STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525270	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROSSROADS CARE CENTER OF FOND DU LAC	115 E ARNDT ST FOND DU LAC, WI 54935

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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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure a physician and POA (power of attorney) were notified when 1 Resident (R) (R1) of 1 residents incurred an injury of unknown origin and a change in condition. On 6/06/20, RN (Registered Nurse)-K noted R1's catheter was obstructed after R1 complained of pain. Following a catheter change, RN-K obtained 1300 cc (cubic centimeters) of thick, cloudy and bloody urine. NP (Nurse Practitioner)-G was notified of the catheter change on 6/08/20 and ordered a UA (urinary analysis). On 6/10/20, R1 was prescribed an antibiotic for a UTI (urinary tract infection). NP-G was not notified of R1's change in condition in a timely manner. In addition, POA (Power of Attorney)-J was not notified of R1's injury of unknown origin, change in condition and the prescription of an antibiotic in a timely manner. Findings include: On 7/13/20, the Surveyor reviewed a complaint filed with the State Survey and Certification Agency. The complaint stated, on 6/09/20, CNA (Certified Nursing Assistant)-D and CNA-E observed a hematoma on the back of R1's head and reported the injury to LPN (Licensed Practical Nurse)-F. The complaint alleged LPN-F did not notify R1's physician or POA (power of attorney). The Surveyor reviewed R1's medical record. R1 was admitted to the facility following a hospitalization for altered mental status and a UTI. R1 had [DIAGNOSES REDACTED]. R1's most recent Quarterly MDS (Minimum Data Set), dated 5/08/20, indicated R1 was severely cognitively impaired and required full assistance of staff for transfers and ADLs (activities of daily living). R1 had an activated power of attorney for healthcare. A progress note, dated 6/12/20, stated the facility was monitoring new bruising to the back of R1's head. The Surveyor reviewed the facility's investigation. The investigation contained statements that indicated on 6/09/20, CNA-D, CNA-E and CNA-H observed an injury on the back of R1's head described as a scab with blood, a large purple, red and blue bump and a mark that was approximately 3 inches wide and 2-1/2 inches high with red, blue and purple colors and white spots around the hair follicles. The statements indicated the CNAs reported the injury to LPN-F who asked if they knew how the injury occurred. LPN-F's statement indicated LPN-F was called into the lounge (date not indicated) by a CNA who showed LPN-F a bump on R1's head. LPN-F stated LPN-F told the CNA that the injury was talked about in report and the nurses knew about it. LPN-F described the injury as a bump the size of a quarter and purplish in color. DON (Director of Nursing)-B's statement indicated DON-B was not notified of R1's injury of unknown origin on 6/09/20, but was notified on 6/12/20 after the injury was observed by another nurse on 6/11/20 and reported to UM (Unit Manager)-I. R1's medical record contained a fax to NP-G, dated 6/11/20, that stated R1 had a large round bruise on the back of R1's head. R1's medical record did not contain documentation to indicate NP-G was notified of R1's injury of unknown origin prior to 6/11/20. In addition, a progress note, dated 6/16/20 at 12:37 PM, indicated POA-J was updated regarding the contusion on the back of R1's head and R1's upcoming CT (computed tomography) scan. R1's medical record did not contain documentation to indicate POA-J was notified of R1's injury of unknown origin prior to 6/16/20 which was one week after the injury was discovered. 