STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345011	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER NURSING CARE/LEXI	279 BRIAN CENTER DRIVE LEXINGTON, NC 27292

(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 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157		3/8/17

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

Electronically Signed | 02/24/2017

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F 157	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to notify the Physician or the Nurse Practitioner when the indwelling catheter was dislodged from the bladder of 1 of 3 sampled residents with an indwelling catheter (Resident #3). Findings included: Resident #3 was admitted to the facility on May 2, 2016 with diagnoses which included: neuromuscular dysfunction of bladder, and a stage 4 pressure ulcer of the sacrum. Review of the clinical record revealed a Physician's Order dated 5/17/16 for Resident #3 to receive an indwelling catheter due to urinary retention. The annual minimum data set (MDS) dated 12/15/16 indicated Resident #3 was cognitively intact; had an indwelling catheter; and had a stage 4 pressure ulcer to her sacrum. The Care Plan dated 1/4/17 revealed the resident was to receive catheter care every shift. During an observation and interview on 2/1/17 at	F 157	F 157 Immediate Correction was achieved for the alleged deficient practice on 2/1/17 when the Unit Manager notified the Nurse Practitioner of the dislodged indwelling catheter for resident #3. An order was received at that time that the catheter was not to be re-inserted. The facility recognizes that all residents with indwelling catheters have the potential to be affected by the alleged deficient practice. Measures implemented to ensure that the alleged deficient practice does not recur includes: On 2/23/17 the Director of Nursing provided education to nurse #1 regarding the expectations for physician notification related to the indwelling catheter being dislodged. Education for licensed staff regarding requirements/expectations for physician notification was provide by the DON/ADON , This education was completed by 3/7/17.	

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F 157	Continued From page 2 9:21am, Resident #3 was sitting up in bed, finishing her breakfast. It was observed that the resident's indwelling catheter bag was not in place. The resident revealed the facility staff had not replaced the indwelling catheter after it became dislodged the day before. During an interview on 2/1/17 at 9:31am, the Treatment Nurse stated that on 1/31/17 at approximately 11:30am, after treating Resident #3's pressure ulcer, she informed N#1 (nurse) the resident's indwelling catheter with the bulb still intact dislodged from the resident's bladder during care and needed to be replaced. She revealed that when a resident's catheter became dislodged, sometimes nurses would wait twenty-four hours before replacing the catheter due to trauma, but; there was no evidence of trauma to Resident #3. On 2/1/17 at 10:15am, Resident #3 was observed in her wheelchair in the facility's beauty salon; there was not a catheter bag attached to the resident's wheelchair. During an interview on 2/1/17 at 10:09am, the Unit Manager revealed the Treatment Nurse informed her on the morning of this interview that Resident #3's indwelling catheter had dislodged the day before and that she (Treatment Nurse) had informed N#1 at that time. During an interview on 2/1/17 at 10:37am, the DON (Director of Nursing) indicated when the resident's indwelling catheter dislodged and it was reported to N#1, her expectation was for N#1 to promptly report it to the Unit Manager and/or the Physician and/or the Physician's Assistant (who was in facility at that time) during the shift.	F 157	A review of residents with catheters to ensure proper placement was completed by the Unit Managers on 2/28/17. An audit of Nursing Notes for 2/1/17-3/2/17 was completed by the DON or designee on 3/3/17 to ensure physician notification was completed as appropriate. Monitoring to ensure that the alleged deficient practice does not recur includes: The DON or designee will review 5 charts per week to ensure appropriate physician notification. The DON will summarize the results of weekly reviews and present monthly to the QAPI committee for 3 months or until substantial compliance is achieved.	

