STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Correction Date: 9/2/22			
F 000 ✓ JB	INITIAL COMMENTS An investigation of complaints #104935-C and #107106-C completed 8/23/22 to 9/1/22 resulted in the following deficiencies. Complaint #104935-C was substantiated. Complaint #107106-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, and staff interview the facility failed to follow physician's orders, failed to process physician's orders appropriately, and failed to clarify physician's orders to assure timely medication administration for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 54 residents. Findings include: According to the Minimum Data Set Assessment (MDS) assessment dated 3/28/22, Resident #3 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, dressing, toilet use, and personal hygiene. The resident's diagnoses included heart	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Rocha — TITLE: Admin — (X6) DATE: 09/20/2022

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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F 658	Continued From page 1 failure, diabetes and a stroke. The Care Plan initiated 2/10/22 identified the resident had constipation related to decreased mobility and medication use. The intervention's included educating the resident/family the relationship of constipation to food, medicine, treatment regimen, disease process and psychosocial factors. Educate the resident/family to identify and avoid causative factors. a. The Medication Administration Record (MAR) for April 2022 included an order dated 2/17/22 for a daily weight, the resident had an as needed (PRN) order of Lasix if the weight increased by two pounds in one day or five pounds in one week. - The daily documentation showed empty spaces on 4/3/22, 4/5/22, 4/9/22, and 4/17/22. The Progress Notes lacked any indication for not weighing the resident on the dates in April. The Progress Note dated 4/18/22 at 12:53 a.m. documented that the resident went out with family, and returned around 7:30 p.m. - The note did not indicate what time the resident left or if that had anything to do with not having the weight taken. The Medication Administration Record for May 22 included a daily weight, the resident had an as needed order of Lasix if the weight increased by 2 pounds in 1 day or 5 pounds in 1 week initiated 2/17/22. - The daily documentation showed an empty space on 5/1/22. The clinical record lacked any indication for not obtaining the resident's weight.	F 658		

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F 658	Continued From page 2	F 658		

b. The Progress Notes dated 4/29/22 at 1:20 p.m. documented that the facility talked with the physician's nurse about the resident refusing her Miralax at times. The physician's nurse said they did a computed tomography (CT) scan of the bowel that revealed the bowel as completely full. She said that she would talk to the physician and see what she wanted to do. The physician then ordered 2 fleets enemas back to back, having results from the first one then giving milk of magnesia (MOM) 30 cubic centimeters (cc). The nurse gave the first Fleets about 11:30 a.m. and she had results about 1 p.m. of a medium soft bowel movement (BM). The nurse gave the second fleets and she couldn't hold it, so they got her on the commode.

The MAR for April 22 included an order dated 4/29/22 to give a Fleets Enema one application rectally one time only related to CONSTIPATION, UNSPECIFIED () for 1 Day, and give a Fleets Enema one application rectally one time only after having BM from the first Fleets.

- Both entries were marked with initials and time they were given.

The Progress Notes dated 4/29/22 at 5:13 p.m. documented that the resident had a medium soft and formed BM from the first Fleets. She then had a large formed BM from her second Fleets. She drank the MOM 30 cc. under protest. They tried to explain to her they needed to open her bowel tract. She had no complaints of nausea and vomiting since the start of the treatments. The resident had hypoactive bowel sounds before the treatments. After the treatments, the bowels moved better but the resident's stomach remained hard, but she denied any pain.

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F 658	Continued From page 3 The MAR for May 22 included an order dated 5/9/22 for a Fleet Enema one application rectally one time only for constipation for two days. Give one enema and once the resident has a BM give the second enema. - The order showed documentation as given at 8:03 p.m. The clinical record lacked any documentation about the effectiveness of the fleets enema. The Progress Notes dated 5/10/22 at 5:42 p.m. documented the resident's family as being upset with the staff, stating the resident needed an enema twice a day, as the CT scan showed her bowels full. The nurse apologized to the family, citing not understanding the order and an enema would be given in the evening. The MAR documented an administration of a Fleet Enema PRN with an effective response at 7: 31a.m. on 5/11/22. The Progress Notes dated 5/11/22 at 7: 31a.m. documented that the nurse gave a Fleets enema per the doctor's order. The first enema resulted in a BM, therefore the nurse gave the second dose 6 hours later as ordered. The second enema also resulted in a BM. The resident stated that she had no discomfort. An assessment of her abdomen revealed it to be soft, non-distended, with active bowel sounds. The nurse would continue to monitor her bowel movements. The Progress Notes dated 5/11/22 at 6:27 p.m. documented the effective results from the Fleets Enema, as the resident had a large BM.	F 658		

