena		STREET ADDRESS, CITY, STATE, ZIP CODE 3434 Watters Rd Pasadena, TX 77504	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's base line care plan completed until 4/9/24 revealed the following, [Resident #5] Indwelling Foley Catheter and is at Risk for Increased Urinary Tract Infections: Pressure Ulcer sacral Urinary Catheter 20FR, 10 CC. Diagnosis: Urinary Retention.</p> <p>Record review of Resident #5's Progress Notes dated 9/16/24 at 6:43 p.m., entered by the ADON, reflected in part, . Foley catheter noted not to be in place and urine was coming out, using aseptic technique, foley catheter replaced with 18fr, 10ml balloon. Resident tolerated procedure and shows no s/s of pain or discomfort at this time</p> <p>Record review of Resident #5's Progress Notes dated 9/29/24 at 11:48 p.m., entered by the LVN C, reflected in part, .16 French, 10cc balloon foley catheter inserted into the urethra without resistance, sterile technique maintained throughout the process, perineal area cleaned with antiseptic solution, new sterile gloves donned (to put on PPE properly to achieve the intended protection and minimize the risk of exposure), clear yellow urine noted in drainage bag, balloon inflated with 10cc of sterile water, catheter secured to thigh with securing tape, resident tolerated the procedure well, no signs of pain after the procedure noted, will continue to monitor urine output .</p> <p>Record review of Resident #5's Progress Notes dated 9/30/24 at 10:45 p.m., entered by the LVN D, reflected in part, .16 French, 10cc balloon foley catheter inserted into the urethra without resistance, sterile technique maintained throughout the process, perinea! area cleaned with antiseptic solution, new sterile gloves donned, clear yellow urine noted in drainage bag, balloon inflated with 10cc of sterile water, catheter secured to thigh with securing tape, resident tolerated the procedure well, no signs of pain after the procedure noted, will continue to monitor urine output .</p> <p>Record review of Resident #5's Order Summary dated 9/30/24 revealed she had a diagnosis of urinary tract infection.</p> <p>Record review of Resident #5's Progress Notes dated 10/05/24 at 12:40a.m., entered by RN A, reflected in part, .Per family request, resident will be sent out to the hospital. The U/A lab results were reviewed and concluded client is positive with Gram negative and positive bacterium. HCP was contacted by documenting nurse with most recent lab results. Requesting how to move forward. No response considering its late hours of the night. After reviewing family concerns of client having blood tinge fluid in her catheter and reviewing medical docs. This nurse is honoring the request of the client's family and sending Resident #5 out .</p> <p>Record review of Resident #5's Progress Notes dated 10/05/24 at 7:56 a.m., entered by the DON, reflected in part, .This writer was made aware that resident RP is requesting her to be sent to the hospital and stated [Resident #5] has UTI, [Physician A] made aware and have orders for 0.9%ns @60ml/hr x 2L, Encourage po fluids. Rp called x 2 no response .</p> <p>Record review of Resident #5's Progress Notes dated 10/05/24 at 5:29 p.m., entered by RN C, reflected in part, . cancelled transportation to hospital per DON. resident alert foley bag exhibits about 10cc of urine. new order for normal saline for hydration 2000 ml per iv. 22g to left wrist patent and no s/s infection. continue to monitor. once started, urine began to flow from catheter dark red urine again. family wanted patient to go to hospital but now they are allowing [resident] to stay at the facility at this time .</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #5's Progress Notes dated 10/8/24 at 7:15p.m., entered by RN D, reflected in part, .Doxycycline Monohydrate, Oral Capsule 100MG, give 1 capsule by mouth two times a day for Prophylaxis for 10 days .</p> <p>Record review of Resident #5's Order summary Report dated 10/8/24, reflected in part, .Doxycycline Monohydrate (used to treat a wide variety of bacterial infections, including those that cause acne), Oral Capsule 100MG, give 1 capsule by mouth two times a day for Prophylaxis for 10 days . Start date: 10/9/24.</p> <p>Record review of Resident #5's hospital records dated 10/10/24 on page 5/16, revealed, altered mental status, unspecified altered mental status type: 2/2 UTI, UTI (urinary tract infection due to urinary indwelling foley catheter (CMS/HCC) (HCC).</p> <p>Observation on 10/8/24 at 1:35p.m. with Resident #5, revealed her lying asleep in bed. She had a fluid IV bag that was almost empty. She was covered up with a blanket. RN B removed the cover from Resident #5's catheter bag and it revealed that her urine was purple. RN B said Resident #5's urine had been a purple color for the past three days. She said she was not sure if it was blood or not.