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F 157	Continued From page 3 The DON revealed that although N#1 did document the resident's catheter became dislodged, she failed to document if she notified anyone.	F 157		
F 224 SS=G	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observations, staff, nurse practitioner and physician interviews and record reviews the facility failed to check for incontinence for two of four sampled residents with incontinence. The facility failed to check Resident #5 with worsened incontinence dermatitis for five hours and failed to check Resident #3 with a leaking indwelling urinary catheter. The findings included: 1. Resident # 5 was admitted to the facility on 11/7/16 with diagnosis of pressure ulcer on the sacrum, need for assistance with personal care, and diabetes. The Quarterly Minimum Data Set (MDS) dated 1/25/17 indicated Resident #5 had some impairment with short term memory, required extensive assistance of two persons for bed mobility, transfers, and dressing, extensive assistance of one person for toileting and personal hygiene, total dependence of two staff for bathing, was always incontinent of bowel and bladder and had a stage 4 pressure ulcer.	F 224	F224 Immediate correction was achieved for the alleged deficient practice when Resident #5 and Resident #3 were provided incontinence care by the C.N.A. On 2/21/17 C.N.A #1 performance was reviewed and action taken according to the facility□s progressive discipline. The facility acknowledges that all residents who are incontinent have the potential to be affected by the alleged deficient practice. Measures implemented to ensure the alleged deficient practice does not recur includes: Education to include review of the Abuse/Neglect Policy definitions was provided by the DON/ADON for C.N.A□s. This education completed on 3/7/17 included expectations for delivery of incontinence care in a timely manner and prior to meals.	3/8/17

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F 224	Continued From page 4 The care plan dated 12/7/16 for a problem of requiring extensive assistance with activities of daily living. Approaches included the resident was to participate to her fullest extent as possible, observe for decline and therapy per physician order. The care plan had an update of 1/31/17 for a problem of incontinence of bowel and bladder which had no goal or approaches. Review of the wound physician progress note dated 1/30/17 indicated a diagnosis of "Incontinence Associated Dermatitis" with the progress as "Deteriorated. Entire buttocks and posterior thighs are inflamed." Observations on 1/31/17 at 10:11 AM revealed Resident #5 was in bed lying on her back. The Nursing Assistant (NA) #1, who was assigned to care for Resident #5 was not available. Observations of incontinence care, provided by Nursing Assistant (NA) #2, revealed two cloth pads were positioned under the resident from her mid back to her upper thighs. Cloth pad #2 was on top of the sheet and under the resident's mid back and partially under the top pad (pad #1). The cloth pads were wet from the top of the pads to the bottom. A dried yellow ring was at the outer edges of pad #2. A disposable brief was folded with the pad side next to the resident between her legs. The brief was folded into a small ball. The resident's skin on the inner thighs, perineal area, and buttocks was red and "scalded" in appearance. There was a strong urine odor, and the resident's gown was wet at the "gown tail" which was underneath the resident's buttocks and upper thighs. During incontinence care, Resident #5 was turned to side. The dressing that was on the sacral/coccyx	F 224	Beginning 2/27/17 Unit Managers or designee will monitor 5 incontinent residents per day for 2 weeks and then 5 residents per week for 4 weeks to ensure that incontinence care is being provided in a timely manner. Beginning 2/27/17 DON/ADON will randomly monitor 3-5 residents per week for 4 weeks to validate that incontinence care is provided as expected. Beginning 2/27/17 all newly hired C.N.As will be provided education regarding incontinence care expectations during their orientation period. Monitoring implemented to ensure that the alleged deficient practice does not recur includes the DON summarizing the results of weekly monitoring of incontinence and will present a report to QAPI committee for 3 months or until substantial compliance is achieved.	

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F 224	Continued From page 5	F 224		

area was off and laying under the buttocks. The dressing looked like a piece of wet rolled gauze that was brown in color.

On 1/31/17 a 10:15 AM, during observations of incontinence care, Resident #5 explained no one had been in to check her, or clean her that morning. She continued with she was "always a clean person, did not like being dirty." During the observation of incontinence care Resident #5 complained of discomfort when cleaned.

Interview with Nursing Aide (NA) #1 on 1/31/17 at 11:35 AM revealed she did not put the folded brief between her legs. NA #1 explained "Whoever changed her last did that." The NA responded she had not checked the resident for incontinence since coming on duty at 6:20 AM. She further explained she had not checked Resident #5 because she was getting other residents up for breakfast in the dining room. NA #1 explained she had five residents to get up for breakfast.