2. On 7/13/20, the Surveyor reviewed a second complaint filed with the State Agency. The complaint stated on the 6/06/20 PM shift, staff noted R1's catheter was not putting out urine and notified RN-K. The complaint stated a day shift nurse was notified R1 was pulling on the catheter and yelling in pain, but nothing was done. The Surveyor reviewed R1's Urinary Catheter care plan. The care plan indicated R1 experience [MEDICAL CONDITION] and had a history of [REDACTED]. A progress note, dated 6/06/20 at 7:09 PM, stated R1 was in visible pain and had no output from the catheter. A progress note, dated 6/16/20 at 8:45 PM, stated RN-K attempted to flush the catheter but obtained no urine return. RN-K then changed the catheter and obtained 1300 cc of thick, extremely cloudy, dark yellow almost tan urine followed by clear but bloody urine. The progress note also stated, Will continue to monitor resident and output. A progress note, dated 6/07/20, indicated R1's catheter bag was changed during rounds due to a lot of blood and clots in the bag. The note stated, Will continue to monitor. A progress note, dated 6/08/20, stated NP-G was updated regarding R1's catheter change on 6/06/20. A progress note, dated 6/09/20, stated a UA was sent (on the 6/08/20 PM shift). A progress note, dated 6/10/20, stated R1 was prescribed [MEDICATION NAME] (an antibiotic used to treat infections caused by bacteria) 500 mg (milligrams) every 6 hours for seven days. A progress note, dated 6/16/20, indicated the writer left a voice message for POA-J and stated, Writer called (POA-J) in regards to resident having a contusion on the back of the head .Also updated on being on antibiotic for UTI. The Surveyor noted R1's medical record indicated NP-G was not updated regarding R1's change in condition until 2 days after the incident. In addition, the Surveyor noted POA-J was not updated regarding R1's change in condition until approximately ten days after the incident. In addition, POA-J was notified of R1's antibiotic prescription until approximately six days after the medication was prescribed. On 7/15/20 at 1:35 PM, the Surveyor interviewed DON-B regarding notification. DON-B verified NP-G and POA-J were not notified in a timely manner when R1 experienced an injury of unknown origin and a change in condition.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure all injuries of unknown origin were reported to the State Survey and Certification Agency for 1 Resident (R) (R1) of 1 resident. On 6/09/20, multiple staff observed a hematoma on the back of R1's head. LPN (Licensed Practical Nurse)-F was notified of the injury of unknown origin; however, LPN-F did not inform NHA (Nursing Home Administrator)-A or DON (Director of Nursing)-B. In addition, a self report was not submitted to the State Survey and Certification Agency. Findings include: The facility's Abuse Prevention Program, dated 2/07/17, states: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment .The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED]. IV. Internal Reporting Requirements and Identification of Allegations Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then report it to the administrator or to a compliance hotline or compliance officer . Reports will be documented and a record kept of the documentation. Supervisors shall immediately inform the administrator or person designated to act in the administrator's absence of all reports of incidents, allegations or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property. Nursing staff is responsible for reporting the appearance of suspicious bruises, lacerations or other abnormalities of an unknown origin as soon as it is discovered .Following the discovery of any

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) suspicious bruises, lacerations or other abnormalities of an unknown origin, the nurse shall complete a full assessment of the resident for other bruises, laceration or pain. VII. External Reporting When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall .notify DQA (Division of Quality Assurance) that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. Within five working days after the report of the occurrence, the Administrator or designee shall complete and submit a Misconduct Incident Report form notifying the regulatory agency of the conclusion of the investigation. On 7/13/20, the Surveyor reviewed two complaints filed with the State Agency. One complaint alleged CNA (Certified Nursing Assistant)-D, CNA-E and CNA-H noted a hematoma on R1's head and reported the injury to LPN-F. The complaint alleged LPN-F did not report the injury to DON-B and did not share the information with oncoming staff. A second complaint stated three CNAs informed LPN-F of a hematoma on R1's head, but LPN-F did not chart or assess the wound. The Surveyor reviewed R1's medical record. R1 was admitted to the facility following hospitalization for altered mental