</p> <p>Interview on 10/8/2024 at 2:21p.m. RN A said Resident #5 had a medical diagnosis of a urinary tract infection on 9/30/2024. On 4/9/2024 Resident #5 was initiated for the catheter. RN A said Resident #5 was care planned for dehydration on, 4/11/2024 7/17/2024, 10/5/2024 and 10/8/2024. She said Resident #5 was not drinking or eating very well. She said Resident #5's family provided a bottle of water for them to give to her. She said sometimes she would take it and sometimes she would not. She said Resident #5 had a change of condition with her urine on 10/5/2024 and it was GI related. Physician A was contacted and put in an order for an IV.</p> <p>Interview on 10/8/24 at 2:36p.m., the NP said he assumed Resident #5 had a catheter to help her wounds heal faster. He said he first saw Resident #5 when she arrived at the facility from the hospital, upon admission, she had a foley catheter. He most of the time, nurses were to change the catheter in 30 days or if there was a malfunction. He said if Resident #5's urine changed color, he would not be able to explain why it happened. He said he would monitor Resident #5. He said he did not see a purple color in the catheter. He said staff should have notified him if there was a change of condition with the resident.</p> <p>Interview on 10/8/2024 at 3:38p.m., the DON said she cancelled the transportation for the Resident #5 going to the hospital on 10/5/2024 because she was able to get Physician A to order IV fluids after he reviewed Resident #5's lab results. She said Physician A gave an order for 2 liters of IV fluid and that if Resident #5 was not drinking any fluids, then her urine was going to be dark. She said she first notified Physician A of the discoloration of dark, yellow urine on 10/5/2024. The DON said when Physician A sent the order for IV fluids, she contacted Resident #5's family and the family agreed to not send Resident #5 to the hospital as they had requested. The DON then said she was first notified about Resident #5 change of condition when a nurse told her about Physician A wanting to prescribe antibiotics for a UTI. She said it happened a week ago.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/8/2024 at 3:35p.m., RN B said the first time she saw discoloration in Resident #5's urine was on 10/7/24. She said she had been working on Resident #5's hall for 3 months. She said she changed her catheter every month. She said she last changed her catheter a month ago and her urine was clear. She said Resident #5's UA came back negative. She said she communicated with the RP that her urine came back negative on 10/1/24. She showed documentation that the lab results revealed, UTI Panel: Enterococcus Faecalis- Gram-positive, Escherichia Coli- Gram-negative, and Proteus Mirabilis- Gram-negative. [Physician A] ordered Doxycycline Monohydrate Oral Capsule 100MG, give 1 capsule by mouth two times a day for prophylaxis UTI for 10 days.</p> <p>Interview on 10/8/24 at 3:48p.m., Physician A said he was first notified on 10/5/2024 about Resident #5's dark urine because she was not drinking enough water. He said if the lab was negative, they would normally start with a fluid and for Resident #5 started on Saturday, 10/5/2024. He said Resident #5 came into the facility with a Foley catheter. He said he had not seen Resident #5 in 3 weeks. He said he had been going off what the facility was telling him about Resident #5. He said he was scheduled to go to the facility on ce a week. He said he was on a monthly schedule to see the residents. He said a nurse at the facility should have informed him that Resident #5 needed to be seen. He said the nurse should have told NP A to see Resident #5 while he was at the facility. He said he had an order for fluids. He said he can give an order over the phone.</p> <p>Observation and interview on 10/8/2024 at 5:06p.m. with Resident #5, the DON, RN B and CNA A revealed Resident #5 lying awake in bed and could hardly speak. The DON grabbed the catheter bag and observed the purple urine. She said the color of the urine was a problem because Resident #5 could have an infection. She said the urine looked purple . CNA A said Resident #5's urine looked like a brownish purple color. She said the color of Resident #5's urine was not a normal color. She said yellow urine would be a normal color. RN B said Resident #5's urine looked like a brownish color, and it was not a normal color. She said it could be due to an infection or the intake of her juice. She said Resident #5 did not drink cranberry juice. The DON said it was her first time seeing Resident #5's catheter filled with purple urine. She said yesterday it was a dark colored urine but not purple.</p> <p>Interview on 10/8/24 at 5:15p.m., Physician A said he was told on 10/5/2024 by a staff member that Resident #5's urine was dark, and they requested fluids. He said staff changed their minds about sending Resident #5 out to the hospital after the order of the fluids and he said he was told the family was okay with the that. He said he did not know the family had requested for Resident #5 to be sent to the hospital and was adamant about her going. He said someone at the facility was supposed to inform him first. Physician A said he did not give orders to send the Resident #5 out to the hospital.