STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING ______ B. WING ______	C 08/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTTISH PINES REHABILITATION AND NURSING CENTER	620 JOHNS ROAD LAURINBURG, NC 28352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, resident, responsible party (RP) and staff interviews and record review, the facility failed to assess 1 of 1 resident for self administration of medication (Resident #3) who was self administering glucose tablets, lubricating eye drops and Simethicone (a medication to relieve gas). Findings included: The facility policy, titled SELF-ADMINISTRATION of DRUGS, revised August 2006, indicated that residents that wished to self administer medications could do so if they were determined to be capable of self-administration. Under POLICY INTERPRETATION and IMPLEMENTATION, Paragraph 1, the policy indicated the staff and practitioner would assess each resident's mental and physical abilities to determine whether a resident was capable of self-administering medications. Additionally, under Paragraph 2, the policy indicated a skills assessment that could include the ability to read, comprehend, remove medications from containers and recognize risks and adverse consequences would be conducted. Per the policy, medications kept at the bedside must be kept in a safe and secure place. Resident # 3 was readmitted on 8/8/14 with diagnoses that included diabetes and gastroesophageal reflux disease.	F 176	DISCLAIMER Scottish Pines Rehabilitation and Nursing acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by (facility name). The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. ALLEGATION OF COMPLIANCE The plan of correction is submitted as written allegation of compliance. **The below plan of correction pertains to F Tag F 176** 1) A) Resident #3 assessed on 9/2/14 by facility Director of Nursing and not deemed safe to self-administer medications, therefore glucose tablets, Simethicone and eye drops were removed from resident room and placed in medication cart. B) Resident care plan scheduled with resident, spouse and resident's daughter on 9/11/14 to review findings of self administration assessment completed by facility Director of Nursing Services on 9/2/14. 2) A) On 9/9/14, monthly Resident Council meeting took place and all residents present were re-educated by facility Unit Coordinator on the	9/2/14 9/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret L. Dickerson, NHA
TITLE: Administrator
(X6) DATE: 9/11/14

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 176	Continued From page 1 The Minimum Data Set (MDS), dated 7/16/14, indicated the resident was cognitively intact. A Consent Form, dated 8/8/14, indicated the resident's Responsible Party (RP) had been informed of the right to self- administer medications. The RP chose to have the facility administer medications to Resident # 3. The RP signed she understood if the resident self administered then the resident would be assessed for self administration and until that decision was made, the facility would administer medications. On 08/22/14 at 9:30 AM an interview was held with Resident #3. During the interview, a bottle of glucose tablets was observed, clearly visible on the resident's over bed table. Resident # 3 stated she took the tablets when she felt her blood sugar was low. Review of the resident's most current monthly orders did not include the glucose tablets. Review of the resident's medical record did not reveal an assessment for self administration of medications. A telephone interview with a family member was held on 8/22/14 at 10:30 AM. This family member had been identified by Resident # 3 as the person that knew about her care in the facility. The family member stated the glucose tabs were provided by the family. The family member added she "assumed" the facility knew about the medication since it was kept at the bedside within reach of the resident. An interview with Admissions Director was held on 8/22/14 at 10:37 AM. The AD stated information on self-administration of medications was in the Admission Packet that was reviewed with the RP. After review of the self administration information, a consent form was signed that indicated if a resident would self	F 176	resident right to self-administer medication and facility policy in order for them to do so. See Attachment A. B) An audit was completed on 9/5/14 by facility Unit Coordinator on each resident room in the facility to ensure resident rooms were free of medications. Those residents who were witnessed to have medications at bedside, were assessed by facility Director of Nursing to determine resident's mental and physical abilities to determine whether the resident was capable of self-administering medications. If deemed appropriate, medication to be kept at bedside in safe and secure place, if not deemed appropriate, medication was removed from resident room and placed in nurses' medication cart. Resident #3 was not deemed appropriate although four residents in the facility were deemed appropriate. See Attachment B. C) On 8/22/14, letter was mailed to all resident's family to explain facility policy of self-administration of medication. See Attachment C. 3) A) All staff was re-in-serviced by facility Administrator and Director of Nursing Services on facility policy of self-administration of medications on 8/26/14. This information will be included in new hire orientation and through annual reviews. See Attachment D.	9/9/14 9/5/14 8/22/14 9/19/14