status and a UTI (urinary tract infection). R1 had [DIAGNOSES REDACTED]. R1's most recent Quarterly MDS (Minimum Data Set), dated 5/08/20, indicated R1 was severely cognitively impaired and required full assistance of staff for transfers and ADLs (activities of daily living). A fax to NP (Nurse Practitioner)-G, dated 6/11/20, stated R1 had a large round bruise on the back of R1's head. The Surveyor reviewed the facility's investigation. CNA-D's statement indicated on 6/09/20, CNA-D and CNA-E observed a scab with blood on R1's head and reported the injury to LPN-F. On 6/12/20, CNA-D and CNA-E were asked if they knew what happened to R1. CNA-D and CNA-E stated they notified LPN-F of R1's injury on 6/09/20. CNA-E's statement indicated on 6/09/20 at 6:30 PM, CNA-H showed CNA-E a large purple, red and blue bump on the back of R1's head. CNA-E notified LPN-F who asked CNA-D and CNA-H if they knew how the injury occurred. On 6/12/20, UM (Unit Manager)-I asked CNA-E about R1's head injury. CNA-E told UM-I the injury was reported to LPN-F on 6/09/20. CNA-H's statement indicated CNA-H observed a mark on the back of R1's head while R1 was sitting in a wheelchair in the lounge. CNA-H stated two coworkers also observed the injury as well as LPN-F who asked the CNAs if they knew how the injury happened. CNA-H described the wound as longish and wide .approximately 3 inches wide and 2/1/2 inches high with red, blue and purple colors and white spots around the hair follicles. LPN-F's statement indicated LPN-F was called into the lounge (date not indicated) by a CNA who showed LPN-F a bump on R1's head. LPN-F stated, I told the CNAs that this was talked about at report and both nurses knew about it. The bump was the size of a quarter and purplish in color . DON-B's statement indicated DON-B was not notified of R1's injury on 6/09/20. A Resident Concern Report, initiated by DON-B and dated 6/12/20, verified the injury was reported to LPN-F on 6/09/20. On 7/15/20 at 1:35 PM, the Surveyor interviewed DON-B regarding R1's injury of unknown origin. DON-B stated, (LPN-F) stated (LPN-F) didn't remember anything about it. DON-B stated LPN-F should have reported the injury to DON-B following the discovery. DON-B stated LPN-F was issued a final written warning regarding the incident. DON-B provided the Surveyor with a copy of education completed with staff regarding reporting requirements; however, DON-B verified a self report was not submitted to the State Survey and Certification Agency. DON-B stated DON-B consulted with the facility's corporate consultant following the investigation and was told a self report should have been submitted.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not ensure all injuries of unknown origin were thoroughly investigated for 1 Resident (R) (R1) of 1 resident. On 6/09/20, multiple staff observed a hematoma on the back of R1's head and notified LPN (Licensed Practical Nurse)-F. LPN-F did not document the injury of unknown origin and did not inform (Nursing Home Administrator)-A or DON (Director of Nursing)-B. The injury was observed by RN (Registered Nurse)-K during rounds on 6/11/20 and reported to UM (Unit Manager)-I. The facility initiated an investigation on 6/12/20; however, the facility did not conduct a thorough investigation to include resident and staff interviews as well as observations and audits to determine the likely cause of R1's injury. Findings include: The facility's Abuse Prevention Program, dated 2/07/17, states: VI. Internal Investigation 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment or misappropriation of resident property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of resident property will result in an investigation. 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury or the location of the injury . If classified as injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given and notification of the resident's physician and responsible party. DQA (Division of Quality Assurance) will be notified. Time frames for reporting and investigating abuse will be followed. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. 4. Investigation Procedures .Any written statements that have been submitted will be reviewed, along with pertinent medical records or other documents. 