STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLINGER HEALTHCARE AND REHABILITATION CENTER	2001 6TH ST BALLINGER, TX 76821

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan regarding appropriate treatment and services to prevent urinary tract infections and complications associated with indwelling catheters for 4 (Resident #1, Resident #2, Resident #3 and Resident #4) of 4 residents reviewed for catheters. The facility failed to provide appropriate treatment and indwelling catheter services consistent with professional standards of practice, for Resident #1 resulting in an emergency situation [MEDICAL CONDITION], physical harm, pain, and mental anguish and emotional distress for Resident #1. An Immediate Jeopardy (IJ) situation was identified on 6/18/20. While the IJ was lowered on 6/21/20, the facility remained out of compliance at a severity level of actual harm a scope of pattern, due to the facility's need to complete in service training and evaluate the effectiveness of their plan of removal. This failure resulted in life threating situation resulting in physical and emotional harm for one resident with the potential for harm for the rest of the facility residents. Findings: Record review of Resident #1 face sheet dated 6/17/20 revealed a [AGE] year old male admitted on [DATE] with a most recent admission date of [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #1 electronic orders accessed on 6/12/20 revealed there were no orders to address his indwelling catheter, his [MEDICAL CONDITION], or pressure ulcers to his scrotum or penis. Resident #1 did have orders to Clean wounds to coccyx and ischium area with wound cleaner apply wet to dry dressing secure with abdominal pads and secure with tape every day one time a day for wound care with a start date of 4/11/2020 with no end date. Record review of skilled nursing facility/nursing home admissions orders for Resident #1 accessed on 6/16/20 revealed he was marked has not having a Foley catheter. The admission orders [REDACTED]. Record review of Resident #1 electronic care plan accessed on 6/12/20 revealed the following: Focus - Resident #1 has Indwelling Foley Catheter: [MEDICAL CONDITION] bladder. Chronic UTI's, Goal - He will show no signs and symptoms of urinary infection through review date. He will be/remain free from catheter-related trauma through review date., Interventions - Check tubing for kinks with routine care., Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter., Monitor/record/report to MD for signs and symptoms 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, change in eating patterns. Initiated date of 8/16/19 and revised date of 6/12/20. Record review of Resident #1 most recent quarterly Minimum Data Set (MDS) after reentry from acute hospital on [DATE] revealed he had the ability to express ideas and wants and was able to understand others clearly. Resident #1 had a Brief Interview for Mental Status (BIMS) of 15 out of score of 15 which indicated an intact cognition. Resident #1 was totally dependent for activities of daily living (ADL) expect for eating where he required extensive assistance. Record review of Resident #1 admission MDS on 8/9/19 revealed Resident #1 had an indwelling catheter on admission. Record review of Resident #1 electronic progress notes accessed on 6/12/20 revealed the last time his foley catheter was addressed was 5/19/20 and it only addressed his catheter bag was in place. Record review of Resident #1 health notes dated 6/8/20 through 6/9/20 for his first 24 hours in a surrounding area hospital revealed the following: Clinical note from hospital Registered Nurse (RN) Resident #1 presented with a foley catheter that was malfunctioning and had to replaced with 2 liters output once old foley was replaced, patient developed acute kidney injury, [MEDICAL CONDITION] was pale and dusky in appearance, and possible concerns of neglect. Further review of hospital records revealed Resident #1 was [MEDICATION NAME] with an altered mental status, in acute [MEDICAL CONDITION], had a distended bladder with hydro[DIAGNOSES REDACTED] bilaterally, it was suspect the foley was obstructed and not in the correct position causing increased volume with backflow acute kidney failure and [MEDICAL CONDITION], mental status changes could be from uremic [MEDICAL CONDITION] and the patient is critically ill and survival is highly unlikely but not impossible. In an interview on 6/12/20 at 1:20 pm Certified Nurse Aide (CNA) A stated they empty bags once a shift and they do not record output. CNA A stated they used to record catheter output, but their kiosk changed, and it does not give them a place to document catheter output. In an interview on 6/15/20 at 10:47 am with License Vocational Nurse (LVN) A stated she cared for Resident #1 on the 5th, 6th, and 7th. LVN A stated on 5/7/20 the aides reported his cath was leaking but that LVN E took care of it. LVN A stated she has worked at the facility since 2/2020 and she has never changed the catheter tubing for Resident #1 but to get direction on his catheter needs she would access the orders, observe what appliances he already has in place, and call the physician to get orders if non-was available. In an interview on 6/15/20 at 12:15 pm the DON stated he could not find any orders related to Resident #1 indwelling catheter. The DON stated he cannot find orders for Resident #2 type and size of strait catheter used to self-catheterize. The DON stated he cannot find any order that addressed catheter care for Resident #3. The DON stated he cannot find orders addressing Resident #4 suprapubic catheter type or size or suprapubic catheter care. The DON stated they do not have an admissions nurse and it is up the nurse who is receiving a new/returning resident to ensure the accuracy of orders. The DON stated he can't say for certain if catheter changes had been done for Resident #1. The DON stated he has not done any training with nursing staff concerning changing, assessing, and monitoring of catheters, and he has not received any training in this area since becoming the DON in January of 2020. In an interview on 6/16/20 at 10:40 am Family B stated Resident #1 reported vomiting on 6/7/20 (Note: there was no notes addressing vomiting) and was requesting to see his doctor. Family B was present when Resident #1 was admitted to the hospital and she was shocked to see Resident #1's condition. Family B stated when Resident #1 was non-responsive and had a swollen hard abdomen. Family B stated when the foley catheter from the nursing home was removed Resident #1 had release of urine from his penis and it was a strong foul odor and a large amount filled with sediment, once the urine stopped flowing on its own they replaced the catheter and Resident #1 filled a bag of urine. Family B stated since Resident #1 admission to the hospital he has been able to come of life support. Family B stated Resident #1 has not been able to sleep and reports he is having nightmares of needing help and no one is coming to his aide. Resident #1 does not like his room door shut if he is alone in the room and this is a new behavior for him. Family B states Resident #1 is now having [MEDICAL CONDITION] and he has no previous history of [MEDICAL CONDITION] activity, and Resident #1 bladder is still not emptying correctly. In an interview on 6/16/20 at 1:59 pm LVA A stated she did not know of any vomiting for Resident #1. LVN A stated Resident #1 usually has [PHONE NUMBER] milliliter urine output for her shift but she never emptied his catheter bag on the 5th, 6th, and 7th on June 2020. In an interview on 6/16/20 at 2:10 pm Certified Medication Aide (CMA) A stated that CMA's do not deal with catheters or assess urine output. CMA A was certain aides empty catheter bags. CMA A stated she knew Resident #1 had vomiting some time during the week but was unsure when. CMA A stated Resident #1 told her he would throw up chunks about 10 hours after he ate. CMA A stated she did not report this to anyone and she told Resident #1 he needs to let a nurse or his doctor know. CMA A was unsure if

