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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570 | |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</p> <p>Based on interview and record review the facility failed to ensure the resident had the right to be free from abuse or neglect, for one of four residents (Resident #2) reviewed for neglect:</p> <p>LVN D and LVN R did not stop advancing the Foley catheter tubing when Resident #2 was experiencing discomfort or pain and crying /groaning out.</p> <p>An Immediate Jeopardy was identified on 12/20/2024. The Immediate Jeopardy template was provided to the facility on [DATE] at 08:43 PM. While the Immediate Jeopardy was removed on 12/21/2024 at 06:05 PM. The IJ was lowered to isolated with no actual harm with a potential for more than minimal harm.</p> <p>This failure could place residents at risk of abuse / neglect resulting in serious injury, harm, impairment or death.</p> <p>Findings include:</p> <p>Record review of Resident #2's Face Sheet, dated 12/20/2024, revealed a [AGE] year old male admitted on [DATE] with the diagnoses including: Urinary Tract Infection (UTI), Hematuria (blood in the urine), benign prostatic hyperplasia without lower urinary tract symptoms (Age-associated prostate gland enlargement that can cause urination difficulty), dementia (a group of thinking and social symptoms that interferes with daily functioning such as forgetfulness, limited social skills, and thinking abilities so impaired that it interferes with daily functioning), and heart failure.</p> <p>Record review of Resident #2's Minimum Data Set assessment dated [DATE] revealed he:</p> <ul style="list-style-type: none"> -Had a BIMS of 00 which indicated severely impaired cognition -Minimal difficulty hearing -Clear speech -Sometimes he was understood by others -Sometimes he understands others <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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>-Incontinence of bladder was not rated. Resident #2 had a indwelling catheter</p> <p>-Always continent of bowel</p> <p>Record review of Resident #2's comprehensive care plan dated 11/26/2024 documented,</p> <p>FOCUS: o I require a foley catheter DX Obstructive Uropathy Date Initiated: 09/10/2024 Created on: 08/14/2023 Revision on:12/21/2024</p> <p>GOALS: o I will not experience any complications associated with my catheter to include trauma, infection or pain, dignity concerns through my next review date. Date Initiated: 08/15/2023 Created on: 08/15/2023 Target Date: 02/24/2025</p> <p>INTERVENTIONS/TASKS: o Catheter Care every shift and as indicated. Provide catheter secure band/tape as indicated. Offer/provide a privacy bag or cover drainage bag as indicated. Date Initiated: 08/14/2023 NSG CNA Created on: 08/14/2023 o Change catheter per my physician's orders. Date Initiated: 09/10/2024 Created on: 08/14/2023 Revision on: 09/10/2024 NSG CNA o Check tubing for kinks each shift & during care encounters. Date Initiated: 08/14/2023 Created on: 08/14/2023 NSG o Monitor for s/sx infection. Date Initiated: 08/14/2023 Created on: 08/14/2023 NSG o Monitor for s/sx of discomfort and abnormalities report those findings to MD as indicated. Date Initiated: 10/02/2024 Created on: 10/02/2024 NSG o Remind pt. not to move foley catheter to prevent leaking and injuries. Date Initiated: 10/02/2024 Created on: 10/02/2024</p> <p>Record review of Resident #2's Progress Notes revealed Resident #2 was transferred to the hospital on 12/06/24 due to blood in the Foley catheter bag.</p> <p>Record review of Resident #2's Progress Notes revealed Resident #2 was</p> <p>Record review of Resident #2's physician's orders revealed, Start Date: 12/14/24</p> <p>Order Summary: Foley Catheter 20Fr 30CC, change 3weeks and PRN, per (Dr.) (urologist), change foley bag with f/c change as needed related to BENIGN PROSTATIC HYPERPLASIA WITHOUT LOWER URINARY TRACT SYMPTOMS</p> <p>Record review of Resident #2's physician's orders revealed, Start Date: 12/16/24</p> <p>Order Summary:</p> <p>REFER TO DR. (name) DX: BLOOD LOSS ANEMIA REQUIRING IRON INFUSION.</p> <p>Record review of Resident #2's Treatment Administration Record revealed Resident #2 had a foley catheter change on 12/06/24.</p> <p>Record review of Resident #2's progress notes dated 12/06/2024 at 11:39 am written by LVN D revealed, Foley catheter changed due to leaking; resident tolerated well, yellow color urine flow noted. Resident tolerated procedure well, no acute distress at this time.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #2's progress notes dated 12/06/2024 at 02:05 pm written by LVN R revealed, placed call out to Dr. d/t foley catheter changed, resident noted with blood in foley leg bag after foley changed, pending call back.</p> <p>Record review of Resident #2's progress notes dated 12/06/2024 at 5:10 pm written by ADON/RN revealed, May flush foley catheter with 60mls of NS as needed for leakage/blockage as needed for leakage/blockage PRN Administration was: Ineffective resident continues with hematuria, resident being sent to ER</p> <p>Record review of Resident #2's progress notes dated 12/06/2024 at 09:36 pm written by LVN S revealed, Received call from RN stating that resident will be admitted to hospital DX: Hematuria.</p> <p>Record review of Resident #2's progress notes dated 12/06/2024 at 10:13 PM written by LVN S revealed, admitted to Hospital.</p> <p>In a telephone interview on 12/20/24 at 02:24 pm Complainant, stated sent pictures of foley bag and video through Messenger of the foley change on Resident #2 on 12/06/24 to surveyor.</p> <p>Observation on 12/20/24 at 02:25 pm of videos of Resident #2's room with audio of foley catheter change with LVN D, LVN R, ADON/RN, and CNA U.</p> <p>In an interview on 12/20/24 at 04:05 pm LVN R stated resident asked what they were doing and LVN D told him they were going to change his foley. LVN R could not remember if resident said anything else during the change. LVN R does not recall resident saying anything or crying out. LVN R stated if the resident tells them to stop or cries out, they are supposed to stop because that is what the resident wants. LVN R stated she was not sure what the negative outcome would be if they did not stop when resident said to or cried out. LVN R stated CNAs notified her of blood in catheter bag when they did their 2 hour check. LVN R stated she notified LVN D and ADON/RN they needed to check the catheter bag and then they went to notify the doctor. LVN R stated the doctor stated to continue to monitor and flush. LVN R stated she heard when she returned from her days off that Resident #2 had been sent out to the hospital and she had not worked in that hall since then. LVN R stated the return at the time of the foley change was light red. LVN R stated resident was not medicated before or after the foley catheter change. LVN R stated catheter was changed every two weeks but since his return from the hospital it is every three weeks. LVN R stated she heard that RNs were the only ones to change Resident #2's foley from now on.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on 12/20/24 T 04:46 pm LVN D stated the DON asked her to assist LVN R with a foley change because two always go in Resident #2's room because the family is particular. LVN D is Medical Records and works the floor and works on call. LVN D stated she had done the foley change on Resident #2. LVN D stated LVN R filled the foley balloon. LVN D stated Resident #2 was not medicated prior to change and did not recall if LVN R gave him something after. LVN D stated Resident #2 did not cry out, say no, or anything. She said he was aware of what was going to happen. LVN D stated she also aided him in breathing when changing the foley. LVN D stated it was not difficult to change the foley catheter. LVN D stated there was yellow urine return when foley catheter was placed. LVN D stated LVN R and a CNA were in the room for the foley change. LVN D stated if a resident says stop or no, we stop. Resident #2 cried out when LVN R inflated the balloon and LVN D told LVN R to stop, deflate the balloon, and get ADON/RN. ADON/RN came in the room and LVN D had pulled catheter out 2-3cm and resident did not react. LVN D stated ADON/RN came in and pushed the catheter in and inflated the balloon. She said the resident did not react. LVN D stated at the end of inflating the balloon, LVN D stated she noticed pink-tinged urine at the connection of the tube to bag. LVN D stated she showed ADON / RN. LVN D stated ADON / RN said that sometimes happens when replacing or changing a foley, you get pink tinged urine. LVN D stated they never pulled the catheter out and in and out and in. LVN D did not say what negative outcome would be if they did not stop when resident said to. LVN D stated she was working when they asked the doctor to come in and check resident. LVN D stated the doctor ordered resident to be sent out to the hospital. LVN D stated they let the RP know the catheter needs changed and she decides who is going to change the catheter. LVN D stated she went on break and when she came back, LVN R told her of blood in the catheter bag. LVN D stated when the doctor came in, ADON / RN did rounds with him.</p> <p>In an interview on 12/20/24 at 05:13 pm ADON/RN stated LVN R came to her and told her LVN D needed her. ADON / RN stated she went to Resident #2's room and LVN D told her when she tried to advance the catheter, she felt resistance and asked for assistance. ADON / RN stated she moved the catheter maybe an inch or two with no resistance and she inflated the balloon. ADON/RN stated the return was yellow with tinge of pink. ADON/RN stated she went back to her office. ADON/RN stated LVN R notified ADON/RN of the hematuria. ADON/RN stated she called the MD and had an order for flush. The ADON/RN stated she flushed the catheter and the resident was not in distress.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on 12/20/24 at 05:28 pm telephone interview with CNA U stating LVN D and LVN R were in Resident #2's room CNA U stated at the end the ADON/RN came in. CNA U stated she was in the room the whole time when the foley catheter was changed. CNA U stated LVN D was doing the Foley change and LVN R was preparing what LVN D needed. CNA U stated LVN R did not do anything. CNA U stated LVN D did everything. CNA U stated at the beginning the resident was asking what they were doing and why. CNA U stated when they were almost done, the resident started complaining. CNA U stated LVN R left the room to get ADON/RN and LVN D stopped what she was doing. CNA U stated ADON/RN came in and asked the resident if he were in pain and he said he was in a little pain. CNA U stated they started assessing the resident. CNU stated ADON/RN checked the foley catheter and said it was in right. CNA U stated ADON/RN asked the resident again if her were in pain and the resident stated no. CNA U stated LVN D and ADON/RN left and LVN R and her stayed to settle the resident. CNA U stated by the time they left, there was no blood. CNA U stated thirty minutes later, she went to drain the bag and it had dark red blood in the bag missed with urine. CNA U stated the bag was 1/4 the way full. CNA U stated the Resident #2 was in his room. CNA U stated she went and told LVN R and they both went back to the room to check the foley bag. CNA U said that was at the end of her shift and when she came back to work, he was in the hospital. CNA U stated Resident #2 never cried out and resident would say he had no pain until the end when they went to get ADON/RN. CNA U stated she was unsure if resident received medication before or after for pain. CNA U stated she asked about resident and the nurses told her he had been sent to the hospital because of bleeding.</p> <p>In an interview on 12/20/24 at 05:45 pm the DON stated she knew about the foley catheter change. DON stated she spoke with RP saying the catheter was leaking. The DON stated LVN R was busy so she asked LVN D to go check his foley catheter. The DON stated one of the LVNs told her the foley was bleeding and the doctor came in and gave orders to send Resident #2 out to the hospital. The DON said RP showed her other videos but she could not remember if she showed her the video of the foley change. The DON stated RP wanted only RNs to change the foley catheter on Resident #2 and the DON told her there were only 2 RNs and if either were at the facility, sure they would, but all the nurses knew how to change a foley catheter. DON stated RP told them it was possibly trauma that caused the bleeding. DON and the administrator were in the administrator's office talking to her and the DON stated if a resident said no or cried out, the nurses should stop because it was the resident's right to say no.