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F 176	Continued From page 2 administer medication or if the facility would administer medication. If self-administration was selected, then the resident met with the care plan team and are deemed to be safe or not to self-administer medications. At 12:45 PM on 8/22/14, Nurse # 1 and the Director of Nursing (DON) made an observation in Resident # 3's room. Medications found on the over bed table by Nurse # 1 included the glucose tablets and the Simethicone. Nurse # 1 also found eye drops at the resident's bedside. All medications were removed by Nurse # 1 at this time. The DON stated Resident # 3 had not been assessed and care planned for self-administration of medication.	F 176	B) Department head in-service on completing "Resident and Resident Room Audits" on all resident rooms weekly by facility department heads. See Attachment E. C) "Resident and Resident Room Audits" will include for department heads to ensure that resident rooms are free of medications, unless deemed safe to self-administer medications. See Attachment F.	8/25/14 9/19/14, ongoing
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and family member interviews and review of records the facility failed to provide a physical assessment for 2 out of 3 residents reviewed (Residents # 1 and # 3) that experienced a change in condition resulting in hospitalization. Findings included: Review of the facility policy titled, CHANGE in a	F 309	4) A) Results of plan and audits will be discussed during morning administrative meeting weekly x 4 weeks with adjustments to plan made as needed followed by: B) Results of audits and compliance with plan will be discussed and minutes recorded x 4 months during the facility's monthly QA meeting, with adjustments to plan made as needed, followed by: C) Results of audits and compliance with plan will be discussed and minutes recorded quarterly x 3 quarters during the facility's quarterly QA committee meeting, with adjustments to plan made as needed followed by: D) Should revisions be necessary, appropriate staff will be re-in-serviced by DON or appropriate designee. E) Any revisions to plan will require monitoring steps to begin again at step 4(A).	9/19/14, ongoing

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F 309	Continued From page 3 RESIDENT'S CONDITION or STATUS, revised April 2006, indicated under Paragraph 8, section b, that in the event a resident had a change in condition, documentation would continue every shift for 72 hours or until the condition resolved. Resident # 3 was admitted on 8/9/12 and readmitted on 8/8/14. Diagnoses included diabetes, congestive heart failure (CHF) and respiratory failure. The Minimum Data Set (MDS), dated 7/16/14, indicated the resident was cognitively intact. She required extensive/total assistance for all activities of daily living. On 7/22/14 at 7:05 PM, nurse's notes revealed the physician had been in the building that morning to assess the resident for continued problems, although she currently received antibiotics for pneumonia. At noon, Resident # 3 was transferred to the hospital for further evaluation. She returned to the facility with orders for Augmentin (an antibiotic) and an order to increase her Ventolin (a medication used to improve breathing) to every 4 hours scheduled and every 6 hours as needed. On readmission, there was no documentation of a respiratory assessment completed by the nurses. On 7/23 at 9:02 AM, the nurse documented no shortness of breath and easy, regular respirations. No lung assessment was completed to determine if the antibiotic was improving the resident's pneumonia. Notes for 7/24/14 at 4:16 PM indicated at 9:20 AM the nurse heard the resident yelling for help. The nurse documented the resident was having difficulty breathing. Pulse oximetry readings were 85-86% (Normal range is greater than 90%). A breathing treatment was given and at 9:45 AM the resident's oxygen saturation was 85-86% on 3 liters of oxygen. The resident was sent to the	F 309	**The below plan of correction pertains to F Tag F309** 1) Resident # 1 and Resident # 3 were transferred to hospital for evaluation. Resident # 1 was discharged from the hospital to another facility and Resident # 3 was readmitted to facility on 8/26/14. 2) A) All licensed nursing staff were re-in-serviced on documentation by facility Corporate Director of Clinical Operations s on 8/28/14 and 8/29/14. See Attachment G. B) All licensed nursing staff were re-in-serviced on 8/26/14 to document any change of condition on 24-hour report q shift and the facility's policy of self administration of medication. See Attachment H. C) Daily Clinical Meeting form was updated on 8/21/14 to include "Change in Condition Review." Clinical IDT to review 24 hour report/telephone order during daily clinical meeting to ensure documentation included in nursing notes. Documentation should include condition change, notification of family and MD. See Attachment I. D). All licensed nursing staff were re-in-serviced by facility Administrator and Director of Nursing on 8/26/14 to document notification of family/RP on	8/26/14 9/19/14 9/19/14 9/19/14