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLINGER HEALTHCARE AND REHABILITATION CENTER	**2001 6TH ST BALLINGER, TX 76821**

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 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Resident #1 report his illness to anyone else. In an interview of 6/16/20 at 3:07 pm the DON stated a CNA or a nurse can empty a catheter bag and they do not document output unless there is an order, and they have no guidelines on when to report findings for catheters or catheter output to the DON or doctor. In an interview on 6/16/20 at 7:50 pm Family A stated that before COVID-19 the facility had been taking good care of Resident #1 and she is not sure what has happened because she has not been able to see Resident #1. Family A stated her and Resident #1 spoke the night of 6/7/20 he sounded fine but told her he had been throwing up undigested food for the last couple of days and Family A though the facility had called his doctor for him. Family A stated the next time she heard anything was around 3 pm on 6/8/20 when she was told they called 911 for Resident #1. Family A was at the hospital when Resident #1 arrived and when she saw him she thought he was going to die. Family A stated Resident #1 looked dirty, his skin was grayish colored, his abdomen was hard and swollen, and he was not breathing right. Family A stated she overheard an emergency medical team member tell the nurse he had been having a change in mental status all day. Family A stated when they removed the urinary catheter urine just started to flow out and it smelled awful and it just kept coming. Family A stated when the flow stopped they replaced the catheter and he quickly filled another bag of urine. Family A stated his catheter bag from the facility was empty when he arrived at the hospital. Family A stated Resident #1 is now having nightmares of people not being able to help him and is scared to sleep and does not want his door shut. Family A stated Resident #1 is now having [MEDICAL CONDITION] that started when he was in the intensive care unit (ICU). Family A stated from what she understands this is all related to his catheter not functioning properly, Resident #1 is still very ill, and a full recovery is unknown. Family A was very emotional and crying during our phone conversation. In an interview on 6/17/20 at 10:15 am CMA B stated she worked with Resident #1 on the day before and the morning he got ill. CMA B stated the day before 6/8/20 he was ok and had no reports of vomiting. CMA B stated on the morning of 6/8/20 she went to his room to pass medication around 8:40 am and she had to touch him to get him to wake up, but he took his pills telling her he was sleeping. CMA B though noting of it because it was not unusual for Resident #1 to sleep late. CMA B stated around lunch she went to give him pills and he would not wake up and was cold to the touch at his arms, he moved his head but gave no verbal response. CMA B stated she informed LVN C of her findings at 1:00 pm and LVN C stated she would check on him. CMA B left for the day around 1:08 pm. CMA B stated for resident concerns they are to fill out a yellow Interact from and give it to the nurse and she acknowledged she did not complete this form on 6/8/20 for Resident #1. In an interview on 6/17/20 at 10:39 am LVN C stated CMA B had to give medication to Resident #1 on 6/8/20 at 11:00 am and she reported to her that he will not wake up enough to take medications. LVN C stated she checked on him about 5-10 minutes later and Resident #1 shook his and said he was just sleeping which was not unusual for him. LVN C states he had 250-300 milliliters of urine amber in color and cloudy in his catheter bag. LVN C told Resident #1 she was going to lunch and would check on him after her lunch. LVN C stated she took approximately a 35-minute lunch and when she returned to Resident #1 he was unresponsive, and she called emergency services. LVN C stated she had no report of vomiting over the weekend when she received report the morning of 6/8/20, but she had heard LVN E had repositioned Resident #1 catheter and that he had low output over the weekend. LVN C stated she had not emptied or replaced the catheter bag for Resident #1 that day. LVN C stated a CNA can empty catheter bags. LVN C stated she is unaware of any parameters of reporting for catheters or catheter output. LVN C stated she has not had any training from the facility on catheters. In an interview on 6/17/20 at 12:45 pm CNA C stated Resident #1 refused breakfast and lunch on 6/8/20 but it was not all that unusual for him to skip those meals as he is up more at night, but when he did not request his snuff by lunch she went to check on him and he did not look right. CNA C stated she told LVN C and LVN C told her that CMA B could not get him awake for medications. CNA C stated she went on lunch break around 2 pm and was back by 3 pm and Resident #1 was gone by then. CNA C stated she did not empty his catheter bag that day and assumed CNA D emptied his bag and she had seen only a little bit of urine in his bag that day. (Note, even though she did not empty Resident #1 catheter bag she noted on ADL care log she did). In an interview on 6/17/20 at 1:46 pm CNA A stated on 6/7/20 Resident #1 got a shower and they noticed he was a little distended in the abdomen and they got LVN E to adjust Resident #1 catheter tubing because he was having leakage. CNA A stated after LVN E adjusted his tubing there was urine flow and it looked normal for him. CNA A stated LVN A did wound care and Resident #1 wanted in his recliner. He ate some cheese sticks and crackers and a little later he vomited mucus. CNA A stated Resident #1 had at least 900 milliliters urine output on her shift. In an interview on 6/17/20 at 3:05 pm LVN E stated on the night of 6/7/20 she deflated and repositioned the catheter tubing for Resident #1 because the CNAs reported it was leaking. LVN E stated when she was done Resident #1 had no more leaking and urine return was seen in the catheter bag. LVN E did not check his orders before adjusting the catheter tubing stating she removed 10 milliliters from the bulb and returned 10 milliliters to the bulb, and she did not check to see when the last time his catheter had been changed. LVN E stated Resident #1 had output of urine after adjusting the tubing but did not know how much. LVN E stated Resident #1 has a history of blockages but that day it was just yellow urine. In an interview on 6/17/20 at 3:26 pm Dr. A stated Resident #1 catheter was to be changed monthly and as needed if clogged. Dr. A stated a urine output of less than 400 milliliters a day would be a concern. Dr. A stated if a blockage was to present the symptoms you would likely see would be mental status changes, nausea and vomiting, fever, chills, and complaints of back pain. Dr. A stated a decrease in output for Resident #1 was never reported to him, nor was the vomiting, all the facility told him was he was unresponsive. In an interview on 6/17/20 at 3:45 pm the DON stated if there was no order for a foley catheter change in a resident's