</p> <p>In an interview on 12/20/24 at 06:00 pm the administrator stated he was notified of the resident being sent out to the hospital. The administrator said he did not think the Resident #2's RP showed or attempted to show video of foley catheter change.</p> <p>12/20/24 06:07 pm meeting with DON, LVN R, LVN D, and ADON / RN. Surveyor asked them all if resident cried out, showed discomfort or pain. LVN R and LVN D stated he did not. Surveyor played video where resident was heard yelling, saying no no no, just put a bullet in me, please, please, [NAME] [NAME], etc. LVNs said nothing. Both LVNs stated that when a resident was in pain or discomfort or calling out, they should stop what they were doing. LVNs would not say anything further.</p> <p>In an interview on 12/21/24 at 02:33 pm The DON stated she had watched/listened to the video FM sent to administrator. She said she was very upset. The DON stated she was not upset with surveyor, she was hurt, disappointed, and upset with her nurses for lying to her (Resident #2's pain and discomfort).</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on 12/20/24 at 06:35 pm FM stated she was sending the video to administrator's email.</p> <p>12/20/24 08:43 pm IJ presented to facility.</p> <p>12/21/24 12:15 am Facility sent POR to surveyor, ARD, and PM.</p> <p>12/21/24 09:05 am POR accepted.</p> <p>Observation on 12/21/24 at 05:27 pm of incontinent care of Resident #2 by CNA V and CNA W with no deficiencies cited.</p> <p>In an interview on 12/21/24 at 02:33 pm The DON stated she had watched/listened to the video FM sent to administrator. She said she was very upset. The DON stated she was not upset with surveyor, she was hurt, disappointed, and upset with her nurses for lying to her.</p> <p>12/21:24 06:05 pm IJ lifted.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 12/21/2024 at 06:05 PM. The facility remained out of compliance at a severity level of 4 and a scope of J due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p> <p>Immediate Corrective Action Response:</p> <p>The resident identified as #2 was reassessed on 12/20/24. Resident #2's plan of care reviewed to validate that appropriate intervention is in place and noted on the care plan related to foley insertion and care.</p> <p>Regional Nurse / Director of Nursing provided in-service training LVN D (now LVN R), E (now LVN D), and RN ADON regarding:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Identification Risk Response</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>All residents who require and indwelling foley catheter may be at risk of the alleged deficient practice.</p> <p>Director of Nursing / Assistant Director of Nursing / Designee conducted an audit to identify all residents with indwelling foley catheters to identify any resident having s/s of pain associated with the catheter and/or s/ s of hematuria.</p> <p>Outcome: There were no negative outcomes identified.</p> <p>Date completed: 12/21/24</p> <p>Director of Nursing / Assistant Director of Nursing / Designee interviewed residents who were identified as interviewable and who require and indwelling foley catheter in order to identify any concerns of pain during the procedure of changing of catheter.</p> <p>Outcome: no negative outcomes identified.</p> <p>Date completed: 12/21/24</p> <p>Systemic Change Response</p> <p>The Regional Nurse / DNS educated the licensed nurses regarding:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Director of Nursing / Assistant Director of Nursing and Clinical Leadership will conduct training for all newly hired nurses, PRN nurses and agency nurses prior to the nurses working. In-service training:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>(continued on next page)</p> |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <ul style="list-style-type: none"> - In-services on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, - Education (computer education), and - Return demonstrations of placing an indwelling foley catheter on dummies both male and female. <p>- Documentation for education and return demonstrations for 97% of nursing staff. 3 PRN nurses will not be allowed on the floor until in-service, education, and return demonstration are completed.</p> <p>Documentation for assessment of 11 residents with indwelling foley catheters with no issues, concerns or change in condition.</p> <p>Record review of the licensed nurse's In-Service Program Attendance Record for the following topic Abuse Neglect and Exploitation Prevention, Reporting and Protecting conducted by DON / designee. 15 LVN's and 1 RN were in-serviced between 12/20/2024 and 12/21/2024.</p> <p>Record review of the licensed nurse's computer-based education on catheter insertion. 15 LVN's and 1 RN reviewed computer-based training between 12/20/2024 and 12/21/2024.</p> <p>Record review of the licensed nurse's return demonstration conducted by DON /designee 15 LVN's and 1 RN were in-serviced between 12/20/2024 and 12/21/2024.</p> <p>Interviews on 12/21/2024 between 12:30 PM and 5:00 PM, the survey team interviewed 8 licensed staff (7 LVN's and 1 RN), interviewed licensed staff verbalized understanding of what they learned during in-services they received between 12/20/2024 and 12/21/2024.</p> <p>Interview on 12/21/2024 at 02:35 PM, LVN T was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 03:13 PM, LVN X was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 03:26 PM, LVN Y was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 03:43 PM, LVN D was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>(continued on next page)</p> |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Interview on 12/21/2024 at 04:04 PM, ADON / RN was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 04:20 PM, LVN Z was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Observation of Timeline on 12/23/24 at 08:30 AM:</p> <p>12/06/24 11:10 AM LVN D, LVN R, and CNA entered room to do a foley catheter change. LVN D explained to resident #2 what and why they were there.</p> <p>12/06/24 11:13 AM Resident starts yelling out. LVN D tells him to breathe.</p> <p>12/06/24 11:21 AM LVN D stopped due to resistance and LVN R went to get RN.</p> <p>12/06/24 11:25 AM RN enters room and advances / completes F/C change. Resident does not cry out.</p> <p>12/06/24 11:27 AM RN leaves room.</p> <p>12/06/24 02:05 PM Doctor #1 first notified of blood in foley bag.</p> <p>12/06/24 02:27 PM Doctor #2 (Urologist) notified. His MA said to monitor resident for discomfort or pain. MA stated it was normal for bleeding to occur when foley is changed.</p> <p>12/06/24 02:38 PM Doctor #3 notified. He said to continue to monitor and new order for UA given.</p> <p>12/06/24 04:09 PM Doctor #4 gave order for IV antibiotics for 1 time a day until 12/13/24.</p> <p>12/06/24 04:49 PM Doctor #3 went in to see resident. Order for resident to be sent out to hospital. Diagnosis was microscopic Acute Hematuria.</p> <p>12/06/24 05:08 PM EMS called to transport resident to hospital.</p> <p>12/06/24 05:30 PM EMS arrives.</p> <p>12/06/24 09:36 PM resident admitted to hospital diagnosis hematuria (blood in urine).</p> <p>12/14/24 04:51 PM Resident readmitted to facility.</p> <p>In an interview and observation on 12/23/24 at 12:45 PM The DON stated check off list for POR had 97% of nursing staff signed off. The DON stated the only staff left to be in-serviced, educated, and trained were the PRN staff. The DON stated they would not be allowed on the floor until they completed all. Check off list was reviewed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the facility's policy on Incontinence and Catheterization Assessment and Evaluation Date revised: January 2023 revealed,</p> <p>Indwelling Catheter</p> <p>For a resident who was admitted to the community with an indwelling urinary catheter or who had one placed after admission, the community will:</p> <ul style="list-style-type: none"> -Recognize and assess factors affecting the resident's urinary function and identified the medical justification for the use of an indwelling urinary catheter. -Define and implement pertinent interventions consistent with resident conditions, goals, and recognized standards of practice to try to minimize complications from an indwelling urinary catheter and to remove it if clinically indicated. -Monitor and evaluate the resident's response to interventions. -Revise the approaches as appropriate. <p>Review of the facility's policy on Pain Management Date Implemented: 03/14/2019, Date Revised: [DATE], revealed:</p> <p>Compliance Guidelines:</p> <p>To assess the resident pain control and management needs at admission/readmission, quarterly, annual and when a change of condition indicates a need for initiating or modifying a pain management program for the residents.</p> <p>The goal of the community Pain Management Program is that pain is identified and treated timely, effectively and consistently.</p> <p>OVERVIEW</p> <p>.Residents who experience a change in condition or have a suspected new onset of pain are evaluated for pain. Residents are also evaluated for pain regularly by team members inquiring if they have pain and observation of the resident for nonverbal signs and symptoms of pain.</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41761</p> <p>Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, for 1 of 8 residents (Resident#2) reviewed for abuse and neglect, in that:</p> <p>The facility failed to implement their Abuse Neglect Exploitation (ANE) policy when LVN D and LVN R did not stop advancing the Foley catheter tubing when Resident #2 was experiencing pain, which resulted in hospitalization . Per region response, the facility's ANE policy was obtained.</p> <p>An Immediate Jeopardy was identified on [DATE]. The Immediate Jeopardy template was provided to the facility on [DATE] at 08:43 PM. While the Immediate Jeopardy was removed on [DATE] at 06:05 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm because LVN D and LVN R did not implement facility abuse policy related to reporting abuse to the Administrator when Resident #2 experienced pain and blood to his urine from advancement of a Foley when there was resistance.</p> <p>This failure could place residents at risk of abuse and neglect.</p> <p>The findings included:</p> <p>Record review of Resident #2's Face Sheet, dated [DATE], revealed a [AGE] year old male admitted on [DATE] with the diagnoses including: Urinary Tract Infection (UTI), Hematuria (blood in the urine), benign prostatic hyperplasia without lower urinary tract symptoms (Age-associated prostate gland enlargement that can cause urination difficulty), dementia (a group of thinking and social symptoms that interferes with daily functioning such as forgetfulness, limited social skills, and thinking abilities so impaired that it interferes with daily functioning), and heart failure.</p> <p>Record review of Resident #2's Minimum Data Set assessment dated [DATE] revealed he:</p> <ul style="list-style-type: none"> -Had a BIMS of 00 which indicated severely impaired cognition -Minimal difficulty hearing -Clear speech -Sometimes he was understood by others -Sometimes he understands others -Incontinence of bladder was not rated. Resident #2 had a indwelling catheter -Always continent of bowel <p>Record review of Resident #2's comprehensive care plan dated [DATE] documented,</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>FOCUS: o I require a foley catheter DX Obstructive Uropathy Date Initiated: [DATE] Created on: [DATE] Revision on:[DATE]</p> <p>GOALS: o I will not experience any complications associated with my catheter to include trauma, infection or pain, dignity concerns through my next review date. Date Initiated: [DATE] Created on: [DATE] Target Date: [DATE]</p> <p>INTERVENTIONS/TASKS: o Catheter Care every shift and as indicated. Provide catheter secure band/tape as indicated. Offer/provide a privacy bag or cover drainage bag as indicated. Date Initiated: [DATE] NSG CNA Created on: [DATE] o Change catheter per my physician's orders. Date Initiated: [DATE] Created on: [DATE] Revision on: [DATE] NSG CNA o Check tubing for kinks each shift & during care encounters. Date Initiated: [DATE] Created on: [DATE] NSG o Monitor for s/sx infection. Date Initiated: [DATE] Created on: [DATE] NSG o Monitor for s/sx of discomfort and abnormalities report those findings to MD as indicated. Date Initiated: [DATE] Created on: [DATE] NSG o Remind pt. not to move foley catheter to prevent leaking and injuries. Date Initiated: [DATE] Created on: [DATE]</p> <p>Record review of Resident #2's Progress Notes revealed Resident #2 was transferred to the hospital on [DATE] due to blood in the Foley catheter bag.