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F 658	Continued From page 4 The Progress Notes dated 5/11/22 at 9:06 p.m. documented the resident transferred to the hospital for constipation. A Bowel Movement Report for the resident documented the following: - 5/9/22 at 12:24 p.m. small BM. - 5/9/22 at 9:59 p.m. no BM. - 5/10/22 at 4:55 a.m. no BM. - 5/10/22 at 9:55 p.m. no BM. - 5/11/22 at 5:45 a.m. large BM. - 5/11/22 at 12:50 p.m. no BM. On 8/30/22 at 4:30 p.m. the Director of Nursing (DON) stated they could not find the order for the Fleets enemas from 5/9/22. She explained that she had a call out to the nurse who put the order in, as she no longer worked at the facility. On 8/31/22 at 9:30 a.m. the DON stated she talked with the nurse who received the order on 5/9/22. She said the order came from the resident's physician. The nurse reported being sure that she notified the pharmacy of the new order, but the pharmacy had no record of it. The DON stated they did not find the order. The only place they found it on MAR. She expected that new orders would be documented in the Progress Notes indicating who they came from. She expected that if staff didn't understand an order they would seek clarification. She stated they had issues with getting signed orders back from the doctor timely. They had tried to get the family to choose a local physician but they declined. It was a very difficult situation. The facility policy Physician/Practitioner Orders reviewed/revised 12/2/21 identified the purpose to provide individualized care to each resident by	F 658		

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F 658	Continued From page 5 obtaining appropriate, accurate, and timely physician/practitioner orders and to provide a procedure that facilitated the timely and accurate processing of physician/practitioner orders. Incomplete or questionable orders required clarification as needed when reviewing any type of physician/practitioner orders. They should never attempt to guess or determine what an order might say. If any question arose, nursing services were responsible for obtaining clarification.	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility policy reviews, and staff interviews, the facility failed to provide an adequate assessment and timely intervention for a change in condition for 1 of 3 residents reviewed (Resident #3). Staff changed Resident #3's catheter due to it being plugged on 7/29/22. After 7/31/22 at 1:59 p.m. Resident #3's clinical record lacked documentation of urinary output. The staff failed to assess the lack of output. On 8/1/22, Certified Nursing Assistants (CNAs) reported that Resident #3 had blood in her incontinent pad. The nurse repositioned the catheter and thought it was okay, not knowing	F 684		

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F 684	Continued From page 6	F 684		

that Resident #3 did not have output recorded for the previous two shifts. She did not check the catheter the rest of her shift to assure it drained. Resident #3 also complained of her stomach hurting. The Speech Therapist (ST) reported that Resident #3 may have aspirated at lunch. The nurse assessed lung sounds and vital signs, noting Resident #3 had a blank stare. The family wanted Resident #3 sent to the hospital. Another nurse assessed Resident #3 and who claimed that was Resident #3 at her baseline. During an assessment, the nurse noted Resident #3's abdomen tender in her lower quadrants. The family pointed out blood in her catheter bag. They discovered Resident #3's incontinent pad saturated in bloody urine. After the nurse changed the catheter, it had an immediate return of 500 cubic centimeters (ccs). The nurse clamped the catheter for a few minutes and when released she had an additional 500 cc's of urine. The family called Resident #3's physician prompting a transfer to the emergency room (ER). The facility reported a census of 54 residents.

Findings include:

According to the Minimum Data Set Assessment (MDS) assessment dated 6/28/22 Resident #3 scored 14 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. Resident #3 required extensive assistance with activities of daily living (ADL's) including bed mobility, dressing, toilet use, and personal hygiene. Resident #3 had an indwelling urinary catheter. Resident #3's diagnoses included heart failure, neurogenic bladder, diabetes, and a stroke. Resident #3 had a feeding tube and a mechanically altered diet.