chart and a nurse felt like it needed to be changed she would need to contact the doctor to get an order. The DON stated he does not have a set schedule of assessment for residents with catheters but he expects his nurses to know the residents well enough to know when there is a change in a resident. The DON stated if a resident was to report vomiting to an CMA or CNA he expects them to let the charge nurse for that side know. In an interview on 6/18/20 at 9:15 am the DON stated he could not find any orders even from Resident #1 admission that addressed his indwelling catheter or [MEDICAL CONDITION]. In an interview on 6/19/20 at 1:05 pm Dr. B the hospitalist stated when Resident #1 left their hospital in March of 2020 he left with a normal bladder. Dr. B stated when he returned to their hospital on [DATE] his foley catheter was jammed into the prostate causing obstruction and improper drainage of his foley catheter, which lead to infection; that lead [MEDICAL CONDITION]; which also resulted in a rupture of his bladder causing him to develop a diverticulum next to the bladder that is larger than his bladder; leaving his bladder distorted beyond use and possibly to an extent of not being saved. Dr. B stated if the bladder cannot be saved the providers are at a loss as how to treat him given his large pressure wounds and already having a [MEDICAL CONDITION] every treatment option for Resident #1 carries a huge risk or just may not be possible. Record review of the https://www.cdc.gov/dengue/training/cme/ccm/page .html Centers for Disease Control and Prevention CDC website accessed on 6/23/20 revealed normal urine output for an average adult is 0.5 to 1.5 cubic centimeters(cc)/kilogram(kg)/hour. Given this formula Resident #1 would have a normal output of 28.44cc to 85.32cc per hour giving him an average output of 56.88cc per hour. Resident #1 average output for a 24-hour period should be 1,365.12cc a day. Record review of hospital records from admission on 6/8/20 revealed Resident #1 had spontaneous drainage of urine when the nursing home catheter was removed and when his catheter was replaced he drained 1 liter of urine into a catheter bag. It is documented he drained 2 liters of urine. (Note 2 liters is equal to 2000cc and Resident #1 average urine output for a 24-hour period is 1,365.12cc a day. The hospital drained two days' worth of urine from Resident #1). Record review of Resident #2 face sheet revealed a [AGE] year old female admitted on [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #2 electronic orders accessed on 6/15/20 revealed an order stating Resident #2 may self-cath but no orders addressing the size or type catheter needed for Resident #2 to self-cath. Record review of Resident #2 electronic care plan accessed on 6/16/20 revealed the following: Focus - I am at risk for Urinary Tract Infection, related to self-cath/Intermittent with 14french non-latex catheter due to: Neuromuscular Dysfunctional bladder. With [DIAGNOSES REDACTED]. Interventions - Encourage fluids unless contraindicated., Observe and report signs and symptoms of UTI: changes in color, odor or consistency or urine, dysuria, frequency, fever, pain. Initiated on 2/13/20 with a revision date of 6/16/20 prior to revision on 6/16/20 this care plan did not address the size and type of catheter Resident one utilized to self-cath. Record review of Resident #2 most recent quarterly Minimum Data Set (MDS) revealed Resident #2 could clearly make herself understood with the ability to understand others. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated a intact cognition. Resident #2 had no history of rejecting evaluation or care for the quarter and only needed supervision for ADLs. The MDS also indicated Resident #2 had a for intermittent catheterization. Record review of Resident #3 face sheet dated 6/17/20 revealed a [AGE] year old male admitted on [DATE] with a most recent admission date of [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #3 electronic orders accessed on 6/12/20 revealed an order for [REDACTED]. Record review of Resident #3 electronic care plan accessed on 6/12/20 revealed the following: Focus - I use an indwelling foley catheter related to neuromuscular dysfunction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLINGER HEALTHCARE AND REHABILITATION CENTER	2001 6TH ST BALLINGER, TX 76821

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 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) of bladder. I have a history of [MEDICAL CONDITION] and frequent UTI's. (18fr5cc ribbed balloon Carson Model Coude Tip), Goal - I will not experience any unidentified complications related to catheter use thru next review date, Interventions - Change catheter tubing/bag per protocol/orders., Irrigate foley cath with Acetic acid solution to decrease UTI's as per order., Observe catheter tubing for kinks or twists in tubing., Observe for acute behavioral changes that may indicate UTI., Position catheter tubing below level of bladder., Provide catheter care every shift., Refer to urologist for evaluation as needed., Secure tubing to thigh to prevent pulling. Record review of Resident #3 most recent quarterly Minimum Data Set (MDS) revealed had unclear speech but could usually make himself understood and had the ability to understand others. Resident #3 had a Brief Interview for Mental Status (BIMS) of score of 12 out of 15 which indicated a moderately impaired cognition. Resident #3 did not have any rejection of evaluation or care for the quarter. Resident #3 needed extensive assistance with all ADLs except for eating which required limited assistance. Resident #3 also required an indwelling catheter. Record review of Resident #3 electronic progress notes and Medication Administration Record [REDACTED]. Record review of Resident #4 face sheet dated 6/17/20 revealed a [AGE] year old female admitted on [DATE] with a most recent admission date of [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #4 electronic orders accessed on 6/12/20 revealed Resident #4 had no current orders addressing her suprapubic catheter placed 2/26/20 or her percutaneous endoscopic gastrostomy (PEG) tube, date of placement is uncertain given chart review. There was orders to address her PEG tube feedings. Record review of Resident #4 electronic care plan accessed on 6/12/20 revealed no care planning for her suprapubic catheter but there was care planning for an indwelling catheter initiated on 3/26/19 but not revised to reflect her suprapubic catheter. Resident #4 did have her PEG tube addressed in her care plan with the following: Focus - Dependent on tube feeding due to: Dysphagia. I am at risk for weight loss and malnutrition. I can have pleasure feedings as requested. I am aware of the choking and aspiration risks. I request to use a pacifier because I believe it strengthens the muscles for swallowing and keeps my mouth from being dry. I have 1 can of Jevita 1 time daily along with my tube feeding., Goal - Maintain nutritional status and body weight., No S/S of aspiration., Will be free from GI Discomfort related to Tube Feeding., Will be free from S/S of complications due to presence of feeding tube., Will be free from S/SX of dehydration.; Interventions - Check tube placement every feeding., Elevate HOB at least 30-45 degrees during and for 30-60 minutes after feeding., Enteral formula and feedings as ordered., Hold feeding if residual is above 50 ml., Monitor lab data as available., Monitor vitals and breathe sounds for S/S of aspiration., Monthly weights., Observe and report skin irritation at the tube site., Observe for S/SX of intolerance to TF: gastic residuals, abdominal distention, vomiting, loose stools, nausea, nasal pain, fever, dehydration., Refer to RD for assessment as needed., Water flushes as ordered. Initiated on 3/27/20 and revised on 4/17/20. Record review of Resident #4 most recent quarterly Minimum Data Set (MDS) revealed she had unclear speech, could sometimes make herself understood, and could understand others. Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated an intact cognition. Resident #4 had rejected evaluation or care for 1 to 3 days in the last quarter and was totally dependent for all ADLS. Resident #4 utilized an indwelling catheter The DON could not provide any policies related to indwelling or suprapubic catheters relating to care, assessment, and monitoring, but was able to provide a Performance Checklist for Skills addressing all them with a date of 2018: Care and Removal of an Indwelling Catheter . 3. Assessed need for catheter care a. Observed urinary output and urine characteristics . 4. Assessed need for catheter removal: a. Reviewed patient's medical, noted length of time catheter was in place . c. Assessed urine color, clarity, odor, and amount; noted any urethral discharge, irritation, or trauma . 9. Checked drainage tubing and bag routinely for proper securement and positioning . Recording and Reporting 1. Recorded time for catheter care and appearance of urine, described condition of meatus and catheter. 2. Recorded and reported time of catheter removal; amount of water removed from balloon; condition of urethral meatus and catheter; and time, amount, and characteristic of first voided urine. Suprapubic Catheter Care, Assessment . 2. Assessed urine in drainage bag for amount, clarity, color, odor, and sediment . Evaluation . 3. Observed catheter insertion site for [DIAGNOSES REDACTED], [MEDICAL CONDITION], discharge, and tenderness; checked dressing at least every 8 hours . Recording and Reporting 1. Recorded and reported character of urine, type of dressing, and patient's comfort level. 2. Recorded urine output on Input and Output (I&0) flow sheet properly. Record review of CDC GUIDELINE FOR PREVENTION OF CATHETERASSOCIATED URINARY TRACT INFECTIONS dated 2009 electronically accessed on 6/19/20 revealed the following: . II. Proper Techniques for Urinary Catheter Insertion . B. Ensure that only properly trained persons who know correct technique of aseptic catheter insertion and maintenance are given this responsibility . III. Proper Techniques for Urinary Catheter Maintenance . B. Maintain unobstructed urine flow . E. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised . G. Do not clean the periurethral area with antiseptics to prevent CAUTI while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate . Management of Obstruction Q. If obstruction occurs and it is likely that the catheter material is contributing to obstruction, change the catheter. Record review of U.S. National Library of Medicine Medline Plus electronically accessed on 6/19/20 revealed the following: Indwelling catheter care . Cleaning the Catheter, follow these steps two times a day to keep your catheter clean and free of germs that can cause infection: Wash your hands well with soap and water. Be sure to clean between your fingers and under your nails. Change the warm water in your container if you are using a container and not a sink. Wet the second washcloth with warm water and soap it up. Gently hold the catheter and begin washing the end near your vagina or penis. Move slowly down the catheter (away from your body) to clean it. NEVER clean from the bottom of the catheter toward your body. Gently dry the tubing with the second clean towel . When to Call the Doctor . A urinary tract infection is the most common problem for people with an indwelling urinary catheter. Call your health care provider if you have signs of an infection, such as: Pain around your sides or lower back. Urine smells bad, or it is cloudy or a different color. Fever or chills. A burning sensation or pain in your bladder or pelvis. Discharge or drainage from around the catheter where it is inserted into your body. You do not feel like yourself. Feeling tired, achy, and have a hard time focusing. Also call your provider if: Your urine bag is filling up quickly, and you have an increase in urine. Urine is leaking around the catheter. You notice blood in your urine. Your catheter seems blocked and not draining. You notice grit or stones in your urine. You have pain near the catheter. You have any concerns about your catheter.; Suprapubic catheter care . Caring for Your Skin Near your Catheter . Check the catheter site a few times a day. Check for redness, pain, swelling, or pus. Wash the area around your catheter every day with mild soap and water. Gently pat it dry . Changing Your Catheter, you will need to change the catheter about every 4 to 6 weeks. Always wash your hands with soap and water before changing it . When to Call the Doctor . You are having trouble changing your catheter or emptying your bag. Your bag is filling up quickly, and you have an increase in urine. You are leaking urine. You notice blood in your urine a few days after you leave the hospital. You are bleeding at the insertion site after you change your catheter, and it does not stop within 24 hours. Your catheter seems blocked. You notice grit or stones in your urine. Your supplies do not seem to be working (balloon is not inflating or other problems). You notice a smell or change in color in your urine, or your urine is cloudy. You have signs of infection (a burning sensation when you urinate, fever, or chills).; High potassium level ([MEDICAL CONDITION]) . Causes, Potassium is needed for cells to function properly. You get potassium through food. The kidneys remove excess potassium through the urine to keep a proper balance of this mineral in the body. If your kidneys are not working well, they may not be able to remove the proper amount of potassium. As a result, potassium can build up in the blood . When to Contact a Medical Professional Call your provider right away if you have vomiting, palpitations, weakness, or difficulty breathing . The Administrator and DON was notified on 6/18/20 at 3:25 pm and Immediate Jeopardy (IJ) had been identified due to the above failures. The IJ template was provided to the Administrator and signed at 3:25 pm. The facility's Plan of Removal was accepted on 6/20/20 at 3:07 pm and revealed the following: Immediate interventions: 1 identified male resident with indwelling urinary catheter, pressure ulcers, and [MEDICAL CONDITION] remains hospitalized Conducted assessments on current identified residents: o 1 male resident with an indwelling urinary catheter and no indication of signs or symptoms related catheter-associated urinary tract infections (CAUTIs) were observed o 1 female resident with a suprapubic catheter and no indication of signs or symptoms related catheter-associated urinary tract infections (CAUTIs) were observed o 1 female resident requiring straight catheter and no indication of signs or symptoms of urinary tract infections (UTIs) or trauma to urinary meatus was observed o 1 female resident with a pressure ulcer and no indication of signs or symptoms of infection was observed Immediate review of potentially affected residents: All potentially affected residents were reviewed for changes in condition via an IDT anal
F 0690 **Level of harm** - Immediate jeopardy **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.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLINGER HEALTHCARE AND REHABILITATION CENTER	2001 6TH ST BALLINGER, TX 76821

