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	345419	A. BUILDING _____ B. WING _____	C 10/13/2017

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LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		10/30/17

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

Electronically Signed | 10/31/2017

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F 309	Continued From page 1 Based on observation, staff interview and record review the facility failed to assess a resident with a newly identified hypospadias (penile injury), failed to determine whether the condition was caused by an indwelling urinary catheter either before or after admission, and failed to identify whether any interventions or treatments should be implemented to address this condition, for 1 of 3 sampled residents (Resident #1). The findings included: According to Journal of the American Geriatrics Society 33:10 1985 Oct page 712-4, "Hypospadias can be caused by prolonged traction on the unsecured (indwelling urinary catheter) between the inflated balloon and the weighted collection system producing a local ischemic necrosis (tissue death caused by lack of blood supply), . This complication can be prevented by securing the (indwelling urinary catheter tube) to the patient with tape, ensuring that the drainage system is properly supported, and by attention to patient position." The article also noted that in some cases the hypospadias could heal and reapproximate (close up). According to the Centers for Disease Control (CDC) , https://www.cdc.gov/ncbddd/birthdefects/hypospadias.html, "Hypospadias is a birth defect in boys in which the opening of the urethra is not located at the tip of the penis. In boys with hypospadias, the urethra forms abnormally during weeks 8-14 of pregnancy. The abnormal opening can form anywhere from just below the end of the penis to the scrotum. There are different degrees of hypospadias; some can be minor and some more severe."	F 309	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F-309 1. Resident #1 developed ventral erosion of penis from foley catheter usage with unknown origin date. 2. All residents with foley catheters were identified at risk. A skin assessment was completed on them to ensure that they had no catheter associated trauma to their genitals and was completed on 10/20/17. This was completed by unit managers/coordinators. All new admissions with foley catheters will be reviewed on admission. A skin assessment will be completed by unit manager/coordinator or designee to ensure there is no catheter associated trauma to their genitals. 3. Education provided to all nursing staff on importance of foley catheter anchors, proper foley catheter care, and reporting all abnormalities to charge nurse and completed by 10/30/17.	

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F 309	Continued From page 2 Resident #1 was admitted 6/8/17 with diagnoses including: thoracic spine fracture, cerebella hemorrhage, Type 2 diabetes mellitus, parapelegia and obstructive sleep apnea. Resident #1 was discharged to hospital on 9/21/17 and readmitted on 9/29/17 with additional diagnoses including hypospadias in male, sepsis, urinary tract infection, pressure ulcer and disorder of bone and cartilage. Review of the Care Plan initiated on 6/9/17 revealed a plan of care for an indwelling catheter due to Neurogenic Bladder. Interventions dated 6/9/17 included: "monitor/document for pain/discomfort due to catheter", "monitor and document intake and output as ordered", and "position catheter bag and tubing below the level of the bladder". Review of the Admission Minimum Data Set dated 6/15/17 revealed Resident #1 was cognitively intact, required extensive assistance of two people for bed mobility and had an indwelling urinary catheter. A Physician ' s Order dated 8/23/17 revealed an order to change the indwelling catheter anchor weekly. Further review of the plan of care for the resident ' s indwelling catheter revealed the following intervention added on 8/23/17: "change catheter (PRN) dysfunction or visible soiling, change anchor as needed." The Treatment Administration Record (TAR) revealed documentation of weekly changes of indwelling catheter anchor from 8/23/17 - 9/21/17.	F 309	Education provided to all licensed nurses on assessing insertion sites of foley catheters weekly with skin assessments and completed by 10/30/17. All education was provided by staff development coordinator and unit managers/coordinators. 4. Skin assessments will be validated for 5 residents with catheters weekly for 4 weeks, 3 residents with catheters weekly for 4 weeks and 2 residents with catheters weekly for 4 weeks. This will be completed by the DON or unit manager/coordinator. Results of audits will be reviewed at quarterly QA meeting x 1.	

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Review of the medical record from admission on 6/8/17 - discharge on 9/21/17 including orders, admission assessment, progress notes, physician notes, treatment administration records, medication administration records, and skin assessments revealed no documentation regarding a potential or diagnoses hypospadias.

Review of the North Carolina Medicaid FL2 Level of Care Screening Tool dated 9/26/17 revealed the resident was diagnosed with hypospadias on 9/23/17.

Review of the Admission Minimum Data Set dated 10/6/17 revealed Resident #1 was cognitively intact, required extensive assistance of two people for bed mobility and had an indwelling urinary catheter.

Further review of the plan of care for the resident ' s indwelling catheter revealed the following intervention added on 10/11/17: "do not use tape to anchor (indwelling catheter)."