Interview with the Nurse Practitioner on 2/1/17 at 4:25 PM revealed if Resident #5 was left wet for a couple of hours, it could make the dermatitis worse. The resident did not want an indwelling catheter, and the staff would need to check her frequently for incontinence and use a protective barrier.

Interview with the wound physician on 2/1/17 at 5:29 PM revealed he saw the resident on a weekly basis for wound care. Each visit he found the resident to be wet with urine. The dermatitis on her buttocks had worsened during the past two weeks. The staff should check her often and keep the skin free from urine.

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Interview with the Director of Nursing on 2/1/17 at 5:50 PM revealed she would expect the aides to provide incontinence care at least every three hours.

2. Resident # 3 was admitted to the facility on 5/2/16 with diagnosis of neuromuscular dysfunction of the bladder, bladder spasms and a pressure ulcer.

Review of the annual Minimum Data Set (MDS) dated 12/15/16 indicated Resident #3 had no long or short term memory problems, required total assistance of one staff for toileting, was occasionally incontinent of urine and always incontinent of bowel. The MDS indicated an indwelling urinary catheter was in use.

Review of the Care Area Assessments (CAAs) indicated the presence of urinary incontinence and an indwelling catheter. The resident required assistance with activities of daily living due to impaired mobility.
The care plan dated 1/4/17 for a problem of bowel incontinence and an indwelling urinary catheter included approaches of catheter care as ordered, check resident every two hours and assist with toileting as needed, provide peri care after each incontinent episode.

Observations of Resident #3 on 1/31/17 at 11:00 AM revealed the resident had an indwelling catheter in place. The resident was turned to her right side by the Treatment nurse to do the treatment. The disposable brief the resident was wearing was saturated with urine, as evidenced by the padding in the disposable brief had seperated, the cloth pad under the resident was

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F 224	Continued From page 7 wet extending up the resident's back, and the resident's gown was wet. There was a strong urine smell at the bedside. Interview with the treatment nurse on 1/31/17 at 11:15 AM revealed the alternating air mattress was wet underneath the resident. The physician was aware the catheter leaked and had tried different sizes without success to prevent leakage of urine. Interview on 1/31/17 at 11:20 AM with Nursing Aide (NA) #1 revealed Resident #3 required total assistance with activities of daily living. NA #1 explained she would check for incontinence every hour for this resident. Further interview revealed she had been in the resident's room to pass the breakfast tray, but had not provided a check for incontinence care as of this time. During the interview NA#1 explained she had not made her way down to Resident #3's room yet, due to getting up five residents for breakfast in the dining room. Interview with Resident #3 on 2/1/17 at 9:30 AM revealed she had been left wet on 1/31/17 due to the catheter leaking. Interview with the Director of Nursing on 2/1/17 at 5:50 PM revealed she would expect staff to check for incontinence at least every three hours.	F 224		
F 241 SS=G	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and	F 241		3/8/17

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F 241	Continued From page 8 promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to promote residents' dignity when incontinence checks were not provided and Residents #5 and were not kept free from excessive urine for two of four sampled residents with incontinence. The findings included: 1. Resident # 5 was admitted to the facility on 11/7/16 with diagnosis of a pressure ulcer on the sacrum, need for assistance with personal care, and diabetes. The Quarterly Minimum Data Set (MDS) dated 1/25/17 indicated Resident #5 had some impairment with short term memory, required extensive assistance of two persons for bed mobility, transfers, and dressing, extensive assistance of one person for toileting and personal hygiene, total dependence of two staff for bathing, was always incontinent of bowel and bladder and had a stage 4 pressure ulcer. The care plan dated 12/7/16 for a problem of requiring extensive assistance with activities of daily living. Approaches included the resident was to participate to her fullest extent as possible, observe for decline and therapy per physician order. The care plan had an update of 1/31/17 for a problem of incontinence of bowel and bladder which had no goal or approaches. Observations on 1/31/17 at 10:11 AM revealed Resident #5 was in bed lying on her back. The Nursing Assistant (NA) #1, who was assigned to care for Resident #5 was not available.	F 241	F241 Immediate correction was achieved for the alleged deficient practice when Resident #5 and Resident #3 were provided incontinence care by the C.N.A. On 2/21/17 C.N.A #1 performance was reviewed and action taken according to the facility□s progressive discipline. The facility acknowledges that all residents who are incontinent have the potential to be affected by the alleged deficient practice. Measures implemented to ensure the alleged deficient practice does not recur includes: Education regarding treatment of residents with dignity and respect was provided by the DON/ADON for C.N.A□s. This education completed on 3/7/17 included expectations for delivery of incontinence care in a timely manner and prior to meals. Beginning 2/27/17 Unit Managers or designee will monitor 5 incontinent residents per day for 2 weeks and then 5 residents per week for 4 weeks to ensure that incontinence care is being provided in a timely manner. Beginning 2/27/17 DON/ADON will randomly monitor 3-5 residents per week for 4 weeks to validate that incontinence care is provided as expected. Beginning 2/27/17 Department Managers	