</p> <p>Interview on 10/8/2024 at 5:22p.m., the DON, said the nurses changed Resident #5's Foley catheter a few times in the past weeks because of the family's request. She said Resident #5's family wanted it done.</p> <p>Interview on 10/8/2024 at 5:30p.m., CNA A said Resident #5's urine was a brownish, a purple color due to dehydration.</p> <p>Interview on 10/8/2024 at 6:02p.m., the NP said he had not assessed Resident #5 since 4/7/2024. He said he was at the facility on 10/8/2024, but the nurse said everything was okay with Resident #5. He said he saw her lying in bed, but he did not go into her room to physically see her. He said one of the nurses told him about another resident but never mentioned Resident #5 to him.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/9/2024 at 12:27p.m., Family member A said they did not change their minds about sending Resident #5 to the hospital. She said they were waiting at home on 10/5/2024, when they received a call from a staff member at the facility, and they told her they were going to leave Resident #5 at the facility. She said the family did not approve it. She said a staff member called yesterday on 10/8/2024 and asked if they wanted to send Resident #5 to the hospital. She said she told them that she wanted to wait and see how Resident #5 was going to do with the new orders. Family member B said she gave permission to staff to send Resident#5 to the hospital on 10/5/2024. She said as of 10/9/2024 she wanted staff to start the antibiotics for the infection. She said she told them to wait to see what her reaction would be to the medication, and they would decide if they wanted to send Resident #5 to the hospital. She said the nurses took the catheter out of Resident #5. She said Physician A told staff to take out the catheter. She said one nurse came in the room looking for the Foley catheter and did not know that it was gone. She said a nurse on 10/4/2024 told her that Resident #5 had an infection.</p> <p>Interview on 10/9/24 at 12:42p.m., Physician A said Resident #5 was diagnosed with a stage 4 ulcer when she was transferred from the hospital, and she received a Foley catheter. He said Resident #5 failed a trial removal of the Foley catheter and had urinary tract retention. He said it failed once and she had a diagnosis of urinary tract infection. He said the facility did not talk about changing</p> <p>Resident #5's Foley catheter on 9/16/2024 or 9/29/2024. He said he never given staff permission to use a different order or talked to staff about using a different Foley catheter against the initial order. Physician A said on 10/8/20024, he gave an order to remove Resident #5's Foley catheter to see if she could pass urine without it. He said it was a trial removal and her Foley catheter was leaking. Physician A said Resident #5's wound reopened, and he was just informed about it. He said it could be due to nutrition. He said Resident #5 had a bad wound when she first entered the facility.</p> <p>Follow-up interview on 10/9/24 at 2:55p.m., with CNA A, said she told nurses and RN B about Resident #5's purple urine a month ago. She said Resident #5's family was concerned about her urine. She said the nurse said it could be from dehydration. CNA A said she was concerned because the color of the urine was yellow in her catheter a month ago. She said she tries to accommodate residents as best she can.</p> <p>Interview on 10/10/24 at 9:27 a.m., the Administrator, said she had been working at the facility since 3/11/24. She said she recently received an IJ for quality of care. She said she would report change of conditions by following protocol. She said when Resident #5 had a change of condition she should have been a part of the conversation with the DON, but she was not notified about it. She said she was notified about Resident #5's purple urine during an end of day on 10/8/24. The Administrator said she was not aware that the size of Resident #5's Foley Catheter was inserted by the nurses on 9/16/24 and 9/29/24 was different from the physician orders. She said the IV was discussed during the morning meeting on 10/7/24. She said there was a problem with the DON not honoring the family's request to send Resident #5 to the hospital, not providing education to staff and lack documentation. She said there was not a lot of documentation on what was going on with Resident #5. She said moving forward she would work on implementing staffing changes, removing people from their roles, providing training, and taking accountability. She said she would start contacting her for everything. She said she would set up a new template for clinical meetings and take advantage of quality monitoring resources that was made available to them.