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F 684	Continued From page 7 The Care Plan revised 6/30/22 identified Resident #3 had an indwelling (urinary) catheter related to chronic urinary tract infections (urinary tract infection (UTI's)) and neurogenic bladder. The interventions included: a. Monitoring/documentation for pain/discomfort due to the catheter. b. Monitoring, recording, and reporting to the health care provider signs/symptoms (s/s) of a UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and a change in eating patterns. c. Catheter care by Certified Nursing Assistants (CNA's) every shift and as needed. d. May wear a leg bag during the day and straight catheter drainage bag at night. e. Reporting unusual observations/conditions to the nurse. f. Resident #3 had a history of recurrent urinary tract infections. The Care Plan Focus initiated on 6/17/22 indicated that Resident #3 required a tube feeding related to neurosarcoidosis (an inflammatory disease that affects the nervous system, such as the brain or spinal cord). The interventions included monitoring/reporting to the nurse signs and symptoms of complications of tube feeding (coughing, choking, etc.). A Follow up Question Report dated 7/21/22 to 8/1/22 recorded the following urinary catheter outputs for Resident #3: 7/31/22 at 1:59 p.m. 400 ccs. 7/31/22 at 7:04 p.m. not applicable.	F 684		

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F 684	Continued From page 8 8/1/22 at 5:10 a.m. response not required. 8/1/22 at 10:12 a.m. response not required. The Progress Notes dated 8/1/22 at 1:13 p.m. documented that at 7:30 a.m. the nurse got called to Resident #3's room. Resident #3 had blood in her urine. When the nurse checked the catheter, she noted it got pulled out about two inches. The nurse deflated the bulb and repositioned it. Resident #3 complained that her stomach hurt. An assessment of her abdomen determined her bowel sounds sounded active. Resident #3 received assistance to her wheelchair, and then to breakfast. She only drank a little bit of juice. She went to therapy to work with Physical Therapy (PT) and Occupational Therapy (OT). Resident #3 talked to the nurse when she checked her blood sugar before dinner. ST took Resident #3 to dinner. She reported that Resident #3 choked on a noodle. The nurse checked Resident #3's vital signs and they were within normal limits. Resident #3's lungs sounded diminished but the nurse did not hear any wheezes. Resident #3 appeared to have a blank expression on her face. The nurse called Resident #3's physician's nurse and left a message for her to call back. Resident #3 had family with her. The nurse had the aides lay her down. The Progress Notes dated 8/1/22 at 1:15 p.m. documented that Staff F, Registered Nurse (RN), evaluated Resident #3 for another nurse, related to her general condition. The assessment determined her neurological check within normal range, her pupils equal and reactive, her lungs clear, and her skin felt warm and dry, noted tenderness in the lower quadrants of her abdomen but her bowel sounds remained active	F 684		

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F 684	Continued From page 9 in all quadrants. Resident #3's had an Accu Chek (blood sugar) of 116 and stable vital signs. The Progress Notes dated 8/1/22 at 2:05 p.m. documented that Staff F assessed Resident #3 with the Nurse Manager (NM) and her family present. Nurse reported findings to the family and the NM. The nurse found Resident #3's assessment within normal limits (WNL). Staff F encouraged Resident #3 to lay down for a while since she had been up in the wheelchair since 8 a.m. The family insisted that Resident #3 needed to be sent out to the hospital as soon as possible. The NM and Staff F explained that the facility had to follow certain procedures especially since Resident #3 did not appear to be in distress. They reassured the family that the prior nurse called the physician's office. The family left the room instantly. The NM then received a call from another family member that informed the NM she had the Power of Attorney (POA) and wanted Resident #3 immediately sent to the hospital. The NM attempted to educate the family that the ambulance could go to the nearest hospital for Resident #3 to be assessed, and they had to have a physician's order to transport to the ER. The family informed the NM that they never had a physician's order to take her to the ER and the ambulance always took her to their preferred hospital. The NM reminded the family that the time she went to the ER, they went to the closest hospital. Once at that hospital, that hospital made the decision to transport her. The family insisted the facility van driver drive her to their preferred hospital ER. The NM again attempted to educate the family that if Resident #3 needed to be seen in the ER for an emergency, for Resident #3's safety, the staff could not transport her to the ER in the facility vehicle. The family then hung up on	F 684		