7. Updates to the Administrator .The person in charge of the investigation will update the administrator or person designated in the administrator's absence during the process of the investigation. The administrator or designee will keep the resident or resident's representative informed of the progress of the investigation. On 7/13/20, the Surveyor reviewed two complaints filed with the State Agency. One complaint alleged CNA (Certified Nursing Assistant)-D, CNA-E and CNA-H observed a hematoma on R1's head and reported the injury to LPN-F. The complaint alleged LPN-F did not report the injury to DON-B and did not share the information with oncoming staff. A second complaint stated three CNAs informed LPN-F of a hematoma on R1's head, but LPN-F did not chart or assess the wound. The Surveyor reviewed R1's medical record. R1 was admitted to the facility following a hospitalization for altered mental status and a UTI (urinary tract infection). R1 had [DIAGNOSES REDACTED]. R1's most recent Quarterly MDS (Minimum Data Set), dated 5/08/20, indicated R1 was severely cognitively impaired and required full assistance of staff for transfers and ADLs (activities of daily living). The Surveyor reviewed the facility's investigation. CNA-D's statement indicated on 6/09/20, CNA-D and CNA-E observed a scab with blood on R1's head and reported the injury to LPN-F. On 6/12/20, CNA-D and CNA-E were asked if they knew what happened to R1. CNA-D and CNA-E stated they notified LPN-F of R1's injury on 6/09/20. CNA-D's statement also indicated CNA-C stated the AM shift must've hit (R1's) head using the Hoyer (lift) to get (R1) into bed. CNA-E's statement indicated on 6/09/20 at 6:30 PM, CNA-E notified LPN-F of a large purple, red and blue bump on the back of R1's head. LPN-F asked CNA-D, CNA-E and CNA-H if they knew how the injury occurred. CNA-E stated CNA-H indicated the injury may have occurred when R1 rested R1's head on the hand rails of R1's wheelchair. CNA-E's statement also indicated CNA-C stated, (The injury) was probably day shift or (CNA-H) and someone else not paying attention and hitting (R1's) head on the headboard while transferring. CNA-H's statement indicated CNA-H observed a mark on the back of R1's head while R1 was sitting in a wheelchair in the lounge. CNA-H stated two coworkers also observed the injury as well as LPN-F who asked the CNAs if they knew what happened. CNA-H described the wound as approximately 3 inches wide and 2/1/2 inches high with red, blue and purple colors and white spots around the hair follicles. LPN-F's statement indicated LPN-F was called to the lounge (date not indicated) by a CNA who showed LPN-F a bump on R1's head. LPN-F stated, I told the CNAs that this was talked about at report and both nurses knew about it . DON-B's statement indicated DON-B was not notified of R1's injury on 6/09/20 and stated, Writer systematically went through every employee from the twenty-four hours prior (to 6/11/20) asking if they (knew) about a bump on (R1's) head if (R1) had bumped (R1's) head during a transfer or repositioning. DON-B interviewed eleven staff, including CNA-D, CNA-E and CNA-F. The statement indicated the maintenance department was asked to put caps on R1's wheelchair bars due to CNA-H's suggestion the injury was caused by R1 slumping or leaning in R1's wheelchair. The Surveyor noted the investigation did not contain interviews with residents, observations or audits of transfers and R1's position in the wheelchair or interview with additional staff who worked with R1 prior to the twenty four hours preceding the discovery of the injury. On 7/15/20 at 1:35 PM, the Surveyor interviewed DON-B regarding R1's injury of unknown origin. DON-B stated, (Staff) reported (the injury) to (LPN-F) who didn't take it any further .Some aides thought it occurred during a boost in bed (Another) aide said it was probably from the bar on the back of the wheelchair. When the staff sat in the chair, it lined up. There was an uncapped bar on (R1's) wheelchair on the left side . DON-B stated LPN-F didn't recall being notified about the injury and verified LPN-F should have reported the injury to DON-B so an investigation could have been initiated in a timely manner. DON-B stated when DON-B was notified of the injury, DON-B used the 6/11/20 schedule to conduct interviews of staff who worked with R1 twenty-four hours prior to the discovery.

