STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455715	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONUMENT REHABILITATION AND NURSING CENTER	**120 STATE LOOP 92 LA GRANGE, TX 78945**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents were free from neglect for one (1) of five (5) residents reviewed for neglect, in that Resident #1 was admitted to the facility on [DATE] without consulting or notifying the physician of his admission or obtaining physician orders [REDACTED]. The facility failed to provide a complete assessment of Resident #1's Foley catheter on admission or develop a plan of care for his Foley catheter. On 08/06/2020 Resident #1 reported pain, burning and discomfort related to his Foley catheter and it was noted his urine was amber colored. No orders for treatment were received prior to Resident #1's removal from the facility on 08/08/2020 by his family due to lack of care and treatment of [REDACTED].#1 was admitted to the hospital on [DATE] with the [DIAGNOSES REDACTED]. Resident #1 Foley was noted to be clogged and Resident #1 had more than a liter of urine in his bladder. These failures could place residents with indwelling urinary catheters at risk [MEDICAL CONDITIONS], pain or death. Finding Include: In an interview on 08/10/2020 at 10:16 AM Resident #1's FM stated she was a Nurse Practitioner. She stated her dad was brought to the facility on [DATE] to complete 20 more days of rehab. Resident #1's FM stated during a window visit on 08/06/2020 it was noted Resident #1's urine was dark brown and appeared infected. She stated on 08/06/2020 family had requested a UA, but nothing had been done. The FM stated on 08/08/2020 the family decided to remove Resident #1 from the facility because they felt he was not getting the care he needed. The FM stated Resident #1 was taken to the hospital on [DATE]. The FM stated the resident was very confused and could no longer speak. The FM stated in the ER his Foley was changed and the hospital staff stated Resident #1's Foley had not been changed in sometime and had not been draining. The FM stated Resident #1 was admitted [MEDICAL CONDITION] and UTI. Review of Resident #1's Face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #1's 5-Day MDS (still in process) reflected Resident #1 was assessed to have a BIMS score of 8 indicating moderate cognitive impairment. Resident #1 was assessed to require extensive to dependent assist with ADL's and supervision for eating. Resident #1 was assessed to have an indwelling urinary catheter. Review of Resident #1's Initial Baseline Care Plan dated 08/04/2020 reflected Resident #1 had a Foley catheter but did not indicate any interventions for the care or monitoring of the Foley catheter. Review of Resident #1's Initial Nursing Evaluation dated 08/04/2020 reflected Foley catheter intact, patent, draining yellow urine to bedside drainage bag. Further review of the Nursing Evaluation reflected the Catheter [DIAGNOSES REDACTED]. Review of Resident #1's MAR and TAR for 08/04/2020 through 08/08/2020 reflected no entries for his Foley Catheter or care of the Foley Catheter. Review of Resident #1's Nursing progress notes for 08/05/2020 through 08/08/2020 reflected no entries for this Foley catheter or care of the Foley Catheter. Review of Resident #1's Hospital Discharge orders dated 08/04/2020 reflected a list of medication. No orders for the Foley Catheter were listed. Review of Resident #1's Consolidated Physician order [REDACTED]. Review of Resident #1's Medical Fax Referral to the physician dated 08/06/2020 at 1:00 PM reflected Resident admitted on [DATE] with Foley Catheter for [MEDICAL CONDITION]. Voicing pain, burning and discomfort, urine amber color and clear in drain bag. Family would like to know when Foley Catheter will be discontinued. May we have order for UA C&S and would you like to do voiding trial? Please Advise. Documented under New orders/ treatment No record of patient in our system, we have no paperwork on him. Where was he admitted from and who gave admit orders? We need admission paperwork. In an interview on 08/10/2020 at 3:45 PM LVN A stated she was Resident #1's nurse on 08/06/2020 and 08/08/2020. LVN A stated Resident #1's family called on 08/08/2020 and stated they were taking Resident #1 out of the facility because he wasn't getting care. LVN A stated they told her his Foley had not been changed and they asked for a UA. LVN A stated she faxed Resident #1's doctor about the UA on 08/06/2020 and the office told her they did not know who he was and needed admission paperwork and she faxed it to the doctor's office. When asked if it was common to admit a resident without contacting the doctor she stated No. When asked if Resident #1 had orders for the care of his Foley Catheter, she looked at the EMR and stated No. LVN A stated Resident #1 should've had orders for the care and monitoring of his Foley. LVN A stated she did not receive orders from the doctor's office for Resident #1 prior to his family taking him home on the morning 08/08/2020 AMA. Review of Resident #1's Hospital Records dated 08/09/2020 reflected Patient is a [AGE] year-old male with history of [MEDICAL CONDITION], he was apparently staying in a nursing home but was