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F 684	Continued From page 10 the NM with no further comments. The Progress Notes dated 8/1/22 at 2:17 p.m. documented that the staff encouraged laid Resident #3 down in bed. When the staff removed Resident #3's, they observed the brief saturated with bright red urine. The nurse attempted to irrigate the catheter, but met resistance. The nurse removed the catheter and discovered the tip had sediment making it hard. The nurse inserted a new catheter without difficulty, and received an immediate return of greater than 500 ccs of bright red urine. The nurse clamped the catheter for a few minutes, and after releasing the clamp, the catheter had an additional immediate return of 500 ccs. The Progress Notes dated 8/1/22 at 2:30 p.m. documented the physician's nurse returned the call, with an okay to send Resident #3 to the ER, if the family felt she had a change in condition. The hospital's History and Physical dated 8/2/22 at 8:04 a.m. identified that Resident #3 got admitted to the hospital on 8/1/22. The documentation indicated that Resident #3 was new to the provider but got asked to see her while in the hospital regarding her chronic health conditions, UTI, and aspiration. Resident #3 presented with catheter complications. Resident #3 had a very complicated medical history with neurosarcoidosis, diabetes, cerebrovascular, and cardiovascular disease. She had a dislodged catheter with hematuria (blood in the urine). She had symptoms for 24 hours of hematuria, urinary retention (likely from the dislodgement of the catheter), and an overall decline in status. Resident #3 did aspirate during lunch the previous day. The diagnoses included gross	F 684		

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F 684	Continued From page 11	F 684		

hematuria, leukocytosis (high white blood cell count), altered mental status, and hypotension (low blood pressure). The plan directed to admit to acute care due to the following:
a. Hematuria with UTI as catheter complication - continue intravenous Levaquin and wait for culture results due to a history of resistant organisms that could require an alteration in drug therapy.
b. Chronic immune suppression for neurosarcoidosis - on methotrexate and prednisone 60 milligrams (mg) daily. Dapsone (antibiotic) for PCP (Pneumocystis carinii pneumonia) prophylaxis
c. Hypotension in the ER, subsequent blood pressures remained stable - if low they could increase the steroid stress dose but Resident #3 already on a substantial dose.

The Progress Notes dated 8/2/22 at 5:25 a.m. documented that the nurse called the hospital to see about Resident #3's status. The hospital nurse reported that they admitted Resident #3 at 9:30 p.m. to the hospital for low blood pressure, hematuria, and an altered mental status. At 12:30 a.m., a hospital nurse reported that they changed Resident #3's catheter that the facility changed on Friday with the hard sediment blocking the catheter flow. The catheter had the sediment blocking the tip making it hard again.

Interviews with staff, family, and providers regarding events preceding, on, and following 8/1/22 included:

a. On 8/24/22 at 9:23 a.m. Resident #3's family stated the ST sat with Resident #3 for lunch on 8/1/22. The ST noticed Resident #3 did not appear at her baseline, and another family

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

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F 684	Continued From page 12	F 684		

member reported that to the nurse. Resident #3 did not follow commands or speech. She had a decreased urinary output. The nurse changed her catheter and the family member heard she had 1300 cc of urine output, then another partially filled bag. The nurse did not think she needed to go to the hospital. The NM told the family they had to follow protocol, and she would not tell them again. She called Resident #3's provider, who called the facility and said to send her to the hospital. She stayed in the hospital for 10 days. The family felt if they wanted their mom to go to the hospital, the facility should send her there. They felt they wasted time.

b. On 8/24/22 at 6:41 p.m. Staff A, CNA, explained that she worked on the floor where Resident #3 resided on 8/1/22 with an agency CNA. Resident #3 had blood in her catheter bag right away that shift. She informed Staff C, Licensed Practical Nurse (LPN) and she pushed fluids through the catheter, then they moved her to a wheelchair. She went to breakfast and didn't eat anything. The nurse reported that because she had okay vital signs (VS) she was okay. She didn't eat anything for lunch. She notified the nurse and she didn't do anything. Resident #3's daughter came around 12:30 p.m. and she wanted Resident #3 to go to the hospital. The NM observed as two other CNA's came and did something with the catheter bag and feeding tube.