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F 241	Continued From page 9 Observations of incontinence care, provided by Nursing Assistant (NA) #2, revealed two cloth pads were positioned under the resident from her mid back to her upper thighs. Cloth pad #2 was on top of the sheet and under the resident's mid back and partially under the top pad (pad #1). The cloth pads were wet from the top of the pads to the bottom. A dried yellow ring was at the outer edges of pad #2. A disposable brief was folded with the pad side next to the resident between her legs. The brief was folded into a small ball. The resident's skin on the inner thighs, perineal area, and buttocks was red and "scalded" in appearance. There was a strong urine odor, and the resident's gown was wet at the "gown tail" which was underneath the resident's buttocks and upper thighs. During incontinence care, Resident #5 was turned to side. The dressing that was on the sacral/coccyx area was off and laying under the buttocks. The dressing looked like a piece of wet rolled gauze that was brown in color. On 1/31/17 a 10:15 AM, during observations of incontinence care, Resident #5 explained no one had been in to check her, or clean her that morning. She continued with she was "always a clean person, did not like being dirty." During the observation of incontinence care Resident #5 complained of discomfort when cleaned. Interview with Nursing Aide (NA) #1 on 1/31/17 at 11:35 AM revealed she did not put the folded brief between her legs. NA #1 explained "Whoever changed her last did that." The NA responded she had not checked the resident for incontinence since coming on duty at 6:20 AM. She further explained she had not checked Resident #5 because she was getting other	F 241	and Manager on Duty will complete Dignity Audits daily for 4 weeks Beginning 2/27/17 all newly hired C.N.As will be provided education regarding treating residents with dignity and respect during their orientation period. Monitoring implemented to ensure that the alleged deficient practice does not recur includes the DON summarizing the results of weekly audits completed by Department Managers and presenting a report to QAPI committee for 3 months or until substantial compliance is achieved.	

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residents up for breakfast in the dining room. NA #1 explained she had five residents to get up for breakfast.

Interview with the Director of Nursing on 2/1/17 at 5:50 PM revealed she would expect the aides to provide incontinence care at least every three hours.

2. Resident # 3 was admitted to the facility on 5/2/16 with diagnosis of neuromuscular dysfunction of the bladder, bladder spasms and a pressure ulcer.
Review of the annual Minimum Data Set (MDS) dated 12/15/16 indicated Resident #3 had no long or short term memory problems, required total assistance of one staff for toileting, was occasionally incontinent of urine and always incontinent of bowel. The MDS indicated an indwelling urinary catheter was in use.
Review of the Care Area Assessments (CAAs) indicated the presence of urinary incontinence and an indwelling catheter. The resident required assistance with activities of daily living due to impaired mobility.
The care plan dated 1/4/17 for a problem of bowel incontinence and an indwelling urinary catheter included approaches of catheter care as ordered, check resident every two hours and assist with toileting as needed, provide peri care after each incontinent episode.
Observations of Resident #3 on 1/31/17 at 11:00 AM revealed the resident had an indwelling catheter in place. The resident was turned to her right side by the Treatment nurse to do the treatment. The disposable brief the resident was wearing was saturated with urine, as evidenced by the padding in the disposable brief had seperated, the cloth pad under the resident was