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 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and complications associated with and indwelling catheter for 4 (Resident #1, Resident #2, Resident #3 and Resident #4) of 4 residents reviewed for catheters. The facility failed to provide appropriate treatment and indwelling catheter services consistent with professional standards of practice, for Resident #1 resulting in an emergency situation [MEDICAL CONDITION], physical harm, pain, and mental anguish and emotional distress for Resident #1. An Immediate Jeopardy (IJ) situation was identified on 6/18/20. While the IJ was lowered on 6/21/20, the facility remained out of compliance at a severity level of actual harm a scope of pattern, due to the facility's need to complete in service training and evaluate the effectiveness of their plan of removal. This failure resulted in life threating situation resulting in physical and emotional harm for one resident with the potential for harm for the rest of the facility residents. Findings: Record review of Resident #1 face sheet dated 6/17/20 revealed a [AGE] year old male admitted on [DATE] with a most recent admission date of [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #1 electronic orders accessed on 6/12/20 revealed there were no orders to address his indwelling catheter, his [MEDICAL CONDITION], or pressure ulcers to his scrotum or penis. Resident #1 did have orders to Clean wounds to coccyx and ischium area with wound cleaner apply wet to dry dressing secure with abdominal pads and secure with tape every day one time a day for wound care with a start date of 4/11/2020 with no end date. Record review of skilled nursing facility/nursing home admissions orders for Resident #1 accessed on 6/16/20 revealed he was marked has not having a Foley catheter. The admission orders [REDACTED]. Record review of Resident #1 electronic care plan accessed on 6/12/20 revealed the following: Focus - Resident #1 has Indwelling Foley Catheter: [MEDICAL CONDITION] bladder. Chronic UTI's, Goal - He will show no signs and symptoms of urinary infection through review date. He will be/remain free from catheter-related trauma through review date., Interventions - Check tubing for kinks with routine care., Monitor for signs and symptoms of discomfort on urination and frequency. Monitor/document for pain/discomfort due to catheter., Monitor/record/report to MD for signs and symptoms 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, change in eating patterns. Initiated date of 8/16/19 and revised date of 6/12/20. Record review of Resident #1 most recent quarterly Minimum Data Set (MDS) after reentry from acute hospital on [DATE] revealed he had the ability to express ideas and wants and was able to understand others clearly. Resident #1 had a Brief Interview for Mental Status (BIMS) of 15 out of score of 15 which indicated an intact cognition. Resident #1 was totally dependent for activities of daily living (ADL) expect for eating where he required extensive assistance. Record review of Resident #1 admission MDS on 8/9/19 revealed Resident #1 had an indwelling catheter on admission. Record review of Resident #1 electronic progress notes accessed on 6/12/20 revealed the last time his foley catheter was addressed was 5/19/20 and it only addressed his catheter bag was in place. Record review of Resident #1 health notes dated 6/8/20 through 6/9/20 for his first 24 hours in a surrounding area hospital revealed the following: Clinical note from hospital Registered Nurse (RN) Resident #1 presented with a foley catheter that was malfunctioning and had to replaced with 2 liters output once old foley was replaced, patient developed acute kidney injury, [MEDICAL CONDITION] was pale and dusky in appearance, and possible concerns of neglect. Further review of hospital records revealed Resident #1 was [MEDICATION NAME] with an altered mental status, in acute [MEDICAL CONDITION], had a distended bladder with hydro[DIAGNOSES REDACTED] bilaterally, it was suspect the foley was obstructed and not in the correct position causing increased volume with backflow acute kidney failure and [MEDICAL CONDITION], mental status changes could be from uremic [MEDICAL CONDITION] and the patient is critically ill and survival is highly unlikely but not impossible. In an interview on 6/12/20 at 1:20 pm Certified Nurse Aide (CNA) A stated they empty bags once a shift and they do not record output. CNA A stated they used to record catheter output, but their kiosk changed, and it does not give them a place to document catheter output. In an interview on 6/15/20 at 10:47 am with License Vocational Nurse (LVN) A stated she cared for Resident #1 on the 5th, 6th, and 7th. LVN A stated on 5/7/20 the aides reported his cath was leaking but that LVN E took care of it. LVN A stated she has worked at the facility since 2/2020 and she has never changed the catheter tubing for Resident #1 but to get direction on his catheter needs she would access the orders, observe what appliances he already has in place, and call the physician to get orders if non-was available. In an interview on 6/15/20 at 12:15 pm the DON stated he could not find any orders related to Resident #1 indwelling catheter. The DON stated he cannot find orders for Resident #2 type and size of strait catheter used to self-catheterize. The DON stated he cannot find any order that addressed catheter care for Resident #3. The DON stated he cannot find orders addressing Resident #4 suprapubic catheter type or size or suprapubic catheter care. The DON stated they do not have an admissions nurse and it is up the nurse who is receiving a new/returning resident to ensure the accuracy of orders. The DON stated he can't say for certain if catheter changes had been done for Resident #1. The DON stated he has not done any training with nursing staff concerning changing, assessing, and monitoring of catheters, and he has not received any training in this area since becoming the DON in January of 2020. In an interview on 6/16/20 at 10:40 am Family B stated Resident #1 reported vomiting on 6/7/20 (Note: there was no notes addressing vomiting) and was requesting to see his doctor. Family B was present when Resident #1 was admitted to the hospital and she was shocked to see Resident #1's condition. Family B stated when Resident #1 was non-responsive and had a swollen hard abdomen. Family B stated when the foley catheter from the nursing home was removed Resident #1 had release of urine from his penis and it was a strong foul odor and a large amount filled with sediment, once the urine stopped flowing on its own they replaced the catheter and Resident #1 filled a bag of urine. Family B stated since Resident #1 admission to the hospital he has been able to come of life support. Family B stated Resident #1 has not been able to sleep and reports he is having nightmares of needing help and no one is coming to his aide. Resident #1 does not like his room door shut if he is alone in the room and this is a new behavior for him. Family B states Resident #1 is now having [MEDICAL CONDITION] and he has no previous history of [MEDICAL CONDITION] activity, and Resident #1 bladder is still not emptying correctly. In an interview on 6/16/20 at 1:59 pm LVA A stated she did not know of any vomiting for Resident #1. LVN A stated Resident #1 usually has [PHONE NUMBER] milliliter urine output for her shift but she never emptied his catheter bag on the 5th, 6th, and 7th on June 2020. In an interview on 6/16/20 at 2:10 pm Certified