</p> <p>Record review of Resident #2's Progress Notes revealed Resident #2 was</p> <p>Record review of Resident #2's physician's orders revealed, Start Date: [DATE]</p> <p>Order Summary: Foley Catheter 20Fr 30CC, change 3weeks and PRN, per (Dr.) (urologist), change foley bag with f/c change as needed related to BENIGN PROSTATIC HYPERPLASIA WITHOUT LOWER URINARY TRACT SYMPTOMS</p> <p>Record review of Resident #2's physician's orders revealed, Start Date: [DATE]</p> <p>Order Summary:</p> <p>REFER TO DR. (name) DX: BLOOD LOSS ANEMIA REQUIRING IRON INFUSION.</p> <p>Record review of Resident #2's Treatment Administration Record revealed Resident #2 had a foley catheter change on [DATE].</p> <p>Record review of Resident #2's progress notes dated [DATE] at 11:39 am written by LVN D revealed, Foley catheter changed due to leaking; resident tolerated well, yellow color urine flow noted. Resident tolerated procedure well, no acute distress at this time.</p> <p>Record review of Resident #2's progress notes dated [DATE] at 02:05 pm written by LVN R revealed, placed call out to Dr. d/t foley catheter changed, resident noted with blood in foley leg bag after foley changed, pending call back.</p> <p>Record review of Resident #2's progress notes dated [DATE] at 5:10 pm written by ADON/RN revealed, May flush foley catheter with 60mls of NS as needed for leakage/blockage as needed for leakage/blockage PRN Administration was: Ineffective resident continues with hematuria, resident being sent to ER</p> <p>(continued on next page)</p> |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Record review of Resident #2's progress notes dated [DATE] at 09:36 pm written by LVN S revealed, Received call from RN stating that resident will be admitted to hospital DX: Hematuria.</p> <p>Record review of Resident #2's progress notes dated [DATE] at 10:13 PM written by LVN S revealed, admitted to Hospital.</p> <p>In a telephone interview on [DATE] at 02:24 pm Complainant, stated sent pictures of foley bag and video through Messenger of the foley change on Resident #2 on [DATE] to surveyor.</p> <p>Observation on [DATE] at 02:25 pm of videos of Resident #2's room with audio of foley catheter change with LVN D, LVN R, ADON/RN, and CNA U.</p> <p>In an interview on [DATE] at 04:05 pm LVN R stated resident asked what they were doing and LVN D told him they were going to change his foley. LVN R could not remember if resident said anything else during the change. LVN R does not recall resident saying anything or crying out. LVN R stated if the resident tells them to stop or cries out, they are supposed to stop because that is what the resident wants. LVN R stated she was not sure what the negative outcome would be if they did not stop when resident said to or cried out. LVN R stated CNAs notified her of blood in catheter bag when they did their 2 hour check. LVN R stated she notified LVN D and ADON/RN they needed to check the catheter bag and then they went to notify the doctor. LVN R stated the doctor stated to continue to monitor and flush. LVN R stated she heard when she returned from her days off that Resident #2 had been sent out to the hospital and she had not worked in that hall since then. LVN R stated the return at the time of the foley change was light red. LVN R stated resident was not medicated before or after the foley catheter change. LVN R stated catheter was changed every two weeks but since his return from the hospital it is every three weeks. LVN R stated she heard that RNs were the only ones to change Resident #2's foley from now on.</p> <p>(continued on next page)</p> |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on [DATE] T 04:46 pm LVN D stated the DON asked her to assist LVN R with a foley change because two always go in Resident #2's room because the family is particular. LVN D is Medical Records and works the floor and works on call. LVN D stated she had done the foley change on Resident #2. LVN D stated LVN R filled the foley balloon. LVN D stated Resident #2 was not medicated prior to change and did not recall if LVN R gave him something after. LVN D stated Resident #2 did not cry out, say no, or anything. She said he was aware of what was going to happen. LVN D stated she also aided him in breathing when changing the foley. LVN D stated it was not difficult to change the foley catheter. LVN D stated there was yellow urine return when foley catheter was placed. LVN D stated LVN R and a CNA were in the room for the foley change. LVN D stated if a resident says stop or no, we stop. Resident #2 cried out when LVN R inflated the balloon and LVN D told LVN R to stop, deflate the balloon, and get ADON/RN. ADON/RN came in the room and LVN D had pulled catheter out ,d+[DATE]cm and resident did not react. LVN D stated ADON/RN came in and pushed the catheter in and inflated the balloon. She said the resident did not react. LVN D stated at the end of inflating the balloon, LVN D stated she noticed pin-tinged urine at the connection of the tube to bag. LVN D stated she showed ADON / RN. LVN D stated ADON / RN said that sometimes happens when replacing or changing a foley, you get pink tinged urine. LVN D stated they never pulled the catheter out and in and out and in. LVN D did not say what negative outcome would be if they did not stop when resident said to. LVN D stated she was working when they asked the doctor to come in and check resident. LVN D stated the doctor ordered resident to be sent out to the hospital. LVN D stated they let the RP know the catheter needs changed and she decides who is going to change the catheter. LVN D stated she went on break and when she came back, LVN R told her of blood in the catheter bag. LVN D stated when the doctor came in, ADON / RN did rounds with him.</p> <p>In an interview on [DATE] at 05:13 pm ADON/RN stated LVN R came to her and told her LVN D needed her. ADON / RN stated she went to Resident #2's room and LVN D told her when she tried to advance the catheter, she felt resistance and asked for assistance. ADON / RN stated she moved the catheter maybe an inch or two with no resistance and she inflated the balloon. ADON/RN stated the return was yellow with tinge of pink. ADON/RN stated she went back to her office. ADON/RN stated LVN R notified ADON/RN of the hematuria. ADON/RN stated she called the MD and had an order for flush. The ADON/RN stated she flushed the catheter and the resident was not in distress.</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on [DATE] at 05:28 pm telephone interview with CNA U stating LVN D and LVN R were in Resident #2's room CNA U stated at the end the ADON/RN came in. CNA U stated she was in the room the whole time when the foley catheter was changed. CNA U stated LVN D was doing the Foley change and LVN R was preparing what LVN D needed. CNA U stated LVN R did not do anything. CNA U stated LVN D did everything. CNA U stated at the beginning the resident was asking what they were doing and why. CNA U stated when they were almost done, the resident started complaining. CNA U stated LVN R left the room to get ADON/RN and LVN D stopped what she was doing. CNA U stated ADON/RN came in and asked the resident if he were in pain and he said he was in a little pain. CNA U stated they started assessing the resident. CNU stated ADON/RN checked the foley catheter and said it was in right. CNA U stated ADON/RN asked the resident again if her were in pain and the resident stated no. CNA U stated LVN D and ADON/RN left and LVN R and her stayed to settle the resident. CNA U stated by the time they left, there was no blood. CNA U stated thirty minutes later, she went to drain the bag and it had dark red blood in the bag missed with urine. CNA U stated the bag was ,d+[DATE] the way full. CNA U stated the Resident #2 was in his room. CNA U stated she went and told LVN R and they both went back to the room to check the foley bag. CNA U said that was at the end of her shift and when she came back to work, he was in the hospital. CNA U stated Resident #2 never cried out and resident would say he had no pain until the end when they went to get ADON/RN. CNA U stated she was unsure if resident received medication before or after for pain. CNA U stated she asked about resident and the nurses told her he had been sent to the hospital because of bleeding.</p> <p>In an interview on [DATE] at 05:45 pm the DON stated she knew about the foley catheter change. DON stated she spoke with RP saying the catheter was leaking. The DON stated LVN R was busy so she asked LVN D to go check his foley catheter. The DON stated one of the LVNs told her the foley was bleeding and the doctor came in and gave orders to send Resident #2 out to the hospital. The DON said RP showed her other videos but she could not remember if she showed her the video of the foley change. The DON stated RP wanted only RNs to change the foley catheter on Resident #2 and the DON told her there were only 2 RNs and if either were at the facility, sure they would, but all the nurses knew how to change a foley catheter. DON stated RP told them it was possibly trauma that caused the bleeding. DON and the administrator were in the administrator's office talking to her and the DON stated if a resident said no or cried out, the nurses should stop because it was the resident's right to say no.</p> <p>In an interview on [DATE] at 06:00 pm the administrator stated he was notified of the resident being sent out to the hospital. The administrator said he did not think the Resident #2's RP showed or attempted to show video of foley catheter change.</p> <p>[DATE] 06:07 pm meeting with DON, LVN R, LVN D, and ADON / RN. Surveyor asked them all if resident cried out, showed discomfort or pain. LVN R and LVN D stated he did not. Surveyor played video where resident was heard yelling, saying no no no, just put a bullet in me, please, please, [NAME] [NAME], etc. LVNs said nothing. Both LVNs stated that when a resident was in pain or discomfort or calling out, they should stop what they were doing. LVNs would not say anything further.</p> <p>In an interview on [DATE] at 02:33 pm The DON stated she had watched/listened to the video FM sent to administrator. She said she was very upset. The DON stated she was not upset with surveyor, she was hurt, disappointed, and upset with her nurses for lying to her (Resident #2's pain and discomfort).</p> <p>In an interview on [DATE] at 06:35 pm FM stated she was sending the video to administrator's email.</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>[DATE] 08:43 pm IJ presented to facility.</p> <p>[DATE] 12:15 am Facility sent POR to surveyor, ARD, and PM.</p> <p>[DATE] 09:05 am POR accepted.</p> <p>Observation on [DATE] at 05:27 pm of incontinent care of Resident #2 by CNA V and CNA W with no deficiencies cited.</p> <p>In an interview on [DATE] at 02:33 pm The DON stated she had watched/listened to the video FM sent to administrator. She said she was very upset. The DON stated she was not upset with surveyor, she was hurt, disappointed, and upset with her nurses for lying to her.</p> <p>,d+[DATE]:24 06:05 pm IJ lifted.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 06:05 PM. The facility remained out of compliance at a severity level of no actual harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p> <p>Immediate Corrective Action Response:</p> <p>The resident identified as #2 was reassessed on [DATE]. Resident #2's plan of care reviewed to validate that appropriate intervention is in place and noted on the care plan related to foley insertion and care.