taken home recently by his daughter, today brought to the hospital for AMS. In the ER he was noted to be septic with UTI. He was noted to be in [MEDICAL CONDITION], a Foley was placed, and he had more than a liter of urine output, he is extremely confused at the time of exam and unable to provide any history. [DIAGNOSES REDACTED]. In an interview on 08/11/2020 at 3:30 PM Resident #1 FM stated Resident #1 did have dementia and would probably not talk with surveyor since he did not know her. Resident #1's FM did provide Resident #1's hospital room phone number. Multiple attempts to contact Resident #1 via phone at the hospital were unsuccessful. In an interview on 08/11/2020 at 12:08 PM Resident #1's Physician stated the facility did send a fax on 08/06/2020 regarding Resident #1 and the resident was having [MEDICAL CONDITION] and voicing pain, but he did not know who the resident was and had not been made aware of his admission and he requested the facility fax over more information on the resident. Resident #1's Physician stated by the time his office had gotten all the information the resident had already been removed from the facility. Resident #1's Physician stated Resident #1 should've had orders for his Foley catheter and the nurses should monitor for changes in output. In an interview on 08/11/2020 at 2:00 PM the DON stated Resident #1 should've had orders for his Foley catheter that included catheter care every shift, irrigation every shift if needed for clogging, to check placement and securement of the catheter and for the catheter to be changed as needed. When asked if Resident #1's admission assessments should have included condition of the Foley catheter on admission she stated yes. The DON stated the physician should have been notified prior to admission of the Resident. The DON was asked how the facility failed to ensure Resident #1 had orders for his admission and Foley catheter she stated the facility did chart audits on all new admits to ensure all care areas are addressed after admission. She stated it just took longer with this resident. She stated it was her expectation that residents admitted to the facility have their physician notified and Residents with a Foley catheter have a complete assessment and orders are obtained for the care of the Foley catheter at the time of admission. Review of the facility's Admission/ Readmission Checklist dated 04/2015 provided as a policy reflected .admission orders [REDACTED].Vendor has been notified of needed enteral products .(i.e. Foley Cath) . Review of the facility's policy Abuse Prevention Program dated September 2018 reflected Our residents have the right to be free from abuse, neglect .Comprehensive polices and procedures have been developed to aid our facility in preventing abuse, neglect .Mandated staff training/ orientation programs .
F 0690 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0690 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services for one (1) of four (4) residents reviewed for indwelling urinary catheters (Foley), in that Resident #1 was admitted to the facility on [DATE] with a Foley catheter for [MEDICAL CONDITION] without physician orders for care and monitoring of his Foley catheter. On 08/06/2020 Resident #1 reported pain, burning and discomfort related to his Foley catheter and it was noted his urine was amber colored. No physician orders for treatment were received and Resident #1's family removed Resident #1 from the facility on 08/08/2020 due to lack of care and treatment. Resident #1 was admitted to the hospital on [DATE] with the [DIAGNOSES REDACTED]. Resident #1 Foley was noted to be clogged and Resident #1 had more than a liter of urine in his bladder. These failures could place residents with indwelling urinary catheters at risk [MEDICAL CONDITIONS], pain or death. Finding Include: In an interview on 08/10/2020 at 10:16 AM Resident #1's FM stated she was a Nurse Practitioner. She stated her dad was brought to the facility on [DATE] to complete 20 more days of rehabilitation. Resident #1's FM stated during a window visit on 08/06/2020 it was noted Resident #1's urine was dark brown and appeared infected. She stated on 08/06/2020 family had requested a UA, but nothing had been done. The FM stated on 08/08/2020 the family decided to remove Resident #1 from the facility because they felt he was not getting the care he needed. The FM stated Resident #1 was taken to the hospital on [DATE]. The FM stated the resident was very confused and could no longer speak. The FM stated in the ER his Foley was changed and the hospital staff stated Resident #1's Foley had not been changed in sometime and had not been draining. The FM stated Resident #1 was admitted [MEDICAL CONDITION] and UTI. Review of Resident #1's Face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #1's 5-Day MDS (still in process) reflected Resident #1 was assessed to have a BIMS score of 8 indicating moderate cognitive impairment. Resident #1 was assessed to require extensive to dependent assist with ADL's and supervision for eating. Resident #1 was assessed to have an indwelling urinary catheter. Review of Resident #1's Initial Baseline Care Plan dated 08/04/2020 reflected Resident #1 had a Foley