c. On 8/25/22 at 9:41 a.m. Staff B, CNA, stated that on 8/1/22 Resident #3 complained of stomach pain in the morning and then at lunch she had a glazed stare. Resident #3's family came at lunchtime. The family wanted her sent out. Staff F said she was just tired. The CNA's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM LUTHERAN HOME	2027 COLLEGE AVENUE ELK HORN, IA 51531

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F 684	Continued From page 13	F 684		

thought it was more than being tired. When they changed Resident #3, they discovered her incontinent pad saturated with blood. They got the nurse to come in and the NM watched her. Staff F changed Resident #3's catheter. She got 1500 cc's out (by looking at the bag), then she kinked it because she learned if they ran out too much at once they could have spasms. She didn't know how much they got out after she unkinked it.

d. On 8/25/22 at 12:01 p.m. Staff C explained that she worked on 8/1/22. She was supposed to work from 6 a.m. to 12 p.m. but the person who would come in had novel Coronavirus 2019 (COVID). Resident #3 had blood in her brief in the morning with the catheter pulled out about two inches. She deflated the bulb, repositioned the tube, reinflated it, and it seemed okay. The ST took Resident #3 to lunch and she had choked or aspirated on something. Her eyes were glazed over, and you could put your hand right up to her face with no response. The family wanted her seen and she got the paperwork ready and called the physician's office. She was supposed to leave at 12 so she told Staff F what happened, what the ST told her, and what the family wanted. She left at that point.

In a follow up on 8/30/22 at 9:48 a.m. Staff C reported that on 8/1/22 Resident #3 had blood in the catheter bag and it did not drain. She did not know there had been no documented output the previous two shifts. She said if the staff noted abnormal output, like no output that should have been reported. She would have changed the catheter if she had known that. She thought it drained when she repositioned the catheter. She did not check the rest of her shift. The ST reported she thought Resident #3 may have

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F 684	Continued From page 14	F 684		

aspirated at lunchtime. She checked her out around 1 p.m. and her eyes didn't move when she put her hand up. Resident #3's daughter wanted her sent out. She told Staff F her family wanted her sent out. She didn't get to do a very good report, because Staff F didn't come back, and it was done in passing.

e. On 8/25/22 at 12:46 p.m. the Speech Therapist (ST) said she did sit with Resident #3 at lunch on 8/1/22. Resident #3 did not follow directions like she had done at other times. The ST thought Resident #3 aspirated on something and told Staff C that she should be NPO (nothing by mouth) because of her high risk for choking. Staff C asked Staff F to assess Resident #3. Staff F said she assessed Resident #3 and she would not send her to the hospital. The family wanted her sent. The ST said Resident #3 definitely had a change from her baseline.

f. On 8/29/22 at 12:10 p.m. the NM stated on 8/1/22 she became involved with Resident #3 around 1:30, 2 o'clock. Staff C left and Resident #3's family wanted her sent out. Staff C said no change in Resident #3's condition. Staff F wanted support. Resident #3 sat in the wheelchair watching TV. Staff F took her vitals, and they were baseline. The family insisted something was wrong. They pulled up her pant leg and her catheter bag had blood tinged urine, maybe 50 ccs. She did not stay in the room when Staff F took care of the catheter.

g. On 8/29/22 at 12:38 p.m. Staff F explained that she worked the other part of the building until Staff C left on 8/1/22. Staff C thought Resident #3 acted a little differently, less responsive, pupils not as reactive. Staff F did not think she

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F 684	Continued From page 15	F 684		

presented any differently than normal. The family wanted her sent out, so Staff C called her physician's office and left a message. As the physician was not easy to get a hold of. Staff F said she had another day when they didn't think Resident #3 acted quite right. When they laid her down, she was just fine. The family said something about the catheter. The urine appeared discolored and not much of it. When they changed her brief, they discovered it soaked with bloody urine. When she changed the catheter she had immediate return of ruby colored urine and the tip plugged in the catheter. After about 500 ccs drained she clamped the catheter. She said the catheter drained another 500 ccs after she unclamped it. She really didn't know about the urine prior to the family bringing it up.