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F 309	Continued From page 4 hospital for evaluation. Resident # 3 was readmitted on 8/8/14 at 1:38 PM. Nursing assessment documentation indicated the resident had left lower lobe crackles (crackles are a sound heard in the lungs that can indicate congestive heart failure). The upper lobe was described as diminished (this could describe decreased air flow). The Physician's readmission note, dated 8/9/14, indicated the resident had been hospitalized with respiratory failure and hypoxia. The physician documented diffuse rhonchi (a type of breath sound that indicates air is not moving smoothly and easily). The Pharmacist Chart Review, dated 8/13/14, indicated the resident had diagnoses that included respiratory failure, end stage chronic obstructive pulmonary disease and acute pneumonia. The care plan for Resident # 3 added on 8/14/14, instructed staff to give the resident oxygen and nebulizer treatments as ordered and if any signs and symptoms of respiratory distress were noted, to refer to the physician and Hospice for treatment instructions. Results of a chest X-ray performed on 8/15/14 indicated the resident had patchy airspace opacity throughout the right lung and left lower lobe most likely representing pneumonia. Review of nurse's notes from the 8/8/14 readmission until 8/22/14 indicated no respiratory assessment had been documented, although the resident had exhibited signs of respiratory issues on her 8/8/14 readmission. On 8/21/14 at 2:50 PM, Nurse # 1 stated documentation for new admissions and	F 309	section indicated on handwritten telephone orders. Clinical IDT will continue to review all telephone orders during daily clinical meeting and will review section that indicates notification of resident family for completion. See Attachment H. 3) A) All licensed nursing staff were re-in-serviced on documentation by facility Corporate Director of Clinical Operations on 8/28/14 and 8/29/14. See Attachment G. B) All licensed nursing staff were re-in-serviced on 8/26/14 to document any change of condition on 24-hour report q shift and the facility's policy of self administration of medication. See Attachment H. C) Daily Clinical Meeting form was updated on 8/21/14 to include "Change in Condition Review." Clinical IDT to review 24 hour report/telephone order during daily clinical meeting to ensure documentation included in nursing notes. Documentation should include condition change, notification of family and MD. See Attachment I. D) All licensed nursing staff were re-in-serviced by facility Administrator and Director of Nursing on 8/26/14 to document notification of family/RP on section indicated on handwritten telephone orders. Clinical IDT will	9/19/14 9/19/14 9/19/14 9/19/14

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F 309	Continued From page 5 readmissions should be daily and recorded in the nurse's notes. She stated lung sounds should be documented for respiratory problems. Nurse # 2 was interviewed on 8/21/14 at 3:19 PM. She stated that new admissions were charted on for 3 days, every 2 hours. Documentation of assessments would be found in the electronic medical record. The nurse added that after the first 3 days of "acute" charting was completed, a resident continued to be charted on daily for 3 days. Nurse # 2 stated if a resident had CHF or pneumonia, she would check vital signs and listen to the resident's lungs. The Director of Nursing (DON) was interviewed on 8/22/14 at 11:25 AM. She stated that any resident newly admitted or readmitted should be assessed every shift for 72 hours. If a resident was admitted with pneumonia, she expected nurses to document if the resident had a fever, cough, oxygen saturation, if the resident was short of breath with exertion and lung sounds. The DON was unable to find documentation in Resident # 3's medical record that indicated assessments had been completed. 2. Resident # 1 was admitted on 7/31/14 with diagnoses that included congestive heart failure (CHF) and edema. Review of the facility policy titled, CHANGE in a RESIDENT'S CONDITION or STATUS, revised April 2006, indicated under Paragraph 8, section b, that in the event a resident had a change in condition, documentation would continue every shift for 72 hours or until the condition resolved. A nursing assessment, dated 7/31/14 confirmed	F 309	continue to review all telephone orders during daily clinical meeting and will review section that indicates notification of resident family for completion. See Attachment H. 4) A) Results of plan and audits will be discussed during morning administrative meeting weekly x 4 weeks with adjustments to plan made as needed followed by: B) Results of audits and compliance with plan will be discussed and minutes recorded x 4 months during the facility's monthly QA meeting, with adjustments to plan made as needed, followed by: C) Results of audits and compliance with plan will be discussed and minutes recorded quarterly x 3 quarters during the facility's quarterly QA committee meeting, with adjustments to plan made as needed followed by: D) Should revisions be necessary, appropriate staff will be re-in-serviced by DON or appropriate designee. E) Any revisions to plan will require monitoring steps to begin again at step 4(A).	9/19/14 9/19/14, ongoing