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F 241	Continued From page 11 wet extending up the resident's back, and the resident's gown was wet. There was a strong urine smell at the bedside. Interview with the treatment nurse on 1/31/17 at 11:15 AM revealed the alternating air mattress was wet underneath the resident. The physician was aware the catheter leaked and had tried different sizes without success to prevent leakage of urine. Interview on 1/31/17 at 11:20 AM with Nursing Aide (NA) #1 revealed Resident #3 required total assistance with activities of daily living. NA #1 explained she would check for incontinence every hour for this resident. Further interview revealed she had been in the resident's room to pass the breakfast tray, but had not provided a check for incontinence care as of this time. During the interview NA#1 explained she had not made her way down to Resident #3's room yet, due to getting up five residents for breakfast in the dining room. Interview with Resident #3 on 2/1/17 at 9:30 AM revealed she had been left wet on 1/31/17 due to the catheter leaking. Further interview revealed this had occurred "often." Interview with the Director of Nursing on 2/1/17 at 5:50 PM revealed she would expect staff to check for incontinence at least every three hours.	F 241		
F 312 SS=G	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff, nurse practitioner	F 312	F312	3/8/17

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F 312	Continued From page 12 and physician interviews and record reviews the facility 1. Failed to check Resident #5 for incontinence in five hours. (Resident #5 had worsening incontinence dermatitis per the wound physician.) 2. Failed to check Resident #3 for incontinence for two of four sampled residents with incontinence. The findings included: 1. Resident # 5 was admitted to the facility on 11/7/16 with diagnosis of pressure ulcer on the sacrum, need for assistance with personal care, and diabetes. The care plan dated 12/7/16 for a problem of requiring extensive assistance with activities of daily living. Approaches included the resident was to participate to her fullest extent as possible, observe for decline and therapy per physician order. The Quarterly Minimum Data Set (MDS) dated 1/25/17 indicated Resident #5 had some impairment with short term memory, required extensive assistance of two persons for bed mobility, transfers, and dressing, extensive assistance of one person for toileting and personal hygiene, total dependence of two staff for bathing, was always incontinent of bowel and bladder and had a stage 4 pressure ulcer. The care plan had an update of 1/31/17 for a problem of incontinence of bowel and bladder which had no goal or approaches. Review of the wound physician progress note dated 1/30/17 indicated a diagnosis of "Incontinence Associated Dermatitis" with the progress as "Deteriorated. Entire buttocks and posterior thighs are inflamed."	F 312	Immediate correction was achieved for the alleged deficient practice when Resident #5 and Resident #3 were provided incontinence care by the C.N.A. On 2/21/17 C.N.A #1 performance was reviewed and action taken according to the facility□s progressive discipline. The facility acknowledges that all residents who are incontinent have the potential to be affected by the alleged deficient practice. Measures implemented to ensure the alleged deficient practice does not recur includes: Education regarding ADL care standards, including providing incontinence care every 2-3 hours, was provided by the DON/ADON for C.N.A□s. This education completed on 3/7/17 included expectations for delivery of incontinence care in a timely manner and prior to meals. Beginning 2/27/17 Unit Managers or designee will monitor 5 incontinent residents per day for 2 weeks and then 5 residents per week for 4 weeks to ensure that incontinence care is being provided in a timely manner. Beginning 2/27/17 DON/ADON will randomly monitor 3-5 residents per week for 4 weeks to validate that incontinence care is provided as expected Beginning 2/27/17 all newly hired C.N.As will be provided education regarding ADL care standards, including incontinence care during their orientation period.	