catheter but did not indicate any interventions for the care or monitoring of the Foley catheter. Review of Resident #1's Initial Nursing Evaluation dated 08/04/2020 reflected Foley catheter intact, patent, draining yellow urine to bedside drainage bag. Further review of the Nursing Evaluation reflected the Catheter [DIAGNOSES REDACTED]. Review of Resident #1's MAR and TAR for 08/04/2020 through 08/08/2020 reflected no entries for his Foley Catheter or care of the Foley Catheter. Review of Resident #1's Nursing progress notes for 08/05/2020 through 08/08/2020 reflected no entries for his Foley Catheter or care of the Foley Catheter. Review of Resident #1's Hospital Discharge orders dated 08/04/2020 reflected a list of medication. No orders for the Foley Catheter were listed. Review of Resident #1's Consolidated Physician Orders from 08/04/2020 through 08/08/2020 reflected no orders for the Foley catheter or the care and monitoring of the catheter. Review of Resident #1's Medical Fax Referral to the physician dated 08/06/2020 at 1:00 PM reflected Resident admitted on [DATE] with Foley Catheter for [MEDICAL CONDITION]. Voicing pain, burning and discomfort, urine amber color and clear in drain bag. Family would like to know when Foley Catheter will be discontinued. May we have order for UA C&S and would you like to do voiding trial? Please Advise. Documented under New orders/ treatment No record of patient in our system, we have no paperwork on him. Where was he admitted from and who gave admit orders? We need admission paperwork. In an interview on 08/10/2020 at 3:45 PM LVN A stated she was Resident #1's nurse on 08/06/2020 and 08/08/2020. LVN A stated Resident #1's family called on 08/08/2020 and stated they were taking Resident #1 out of the facility because he wasn't getting care. LVN A stated they told her his Foley had not been changed and they asked for a UA. LVN A stated she faxed Resident #1's doctor about the UA on 08/06/2020 and the office told her they did not know who he was and needed admission paperwork and she faxed it to the doctor's office. When asked if it was common to admit a resident without contacting the doctor she stated No. When asked if Resident #1 had orders for the care of his Foley Catheter, she looked a the EMR and stated No. LVN A stated Resident #1 should've had orders for the care and monitoring of his Foley. LVN A stated she did not receive orders from the doctor's office for Resident #1 prior to his family taking him home on the morning 08/08/2020 AMA. Review of Resident #1's Hospital Records dated 08/09/2020 reflected Patient is a [AGE] year-old male with history of [MEDICAL CONDITION], he was apparently staying in a nursing home but was taken home recently by his daughter, today brought to the hospital for AMS. In the ER he was noted to be septic with UTI. He was noted to be in [MEDICAL CONDITION], a Foley was placed, and he had more than a liter of urine output, he is extremely confused at the time of exam and unable to provide any history. [DIAGNOSES REDACTED]. In an interview on 08/11/2020 at 3:30 PM Resident #1 FM stated Resident #1 did have dementia and would probably not talk with surveyor since he did not know her. Resident #1's FM did provide Resident #1's hospital room phone number. Multiple attempts to contact Resident #1 via phone at the hospital were unsuccessful. In an interview on 08/11/2020 at 12:08 PM Resident #1's Physician stated the facility did send a fax on 08/06/2020 regarding Resident #1 and the resident was having [MEDICAL CONDITION] and voicing pain, but he did not now who the resident was and had not been made aware of his admission and he requested the facility fax over more information on the resident. Resident #1's Physician stated by the time his office had gotten all the information the resident had already been removed from the facility.Resident #1's Physician stated Resident #1 should've had orders for his Foley catheter and the nurses should monitor for changes in output. In an interview on 08/11/2020 at 2:00 PM the DON stated Resident #1 should've had orders for his Foley catheter that included catheter care every shift, irrigation every shift if needed for clogging, to check placement and securement of the catheter and for the catheter to be changed as needed. When asked if Resident #1's admission assessments should have included condition of the Foley Catheter on admission she stated yes. The DON stated the physician should have been notified prior to admission of the Resident. The DON was asked how the facility failed to ensure Resident #1 had orders for his admission and Foley catheter she stated the facility did chart audits on all new admits to ensure all care areas are addressed after admission. She stated it just took longer with this resident. She stated it was her expectation that residents admitted to the facility have their physician notified and Residents with a Foley catheter have a complete assessment and orders are obtained for the care of the Foley catheter at the time of admission. Review of the facility's Admission/ Readmission Checklist dated 04/2015 provided as a policy reflected .admission orders [REDACTED].Vendor has been notified of needed enteral products .(i.e. Foley Cath) .