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F 309	Continued From page 6	F 309		

edema, but did not describe the degree of edema (Edema is measured in degree by using 1+ (being a little edema) to 4+(a large amount of edema).

Review of the Admission Care Plan, dated 7/31/14, indicated the resident should receive medications as ordered and encourage the resident to elevate her lower extremities for edema as needed.

A telephone order, dated 8/6/14, increased the resident's Lasix (Lasix is a diuretic used to help control blood pressure by eliminating extra fluid from the body) from 40 milligrams (mgs) once daily to twice daily. There is no documentation in the nurse's notes that indicated why the increase in Lasix was needed. There is no documentation that addressed the outcome of the increased Lasix.

Review of the electronic medical record revealed the next nurse's documentation was dated 8/2/14 at 7:59 AM. This was 2 days after admission. There is no documentation that addressed the resident's edema or lung sounds from the time of admission until her transfer to the hospital on 8/11/14.

The resident's Responsible Party (RP) was interviewed on 8/21/14 at 11:47 AM. She stated Resident # 1 had edema on admission. During her stay, the edema got worse. The RP explained that on admission, the top of the resident's foot was aligned with her toes, but as the edema got worse the top of the foot puffed up over the resident's toes. She demonstrated by holding her fingers over her other hand to show an increase of approximately 1 inch. The RP

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F 309	Continued From page 7 added the edema got so bad, the resident could not wear her shoes. Since the resident was receiving therapy, the RP stated she had to buy larger shoes. The RP stated when she would push the top of the resident's foot with her fingers, there would be a large indentation on top of the resident's foot. The RP stated the Resident was not getting better. On 8/10/14, the RP stated she noted a difference in the resident, but could not identify exactly what was different. The RP added the resident seemed more tired and more short of breath. She stated her concern was so great, she returned to the facility on 8/11/14, arriving between 9:00 and 9:30 AM. She spoke with the Director of Nursing (DON) and told her she felt she needed to take the resident somewhere else. The DON followed the RP to the resident's room, but the RP stated she never touched the resident or assessed her. The RP stated she left for the hospital between 11:30 - 11:45 AM. On 8/21/14 at 2:00 PM, Nurse # 5 was interviewed. Nurse # 5 had worked with Resident # 1 during her admission and stated he remembered her. The nurse added the resident had 2 + edema. He admitted he had not documented about her edema or interventions to decrease the edema. The nurse was unsure if he had listened to lung sounds. Nurse # 1 was interviewed on 8/21/14 at 2:50 PM. She stated she was the Unit Coordinator for the Rehabilitation Unit. Her responsibilities included admitting new residents. The nurse stated she had been the one that admitted Resident # 1 on 7/31/14. New admissions, she added were to be assessed daily with documentation in the nurse's notes. The nurse added if a resident had a	F 309		

