STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 06/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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 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 record review, observations and staff interviews, the facility failed to catheterize a resident using aseptic technique to prevent a Urinary Tract Infection (UTI) for 1 of 3 residents reviewed for activities of daily living (resident #1). Findings included: The resident was admitted on 12/31/15 with current diagnoses of Spinal Bifida and hypertension. The resident ' s Minimum Data Set dated 4/8/16 revealed resident #1 was cognitively intact. The resident required extensive assistance with bed mobility, dressing, eating, and personal hygiene and total assistance with toilet use. The resident was intermittently catheterized. The resident had upper extremity impairment on one side and lower extremity impairment on both sides. The resident ' s care plan for intermittent catheterization updated on 5/17/26 stated the resident had a neurogenic bladder. The facility ' s catheter associated urinary tract infection (UTI) prevention policy stated, " Catheters are inserted using aseptic technique	F 315	1. Nurse #1 was re-educated in aseptic techniques for in and out catheter procedures during the time of survey on 6/4/2016.Resident #1 no longer resides in the facility.Other nurses providing care for Res. #1 have been re-educated on aseptic technique with return demonstration. 2. The Director of Nursing identified all residents with catheters. The licensed nurses were re-educated on aseptic techniques for in and out catheter procedure and observed in return demonstration by the Staff Development Coordinator. by 6/17/2016. Newly hired nurses will be inserviced on aseptic catheter procedures during orientation. 3. The Unit Managers or the Staff Development Coordinator or the 3rd Shift Manager will observe 1-2 catheter procedures per month for the next 3 months to observe aseptic technique. 4.The Director of Nurses will present the	6/17/16

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

Electronically Signed | 06/17/2016

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F 315	Continued From page 1 and sterile equipment " and " maintain a closed sterile drainage system " . The resident had physician ' s orders dated 12/31/15 for in and out catheterization every 6 hours related to a neurogenic bladder. The resident ' s Medication Administration Record for June 2016 revealed the resident was not receiving any antibiotics for a UTI. An observation of the intermittent urinary catheterization was made on 6/4/16 at 12:41 PM. Nurse #1 and Nursing Assistant #1 repositioned the resident in bed. Nurse #1 washed her hands and put on non-sterile (clean) gloves. Nurse #1 opened the catheter kit with clean gloves and took out the sterile towelette. Nurse #1 opened the towelette and placed it near the resident ' s perineum. Nurse #1 then picked up the sterile urinary catheter from the kit with non-sterile gloves on and placed it on another towelette on the resident ' s bedside table. The lubricant was then placed on the edge of the towelette that was near the resident ' s perineum. Nurse #1 then took off the non-sterile gloves and put on the sterile gloves by using her right bare hand to put the left sterile glove on. The nurse put her bare hand in-between the fingers of the sterile glove to help get the glove on then a sterile glove was placed on right hand with help from the left gloved hand. The resident was cleaned with the swabs provided in the urinary kit. Then the urinary catheter was inserted into the resident urethra. The tip of the catheter touched the outside of the resident ' s skin before being inserted in the urethra. Five hundred milliliters of urine was measured from the catheterization and then the urinary catheter was taken out. Nurse #2 was interviewed on 6/4/16 at 2:46 PM. He stated if he was catheterizing a resident he would get a catheter kit and that sterile gloves	F 315	findings of the above observations to the Quality Assurance and Performance Improvement Committee monthly for the next 3 months. The committee will evaluate the effectiveness of this plan and amend as deemed necessary. Alleged Compliance date is 6/20/2016	

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F 315	Continued From page 2	F 315		

were in the kit. He stated one hand would be sterile and the other hand would be clean. He stated that with his sterile hand he would only touch the sterile catheter and the sterile drape. That if he messed up he would then get a new catheter kit and start over.

Nurse #1 was interviewed on 6/4/16 at 2:48 PM. She stated the resident was catheterized every 6 hours. She stated when she catheterized the resident, she would enter the room, wash her hands and put on gloves. Then she would explain what she was going to do to the resident and would set up her sterile field. She stated she would remove her gloves and wash her hands again. She would put on her sterile gloves and would clean the resident with betadine swabs that were in the kit. She would put the lubricant on the end of the catheter and would catheterize the resident. When the urine stopped coming out then she would take the catheter out and wash her hands. She stated she did use her ungloved hand to put on the sterile glove but was not sure of another way to do it. She stated she did touch the catheter and the sterile field with non-sterile gloves.

The Director of Nursing (DON) and Administrator were interviewed on 6/4/16 at 5:20 PM. The DON stated her expectation for catheter care was to follow the physician ' s order and to follow the Policy and Procedure.