</p> <p>Regional Nurse / Director of Nursing provided in-service training LVN D (now LVN R), E (now LVN D), and RN ADON regarding:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Identification Risk Response</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570 | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>All residents who require and indwelling foley catheter may be at risk of the alleged deficient practice.</p> <p>Director of Nursing / Assistant Director of Nursing / Designee conducted an audit to identify all residents with indwelling foley catheters to identify any resident having s/s of pain associated with the catheter and/or s/ s of hematuria.</p> <p>Outcome: There were no negative outcomes identified.</p> <p>Date completed: [DATE]</p> <p>Director of Nursing / Assistant Director of Nursing / Designee interviewed residents who were identified as interviewable and who require and indwelling foley catheter in order to identify any concerns of pain during the procedure of changing of catheter.</p> <p>Outcome: no negative outcomes identified.</p> <p>Date completed: [DATE]</p> <p>Systemic Change Response</p> <p>The Regional Nurse / DNS educated the licensed nurses regarding:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Director of Nursing / Assistant Director of Nursing and Clinical Leadership will conduct training for all newly hired nurses, PRN nurses and agency nurses prior to the nurses working. In-service training:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>(continued on next page)</p> |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Date completed: [DATE]</p> <p>Director of Nursing / Assistant Director of Nursing will require nurses to perform return demonstration of the procedure for the insertion of the foley catheter in order to establish competency prior to the nurse performing this procedure on the actual resident / patient.</p> <p>Date completed: [DATE]</p> <p>The Administrator and Director of Nurses conducted and Ad Hoc QAPI review of this situation and this immediate corrective action plan with the facility's Medical Director.</p> <p>Date completed: [DATE]</p> <p>Monitoring response:</p> <p>Director of Nursing / Assistant Director of Nursing / Designee will conduct at least weekly audits / rounds to inspect resident / residents with indwelling foley catheters to identify s/s of hematuria and will observe nurse / nurses during the procedure of placing / changing an indwelling catheter in order to evaluate competency. Director of Nursing / Assistant Director of Nursing / Designee will review the nursing 24hr report, and progress notes to identify and issues placing / changing the indwelling foley catheter and ensure appropriate follow up interventions are in place. All findings will be reported to the QAPI committee for the next 2 months and the committee will then determine compliance or will determine additional training and oversight is required.</p> <p>Verification: Started on [DATE] at 12:30 PM and included:</p> <p>The following observations, record reviews and interviews were conducted by the survey team to ensure licensed staff's understanding of in-service trainings received between [DATE] and [DATE]:</p> <p>Head to toe assessments completed on 11 / 11 residents with Foley catheters. 11 /11 resident's foley catheters draining yellow urine. ,d+[DATE] residents foley bag with no blood in the urine or bag. 7 verbal residents out of 7 verbal residents denied pain or discomfort.</p> <p>Interviews with 8 nurses verbalizing understanding regarding:</p> <p>- In-services on Abuse Neglect and Exploitation Prevention, Reporting and Protecting,</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <ul style="list-style-type: none"> - Education (computer education), and - Return demonstrations of placing an indwelling foley catheter on dummies both male and female. - Documentation for education and return demonstrations for 97% of nursing staff. 3 PRN nurses will not be allowed on the floor until in-service, education, and return demonstration are completed. <p>Documentation for assessment of 11 residents with indwelling foley catheters with no issues, concerns or change in condition.</p> <p>Record review of the licensed nurse's In-Service Program Attendance Record for the following topic Abuse Neglect and Exploitation Prevention, Reporting and Protecting conducted by DON / designee. 15 LVN's and 1 RN were in-serviced between [DATE] and [DATE].</p> <p>Record review of the licensed nurse's computer-based education on catheter insertion. 15 LVN's and 1 RN reviewed computer-based training between [DATE] and [DATE].</p> <p>Record review of the licensed nurse's return demonstration conducted by DON /designee 15 LVN's and 1 RN were in-serviced between [DATE] and [DATE].</p> <p>Interviews on [DATE] between 12:30 PM and 5:00 PM, the survey team interviewed 8 licensed staff (7 LVN's and 1 RN), interviewed licensed staff verbalized understanding of what they learned during in-services they received between [DATE] and [DATE].</p> <p>Interview on [DATE] at 02:35 PM, LVN T was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on [DATE] at 03:13 PM, LVN X was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on [DATE] at 03:26 PM, LVN Y was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on [DATE] at 03:43 PM, LVN D was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on [DATE] at 04:04 PM, ADON / RN was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>(continued on next page)</p> |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Interview on [DATE] at 04:20 PM, LVN Z was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Observation of Timeline on [DATE] at 08:30 AM:</p> <p>[DATE] 11:10 AM LVN D, LVN R, and CNA entered room to do a foley catheter change. LVN D explained to resident #2 what and why they were there.</p> <p>[DATE] 11:13 AM Resident starts yelling out. LVN D tells him to breathe.</p> <p>[DATE] 11:21 AM LVN D stopped due to resistance and LVN R went to get RN.</p> <p>[DATE] 11:25 AM RN enters room and advances / completes F/C change. Resident does not cry out.</p> <p>[DATE] 11:27 AM RN leaves room.</p> <p>[DATE] 02:05 PM Doctor #1 first notified of blood in foley bag.</p> <p>[DATE] 02:27 PM Doctor #2 (Urologist) notified. His MA said to monitor resident for discomfort or pain. MA stated it was normal for bleeding to occur when foley is changed.</p> <p>[DATE] 02:38 PM Doctor #3 notified. He said to continue to monitor and new order for UA given.</p> <p>[DATE] 04:09 PM Doctor #4 gave order for IV antibiotics for 1 time a day until [DATE].</p> <p>[DATE] 04:49 PM Doctor #3 went in to see resident. Order for resident to be sent out to hospital. Diagnosis was microscopic Acute Hematuria.</p> <p>[DATE] 05:08 PM EMS called to transport resident to hospital.</p> <p>[DATE] 05:30 PM EMS arrives.</p> <p>[DATE] 09:36 PM resident admitted to hospital diagnosis hematuria (blood in urine).</p> <p>[DATE] 04:51 PM Resident readmitted to facility.</p> <p>In an interview and observation on [DATE] at 12:45 PM The DON stated check off list for POR had 97% of nursing staff signed off. The DON stated the only staff left to be in-serviced, educated, and trained were the PRN staff. The DON stated they would not be allowed on the floor until they completed all. Check off list was reviewed.</p> <p>Review of the facility's policy on Abuse Guidance: Preventing, Identifying, and Reporting Date Implemented: February 2017 Date revised: [DATE] revealed,</p> <p>Types of Abuse</p> <p>(continued on next page)</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing.</p> <p>-Neglect occurs when the facility is aware of or should have been aware of, goods or services that are resident requires but the facility fails to revive them to the resident that has resulted in or may result in physical harm pain mental anguish or emotional distress. Neglect includes cases where the facilities indifference or disregard for resident care comfort or safety resulted in or could have resulted in physical harm pain mental anguish or emotional distress.</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on interview and record review, the facility failed to ensure that all alleged violations involving neglect, were reported immediately to the State Survey Agency, not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for 1 of 4 residents (R#1) reviewed for abuse/neglect.</p> <p>The facility failed to report within the allotted time frame that on 03/21/2024, R#1 exited the facility unsupervised through the front door and was found leaving the premises through the parking lot.</p> <p>This failure could place all residents at increased risk for potential neglect due to unreported allegations of abuse and neglect.</p> <p>The findings included:</p> <p>Record review of R#1's admission record dated 12/18/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and an original admitted [DATE]. Her diagnoses including dementia, muscle weakness, and malnutrition.</p> <p>Record review of R#1's quarterly MDS dated [DATE] reflected a BIMS score of 03, indicating R#1 was severely cognitive impaired and had a wandering behavior that occurred 4-6 days, but less than daily.</p> <p>Record review of R#1's quarterly care plan dated 12/18/2024 reflected a focus of [R#1] was exit seeking and a risk for elopement and/or wandering with unsafe boundaries r/t cognitive impairment, date initiated 03/27/2024. The following Interventions/tasks created on 03/27/2024 included 1:1 until further notice, and to be distracted from exit seeking by being offered pleasant diversions, structured activities, food, conversation, television, and books.</p> <p>Record review of R#1's Exit Seeking Risk Tool dated 03/21/2021 reflected:</p> <p>A. History/Behaviors: wandering (exhibited wandering and/or confused behavior), exit seeking (resident has on one (1) or more occasions attempted to exit o has exited the facility in an effort to wander away; whether intentionally or due to confusion), verbalization (resident verbalized the need and/or desire to go home or to another location and has the ability to act on that verbalization), and mobility (resident is physically able to exit on foot or by wheelchair.)</p> <p>B. 2. Based on the above assessment, does the resident display exit seeking behavior-left blank</p> <p>3. Comments: yes. Resident did exit the facility into the parking lot. Resident was assisted back to facility with no resistance. Resident stating, she was going home.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of facility's in-service training/retraining log date 03/20/24 and 03/21/24 presented by the DON reflected: Staff were in-serviced in the topic of falls. Outline of in-service content was to anticipate resident needs, not to leave resident unattended in room, frequent rounds, exit seeking and code yellow (facility's code to inform staff of a missing resident).</p> <p>Record review of facility's in-service training/retraining log dated 03/20/24 and 03/21/24 presented by the DON reflected: staff were in-services in the topic of customer service. Outline of in-service content was exit seeking, code yellow and [R#1] was on a 1:1.</p> <p>Record review of R#1's progress note (late entry) on 03/21/2024, authored by LVN L reflected .RP requested to take mother home for a couple of days with all medications to see how resident does at home.</p> <p>Record review of R#1's progress notes reflected she was out on pass on 03/21/2024.</p> <p>Record review of R#1's progress note on 03/22/2024 documented by LVN L reflected late entry for 03/21/24 during noon time SN was called that resident was outside in the parking lot .resident continues to ask (I want to go home).</p> <p>Record review of R#1's progress note reflected she was out on pass on 03/22/2024.</p> <p>Record review of R#1's progress note reflected she was out on pass on 03/23/2024.</p> <p>Record review of R#1's progress note reflected she was out on pass on 03/24/2024.</p> <p>Record review of R#1's progress note on 03/25/2024 to 03/28/2024 she had been one a 1:1 monitoring due to her exiting the facility on 03/21/2024.</p> <p>Record review of R#1's progress note on 03/28/2024 at 4:02 authored by LVN O reflected R#1 was discharged .