F 0710 **Level of harm -** Actual harm **Residents Affected -** Few	**Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a physician approved in writing that an individual be admitted to the facility, and provide orders for the resident's immediate care needs, in that Resident #1 was admitted to the facility on [DATE] without consulting or notifying the physician of his admission or obtaining physician orders [REDACTED]. On 08/06/2020 Resident #1 reported pain, burning and discomfort related to his Foley catheter and it was noted his urine was amber colored. No orders for treatment were received prior to Resident #1 removal from the facility on 08/08/2020 by his family due to lack of care and treatment of [REDACTED].#1 was admitted to the hospital on [DATE] with the [DIAGNOSES REDACTED]. Resident #1 Foley was noted to be clogged and Resident #1 had more than a liter of urine in his bladder. These failures could place residents with indwelling urinary catheters at risk [MEDICAL CONDITIONS], pain or death. Finding include: Review of Resident #1's Face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #1's 5-Day MDS (still in process) reflected Resident #1 was assessed to have a BIMS score of 8 indicating moderate cognitive impairment. Resident #1 was assessed to require extensive to dependent assist with ADL's and supervision for eating. Resident #1 was assessed to have an indwelling urinary catheter. Review of Resident #1's Initial Baseline Care Plan dated 08/04/2020 reflected Resident #1 had a Foley catheter but did not indicate any interventions for the care or monitoring of the Foley catheter. Review of Resident #1's Initial Nursing Evaluation dated 08/04/2020 reflected Foley catheter intact, patent, draining yellow urine to bedside drainage bag. Further review of the Nursing Evaluation reflected the Catheter [DIAGNOSES REDACTED]. Review of Resident #1's MAR and TAR dated 08/04/2020 through 08/08/2020 reflected no entries for his Foley Catheter or care of the Foley Catheter. Review of Resident #1's Nurisng Progress notes dated 08/05/2020 through 08/08/2020 reflected no entries for his Foley Catheter or care of the Foley Catheter. Review of Resident #1's Hospital Discharge orders dated 08/04/2020 reflected a list of medication. No orders for the Foley Catheter were listed. Review of Resident #1's Consolidated Physician order [REDACTED]. In an interview on 08/10/2020 at 3:45 PM LVN A stated she was Resident #1's nurse on 08/06/2020 and 08/08/2020. LVN A

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F 0710 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) stated Resident #1's family called on 08/08/2020 and stated they were taking Resident #1 out of the facility because he wasn't getting care. LVN A stated they told her his Foley had not been changed and they asked for a UA. LVN A stated she faxed Resident #1's doctor about the UA on 08/06/2020 and the office told her they did not know who he was and needed admission paperwork and she faxed it to the doctor's office. When asked if it was common to admit a resident without contacting the doctor she stated No. When asked if Resident #1 had orders for the care of his Foley Catheter, she looked at the EMR and stated No. LVN A stated Resident #1 should've had orders for the care and monitoring of his Foley. LVN A stated she did not receive orders from the doctor's office for Resident #1 prior to his family taking him home on the morning 08/08/2020 AMA. Review of Resident #1's Medical Fax Referral to the physician dated 08/06/2020 at 1:00 PM reflected Resident admitted on [DATE] with Foley catheter for [MEDICAL CONDITION]. Voicing pain, burning and discomfort, urine amber color and clear in drain bag. Family would like to know when Foley catheter will be discontinued. May we have order for UA C&S and would you like to do voiding trial? Please Advise. Documented under New orders/ treatment No record of patient in our system, we have no paperwork on him. Where was he admitted from and who gave admit orders? We need admission paperwork. In an interview on 08/11/2020 at 12:08 PM Resident #1's Physician stated the facility did send a fax on 08/06/2020 regarding Resident #1 and that the resident was having [MEDICAL CONDITION] and voicing pain, but he did not now who the resident was and had not been made aware of his admission and he requested the facility fax over more information on the resident. Resident #1's Physician stated by the time his office had gotten all the information the resident had already been removed from the facility. Resident #1 stated the facility was usually pretty good about notifications of admission. Resident #1's Physician stated Resident #1 should've had orders for his Foley catheter and the nurses should monitor for changes in output. In an interview on 08/11/2020 at 2:00 PM the DON stated Resident #1 should've had orders for his Foley Catheter that included catheter care every shift, irrigation every shift if needed for clogging, to check placement and securement of the Catheter and for the catheter to be changed as needed. The DON stated the physician should have been notified prior to admission of the Resident. The DON was asked how the facility failed to ensure Resident #1 had orders for his admission and Foley catheter she stated the facility did chart audits on all new admits to ensure all care areas are addressed after admission. She stated it just took longer with this resident. She stated it was her expectation that residents admitted to the facility have their physician notified and Residents with a Foley catheter have a complete assessment and orders are obtained for the care of the Foley catheter at the time of admission. Review of the facility's Admission/ Readmission Checklist dated 04/2015 provided as a policy reflected .admission orders [REDACTED].Vendor has been notified of needed enteral products .(i.e. Foley Cath) .