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 10/10/24 at 11:27a.m., with the ADON said she had been working at the facility for over a year. She said she believed the communication between her, and staff had been going well. She said the family requested that Resident #5 be sent out to the hospital. She said the doctor was called and he gave an order for an IV due to possible dehydration and not eating well. She said she did not know there was an issue with Resident #5. She said she was not aware that Resident #5's urine was purple. She said no one mentioned anything to her about Resident #5's purple urine.</p> <p>During a phone interview on 10/13/2024 at 1:17p.m., with CNA B, said she had been working at the facility since 7/23/24. She said she had been working 200-hall, the same hall as Resident #5, since she started at the facility. She said she had noticed that Resident #5's urine in her catheter was purple about a month ago. She said she mentioned it several times to the nurses that were on duty during that time. She said she did not know if it was normal for Resident #5 to have purple urine, or if something was wrong. She said nurses reinserted Resident #5's catheter several times because of the purple urine. She said if there was a change of condition with a resident and nothing was done, the resident could die depending on how serious the situation was. She said she told a male and female nurse about Resident #5's purple urine, but she could not remember their names.</p> <p>Interview on 10/13/24 at 3:20p.m., with CNA C, said she had been working at the facility for 7 months. She said she would work 200-hall with Resident #5 depending on the schedule. She said at the beginning when she would measure the urine and the urine was yellow. She said in September 2024, she noticed the color change of Resident #5's urine. She said it would stain the bag and it was purple and brownish urine. She said when she drained the urine. It was a dark color but not as purple. She said she told RN B and another male nurse that works night shift about the color of the urine. She said RN B saw Resident #5's urine. She said the family would point it out to the nurses. She said she told staff about it two or three weeks ago. She said if a change of condition was not being treated, it could be bad for the resident or it could cause a problem that would require the resident to be sent to the hospital. She said it could also lead to death depending on how serious the condition of the resident.</p> <p>Interview on 10/14/2024 at 12:31p.m., with a staff member who requested to remain anonymous, said communication with the staff at the facility was not good. She said staff did not respond quickly when a resident needed assistance with care. She said she told the DON about another resident's urine being a dark blue color about a month and a half ago and was told it was that color due to him being on a lot of medications. She said staff did not follow the stop and watch protocol.</p> <p>Interview on 10/14/2024 at 4:32p.m., with the Administrator and Facility Abuse Coordinator revealed when asked how she thought the IJ happened, said ultimately it was communication failure with Resident #5. She said that nursing should have been responsible for the catheter competencies and that they were in the process or reviewing. She said the DON was responsible for infection control tracking, trending and ABT stewardship. She said that they held a monthly QAPI, and that this month had to be rescheduled due to current state investigations and subsequent IJs. She said an Ad Hoc rescheduled QAPI had not been set with a date yet. She said that regarding Resident #5, she had not spoken to the family yet regarding their concerns but that there was a care plan meeting scheduled for 10/15/2024 that she would attend. She said there had been one scheduled last week, but family could not attend at that time and the date they had rescheduled for, the resident was out at the hospital. She said that upon initial hire, nursing was responsible for ensuring all nursing competencies and that nursing was responsible for documentation, but that moving forward she would also have to be oversight and was in the process of hiring a new ADON as well to help.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record Review of the facility's policy titled Change in a Resident's Condition or Status dated 5/2017, reflected in part, . Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): accident or incident involving the resident; discovery of injuries of an unknown source; adverse reaction to medication; significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; refusal of treatment or medications two (2) or more consecutive times); need to transfer the resident to a hospital/treatment center; discharge without proper medical authority; and/or specific instruction to notify the Physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); Impacts more than one area of the residents health status; Requires interdisciplinary review and/or revision to the care plan; and Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47215</p> <p>Based on observation, interview and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1 of 1 kitchen:</p> <ul style="list-style-type: none"> -The facility failed to ensure that the kitchen floors were clean and free of food particles. -The facility failed to ensure gloves were worn by staff during food preparation. <p>These failures placed all residents who ate food served by the kitchen at risk of a food-borne illness.