On 10/13/17 at 1:30 PM post bowel incontinent care observation Resident #1 ' s indwelling catheter was observed. At this time, the resident ' s penis shaft was buried into his body with only the head visible. The catheter tubing did not appear to be coming out of the urethral opening but appeared to be inserted through the side of the resident ' s penis. In addition, there was a leg strap for securing the catheter tubing observed on the resident ' s right leg, however the catheter tubing was not secured to the leg strap. With the resident ' s permission Nurse #1 used her gloved hand to lift the resident ' s penis for further inspection. The shaft of his penis became visible and the underside of it was observed to be open,

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F 309	Continued From page 4	F 309		

but fully healed, from the tip of his penis to his scrotal sac. The indwelling catheter was emerging from the base of his penis. Resident #1 had a diagnosis of paraplegia and did not make any indication of pain below the waist during the observation.

Nurse #1 was interviewed on 10/13/17 at 1:40 PM with Nurse #2 and Nursing Assistant #2 present and acknowledged that she had been aware that Resident #1 had a hypospadias penis. She stated that it had been present since his original admission from the hospital (6/8/17). She was not aware of any documentation regarding this in the resident ' s medical record.

On 10/13/17 at 1:50 PM the Nurse Consultant was observed examining Resident #1 ' s penis, with his permission. The indwelling catheter tubing was not secured but al eg strap was present on the resident ' s right leg. The Nurse Consultant secured the tubing to the leg strap.

During interview with the Nurse Consultant on 10/13/17 at 1:52 PM she indicated that she thought the hypospadias occurred during Resident #1 ' s 9/21/17 - 9/30/17 hospital stay. She was advised at this time that the Hospital Record shower that Resident #1 was diagnosed with hypospadias on day two of his hospital (9/23/17). She acknowledged that it did not seem likely a tear of that length occurred during two days at the hospital noted that it was fully healed so did not look recent. The Nurse Consultant added that she had observed the indwelling catheter had been secured to the resident ' s leg on 10/11/17 but that he had a reaction to the securing tape. Because of this the securing device was changed out to a leg strap type

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F 309	Continued From page 5 device. Interview with the Nurse Consultant on 10/13/17 at 2:50 PM revealed she had been unable to locate any documentation indicating Resident #1 had a hypospadias at the time of his original admission, or during his stay in the facility from 6/6/17 - 9/21/17. She added that she had proceeded to interview several nursing staff members who said the resident did have a hypospadias during his original admission but when it was identified was unclear. In regard to the intervention noted on the TAR to ensure the resident ' s catheter was secured (initiated 8/23/17), the Nurse Consultant said that it was not initiated due to any problems. She stated that she could do remote chart audits and had initiated the intervention remotely. She added that it did not mean the catheter had not been secured prior to that incident but it was good practice to have a reminder to check it. The Nurse Consultant stated that it was her expectation that staff secure indwelling urinary catheters, report and document findings of a penile injury, and that appropriate interventions be implemented as needed. Telephone interview with the physician on 10/13/17 at 3:15 PM revealed he was new to the facility and had started there a couple of months previously. He stated that he had been aware that the resident had a diagnoses of hypospadias penis upon his readmission to the facility. He stated that he believed that the resident must have already had the condition at the time of his original admission because there would have been reports from staff and signs of bleeding if a tear occurred during the resident ' s facility stay.	F 309		

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F 309	Continued From page 6 Interview with Nursing Assistant #1 (NA #1) on 10/13/17 at 3:30 revealed that she was aware that Resident #1 had an opening down the shaft of his penis during his original admission at the facility. She could not recall when she became aware of it but indicated she did not recall it having any bloody discharge, as if it was a recent injury. She added that she thought the area had closed up at one point. NA #1 stated she had not been the resident ' s Nursing Assistant since his readmission so she was not aware the area had reopened. She added that it was her understanding that the hall nurses had been aware of the condition so there was nothing new to report when she observed it. NA #1 was aware all indwelling urinary catheters needed to be anchored.	F 309		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315		10/30/17

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F 315	Continued From page 7 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to secure an indwelling urinary catheter 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted 6/8/17 with diagnoses including: thoracic spine fracture, cerebella hemorrhage, Type 2 diabetes mellitus, paraplegia and obstructive sleep apnea. Resident #1 was discharged to hospital on 9/21/17 and readmitted on 9/29/17 with additional diagnoses including hypospadias in male, sepsis, urinary tract infection, pressure ulcer and disorder of bone and cartilage. Review of the Care Plan initiated on 6/9/17 revealed a plan of care for an indwelling catheter due to Neurogenic Bladder. Interventions dated 6/9/17 included: "monitor/document for	F 315	F315 1. Resident #1 developed ventral erosion of penis from foley catheter usage with unknown origin date. 2. All residents with Foley catheters were identified at risk. Their orders were reviewed to ensure they had orders to anchor the foley. Care plans were reviewed and updated as necessary. Completed 10/20/17. All new admissions with foley catheters will be reviewed on admission. Their orders will be reviewed to ensure they have orders to anchor the foley. Care plan for foley catheter will be initiated. 3. Education provided to all nursing staff on importance of foley catheter anchors,	