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) DON-B stated DON-B didn't interview staff who worked with R1 prior to 6/11/20 and stated, My CNAs are working the same shifts over and over again. I didn't have any new staff. DON-B stated resident interviews were not conducted because there weren't any interviewable residents in R1's hallway. When asked if staff were observed completing transfers, DON-B stated there was no reason to believe R1's head hit the wall or a lift during a transfer. DON-B provided the Surveyor with a copy of education provided to staff following the incident. The education did not include the facility's requirements for conducting a thorough investigation. In addition, DON-B verified a self report was not submitted to the State Survey and Certification Agency. DON-B stated DON-B consulted with the facility's corporate consultant following the investigation and was told a self report should have been submitted.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility did not provide the necessary care and services to maintain the highest practicable physical well being in accordance with the comprehensive assessment and plan of care related to pain management for 1 Resident (R) (R1) of 5 residents. Staff observed R1 display verbal and non-verbal signs of pain and reported changes in the frequency and consistency of R1's urinary output. On the 6/06/20 AM shift, R1 displayed pain at a level seven (on a scale of one to ten) and was administered PRN (as needed) narcotic medication. RN (Registered Nurse)-L was unable to determine the origin of R1's pain and did not complete a comprehensive pain assessment. On the 6/06/20 PM shift, R1's catheter was obstructed and had no output. RN-K changed R1's catheter and noted a return of 1300 ccs (cubic centimeters) of curdled and bloody urine. R1's MD (Medical Doctor) was not notified by RN-L when R1 displayed increased signs and symptoms of undeterminable pain. Findings include: The facility's Management of Pain policy, dated 7/15/20, states: Policy Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence and enhance dignity and life involvement. We will achieve these goals through: Promptly and accurately assessing and diagnosing pain. Aggressively assessing pain in non-verbal and cognitively impaired residents. Procedure: 2. Physician Communication and Involvement Pain will be assessed and managed in a timely fashion, especially if it's of recent onset. The physician will be notified of a resident's complaint of pain when not relieved by medication as ordered by the physician. Thorough communication with the physician will ensure an appropriate pain management plan. 3. Nursing Involvement: A. Pain Screening Upon admission, readmission, each MDS (Minimum Data Set) assessment and change of condition, the Pain Screening will be filled out with input from the resident, family member or responsible party. By receiving input from someone who knows the resident well, pain management can be more specific to the resident. If the resident scores 5 or above on the Pain Screening, the Comprehensive Pain Assessment must be completed. B. Comprehensive Pain Assessment 1. The assessment will cover the following areas: intensity, location, onset, type and frequency, description, change, treatment, effect and what makes it better or worse . 2. A licensed nurse will initiate the Comprehensive Pain Assessment under and of the following circumstances: a. Score of 5 or above on the Pain Screening b. A change in resident condition occurs which requires pain control c. New pain is reported d. Initiation of a PRN or routine pain medication 5. Physical Examination The nurse will complete a physical examination of the resident. The physician may complete a more thorough examination if needed. On 7/13/20, the Surveyor reviewed a complaint filed with the State Agency. The complaint stated on the 6/06/20 AM shift, R1 pulled on R1's catheter and yelled out in pain. Staff noted R1's catheter was not putting out urine and notified the nurse however, nothing was done. At 6:00 PM, staff notified the PM nurse who changed R1's catheter and got a return of 1300 ccs of very thick urine with cottage cheese appearance. The Surveyor reviewed R1's medical record. R1 was admitted to the facility following a hospitalization for altered mental status and a UTI (urinary tract infection). R1 had [DIAGNOSES REDACTED]. R1's most recent Quarterly MDS (Minimum Data Set), dated 5/08/20, indicated R1 was severely cognitively impaired and required full assistance of staff for transfers and ADLs (activities of daily living). R1's Urinary Catheter care plan indicated R1 experience [MEDICAL CONDITION] and had a history of [REDACTED]. of pain, blood tinged urine, cloudiness, no output and deepening of urine color. A progress note, dated 6/06/20 at 8:38 AM and written by RN-L stated, Resident keeps saying ouch but cannot tell (RN-L) where (resident) hurts. Facial grimacing and clenched fists. The note indicated R1 was given 325 mg (milligrams) of [MEDICATION NAME]-[MEDICATION NAME] (a narcotic medication used to treat moderate to severe pain) for comfort at 8:38 AM. R1's MAR (medication administration record) indicated R1's pain was at a level seven prior to receiving the medication. The Surveyor noted R1's medical record did not contain a comprehensive pain assessment. On 7/15/20 at 2:16 PM, the Surveyor interviewed RN-K regarding R1. On 6/06/20, RN-K encountered CNA (Certified Nursing Assistant)-E in the parking lot on the way into work. CNA-E stated R1 was tugging on R1's catheter since the 6/05/20 NOC (night) shift. RN-K received report from LPN (Licensed Practical Nurse)-M who indicated R1 was administered pain medication because something was going on with R1's catheter. RN-K attempted to flush R1's catheter, but got not return. RN-K then changed R1's catheter and stated, I immediately got 1300 ccs of curdled milk and later got bloody urine. RN-K pushed fluids throughout the night and stated R1's catheter started to clear. RN-K stated the incident was concerning because R1 was admitted to the facility following hospitalization for a UTI [MEDICAL CONDITION]. R1's medical record contained a fax, dated 6/07/20, that stated, Can we get an order for [REDACTED]. Resident seems more lethargic and confused today. The fax did not indicate R1's catheter was changed and R1 reported increased pain. On 7/14/20 at 5:58 PM, the Surveyor interviewed CNA-E via telephone. CNA-E stated, (R1) kept saying 'ow' and holding (R1's) catheter. CNA-E stated that was not normal behavior for R1 and stated, I never saw (R1) (play with or hold the catheter) unless it was bothering (R1). On 7/15/20 at 1:22 PM, the Surveyor interviewed LPN-N who worked the 6/05/20 NOC shift. LPN-N stated, I don't remember anything about (R1's) catheter being plugged . On 7/15/20 at 1:29 PM, the Surveyor interviewed CNA-H who stated, I asked several nurses to change (R1's) catheter. It was cloudy and didn't look right. I asked nurses on our shift (PM) and those who were coming in. (RN-K) was the only one who looked at it .We had been asking everyone to change it. (R1) looked like (R1) was in pain .grabbing (R1's) groin. Maybe (R1) pulled (the catheter) out It scared me because (R1) was wincing. (R1) doesn't fake pain. (R1) was definitely in pain. CNA-H stated R1's non-verbal pain indicators included bringing (R1's) knees up and curling up. On 7/15/20 at 3:05 PM, the Surveyor interviewed LPN-M who worked the 6/06/20 PM shift. LPN-M stated, I remember some catheter issues. LPN-M stated the AM nurse reported R1 was given pain medication and was pulling on R1's catheter. LPN-M stated, I checked (R1) and noticed (R1) was pulling (on the catheter) between 2:00 and 3:00 PM. LPN-M stated R1 didn't appear to be in pain at that time and staff stated it was typical for R1 to pull on the catheter. LPN-M stated an unnamed aide later reported R1 was grinding and clenching (R1's) teeth in pain. LPN-M completed a pain assessment in which R1 rocked back and forth. LPN-M attempted to change R1's catheter; however, R1 grabbed LPN-M's arm and dug (R1's) nails in. LPN-M stated, (R1) wouldn't let me get close enough. LPN-M administered pain medication and reported the encounter to the NOC nurse (RN-K). LPN-M stated R1's catheter was draining during the PM shift; however, staff monitored R1's urine output because it was decreased and discolored. LPN-M stated, I didn't know if (R1's) pain was because of (R1's) catheter, but putting the non-verbals together, I assumed it was the catheter. R1's MAR indicated [REDACTED]. On 7/15/20 at 3:36 PM, the Surveyor interviewed RN-L who worked the 6/06/20 AM shift. RN-L flushed R1's catheter and noted there was not as much output. RN-L asked the PM shift nurse to watch R1's catheter. RN-L thought the pain medication RN-L administered at 8:38 AM was for R1's therapy/knees as R1 was not able to verbalize the site of the pain and didn't point to anything. RN-L stated the NOC nurse (LPN-N) stated R1 was tugging on the catheter, but didn't report R1 was in pain. RN-L stated tugging and playing with the catheter as well as fist clenching and grimacing were normal behavior for R1. RN-L determined R1's pain by using a dementia scale and stated R1's catheter bag was empty when RN-L administered the pain medication. RN-L couldn't recall if R1's MD was updated following R1's report of increased undeterminable pain. On 7/15/20 at 1:35 PM, the Surveyor interviewed DON (Director of Nursing)-B regarding R1. DON-B received a text from RN-K with concerns regarding R1's catheter. DON-B stated, (RN-K) was worried because (RN-K) heard (R1) didn't have output (on the 6/06/20 AM shift), but (RN-L) reported (R1) did. When R1 displayed undeterminable pain at a level seven and was administered narcotic medication, DON-B stated, (RN-L) should have done an immediate comprehensive assessment and called me. DON-B also verified R1's MD should have been notified of R1's new onset on pain and the fact RN-L was unable to determine the origin of the pain.