</p> <p>An interview on 12/18/2024 at 2:18 p.m., the Administrator said on 03/21/2024, R#1 had exited the facility through the front doors and had been found in the middle of the parking lot in front of the facility but did not leave the premises. He said the facility does have surveillance camera's outside the building, but he no longer had the footage of the incident since it had been over 60 days and it had not been saved. The Administrator said certainly [R#1] was wandering but didn't mean that was going to lead to exit. The Administrator said he recalled two previous care plan meetings in which R#1's behavior of wandering and the need for her to be on a 1:1 supervision had been discussed the IDT and with her RP. The Administrator said he had not reported the incident to state because based on the corporate guidelines he didn't have to. He also said R#1 had been found pretty quickly and didn't seem like they needed to report it.</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A phone interview on 12/19/2024 at 8:40 a.m., CNA B said that on 03/21/2024 she remembered working the 6a-2p shift. She said sometime in the morning she remembered CNA C and CNA J were taking their break in the dining room located at the end of hall 100 when all of a sudden one of them ran down the hall shouting that R#1 was in the parking lot in the front of the facility. CNA B said both CNA C and CNA J had seen R#1 through the windows while taking their break in the dining room. CNA B said she remembered staff immediately going outside including herself to re-direct R#1. She said by the time she made it outside; R#1 was already being escorted back into the facility by another staff member but got to see R#1 was at the far end of the parking lot which was close to the 2-way street in front of the facility. CNA B said R#1 was dressed in her own personal clothing and was wearing shoes. CNA B said staff had not noticed R#1 had been missing until CNA C and CNA J saw her through the window. CNA B said she had been in-serviced that same day on exit seeking.</p> <p>An interview on 12/19/2024 at 10:36 a.m., CNA J said that on 03/21/2024 she worked the 6a-2p shift. She said while she and CNA C were taking their break in the dining room located at the end of hall 100, CNA C asked her to look out the window and check if the person walking through the middle of the parking lot was R#1. CNA J said took a quick look and immediately recognized R#1. CNA J said R#1 had already reached the far end of the parking lot, close to the busy two-way street that ran directly in front of the facility. CNA J said that's when CNA C ran down the hall shouting R#1 was in the parking lot in front of the facility. CNA J said she did not see any staff members following R#1 at the time she saw her through the window. She said staff were in-serviced that day on exit seeking behaviors.</p> <p>An interview on 12/19/2024 at 9:55 a.m., CNA C said that on 03/21/2024 she worked the 6a-2p shift. She said while she and CNA J were taking their break in the dining room located at the end of hall 100, she saw a person outside the facility walking through the middle of the parking lot that resembled R#1. She said she immediately asked CNA J to look out the window to confirm if that person was R#1. She said CNA J confirmed that it was R#1 and that's when she ran down the hall shouting R#1 was in the front parking lot in front of the facility. CNA C said by the time R#1 was first noticed outside she had made her way to the far end of the parking lot which was close to the 2-way street in front of the facility. she did not see any staff member following R#1 when she saw her through the window. CNA C said R#1 was dressed in her own clothing and was wearing shoes. She said staff were in-serviced that day on exit seeking behaviors.</p> <p>An interview on 12/19/2024 at 1:48 p.m., the DON said that on 03/21/2024, R#1 made her way to the front lobby and exited the facility. The DON said the front receptionist was on the phone and when she saw R#1 exit the facility, she quickly hung up the phone and ran after her. She said the receptionist always had eyes on R#1 as she was trying to catch up to her. The DON said despite R#1 being [AGE] years old, she was able to walk fast and was able to make her way to the parking lot before the receptionist caught up to her. The DON said R#1 was redirected back to the facility and had not sustained any injuries. The DON said because R#1 had a low BIMS score, she was not able to say if she lacked safety awareness and/or had a sense of direction. The DON said the incident was not reported to state because R#1 was still in the parking lot.</p> <p>Record review of the facility's Abuse Guidance: Preventing, Identifying and Reporting policy dated February 2017 and revised in January 2024 reflected:</p> <p>Compliance Guidelines:</p> <p>(continued on next page)</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Every resident has the right to be free from abuse, neglect, misappropriation of the resident property, and exploitation. Residents should not be subjected to any abuse by anyone, building, but not limited to, community team members, other residents, consultants, were volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It is the responsibility of our team members, community consultants, attending physicians, family members, visitors, etcetera. To promptly report any incident of suspected neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to community management.</p> <p>Reporting allegations or suspicions of abuse:</p> <p>Allegations of, incidents of or suspicions of abuse or neglect are reportable to state authorities in accordance with HHSC's PL 19-17.</p> <p>Report alleged or suspicions of abuse to HHSC by email reporting or via TULIP reporting within the designated time frames in accordance with HHSC's PL 19-17: not later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury.</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for 1 of 4 residents (R#1), reviewed for comprehensive care plans in that:</p> <p>The facility failed to care plan R#1's wandering and exit seeking behaviors prior to 03/21/2024.</p> <p>This deficient practice could affect residents with comprehensive care plans and could result in missed or delayed continuity of care.</p> <p>The findings included:</p> <p>Record review of R#1's admission record dated 12/18/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and an original admitted [DATE]. Her diagnoses including dementia, muscle weakness, and malnutrition.</p> <p>Record review of R#1's quarterly MDS dated [DATE] reflected a BIMS score of 03, indicating R#1 was severely cognitive impaired and had a wandering behavior that occurred 4-6 days, but less than daily.</p> <p>Record review of R#1's quarterly care plan dated 12/18/2024 reflected a focus of [R#1] she was exit seeking and a risk for elopement and/or wandering with unsafe boundaries r/t cognitive impairment, date initiated 03/27/2024. The following Interventions/tasks created on 03/27/2024 included 1:1 until further notice, and to be distracted from exit seeking by being offered pleasant diversions, structured activities, food, conversation, television, and books.</p> <p>Record review of R#1's admission assessment dated [DATE] reflected R#1 was not physically able to leave the building on her own.</p> <p>Record review of R#1' progress note dated 01/04/2024 at 11:48 a.m., authored by SW reflected contacted RP to discuss a care plan meeting regarding her other's care. She was informed that due to her mother's decline in memory and wandering, it would be best that we discuss with family options that may include a memory care unit.</p> <p>Record review of R#1's progress note dated 02/19/2024 at 11:40 a.m., authored by the DON reflected Resident noted in front lobby. Re-directed back to dining area for lunch.</p> <p>Record review of R#1's progress note dated 02/20/2024 at 3:57 p.m. authored by LVN L, resident brought back to nurses station from secretary desk and redirected to hall 400.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570 | |
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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Record review of R#1's progress note dated 02/20/2024 at 4:22 p.m., authored by the SW reflected contacted RP along with DON. We discussed R#1's walking and wanting to go home. RP acknowledged understanding that his mother is at risk for exit seeking. He related that he would be talking with family about sending more support to be with her during the day. He also agreed for care plan meeting on Friday February 23, 2024, at 1pm.</p> <p>Record review of R#1's Exit Seeking Risk Tool dated 02/20/2024 and signed on 03/22/2024 reflected the following behaviors were checked off for R#1 wandering (exhibited wandering and/or confused behavior), confusion (although there is no medical diagnosis with symptoms of confusion, resident sometimes exhibits behavior associated with confusion, possibly leading to wandering in the future), and mobility (resident is physically able to exit on foot or by wheelchair.)</p> <p>An interview and observation on 12/18/2024 at 10:38 a.m., MDS-RN said he was new to the facility and did not remember R#1. Surveyor observed him review R#1's care plan dated 11/2023 and said it did not include any wandering and/or exit seeking behaviors. He was not able to say how not care planning her wandering and/or exit seeking behavior could have affected R#1.</p> <p>An interview on 12/18/2024 at 12:30 p.m., CNA A said she remembered of at least 2 or 3 times the front receptionist had called the cna 's to inform them R#1 was in the front lobby wanting to exit the facility. She said whoever was available would go to the front lobby to re-direct R#1 back to her room. She said she reported R#1's behavior to her charge nurse on several occasions.</p> <p>An interview on 12/18/2024 at 1:06 p.m., the SW said he had contacted R#1's RP regarding her wandering and exit seeking behavior and had requested a care plan meeting. He said staff had notified him of her wandering and exit seeking behaviors and he had personally observed her in the front lobby trying to exit the facility. He said the times R#1 was observed in the front of the building trying to exit the facility, staff would redirect her. The SW said during the care plan meeting, R#1's RP and the IDT were present. He said R#1's wandering and exit seeking behaviors had been discussed and family had been informed R#1 would benefit from being in a memory care unit at another facility. He said on 2/20/24, he and the DON called the RP to notify him R#1 behaviors of wandering and exit seeking continued and required constant re-direction and at times requiring 1:1 supervision.</p> <p>An interview and observation on 12/18/24 at 1:15 pm, the ADON/RN said R#1 was admitted to the facility to receive rehabilitation services and required a wheelchair to ambulate. She said R#1's mobility started to improve with therapy, and she started walking on her own soon after. ADON/RN said that's when R#1's behavior of wandering and exit seeking began. She said had been advised by the nursing staff that R#1 would try to push to emergency exits doors to exit the facility and would also try to exit the facility through the front doors. She said R#1's behaviors had been discussed in their morning meetings but was not sure if they had been care planned. She said the MDS staff were responsible for care plans. ADON/RN was observed checking R#1's electronic medical record (care plan) to verify if her wandering and exit seeking behavior had been care planned prior to 03/21/24, and she said, I don't see one not for before 3/21/24. ADON/RN was not able to say if there was a negative outcome to R#1 not having her wandering and exit seeking behavior care planned.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview on 12/19/2024 at 1:48 p.m., the DON said R#1's wandering and exit seeking behavior had not been care planned prior to 03/21/2024 because she didn't have an exit seeking behavior. The DON said R#1 would wander around the facility but said the facility was her house and she had every right to wander inside the facility if she wanted to. The DON was not able to say if there were any negative outcome to R#1 not having her wandering and exit seeking behavior care planned.</p> <p>Record review of the facility's Care Plan policy dated 02/2017 and revised on 01/2023 reflected:</p> <p>The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, measurable outcome objective, and the resident's ability, needs, medical condition, preventive measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout medical record is developed and/or recommended to attend or maintain the resident's highest practicable physical, mental, psychosocial well-being.