Medication Aide (CMA) A stated that CMA's do not deal with catheters or assess urine output. CMA A was certain aides empty catheter bags. CMA A stated she knew Resident #1 had vomiting some time during the week but was unsure when. CMA A stated Resident #1 told her he would throw up chunks about 10 hours after he ate. CMA A stated she did not report this to anyone and she told Resident #1 he needs to let a nurse or his doctor know. CMA A was unsure if Resident #1 report his illness to anyone else. In an interview of 6/16/20 at 3:07 pm the DON stated a CNA or a nurse can empty a catheter bag and they do not document output unless there is an order, and they have no guidelines on when to report findings for catheters or catheter output to the DON or doctor. In an interview on 6/16/20 at 7:50 pm Family A stated that before COVID-19 the facility had been taking good care of Resident #1 and she is not sure what has happened because she has not been able to see Resident #1. Family A stated her and Resident #1 spoke the night of 6/7/20 he sounded fine but told her he had been throwing up undigested food for the last couple of days and Family A though the facility had called his doctor for him. Family A stated the next time she heard anything was around 3 pm on 6/8/20 when she was told they called 911 for Resident #1. Family A was at the hospital when Resident #1 arrived and when she saw him she thought he was going to die. Family A stated Resident #1 looked dirty, his skin was grayish colored, his abdomen was hard and swollen, and he was not breathing right. Family A stated she overheard an emergency medical team member tell the nurse he had been having a change in mental status all day. Family A stated when they removed the urinary catheter urine just started to flow out and it smelled awful and it just kept coming. Family A stated when the flow stopped they replaced the catheter and he quickly filled another bag of urine. Family A stated his catheter bag from the facility was empty when he arrived at the hospital. Family A stated Resident #1 is now having nightmares of people not being able to help him and is scared to sleep and does not want his door shut. Family A stated Resident #1 is now having [MEDICAL CONDITION] that started when he was in the intensive care unit (ICU). Family A stated from what she understands this is all related to his catheter not functioning properly, Resident #1 is still very ill, and a full recovery is unknown. Family A was very emotional and crying during our phone conversation. In an interview on 6/17/20 at 10:15 am CMA B stated she worked with Resident #1 on the day before and the morning he got ill. CMA B stated the day before 6/8/20 he was ok and had no reports of vomiting. CMA B stated on the morning of 6/8/20 she went to his room to pass medication around 8:40 am and she had to touch him to get him to wake up, but he took his pills telling her he was sleeping. CMA B though noting of it because it was not unusual for Resident #1 to sleep late. CMA B stated around lunch she went to give him pills and he would not wake up and was cold to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLINGER HEALTHCARE AND REHABILITATION CENTER	2001 6TH ST BALLINGER, TX 76821

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 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) the touch at his arms, he moved his head but gave no verbal response. CMA B stated she informed LVN C of her findings at 1:00 pm and LVN C stated she would check on him. CMA B left for the day around 1:08 pm. CMA B stated for resident concerns they are to fill out a yellow Interact from and give it to the nurse and she acknowledged she did not complete this form on 6/8/20 for Resident #1. In an interview on 6/17/20 at 10:39 am LVN C stated CMA B had to give medication to Resident #1 on 6/8/20 at 11:00 am and she reported to her that he will not wake up enough to take medications. LVN C stated she checked on him about 5-10 minutes later and Resident #1 shook his and said he was just sleeping which was not unusual for him. LVN C states he had 250-300 milliliters of urine amber in color and cloudy in his catheter bag. LVN C told Resident #1 she was going to lunch and would check on him after her lunch. LVN C stated she took approximately a 35-minute lunch and when she returned to Resident #1 he was unresponsive, and she called emergency services. LVN C stated she had no report of vomiting over the weekend when she received report the morning of 6/8/20, but she had heard LVN E had repositioned Resident #1 catheter and that he had low output over the weekend. LVN C stated she had not emptied or replaced the catheter bag for Resident #1 that day. LVN C stated a CNA can empty catheter bags. LVN C stated she is unaware of any parameters of reporting for catheters or catheter output. LVN C stated she has not had any training from the facility on catheters. In an interview on 6/17/20 at 12:45 pm CNA C stated Resident #1 refused breakfast and lunch on 6/8/20 but it was not all that unusual for him to skip those meals as he is up more at night, but when he did not request his snuff by lunch she went to check on him and he did not look right. CNA C stated she told LVN C and LVN C told her that CMA B could not get him awake for medications. CNA C stated she went on lunch break around 2 pm and was back by 3 pm and Resident #1 was gone by then. CNA C stated she did not empty his catheter bag that day and assumed CNA D emptied his bag and she had seen only a little bit of urine in his bag that day. (Note, even though she did not empty Resident #1 catheter bag she noted on ADL care log she did). In an interview on 6/17/20 at 1:46 pm CNA A stated on 6/7/20 Resident #1 got a shower and they noticed he was a little distended in the abdomen and they got LVN E to adjust Resident #1 catheter tubing because he was having leakage. CNA A stated after LVN E adjusted his tubing there was urine flow and it looked normal for him. CNA A stated LVN A did wound care and Resident #1 wanted in his recliner. He ate some cheese sticks and crackers and a little later he vomited mucus. CNA A stated Resident #1 had at least 900 milliliters urine output on her shift. In an interview on 6/17/20 at 3:05 pm LVN E stated on the night of 6/7/20 she deflated and repositioned the catheter tubing for Resident #1 because the CNAs reported it was leaking. LVN E stated when she was done Resident #1 had no more leaking and urine return was seen in the catheter bag. LVN E did not check his orders before adjusting the catheter tubing stating she removed 10 milliliters from the bulb and returned 10 milliliters to the bulb, and she did not check to see when the last time his catheter had been changed. LVN E stated Resident #1 had output of urine after adjusting the tubing but did not know how much. LVN E stated Resident #1 has a history of blockages but that day it was just yellow urine. In an interview on 6/17/20 at 3:26 pm Dr. A stated Resident #1 catheter was to be changed monthly and as needed if clogged. Dr. A stated a urine output of less than 400 milliliters a day would be a concern. Dr. A stated if a blockage was to present the symptoms you would likely see would be mental status changes, nausea and vomiting, fever, chills, and complaints of back pain. Dr. A stated a decrease in output for Resident #1 was never reported to him, nor was the vomiting, all the facility told him was he was unresponsive. In an interview on 6/17/20 at 3:45 pm the DON stated if there was no order for a foley catheter change in a resident's chart and a nurse felt like it needed