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F 315	Continued From page 8 pain/discomfort due to catheter", "monitor and document intake and output as ordered", and "position catheter bag and tubing below the level of the bladder". Review of the Admission Minimum Data Set dated 6/15/17 revealed Resident #1 was cognitively intact, required extensive assistance of two people for bed mobility and had an indwelling urinary catheter. A Physician ' s Order dated 8/23/17 revealed an order to change the indwelling catheter anchor weekly. Further review of the plan of care for the resident ' s indwelling catheter revealed the following intervention added on 8/23/17: "change catheter (PRN) dysfunction or visible soiling, change anchor as needed." The Treatment Administration Record (TAR) revealed documentation of weekly changes of indwelling catheter anchor from 8/23/17 - 9/21/17. Review of the Admission Minimum Data Set dated 10/6/17 revealed Resident #1 was cognitively intact, required extensive assistance of two people for bed mobility and had an indwelling urinary catheter. Further review of the plan of care for the resident ' s indwelling catheter revealed the following intervention added on 10/11/17: "do not use tape to anchor (indwelling catheter)." On 10/13/17 from 12:30 PM - 1:40 PM Nurse #1, Nurse #2 and Nursing Assistant #2 (NA #2) were observed doing Resident #1 ' s bowel incontinent	F 315	proper foley catheter care, and reporting all abnormalities to charge nurse and completed by 10/30/17. Education provided to all licensed nurses on assessing insertion sites of foley catheters weekly with skin assessments and completed by 10/30/17. All education was provided by staff development coordinator and unit managers/coordinators. 4. Orders for catheter anchors and the presence of the anchor on the resident will be validated for 5 residents with catheters weekly for 4 weeks, 3 residents with catheters weekly for 4 weeks and 2 residents with catheters weekly for 4 weeks. This will be completed by the DON or unit manager/coordinator. Results of audits will be reviewed at quarterly QA meeting x 1.	

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care and then his wound dressing and wound vac (a device that uses localized vacuum pressure to aid in wound healing) changes. During this observation, the resident ' s catheter was observed and was not anchored. There was a catheter leg strap on the resident ' s right leg but the catheter was not anchored to it. On three occasions during the procedure tension was noted on the catheter tubing and Nurse #1 adjusted the tubing to release the tension, when it was pointed out. The leg strap was observed to have an attachment for securing the catheter tubing but none of the staff members present used it to secure the catheter tubing. Resident #1 had a diagnosis of paraplegia and did not make any indication of pain below the waist during the observation.

On 10/13/17 at 1:50 PM the Nurse Consultant was observed examining Resident #1 ' s indwelling urinary catheter, with his permission. The indwelling catheter tubing was not secured but a leg strap was present on the resident ' s right leg. The Nurse Consultant secured the tubing to the leg strap.

During interview with the Nurse Consultant on 10/13/17 at 1:52 PM the Nurse Consultant stated that she had observed the indwelling urinary catheter had been secured to Resident #1 ' s leg on 10/11/17, but that he had a reaction to the securing tape. She said that because of the reaction to the tape, the securing device was changed out to a leg strap type device.

Interview with the Nurse Consultant on 10/13/17 at 2:50 PM revealed that the intervention noted on the TAR, to ensure the resident ' s catheter was secured, was initiated on 8/23/17 by the

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Nurse Consultant. She stated said that it was not initiated due to any problems. The Nurse Consultant added that she could do remote chart audits and had initiated the intervention remotely. She added that it did not mean the catheter had not been secured prior to that incident but it was good practice to have a reminder to check it. The Nurse Consultant stated that it was her expectation that staff secure indwelling urinary catheters.

Telephone interview with the physician on 10/13/17 at 3:15 PM revealed he was new to the facility and had started there a couple of months previously. He stated that an indwelling urinary catheter could should be secured and that not securing it could lead to catheter related complications.

Interview with Nursing Assistant #1 (NA #1) on 10/13/17 at 3:30 revealed that she was aware all indwelling urinary catheters needed to be anchored and that it was her recollection Resident #1 ' s catheter had been anchored when she worked with him during his 6/8/17 - 9/21/17 facility stay. She indicated she had not been assigned to Resident #1 since his return to the facility.