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F 312	Continued From page 13 Observations on 1/31/17 at 10:11 AM revealed Resident #5 was in bed lying on her back. The Nursing Assistant (NA) #1, who was assigned to care for Resident #5 was not available. Observations of incontinence care, provided by Nursing Assistant (NA) #2, revealed two cloth pads were positioned under the resident from her mid back to her upper thighs. Cloth pad #2 was on top of the sheet and under the resident's mid back and partially under the top pad (pad #1). The cloth pads were wet from the top of the pads to the bottom. A dried yellow ring was at the outer edges of pad #2. A disposable brief was folded with the pad side next to the resident between her legs. The brief was folded into a small ball. The resident's skin on the inner thighs, perineal area, and buttocks was red and "scalded" in appearance. There was a strong urine odor, and the resident's gown was wet at the "gown tail" which was underneath the resident's buttocks and upper thighs. During incontinence care, Resident #5 was turned to her side. The dressing that was on the sacral/coccyx area was off and laying under the buttocks. The dressing looked like a piece of wet rolled gauze that was brown in color. On 1/31/17 a 10:15 AM, during observations of incontinence care, Resident #5 explained no one had been in to check her, or clean her that morning. She continued with she was "always a clean person, did not like being dirty." During the observation of incontinence care Resident #5 complained of discomfort when cleaned. Interview with Nursing Aide (NA) #1 on 1/31/17 at 11:35 AM revealed she did not put the folded brief between her legs. NA #1 explained "Whoever changed her last did that." The NA responded	F 312	Monitoring implemented to ensure that the alleged deficient practice does not recur includes the DON summarizing the results of weekly audits completed by Department Managers and presenting a report to QAPI committee for 3 months or until substantial compliance is achieved.	

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she had not checked the resident for incontinence since coming on duty at 6:20 AM. She further explained she had not checked Resident #5 because she was getting other residents up for breakfast in the dining room. NA #1 explained she had five residents to get up for breakfast.
Interview with the Nurse Practitioner on 2/1/17 at 4:25 PM revealed if Resident #5 was left wet for a couple of hours, it could make the dermatitis worse. The resident did not want an indwelling catheter, and the staff would need to check her frequently for incontinence and use a protective barrier.

Interview with the wound physician on 2/1/17 at 5:29 PM revealed he saw the resident on a weekly basis for wound care. Each visit he found the resident to be wet with urine. The dermatitis on her buttocks had worsened during the past two weeks. The staff should check her often and keep the skin free from urine.

Interview with the Director of Nursing on 2/1/17 at 5:50 PM revealed she would expect the aides to provide incontinence care at least every three hours.

2. Resident # 3 was admitted to the facility on 5/2/16 with diagnosis of neuromuscular dysfunction of the bladder, bladder spasms and a pressure ulcer.

Review of the annual Minimum Data Set (MDS) dated 12/15/16 indicated Resident #3 had no long or short term memory problems, required total assistance of one staff for toileting, was occasionally incontinent of urine and always incontinent of bowel. The MDS indicated an

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F 312	Continued From page 15	F 312		

indwelling urinary catheter was in use.

Review of the Care Area Assessments (CAAs) indicated the presence of urinary incontinence and an indwelling catheter. The resident required assistance with activities of daily living due to impaired mobility.

The care plan dated 1/4/17 for a problem of bowel incontinence and an indwelling urinary catheter included approaches of catheter care as ordered, check resident every two hours and assist with toileting as needed, provide peri care after each incontinent episode.

Observations of Resident #3 on 1/31/17 at 11:00 AM revealed the resident had an indwelling catheter in place. The resident was turned to her right side by the Treatment nurse to do the treatment. The disposable brief the resident was wearing was saturated with urine, as evidenced by the padding in the disposable brief had seperated, the cloth pad under the resident was wet extending up the resident's back, and the resident's gown was wet. There was a strong urine smell at the bedside.

Interview with the treatment nurse on 1/31/17 at 11:15 AM revealed the alternating air mattress was wet underneath the resident. The physician was aware the catheter leaked and had tried different sizes without success to prevent leakage of urine.
Interview on 1/31/17 at 11:20 AM with Nursing Aide (NA) #1 revealed Resident #3 required total assistance with activities of daily living. NA #1 explained she would check for incontinence every hour for this resident. Further interview revealed she had been in the resident's room to pass the

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F 312	Continued From page 16 breakfast tray, but had not provided a check for incontinence care as of this time. During the interview NA#1 explained she had not made her way down to Resident #3's room yet, due to getting up five residents for breakfast in the dining room. Interview with Resident #3 on 2/1/17 at 9:30 AM revealed she had been left wet on 1/31/17 due to the catheter leaking. Interview with the Director of Nursing on 2/1/17 at 5:50 PM revealed she would expect staff to check for incontinence at least every three hours.	F 312		