</p> <p>The care plan should be initiated upon admission, continues to be developed during the initial 48-72 hours., throughout the completion of the admission comprehensive assessment. The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in conditions as defined in the RAI manual. Additional updates to the care plan may be done as indicated.</p> <p>Record review of the facility's Elopement and Exit Seeking Management policy dated 2019 and revised in January 2023 reflected:</p> <p>E. Risk response: Identifying those at risk for exit seeking or elopement:</p> <ol style="list-style-type: none"> 1. IDT will review and/or complete the elopement/exit seeking risk assessment in PCC to determine we have identified those at risk. 3. Update the care plan accordingly. | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47828</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and supervision, in that:</p> <p>The facility failed to ensure R#1 received adequate supervision to prevent her from exiting the facility undetected on 03/21/2024.</p> <p>The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 03/21/2024 and ended on 03/21/2024. The facility corrected the non-compliance before the investigation began.</p> <p>Past Non-Compliance form sent to Administrator on 12/20/2024 at 9:59 a.m.</p> <p>This failure could place the residents with exit seeking behaviors at risk for injury or death.</p> <p>The findings included:</p> <p>Record review of R#1's admission record dated 12/18/2024 reflected a [AGE] year-old female admitted to the facility on [DATE] and an original admitted [DATE]. Her diagnoses including dementia, muscle weakness, and malnutrition.</p> <p>Record review of R#1's quarterly MDS dated [DATE] reflected a BIMS score of 03, indicating R#1 was severely cognitive impaired and had a wandering behavior that occurred 4-6 days, but less than daily.</p> <p>Record review of R#1's quarterly care plan dated 12/18/2024 reflected a focus of [R#1] she was exit seeking and a risk for elopement and/or wandering with unsafe boundaries r/t cognitive impairment, date initiated 03/27/2024. The following Interventions/tasks created on 03/27/2024 included 1:1 until further notice, and to be distracted from exit seeking by being offered pleasant diversions, structured activities, food, conversation, television, and books.</p> <p>Record review of R#1's admission assessment dated [DATE] completed by LVN S reflected R#1 was not physically able to leave the building on her own and no behaviors were identified.</p> <p>Record review of R#1' progress note dated 01/04/2024 at 11:48 a.m., authored by SW reflected contacted RP to discuss a care plan meeting regarding her [R#1's] care. She was informed that due to her [R1's] decline in memory and wandering, it would be best that we discuss with family options that may include a memory care unit.</p> <p>Record review of R#1's progress note dated 02/19/2024 at 11:40 a.m., authored by the DON reflected Resident noted in front lobby. Re-directed back to dining area for lunch.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Record review of R#1's progress note dated 02/20/2024 at 3:57 p.m. authored by LVN L, resident brought back to nurses station from secretary desk and redirected to hall 400.</p> <p>Record review of R#1's progress note dated 02/20/2024 at 4:22 p.m., authored by the SW reflected contacted RP along with DON. We discussed R#1's walking and wanting to go home. RP acknowledged understanding that his mother is at risk for exit seeking. He related that he would be talking with family about sending more support to be with her during the day. He also agreed for care plan meeting on Friday February 23, 2024, at 1pm.</p> <p>Record review of R#1's Exit Seeking Risk Tool dated 02/20/2024 and signed on 03/22/2024 reflected the following behaviors were checked off for R#1 wandering (exhibited wandering and/or confused behavior), confusion (although there is no medical diagnosis with symptoms of confusion, resident sometimes exhibits behavior associated with confusion, possibly leading to wandering in the future), and mobility (resident is physically able to exit on foot or by wheelchair.)</p> <p>Record review of R#1's progress note on 03/22/2024 at 7:27 a.m., authored by LVN L reflected late entry for 03/21/24 during noon time SN was called that resident was outside in the parking lot .resident continues to ask (I want to go home).</p> <p>Record review of R#1's progress note (late entry) on 03/21/2024, authored by LVN L reflected .RP requested to take [R#1] home for a couple of days with all medications to see how resident does at home.</p> <p>Record review of R#1's progress notes reflected she was out on pass from 03/21/2024.</p> <p>Record review of R#1's progress note reflected she was out on pass on 03/22/2024.</p> <p>Record review of R#1's progress note reflected she was out on pass on 03/23/2024.</p> <p>Record review of R#1's progress note reflected she was out on pass on 03/24/2024.</p> <p>Record review of R#1's progress note on 03/25/2024 to 03/28/2024 she had been one a 1:1 monitoring due to her exiting the facility on 03/21/2024.</p> <p>Record review of R#1's progress note on 03/28/2024 at 4:02 authored by LVN O reflected R#1 was discharged .</p> <p>An interview on 12/18/2024 at 12:30 p.m., CNA A said she remembered of at least 2 or 3 times the front receptionist had called the cna's to inform them R#1 was in the front lobby wanting to exit the facility. She said whoever was available would go to the front lobby to re-direct R#1 back to her room. She said she reported R#1's behavior to her charge nurse on several occasions.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>An interview on 12/18/24 at 12:37 p.m., LVN L, said R#1 would ambulate on her own or on a wheelchair depending on how she would wake up. LVN L said R#1 would sometimes wander into other resident's rooms when not sleeping at night. She said she notified the DON of R#1's behaviors. LVN L said had made a late entry progress note on 03/22/2024 for the 03/21/2024 incident where R#1 exited the facility. She said all she remembered was that the staff was notified R#1 was outside in the front parking lot and had been re-directed back to the facility. She said she R#1 had not sustained any injuries. She said after 03/21/2024, R#1 was on a 1:1 supervision until she was discharged .</p> <p>An interview on 12/18/2024 at 1:06 p.m., the SW said he had contacted R#1's RP regarding her wandering and exit seeking behavior on at least 2 occasions. The SW said staff had notified him of R#1's wandering and exit seeking behaviors and he had also personally observed R#1 in the front lobby trying to exit the facility. He said R#1's wandering and exit seeking behaviors had been discussed with RP and had been informed R#1 would benefit from being in a memory care unit at another facility. He said on 2/20/24, he and the DON called the RP to notify him that R#1 wandering and exit seeking behaviors continued and that she required constant re-direction and at times 1:1 supervision. The SW said RP expressed understanding and had agreed to send family members to assist the facility in caring for R#1.</p> <p>An interview and observation on 12/18/24 at 1:15 pm, the ADON/RN said R#1 was admitted to the facility for rehabilitation services and required a wheelchair to ambulate. She said R#1's mobility started to improve with therapy, and she started walking on her own soon after. ADON/RN said that's when R#1's behavior of wandering and exit seeking began. She said had been advised by the nursing staff that R#1 would try to push to emergency exits doors to exit the facility and would also try to exit the facility through the front doors. She said R#1's behaviors had been discussed in their morning meetings but was not sure if they had been care planned. She said MDS was responsible for care plans. The ADON/RN said the facility did not have wander guards, but the emergency exits do have an alarm. ADON/RN was observed checking R#1's electronic medical record (care plan) to verify if her wandering and exit seeking behavior had been care planned prior to 03/21/24, and she said, I don't see one not for before 3/21/24. ADON/RN was not able to say if there was a negative outcome to R#1 not having her wandering and exit seeking behavior care planned.</p> <p>An interview on 12/18/2024 at 2:18 p.m., the Administrator said on 03/21/2024, R#1 had exited the facility through the front doors and had been found in the middle of the parking lot in front of the facility but did not leave the premises. He said the facility does have surveillance camera's outside the building, but he no longer had the footage of the incident since it had been over 60 days and it had not been saved. The Administrator said certainly [R#1] was wandering but didn't mean that was going to lead to exit. The Administrator said he recalled two previous care plan meetings in which R#1's behavior of wandering and the need for her to be on a 1:1 supervision had been discussed with the IDT and with her RP. The Administrator said he had not reported the incident to state because based on the guidelines he didn't have to. He also said R#1 had been found pretty quickly and didn't seem like they needed to report it. The Administrator said he was not sure if the facility's code yellow was activated.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>A phone interview on 12/19/2024 at 8:40 a.m., CNA B said that on 03/21/2024 she remembered working the 6a-2p shift. She said sometime in the morning she remembered CNA C and CNA J were taking their break in the dining room located at the end of hall 100 when all of a sudden one of them ran down the hall shouting that R#1 was in the parking lot in the front of the facility. CNA B said both CNA C and CNA J had seen R#1 through the windows while taking their break in the dining room. CNA B said she remembered staff immediately going outside including herself to re-direct R#1. She said by the time she made it outside; R#1 was already being escorted back into the facility by another staff member but got to see R#1 was at the far end of the parking lot which was close to the 2-way street in front of the facility. CNA B said R#1 was dressed in her own personal clothing and was wearing shoes. CNA B said staff had not noticed R#1 missing until CNA C and CNA J saw her through the window. CNA B said she had been in-serviced that same day on exit seeking.</p> <p>An interview on 12/19/2024 at 10:36 a.m., CNA J said that on 03/21/2024 she worked the 6a-2p shift. She said while she and CNA C were taking their break in the dining room located at the end of hall 100, CNA C asked her to look out the window and check if the person walking through the middle of the parking lot was R#1. CNA J said took a quick look and immediately recognized R#1. CNA J said R#1 had already reached the far end of the parking lot, close to the busy two-way street that ran directly in front of the facility. CNA J said that's when CNA C ran down the hall shouting R#1 was in the parking lot in front of the facility. CNA J said she did not see any staff members following R#1 at the time she saw her through the window. She said staff were in-serviced that day on exit seeking behaviors.</p> <p>An interview on 12/19/2024 at 9:55 a.m., CNA C said that on 03/21/2024 she worked the 6a-2p shift. She said while she and CNA J were taking their break in the dining room located at the end of hall 100, she saw a person outside the facility walking through the middle of the parking lot that resembled R#1. She said she immediately asked CNA J to look out the window to confirm if that person was R#1. She said CNA J confirmed that it was R#1 and that's when she ran down the hall shouting R#1 was in the front parking lot in front of the facility. CNA C said by the time R#1 was first noticed outside she had made her way to the far end of the parking lot which was close to the 2-way street in front of the facility. she did not see any staff member following R#1 when she saw her through the window. CNA C said R#1 was dressed in her own clothing and was wearing shoes. She said staff were in-serviced that day on exit seeking behaviors.