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F 309	Continued From page 8 diagnosis of CHF, then she would look for edema, check an apical pulse and definitely check lung sounds. The nurse stated she could not remember if Resident # 1 had edema or not on admission. The nurse reviewed her admission note that was written on 8/4/14 as a late entry for 7/31/14 and acknowledged there was no documentation about edema or lung sounds. The nurse reviewed the documentation for Resident # 1 and stated the expectation was 2 days should not go by without assessment. She added without a note, there was no way to prove the resident had been assessed. Nurse # 1 added when a medication was changed, such as the Lasix for Resident # 1, there should be some reason documented in the chart. On 8/21/14 at 3:19 PM, Nurse # 2 was interviewed. The nurse worked with Resident # 1 during her facility stay. Nurse # 2 stated when a resident had CHF, she would assess for and document the presence of edema, coughing, vital signs and an assessment of lung sounds. The nurse stated Resident # 1 did have edema on admission adding the edema never went over 2 +. Nurse # 1 added she did assess the resident, but does not recall if she documented her findings. The nurse was unaware the resident's Lasix had been increased. Nurse # 2 reviewed all notes for Resident # 1 and acknowledged there was no assessment of edema, lung sounds or medication changes documented. Nurse # 3 was interviewed on 8/21/14 at 4:05 PM. The nurse worked with Resident # 1 during her facility admission. Nurse # 3 stated assessments for CHF should include presence of edema, lung sounds, oxygen saturation and any difficulty breathing. Documentation of the assessments	F 309		

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F 309	Continued From page 9 should be found in the nurse's notes. The nurse stated she was unaware the resident had edema. The DON was interviewed on 8/22/14 at 11:25 AM. She stated all residents that were newly admitted should have assessments with documentation every shift for 72 hours. If a resident was admitted with CHF, the expectation would be to weigh the resident every 3 days to look for weight gain associated with fluid retention, assess for shortness of breath, jugular vein distention, lung sounds and edema. If a resident experienced edema, the expectation would be for the nurse to document the location and degree of edema and what interventions improved the edema.	F 309	The below plan of correction pertains to F Tag F315 1) A) Physician Order was written for indwelling urinary catheter for resident #3 on 8/22/14. Resident's catheter was secured with a leg strap on 8/22/14. B) "Urinary Catheter Order Clarification" form completed by facility Director of Nursing, signed by facility Medical Director and filed in resident chart on 8/22/14.	8/22/14 8/22/14
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and review of the medical record, the facility failed to obtain a physician's order for an indwelling urinary catheter and failed to secure the urinary catheter to prevent trauma for 1 of 1	F 315	C) Resident's indwelling urinary catheter was discontinued per resident request on 8/23/14. Telephone order was written and family was made aware of resident preference to discontinue indwelling urinary catheter. 2) A) Audit completed on 8/23/14 by facility weekend nurse supervisor on all resident's with urinary catheter to ensure telephone order and "Urinary Catheter Order Clarification" in place. B) All licensed nursing staff re-in-serviced by facility Director of Nursing on 8/26/14 of facility policy that physician's order to be in place for all residents with indwelling urinary catheter and that catheter should remain secured with leg strap to reduce friction and movement at the insertion site. See Attachment H.	8/23/14 8/23/14 8/26/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 10 residents (Resident # 3) that was assessed for the presence of an indwelling urinary catheter. Findings included: The facility policy, titled Catheter Care, Urinary, revised December 2007 indicated under Paragraph 15 that the catheter should remain secured with a leg strap to reduce friction and movement at the insertion site. Resident # 3 was readmitted on 8/8/14 with diagnoses that included respiratory failure, urinary tract infection, congestive heart failure, diabetes, chronic pain and generalized muscle weakness. The Minimum Data Set (MDS), dated 7/16/14, indicated the resident was cognitively intact. Resident # 3 was coded as requiring extensive to total assistance with all activities of daily living. The resident was coded as frequently incontinent of urine. Review of the readmission physician's orders, dated 8/8/14, did not include orders for the indwelling urinary catheter. A Resident Data Collection sheet, dated 8/8/14, indicated the resident's status on admission included the presence of an indwelling urinary catheter. The area designated to record the type and size had been left blank. Nurse's notes for 8/8/14 indicated an indwelling urinary catheter was in place and draining clear yellow urine. A PROGRESS NOTE, dated 8/8/14, signed by the family nurse practitioner (FNP) indicated the resident had an indwelling urinary catheter placed. The note also indicated Resident # 3 asked if the catheter was to remain in place. The FNP documented she could see risks both ways and documented the catheter could always be removed and/or put back in. The note indicated the resident would like to leave it in for now. The note included "foley care as per protocol", but did not include a size for the indwelling catheter and	F 315	C) Daily Clinical IDT Meeting will continue to review new admissions and readmissions charts times five days following all admissions/readmissions to the facility. During chart review, IDT will utilize form which indicates to check if indwelling urinary catheter in place and if so order to be written appropriately. Chart review will also indicate if indwelling urinary catheter in place, "Urinary Catheter Order Clarification" completed for resident. See Attachment J. D) "Resident and Resident Room Audits" to be completed on all resident rooms weekly by facility department heads. Audits will include for staff to ensure that is resident with indwelling urinary catheter are positioned appropriately (with bag cover). See Attachment F. 3) A) Audit completed on 8/23/14 by facility weekend nurse supervisor on all resident's with urinary catheter to ensure telephone order and "Urinary Catheter Order Clarification" in place. B) All licensed nursing staff re-in-serviced by facility Director of Nursing on 8/26/14 of facility policy that physician's order to be in place for all residents with indwelling urinary catheter and that catheter should remain secured with leg strap to reduce friction and movement at the insertion site. See Attachment H.	9/19/14 ongoing 9/19/14, ongoing 8/23/14 9/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345383	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 08/22/2014