</p> <p>Findings included:</p> <p>Observation on 10/16/24 from 2:25 p.m., revealed the following:</p> <p>The kitchen floor near the stove, deep fryer, and handwashing sink, was dirty with food particles and grease stains.</p> <p>Cook A was preparing food and placed turkey meet in a grinder without wearing gloves.</p> <p>Interview on 10/16/24 at 2:28p.m., the Dietary Manager said he needed to buy soap. He said he put in an order to purchase soap for the kitchen. He said housekeeping was supposed to refill it, but they did not do it. He said they used dishwashing liquid, but he could not find the dishwashing liquid. He said staff is supposed to wear gloves when preparing or touching the food. He said if a cook is not wearing gloves when preparing the food, it could cause cross contamination.</p> <p>Interview on 10/16/24 at 2:32p.m., [NAME] A said he had been working at the facility for about a year. He said he did not need to wear gloves to stir the food. He said he was only supposed to wear gloves when he was handling food. He said not wearing gloves can cause cross contamination. He said the turkey was cooked and not raw, so he did not have to wear gloves while placing it in the grinder.</p> <p>Interview on 10/16/24 at 2:38p.m., the FSA said staff was supposed to wear gloves when handling food. She said if gloves are not worn while handling food, it could cause cross contamination, and someone could get sick. She said if hands are not washed while handling food, it could cause bacteria and spread a virus.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's policy entitled Preventing Foodborne Illness - Food Handling dated 4/20/2022, reflected in part- .This facility recognizes that the critical factors implicated in foodborne illness are: Poor personal hygiene of food service employees; Inadequate cooking and improper holding temperatures; Contaminated equipment; and Unsafe food sources. With these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents. All employees who handle, prepare, or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. This facility only accepts prepared foods from suppliers subject to federal, state, or Local food service inspections and who remain in good standing with such agencies .</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>47215</p> <p>Based on observation, interview and record review, the facility failed to ensure waste were properly contained in dumpster and covered, in 2 of 2 kitchen and outside dumpster:</p> <ul style="list-style-type: none"> -The facility failed close the lid to the dumpster. -The facility failed to provide lids to two trash cans that were placed inside of the kitchen. <p>This failure placed residents at risk for infection and a decreased quality of life due to having an exterior environment which could attract flying pests, rodents, and other animals.</p> <p>Findings include:</p> <p>Observation on 10/16/24 at 2:45 p.m., revealed a commercial-sized dumpster in the lot behind the dietary department and the lid was open and trash inside.</p> <p>Observation on 10/16/24 at 2:32p.m., revealed two trash cans in the kitchen that was not being used, with no lids on them. One of the trash cans was near the stove and the other trash can was between the deep fryer and the back door. Both trash cans had food particles inside of them.</p> <p>Interview on 10/16/2024 at 2:50p.m., with the Dietary Manager, he said trash cans with no lids should not be inside of the kitchen. He said it was unsanitary. He said he had been working in the kitchen for a month and the trash near the door and the deep fryer never had a lid on it. He said he ordered one, but it hasn't come in yet. He said the lid to the dumpster was supposed to be closed. He observed that the lid was open and said it was supposed to be closed. He said if the lid was open, it could cause dogs, rodents, debris, flies, and maggots to take over the trash and come on the facility grounds.</p> <p>Interview on 10/16/2024 at 3:00p.m., with the Regional VP of Operations, said the lid to the dumpster should have been closed. She said the trash cans in the kitchen should have had lids on them as well. She said it was not sanitary to have the lids off the trash cans in the kitchen.</p> <p>Record review of the facility's policy entitled Food and Nutrition Services will ensure that waste containers are properly maintained dated 4/20/2022, reflected in part-. Waste containers and dumpsters have lids covering them when not in use and are not overflowing. Area around dumpsters are kept clean and odor and rodent free. Dumpster plug is to be in place if not a sealed unit</p>