</p> <p>An interview on 12/19/2024 at 1:48 p.m., the DON said that on 03/21/2024, R#1 made her way to the front lobby and exited the facility. The DON said the front receptionist was on the phone and when she saw R#1 exit the facility, she quickly hung up the phone and ran after her. She said the receptionist always had eyes on R#1. The DON said despite R#1 being [AGE] years old, she was able to walk fast and was able to make her way to the parking lot before the receptionist caught up to her. The DON said R#1 was redirected back to the facility and had not sustained any injuries. The DON said because R#1 had a low BIMS score, she was not able to say if she lacked safety awareness and/or had a sense of direction. The DON said the incident was not reported to state because R#1 was still in the parking lot. The DON said the reason R#1's exit seeking risk tool dated 02/20/2024 and signed on 03/22/2024 was because she probably forgot to sign it until 03/22/2024. She said even though, she signed it on 03/22/2024 staff had access to see the form on PCC. The DON said code yellow was not activated because R#1 was not missing. She said staff were in-serviced on 03/21/2024 on exit seeking behaviors and code used to alert of a missing resident.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Record review of the facility's Elopement and Exit Seeking Management policy dated 2019 and revised in January 2023 reflected:</p> <p>E. Risk response: Identifying those at risk for exit seeking or elopement:</p> <ol style="list-style-type: none"> 1. IDT will review and/or complete the elopement/exit seeking risk assessment in PCC to determine we have identified those at risk. 3. Update the care plan accordingly. <p>Record review of facility's in-services revealed the following in-services were conducted with staff after the incident:</p> <p>Record review of the facility's in-service reflected the following in-services were conducted with staff after the incident on 03/21/2024:</p> <p>Topic: falls (anticipate resident needs, do not leave resident unattended in room, frequent rounds, exit seeking, and code yellow which was to announce a missing resident)</p> <p>Topic: customer service (exit seeking, code yellow which was to announce a missing resident, and R#1 requiring 1:1 supervision).</p> <p>An interview on 12/18/2024 CNA's A, B, C, E, F, G, H, I, J, and K said they had been in-serviced on the topics of definitions of exit seeking and wandering, and code yellow.</p> <p>An interview on 12/18/2024 LVN's D, E, L, M, N, O, P, Q and R said they had been in-serviced on the topics of definitions of exit seeking and wandering, and code yellow.</p> |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</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** 41761</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident with a urinary catheter received appropriate treatment and services for 1 (Resident #2) of 8 Residents reviewed for catheter care, in that:</p> <p>The facility failed to ensure LVN D and LVN R did not stop and notify doctor when resistance was felt during Resident #2's Foley catheter change.</p> <p>An Immediate Jeopardy was identified on 12/20/2024. The Immediate Jeopardy template was provided to the facility on [DATE] at 08:43 PM. While the Immediate Jeopardy was removed on 12/21/2024 at 06:05 PM. Immediate Jeopardy was lowered to isolated with no actual harm with a potential for more than minimal harm, as once Immediate Jeopardy is lowered, harm cannot exist.</p> <p>This failure had the potential to affect residents receiving Foley catheter change could experience injury and pain.</p> <p>The findings included:</p> <p>Record review of Resident #2's Face Sheet, dated 12/20/2024, revealed a [AGE] year old male admitted initially on 08/14/2023, readmitted on [DATE] with the diagnoses including: Urinary Tract Infection (UTI), Hematuria (blood in the urine), benign prostatic hyperplasia without lower urinary tract symptoms (Age-associated prostate gland enlargement that can cause urination difficulty), dementia (a group of thinking and social symptoms that interferes with daily functioning such as forgetfulness, limited social skills, and thinking abilities so impaired that it interferes with daily functioning), and heart failure.</p> <p>Record review of Resident #2's Minimum Data Set assessment dated [DATE] revealed he:</p> <ul style="list-style-type: none"> -Had a BIMS of 00 which indicated severely impaired cognition -Minimal difficulty hearing -Clear speech -Sometimes he was understood by others -Sometimes he understands others -Incontinence of bladder was not rated. Resident #2 had an indwelling catheter. -Always continent of bowel <p>Record review of Resident #2's comprehensive care plan dated 11/26/2024 documented,</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>FOCUS: o I require a foley catheter DX Obstructive Uropathy (a structural or functional hindrance of normal urine flow, sometimes leading to renal dysfunction) Date Initiated: 09/10/2024 Created on: 08/14/2023 Revision on:12/21/2024</p> <p>GOALS: o I will not experience any complications associated with my catheter to include trauma, infection or pain, dignity concerns through my next review date. Date Initiated: 08/15/2023 Created on: 08/15/2023 Target Date: 02/24/2025</p> <p>INTERVENTIONS/TASKS: o Monitor for s/sx infection. Date Initiated: 08/14/2023 Created on: 08/14/2023 NSG o Monitor for s/sx of discomfort and abnormalities report those findings to MD as indicated. Date Initiated: 10/02/2024 Created on: 10/02/2024 NSG</p> <p>Record review of Resident #2's physician's orders revealed, Start Date: 12/14/24</p> <p>Order Summary: Foley Catheter 20Fr 30CC, change 3weeks and PRN, per (Dr.) (urologist), change foley bag with f/c change as needed related to BENIGN PROSTATIC HYPERPLASIA WITHOUT LOWER URINARY TRACT SYMPTOMS</p> <p>Record review of Resident #2's physician's orders revealed, Start Date: 12/16/24</p> <p>Order Summary:</p> <p>REFER TO DR. DX: BLOOD LOSS ANEMIA REQUIRING IRON INFUSION.</p> <p>Record review of 12/14/24 Hospital's Final Report, revealed:</p> <p>HISTORY OF PRESENT ILLNESS:</p> <p>84 -year-old male with . BPH with chronic urinary obstruction with chronic indwelling Foley catheter status, recurrent UTIs, nursing home resident, bedbound, Alzheimer's dementia, who has Foley catheter exchanged today and at 11 AM initiated with [NAME] hematuria, persistent, associated with suprapubic and penile pain. Sent to hospital for further evaluation, urology consulted and agreed to evaluate.</p> <p>ASSESSMENT/PLAN:</p> <p>1. Hematuria R31.9</p> <p>Most likely traumatic after Foley insertion, regardless the UA looks dirty.</p> <p>Record review of Resident #2's Treatment Administration Record revealed Resident #2 had a foley catheter change on 12/06/24.</p> <p>Record review of Resident #2's progress notes dated 12/06/2024 at 11:39 am written by LVN D revealed, Foley catheter changed due to leaking; resident tolerated well, yellow color urine flow noted. Resident tolerated procedure well, no acute distress at this time.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on 12/20/24 at 04:05 pm LVN R stated she went in with LVN D for the foley change. LVN R stated when she went into the room, LVN D had started the change. LVN R stated resident asked what they were doing and LVN D told him they were going to change his foley. LVN R could not remember if resident said anything else during the change. LVN R does not recall resident saying anything or crying out. LVN R stated if the resident tells them to stop or cries out, they are supposed to stop because that is what the resident wants. LVN R stated she was not sure what the negative outcome would be if they did not stop when resident said to or cried out. LVN R stated CNAs notified her of blood in catheter bag when they did their 2 hour check. LVN R stated she notified LVN D and ADON/RN they needed to check the catheter bag and then they went to notify the doctor.</p> <p>In an interview on 12/20/24 at 04:46 pm LVN D stated she had done the foley change on Resident #2. LVN D stated LVN R filled the foley balloon. LVN D stated Resident #2 was not medicated prior to change and did not recall if LVN R gave him something after. LVN D stated Resident #2 did not cry out, say no, or anything. She said he was aware of what was going to happen. LVN D stated she also aided him in breathing to relax when changing the foley. LVN D stated it was not difficult to change the foley catheter. LVN D stated there was yellow urine return when foley catheter was placed. LVN D stated if a resident says stop or no, we stop. LVN D stated at the end of inflating the balloon, LVN D stated she noticed pink-tinged urine at the connection of the tube to the bag. LVN D stated she showed ADON / RN. LVN D stated ADON / RN said that sometimes happens when replacing or changing a foley, you get pink tinged urine. LVN D stated they never pulled the catheter out and in and out and in. LVN D did not say what negative outcome would be if they did not stop when resident said to. LVN D stated she went on break and when she came back, LVN R told her of blood in the catheter bag. LVN D stated when the doctor came in, ADON / RN did rounds with him. LVN D stated she was working when they asked the doctor to come in and checked Resident #2. LVN D stated the doctor ordered resident to be sent out to the hospital</p> <p>In an interview on 12/20/24 at 05:13 pm ADON/RN stated LVN R came to her and told her LVN D needed her. ADON / RN stated she went to Resident #2's room and LVN D told her when she tried to advance the catheter, she felt resistance and asked for assistance. ADON / RN stated she moved the catheter maybe an inch or two with no resistance and she inflated the balloon. ADON/RN stated the return was yellow with tinge of pink. ADON/RN stated she went back to her office. ADON/RN stated LVN R notified ADON/RN of the hematuria. ADON/RN stated she called the MD and had an order for flush. The ADON/RN stated she flushed the catheter and the resident was not in distress.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>In an interview on 12/20/24 at 05:28 pm telephone interview with CNA U stating LVN D and LVN R were in Resident #2's room CNA U stated at the end the ADON/RN came in. CNA U stated she was in the room the whole time when the foley catheter was changed (on Resident #2). CNA U stated LVN D was doing the Foley change and LVN R was preparing what LVN D needed. CNA U stated LVN R did not do anything. CNA U stated LVN D did everything. CNA U stated at the beginning the resident was asking what they were doing and why. CNA U stated when they were almost done, the resident started complaining. CNA U stated LVN R left the room to get ADON/RN and LVN D stopped what she was doing. CNA U stated ADON/RN came in and asked the resident if he were in pain and he said he was in a little pain. CNA U stated they started assessing the resident. CNU stated ADON/RN checked the foley catheter and said it was in right. CNA U stated ADON/RN asked the resident again if her were in pain and the resident stated no. CNA U stated by the time they left, there was no blood. CNA U stated thirty minutes later, she went to drain the bag and it had dark red blood in the bag missed with urine. CNA U stated the bag was 1/4 the way full. CNA U stated the Resident #2 was in his room. CNA U stated she went and told LVN R and they both went back to the room to check the foley bag. CNA U said that was at the end of her shift and when she came back to work, he was in the hospital. CNA U stated Resident #2 never cried out and resident would say he had no pain until the end when they went to get ADON/RN. CNA U stated she was unsure if resident received medication before or after for pain. CNA U stated she asked about resident and the nurses told her he had been sent to the hospital because of bleeding.</p> <p>In an interview on 12/20/24 at 05:45 pm the DON stated one of the LVNs told her the Resident #2's foley was bleeding and the doctor came in and gave orders to send Resident #2 out to the hospital. The DON stated RP told them it was possibly trauma that caused the bleeding.