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F 315	Continued From page 11 a schedule for changing the catheter. On 8/11/14 at 3:03 PM, notes indicated the resident had questions about how long she would keep the catheter. The note indicated the physician would be in on 8/12/14 to follow up with Resident # 3. Review of nurse's notes did not reveal documentation the physician addressed the resident's questions and did not reveal education for the resident regarding risks of maintaining the indwelling urinary catheter. Resident # 3 was interviewed on 8/22/14 at 9:30 AM. She stated she had been to the hospital recently and had returned to the facility with the indwelling urinary catheter. The resident stated she did not have problems with urinary retention, but did experience incontinent episodes. Resident # 3 stated she thought the reason the catheter had been placed was because she had frequent urinary tract infections. The resident raised the covers to reveal there was no leg strap securing the catheter. The urine collection bag with clear, dark urine, was attached to the lower side of the bed rail. A telephone interview was held with a family member on 8/22/14 at 10:30 AM. The family member stated the indwelling urinary catheter had been placed in the hospital. The reason for the catheter was the inability to toilet independently. The family member stated if the resident didn't have the catheter she would "lay in wetness all the time". An interview was held with the Director of Nursing (DON) on 8/22/14 at 11:45 AM. The DON stated the policy for indwelling urinary catheters indicated the catheter had to have a physician's order that included a supporting diagnosis, the	F 315	C) Daily Clinical IDT Meeting will continue to review new admissions and readmissions charts times five days following all admissions/readmissions to the facility. During chart review, IDT will utilize form which indicates to check if indwelling urinary catheter in place and if so order to be written appropriately. Chart review will also indicate if indwelling urinary catheter in place, "Urinary Catheter Order Clarification" completed for resident. See Attachment J. D) "Resident and Resident Room Audits" to be completed on all resident rooms weekly by facility department heads. Audits will include for staff to ensure that is resident with indwelling urinary catheter are positioned appropriately (with bag cover). See Attachment F. 4) A) Results of plan and audits will be discussed during morning administrative meeting weekly x 4 weeks with adjustments to plan made as needed followed by: B) Results of audits and compliance with plan will be discussed and minutes recorded x 4 months during the facility's monthly QA meeting, with adjustments to plan made as needed, followed by: C) Results of audits and compliance with plan will be discussed and	9/19/14 ongoing 9/19/14 ongoing

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F 315	Continued From page 12 size of the catheter, orders for catheter care and a schedule for changing the catheter. The policy also indicated the catheter should be secured in order to prevent trauma. A corporate representative presented a Urinary Catheter Order Clarification sheet used by the facility on 8/22/14 at 11:55 AM. Within the sheet was a section titled Catheter order. Resident # 3 had no clarification sheet in her chart. The DON observed the resident on 8/22/14 at 12:45 PM and found the indwelling urinary catheter was not secured. The DON stated an unsecured catheter could accidentally be pulled out during positioning which could cause trauma to the resident.	F 315	minutes recorded quarterly x 3 quarters during the facility's quarterly QA committee meeting, with adjustments to plan made as needed followed by: D) Should revisions be necessary, appropriate staff will be re-in-serviced by DON or appropriate designee. E) Any revisions to plan will require monitoring steps to begin again at step 4(A).	9/19/14, ongoing