to be changed she would need to contact the doctor to get an order. The DON stated he does not have a set schedule of assessment for residents with catheters but he expects his nurses to know the residents well enough to know when there is a change in a resident. The DON stated if a resident was to report vomiting to an CMA or CNA he expects them to let the charge nurse for that side know. In an interview on 6/18/20 at 9:15 am the DON stated he could not find any orders even from Resident #1 admission that addressed his indwelling catheter or [MEDICAL CONDITION]. In an interview on 6/19/20 at 1:05 pm Dr. B the hospitalist stated when Resident #1 left their hospital in March of 2020 he left with a normal bladder. Dr. B stated when he returned to their hospital on [DATE] his foley catheter was jammed into the prostate causing obstruction and improper drainage of his foley catheter, which lead to infection; that lead [MEDICAL CONDITION]; which also resulted in a rupture of his bladder causing him to develop a diverticulum next to the bladder that is larger than his bladder; leaving his bladder distorted beyond use and possibly to an extent of not being saved. Dr. B stated if the bladder cannot be saved the providers are at a loss as how to treat him given his large pressure wounds and already having a [MEDICAL CONDITION] every treatment option for Resident #1 carries a huge risk or just may not be possible. Record review of the https://www.cdc.gov/dengue/training/cme/ccm/page .html Centers for Disease Control and Prevention CDC website accessed on 6/23/20 revealed normal urine output for an average adult is 0.5 to 1.5 cubic centimeters(cc)/kilogram(kg)/hour. Given this formula Resident #1 would have a normal output of 28.44cc to 85.32cc per hour giving him an average output of 56.88cc per hour. Resident #1 average output for a 24-hour period should be 1,365.12cc a day. Record review of hospital records from admission on 6/8/20 revealed Resident #1 had spontaneous drainage of urine when the nursing home catheter was removed and when his catheter was replaced he drained 1 liter of urine into a catheter bag. It is documented he drained 2 liters of urine. (Note 2 liters is equal to 2000cc and Resident #1 average urine output for a 24-hour period is 1,365.12cc a day. The hospital drained two days' worth of urine from Resident #1). Record review of Resident #2 face sheet revealed a [AGE] year old female admitted on [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #2 electronic orders accessed on 6/15/20 revealed an order stating Resident #2 may self-cath but no orders addressing the size or type catheter needed for Resident #2 to self-cath. Record review of Resident #2 electronic care plan accessed on 6/16/20 revealed the following: Focus - I am at risk for Urinary Tract Infection, related to self-cath/Intermittent with 14french non-latex catheter due to: Neuromuscular Dysfunctional bladder. With [DIAGNOSES REDACTED]. Interventions - Encourage fluids unless contraindicated., Observe and report signs and symptoms of UTI: changes in color, odor or consistency or urine, dysuria, frequency, fever, pain. Initiated on 2/13/20 with a revision date of 6/16/20 prior to revision on 6/16/20 this care plan did not address the size and type of catheter Resident one utilized to self-cath. Record review of Resident #2 most recent quarterly Minimum Data Set (MDS) revealed Resident #2 could clearly make herself understood with the ability to understand others. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated a intact cognition. Resident #2 had no history of rejecting evaluation or care for the quarter and only needed supervision for ADLs. The MDS also indicated Resident #2 had a for intermittent catheterization. Record review of Resident #3 face sheet dated 6/17/20 revealed a [AGE] year old male admitted on [DATE] with a most recent admission date of [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #3 electronic orders accessed on 6/12/20 revealed an order for [REDACTED]. Record review of Resident #3 electronic care plan accessed on 6/12/20 revealed the following: Focus - I use an indwelling foley catheter related to neuromuscular dysfunction of bladder. I have a history of [MEDICAL CONDITION] and frequent UTI's. (18fr5cc ribbed balloon Carson Model Coude Tip), Goal - I will not experience any unidentified complications related to catheter use thru next review date, Interventions - Change catheter tubing/bag per protocol/orders., Irrigate foley cath with Acetic acid solution to decrease UTI's as per order., Observe catheter tubing for kinks or twists in tubing., Observe for acute behavioral changes that may indicate UTI., Position catheter tubing below level of bladder., Provide catheter care every shift., Refer to urologist for evaluation as needed., Secure tubing to thigh to prevent pulling. Record review of Resident #3 most recent quarterly Minimum Data Set (MDS) revealed had unclear speech but could usually make himself understood and had the ability to understand others. Resident #3 had a Brief Interview for Mental Status (BIMS) of score of 12 out of 15 which indicated a moderately impaired cognition. Resident #3 did not have any rejection of evaluation or care for the quarter. Resident #3 needed extensive assistance with all ADLs except for eating which required limited assistance. Resident #3 also required an indwelling catheter. Record review of Resident #3 electronic progress notes and Medication Administration Record [REDACTED]. Record review of Resident #4 face sheet dated 6/17/20 revealed a [AGE] year old female admitted on [DATE] with a most recent admission date of [DATE] with the following Diagnosis: [REDACTED]. Record review of Resident #4 electronic orders accessed on 6/12/20 revealed Resident #4 had no current orders addressing her suprapubic catheter placed 2/26/20 or her percutaneous endoscopic gastrostomy (PEG) tube, date of placement is uncertain given chart review. There was orders to address her PEG tube feedings. Record review of Resident #4 electronic care plan accessed on 6/12/20 revealed no care planning for her suprapubic catheter but there was care planning for an indwelling catheter initiated on 3/26/19 but not revised to reflect her suprapubic catheter. Resident #4 did have her PEG tube addressed in her care plan with the following: Focus - Dependent on tube feeding due to: Dysphagia. I am at risk for weight loss and malnutrition. I can have pleasure feedings as requested. I am aware of the choking and aspiration risks. I request to use a pacifier because I believe it strengthens the muscles for swallowing and keeps my mouth from being dry. I have 1 can of Jevita 1 time daily along with my tube feeding., Goal - Maintain nutritional status and body weight., No S/S of aspiration., Will be free from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675614	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BALLINGER HEALTHCARE AND REHABILITATION CENTER	2001 6TH ST BALLINGER, TX 76821