</p> <p>In an interview on 12/20/24 06:07 pm meeting with DON, LVN R, LVN D, and ADON/RN. Surveyor asked them if Resident #2 had cried out, showed discomfort or pain. LVN R and LVN D stated Resident #2 had not. Surveyor played video from 12/06/24 during Foley catheter change, where resident was heard yelling, saying no no no, just put a bullet in me, please, please, etc. LVNs said nothing. Both LVNs stated that when a resident was in pain or discomfort or calling out, they should stop what they were doing. LVNs would not say anything further.</p> <p>In an interview on 12/21/24 at 02:33 pm The DON stated she had watched/listened to the video FM sent to administrator. She said she was very upset. The DON stated she was not upset with surveyor, she was hurt, disappointed, and upset with her nurses for lying to her (Resident #2's pain and discomfort).</p> <p>In an interview on 12/20/24 at 06:35 pm FM stated she was sending the video to administrator's email.</p> <p>An Immediate Jeopardy was identified on 12/20/2024. The Immediate Jeopardy template was provided to the facility on [DATE] at 08:43 PM. While the Immediate Jeopardy was removed on 12/21/2024 at 06:05 PM, the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had not been trained on residents receiving appropriate treatment and services to prevent urinary tract infections and restore continence to the extent possible .</p> <p>This was determined to be an IJ and the Administrator was provided the IJ template on 12/20/24 at 08:43 pm.</p> <p>The following Plan of Removal submitted by the facility was accepted on 12/21/24 at 09:05 am.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Immediate Corrective Action Response:</p> <p>The resident identified as #2 was reassessed on 12/20/24. Resident #2's plan of care reviewed to validate that appropriate intervention is in place and noted on the care plan related to foley insertion and care.</p> <p>Regional Nurse / Director of Nursing provided in-service training LVN D (now LVN R), E (now LVN D), and RN ADON regarding:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Identification Risk Response</p> <p>All residents who require and indwelling foley catheter may be at risk of the alleged deficient practice.</p> <p>Director of Nursing / Assistant Director of Nursing / Designee conducted an audit to identify all residents with indwelling foley catheters to identify any resident having s/s of pain associated with the catheter and/or s/ s of hematuria.</p> <p>Outcome: There were no negative outcomes identified.</p> <p>Date completed: 12/21/24</p> <p>Director of Nursing / Assistant Director of Nursing / Designee interviewed residents who were identified as interviewable and who require and indwelling foley catheter in order to identify any concerns of pain during the procedure of changing of catheter.</p> <p>Outcome: no negative outcomes identified.</p> <p>Date completed: 12/21/24</p> <p>Systemic Change Response</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>The Regional Nurse / DNS educated the licensed nurses regarding:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Director of Nursing / Assistant Director of Nursing and Clinical Leadership will conduct training for all newly hired nurses, PRN nurses and agency nurses prior to the nurses working. In-service training:</p> <ul style="list-style-type: none"> - Abuse Neglect and Exploitation Prevention, Reporting and Protecting - Procedure for insertion of indwelling foley catheter. <p>Monitoring, assessing for s/s of pain prior to procedure, during procedure and responding to any complaints of s/s of pain; to include but not limited to stopping the procedure, providing non-pharmacological and pharmacological interventions in order to relieve the resident's discomfort.</p> <p>Insertion of the indwelling foley catheter and if resistance is noted upon insertion and the catheter is not advancing as usual expect process when inserting the catheter, the nurse should cease the procedure, ensure the resident is safe and comfortable, then the nurse should notify the PCP for further instructions.</p> <p>Nursing should continue to monitor the resident status and communicate abnormal findings to the PCP.</p> <p>Date completed: 12/21/24</p> <p>Director of Nursing / Assistant Director of Nursing will require nurses to perform return demonstration of the procedure for the insertion of the foley catheter in order to establish competency prior to the nurse performing this procedure on the actual resident / patient.</p> <p>Date completed: 12/21/24</p> <p>The Administrator and Director of Nurses conducted and Ad Hoc QAPI review of this situation and this immediate corrective action plan with the facility's Medical Director.</p> <p>(continued on next page)</p> |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Date completed: 12/21/24</p> <p>Monitoring response:</p> <p>Director of Nursing / Assistant Director of Nursing / Designee will conduct at least weekly audits / rounds to inspect resident / residents with indwelling foley catheters to identify s/s of hematuria and will observe nurse / nurses during the procedure of placing / changing an indwelling catheter in order to evaluate competency. Director of Nursing / Assistant Director of Nursing / Designee will review the nursing 24hr report, and progress notes to identify and issues placing / changing the indwelling foley catheter and ensure appropriate follow up interventions are in place. All findings will be reported to the QAPI committee for the next 2 months and the committee will then determine compliance or will determine additional training and oversight is required.</p> <p>Verification: Started on 12/21/2024 at 12:30 PM and included:</p> <p>The following observations, record reviews and interviews were conducted by the survey team to ensure licensed staff's understanding of in-service trainings received between 12/20/2024 and 12/21/2024:</p> <p>Head to toe assessments completed on 11 / 11 residents with Foley catheters. 11 /11 resident's foley catheters draining yellow urine. 11/11 residents foley bag with no blood in the urine or bag. 7 verbal residents out of 7 verbal residents denied pain or discomfort.</p> <p>Interviews with 8 nurses verbalizing understanding regarding:</p> <ul style="list-style-type: none"> - In-services on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, - Education (computer education), and - Return demonstrations of placing an indwelling foley catheter on dummies both male and female. - Documentation for education and return demonstrations for 97% of nursing staff. 3 PRN nurses will not be allowed on the floor until in-service, education, and return demonstration are completed. <p>Documentation for assessment of 11 residents with indwelling foley catheters with no issues, concerns or change in condition.</p> <p>Record review of the licensed nurse's In-Service Program Attendance Record for the following topic Abuse Neglect and Exploitation Prevention, Reporting and Protecting conducted by DON / designee. 15 LVN's and 1 RN were in-serviced between 12/20/2024 and 12/21/2024.</p> <p>Record review of the licensed nurse's computer-based education on catheter insertion. 15 LVN's and 1 RN reviewed computer-based training between 12/20/2024 and 12/21/2024.</p> <p>Record review of the licensed nurse's return demonstration conducted by DON /designee 15 LVN's and 1 RN were in-serviced between 12/20/2024 and 12/21/2024.</p> <p>(continued on next page)</p> | | |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Interviews on 12/21/2024 between 12:30 PM and 5:00 PM, the survey team interviewed 8 licensed staff (7 LVN's and 1 RN), interviewed licensed staff verbalized understanding of what they learned during in-services they received between 12/20/2024 and 12/21/2024.</p> <p>Interview on 12/21/2024 at 02:35 PM, LVN T was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 03:13 PM, LVN X was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 03:26 PM, LVN Y was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 03:43 PM, LVN D was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 04:04 PM, ADON / RN was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Interview on 12/21/2024 at 04:20 PM, LVN Z was able to verbalize understanding of the following: in-service on Abuse Neglect and Exploitation Prevention, Reporting and Protecting, computer-based education on catheter placement / insertion, and return demonstration of placing / insertion of an indwelling foley catheter on males and females.</p> <p>Observation of Timeline on 12/23/24 at 08:30 AM:</p> <p>12/06/24 11:10 AM LVN D, LVN R, and CNA entered room to do a foley catheter change. LVN D explained to resident #2 what and why they were there.</p> <p>12/06/24 11:13 AM Resident starts yelling out. LVN D tells him to breathe.</p> <p>12/06/24 11:21 AM LVN D stopped due to resistance and LVN R went to get RN.</p> <p>12/06/24 11:25 AM RN enters room and advances / completes F/C change. Resident does not cry out.</p> <p>12/06/24 11:27 AM RN leaves room.</p> <p>12/06/24 02:05 PM Doctor #1 first notified of blood in foley bag.</p> <p>(continued on next page)</p> |

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| <p>F 0690</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>12/06/24 02:27 PM Doctor #2 (Urologist) notified. His MA said to monitor resident for discomfort or pain. MA stated it was normal for bleeding to occur when foley is changed.</p> <p>12/06/24 02:38 PM Doctor #3 notified. He said to continue to monitor and new order for UA given.</p> <p>12/06/24 04:09 PM Doctor #4 gave order for IV antibiotics for 1 time a day until 12/13/24.</p> <p>12/06/24 04:49 PM Doctor #3 went in to see resident. Order for resident to be sent out to hospital. Diagnosis was microscopic Acute Hematuria.</p> <p>12/06/24 05:08 PM EMS called to transport resident to hospital.</p> <p>12/06/24 05:30 PM EMS arrives.</p> <p>12/06/24 09:36 PM resident admitted to hospital diagnosis hematuria (blood in urine).</p> <p>12/14/24 04:51 PM Resident readmitted to facility.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 12/21/2024 at 06:05 PM. The facility remained out of compliance at a severity level of no actual harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p> <p>In an interview and observation on 12/23/24 at 12:45 PM The DON stated check off list for POR had 97% of nursing staff signed off. The DON stated the only staff left to be in-serviced, educated, and trained were the PRN staff. The DON stated they would not be allowed on the floor until they completed all. Check off list was reviewed.</p> <p>Review of the facility's policy on Incontinence and Catheterization Assessment and Evaluation Date revised: January 2023 revealed,</p> <p>Indwelling Catheter</p> <p>For a resident who was admitted to the community with an indwelling urinary catheter or who had one placed after admission, the community will:</p> <ul style="list-style-type: none"> -Recognize and assess factors affecting the resident's urinary function and identified the medical justification for the use of an indwelling urinary catheter. -Define and implement pertinent interventions consistent with resident conditions, goals, and recognized standards of practice to try to minimize complications from an indwelling urinary catheter and to remove it if clinically indicated. -Monitor and evaluate the resident's response to interventions. -Revise the approaches as appropriate. <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676414 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2024 |
| NAME OF PROVIDER OR SUPPLIER Mid Valley Nursing & Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 601 N Mile 2 West Mercedes, TX 78570 | |

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 - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Review of the facility's policy on Pain Management Date Implemented: 03/14/2019, Date Revised: [DATE], revealed:</p> <p>Compliance Guidelines:</p> <p>To assess the resident pain control and management needs at admission/readmission, quarterly, annual and when a change of condition indicates a need for initiating or modifying a pain management program for the residents.</p> <p>The goal of the community Pain Management Program is that pain is identified and treated timely, effectively and consistently.</p> <p>OVERVIEW</p> <p>.Residents who experience a change in condition or have a suspected new onset of pain are evaluated for pain. Residents are also evaluated for pain regularly by team members inquiring if they have pain and observation of the resident for nonverbal signs and symptoms of pain.</p> |