h. On 8/29/22 at 12:53 p.m. the Staffing Agency CNA reported that she worked on 8/1/22, the day Resident #3 went to the hospital. When they got her up in the morning she had blood in her brief. They told the nurse and she flushed the catheter. Resident #3 refused to eat and reported that she didn't feel good. After lunch she had more blood in her brief and not much in the bag. Resident #3 said she puked but she did not.

i. On 8/29/22 at 3:55 p.m. the Physician who cared for Resident #3 in the hospital stated Resident #3 needed to be in the hospital. She needed fluids for hypotension when she came in. She needed antibiotics. Those were started but had to be changed because they didn't cover the infection. The facility should have checked to make sure the catheter continued to drain after they adjusted it. If Resident #3 had no urine output, they should have assessed why she had

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F 684	Continued From page 16	F 684		

no output.

In a follow up interview on 8/30/22 at 2:40 p.m. the Physician stated the hypotension was not life threatening. She said Resident #3 was septic (the body's extreme response to an infection) by blood cultures. She said Resident #3's medications could mask the symptoms of infection.

j. On 8/29/22 at 4:14 p.m. Staff H, CNA, said that Resident #3 did not have any output to record on 8/1/22 at 5:10 a.m.

k. On 8/30/22 at 8:38 a.m. Staff I, CNA, stated she didn't remember, but if she documented not applicable on the 7/31/22 evening shift urine output record, either Resident #3 had no output, or someone else had emptied it.

l. On 8/30/22 at 12:13 p.m. Staff J, CNA, stated she worked the day Resident #3 transferred to the hospital. Resident #3 was bleeding and had blood in her bed. The nurse kept saying she was fine, just a little blood. They were worried because it seemed like she had something wrong.

m. On 8/31/22 at 9:48 a.m. the Physician's nurse stated they received a call in the morning of 8/1/22 from the facility regarding insulin. At 2:02 p.m. Resident #3's family member called concerned about Resident #3 and told them about the catheter. They in turn called the facility and told them Resident #3 needed to be evaluated in the ER. She said Resident #3 had a complex case.

n. On 8/31/22 at 10:13 a.m. the Director of Nursing stated she expected staff to monitor

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F 684	Continued From page 17 catheter outputs, and report to the nurse low or no output. The nurse should assess the situation and intervene accordingly. The facility policy Intake & Output with Hydration Guidelines reviewed/revised 4/25/22 directed to measure fluid intake and/or output on residents who received tube feedings, intravenous fluids, or had urinary catheters. Residents with urinary catheters needed the contents of the drainage bag measured and recorded in the EMR (electronic health record).	F 684		

Tag: F658 Services Provided Meet Professional Standards

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Resident #3 is no longer a resident at Salem Lutheran Homes.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents with physician's orders have the potential to be affected.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   The nurses were educated on August 30, 2022 by the director of nursing and staff development coordinator on properly processing orders and properly clarifying and double checking orders to assure they are administered timely. Nurses were also educated on discontinuing orders including any additional orders given at the time of initial order. The nurses were educated on proper documentation of physician orders, including refusal documentation.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   The nurse manager will audit all orders Monday-Friday weekly x4, monthly x2, bi-monthly x2. The night shift will audit all orders weekly x4, monthly x 2, bi-monthly x2. The MDS coordinator will audit EMAR/ETAR documentation weekly x4, monthly x2, bi-monthly x2. All results will be brought to monthly quality assurance meetings for further review and recommendations.

   Completed by: 09/02/2022

Tag: F 684 Quality of Care

1. **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.**

   Resident # 3 no longer resides at Salem Lutheran Homes.

2. **Address how facility will identify other residents having the potential to be affected by the same deficient practice.**

   All residents with catheters are at risk for potential complications and missed documentation/assessment.

3. **Address what measures will be put into place or what systematic changes made to ensure that the deficient practice will not occur.**

   All licensed nursing and certified nursing staff educated on proper assessment of urine output and assessment for catheters. All licensed nursing and certified nursing staff educated on documentation of output for residents with catheters. All education provided on 08-30-2022 by staff development coordinator and director of nursing.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**

   Director of Nursing will audit resident's catheter output and assessment daily x5 weeks, weekly x4, bi weekly x 2 weeks, monthly x2 months. All results will be brought to monthly quality assurance meetings for further review and recommendations.

   Completed by: 09/02/2022