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 0690 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) GI Discomfort related to Tube Feeding., Will be free from S/S of complications due to presence of feeding tube., Will be free from S/SX of dehydration.; Interventions - Check tube placement every feeding., Elevate HOB at least 30-45 degrees during and for 30-60 minutes after feeding., Enteral formula and feedings as ordered., Hold feeding if residual is above 50 ml., Monitor lab data as available., Monitor vitals and breathe sounds for S/S of aspiration., Monthly weights., Observe and report skin irritation at the tube site., Observe for S/SX of intolerance to TF: gastic residuals, abdominal distention, vomiting, loose stools, nausea, nasal pain, fever, dehydration., Refer to RD for assessment as needed., Water flushes as ordered. Initiated on 3/27/20 and revised on 4/17/20. Record review of Resident #4 most recent quarterly Minimum Data Set (MDS) revealed she had unclear speech, could sometimes make herself understood, and could understand others. Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated an intact cognition. Resident #4 had rejected evaluation or care for 1 to 3 days in the last quarter and was totally dependent for all ADLS. Resident #4 utilized an indwelling catheter The DON could not provide any policies related to indwelling or suprapubic catheters relating to care, assessment, and monitoring, but was able to provide a Performance Checklist for Skills addressing all them with a date of 2018: Care and Removal of an Indwelling Catheter . 3. Assessed need for catheter care a. Observed urinary output and urine characteristics . 4. Assessed need for catheter removal: a. Reviewed patient's medical, noted length of time catheter was in place . c. Assessed urine color, clarity, odor, and amount; noted any urethral discharge, irritation, or trauma . 9. Checked drainage tubing and bag routinely for proper securement and positioning . Recording and Reporting 1. Recorded time for catheter care and appearance of urine, described condition of meatus and catheter. 2. Recorded and reported time of catheter removal; amount of water removed from balloon; condition of urethral meatus and catheter; and time, amount, and characteristic of first voided urine. Suprapubic Catheter Care, Assessment . 2. Assessed urine in drainage bag for amount, clarity, color, odor, and sediment . Evaluation . 3. Observed catheter insertion site for [DIAGNOSES REDACTED], [MEDICAL CONDITION], discharge, and tenderness; checked dressing at least every 8 hours . Recording and Reporting 1. Recorded and reported character of urine, type of dressing, and patient's comfort level. 2. Recorded urine output on Input and Output (I&0) flow sheet properly. Record review of CDC GUIDELINE FOR PREVENTION OF CATHETERASSOCIATED URINARY TRACT INFECTIONS dated 2009 electronically accessed on 6/19/20 revealed the following: . II. Proper Techniques for Urinary Catheter Insertion . B. Ensure that only properly trained persons who know correct technique of aseptic catheter insertion and maintenance are given this responsibility . III. Proper Techniques for Urinary Catheter Maintenance . B. Maintain unobstructed urine flow . E. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised . G. Do not clean the periurethral area with antiseptics to prevent CAUTI while the catheter is in place. Routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate . Management of Obstruction Q. If obstruction occurs and it is likely that the catheter material is contributing to obstruction, change the catheter. Record review of U.S. National Library of Medicine Medline Plus electronically accessed on 6/19/20 revealed the following: Indwelling catheter care . Cleaning the Catheter, follow these steps two times a day to keep your catheter clean and free of germs that can cause infection: Wash your hands well with soap and water. Be sure to clean between your fingers and under your nails. Change the warm water in your container if you are using a container and not a sink. Wet the second washcloth with warm water and soap it up. Gently hold the catheter and begin washing the end near your vagina or penis. Move slowly down the catheter (away from your body) to clean it. NEVER clean from the bottom of the catheter toward your body. Gently dry the tubing with the second clean towel . When to Call the Doctor . A urinary tract infection is the most common problem for people with an indwelling urinary catheter. Call your health care provider if you have signs of an infection, such as: Pain around your sides or lower back. Urine smells bad, or it is cloudy or a different color. Fever or chills. A burning sensation or pain in your bladder or pelvis. Discharge or drainage from around the catheter where it is inserted into your body. You do not feel like yourself. Feeling tired, achy, and have a hard time focusing. Also call your provider if: Your urine bag is filling up quickly, and you have an increase in urine. Urine is leaking around the catheter. You notice blood in your urine. Your catheter seems blocked and not draining. You notice grit or stones in your urine. You have pain near the catheter. You have any concerns about your catheter.; Suprapubic catheter care . Caring for Your Skin Near your Catheter . Check the catheter site a few times a day. Check for redness, pain, swelling, or pus. Wash the area around your catheter every day with mild soap and water. Gently pat it dry . Changing Your Catheter, you will need to change the catheter about every 4 to 6 weeks. Always wash your hands with soap and water before changing it . When to Call the Doctor . You are having trouble changing your catheter or emptying your bag. Your bag is filling up quickly, and you have an increase in urine. You are leaking urine. You notice blood in your urine a few days after you leave the hospital. You are bleeding at the insertion site after you change your catheter, and it does not stop within 24 hours. Your catheter seems blocked. You notice grit or stones in your urine. Your supplies do not seem to be working (balloon is not inflating or other problems). You notice a smell or change in color in your urine, or your urine is cloudy. You have signs of infection (a burning sensation when you urinate, fever, or chills).; High potassium level ([MEDICAL CONDITION]) . Causes, Potassium is needed for cells to function properly. You get potassium through food. The kidneys remove excess potassium through the urine to keep a proper balance of this mineral in the body. If your kidneys are not working well, they may not be able to remove the proper amount of potassium. As a result, potassium can build up in the blood . When to Contact a Medical Professional Call your provider right away if you have vomiting, palpitations, weakness, or difficulty breathing . The Administrator and DON was notified on 6/18/20 at 3:25 pm and Immediate Jeopardy (IJ) had been identified due to the above failures. The IJ template was provided to the Administrator and signed at 3:25 pm. The facility's Plan of Removal was accepted on 6/20/20 at 3:07 pm and revealed the following: Immediate interventions: 1 identified male resident with indwelling urinary catheter, pressure ulcers, and [MEDICAL CONDITION] remains hospitalized Conducted assessments on current identified residents: o 1 male resident with an indwelling urinary catheter and no indication of signs or symptoms related catheter-associated urinary tract infections (CAUTIs) were observed o 1 female resident with a suprapubic catheter and no indication of signs or symptoms related catheter-associated urinary tract infections (CAUTIs) were observed o 1 female resident requiring straight catheter and no indication of signs or symptoms of urinary tract infections (UTIs) or trauma to urinary meatus was observed o 1 female resident with a pressure ulcer and no indication of signs or symptoms of infection was observed Immediate review of potentially affected residents: All potentially affected residents were reviewed for changes in condition via an IDT analysis, which encompassed: o An accumulation of subjective and objective data obtained during asses