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<th>ID</th>
<th>PREMIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>F 315</td>
<td>SS-G</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>The Center provided the following Plan of Correction (POC) without admitting or denying the validity or existence of the alleged deficiencies. The POC is prepared and executed solely because it is required by provisions of the Federal and State Law. The facility reserves all rights to contest findings through dispute, resolution, final appeal proceeding and any administrator or legal proceeding.</td>
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   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 and staff interviews, the facility failed to have medical justification for the use of an indwelling urinary catheter for 1 of 3 sampled residents (Resident #1) who had indwelling catheters. Findings include:

   Review of the facility policy and procedure titled Catheter Care revised on 10/1/05 revealed, in part, that indwelling catheters could be used for: urinary retention that could not be corrected medically or surgically, documented post void residual volumes over 200 ml (milliliters), inability to manage retention/incontinence with intermittent catheterization, persistent overflow incontinence, symptomatic infections, and/or renal dysfunction, contamination of Stage III or IV wounds with urine that impedes healing and terminal illness or severe impairment which makes positioning or clothing changes uncomfortable or painful.

   Resident #1 was originally admitted to the facility on 2-28-12.
Continued From page 1 on 7/9/10 and last readmitted on 10/4/11. Cumulative diagnoses included seizure disorder, cerebral vascular accident (CVA) with hemiparesis, dysphasia, history of Klebsiella urinary tract infection (UTI) and history of pneumonia. Resident #1 also had multiple contractures and a gastrostomy tube (G-tube).

Review of the physician's progress notes revealed that when the resident was readmitted from hospital on 5/21/11 she returned to the nursing home with an indwelling catheter which was discontinued.

Review of the Care Plan initiated on 8/18/11 revealed Resident #1 was care planned for urinary incontinence and interventions included assist with perineal care as needed, encourage resident to consume all fluids during meals, monitor output for color, consistency and amount, and use absorbent products as needed. There were no revisions present on the Care Plan for urinary incontinence.

According to a hospital discharge summary dated 10/4/11 Resident #1 was on antibiotics (Vancocin, Zosyn and Bactrim) on presentation to the Emergency Room (10/2/11) for a combination of a UTI, which was Extended Spectrum Beta Lactamase (ESBL) Klebsiella and a presumed pneumonia. The antibiotics were discontinued prior to readmission to the nursing home facility and a repeat urinalysis showed no growth on culture.

Review of the Quarterly Minimum Data Set (MDS) dated 11/8/11 revealed Resident #1 had short and long term memory problems and was
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<td>Continued From page 2 severely impaired in decision making. The MDS indicated she did not have an indwelling catheter, was always incontinent of bowel and bladder, was totally dependent and required a one person physical assist for all activities of daily living. In addition, the MDS indicated Resident #1 had upper and lower extremity range of motion impairment. The Physician's Telephone Orders dated 12/12/11 revealed &quot;FC (Foley Catheter) care q5 every shift, (change) FC bag q (every) 30 days and (change) FC q 90 days. FC catheter and bag (changed) today on second shift.&quot; There was no medical indication listed for the indwelling catheter and the date of initial catheter insertion was not evident from the medical record. The 12/16/11 Physician's Telephone Orders and Medication Administration Record (MAR) revealed Resident #1 was started on IV (Intravenous) antibiotics (Vancomycin, Zosyn and Ciprofloxacin) to be continued for 10 days. Results of a blood culture collected on 12/15/11 were no growth at both 24 hours and 5 days. Results of a urine culture collected on 12/16/11 read, in part, &quot;Multiple Flora Present.&quot; A report of &quot;Multiple Flora Present&quot; means that several different bacterial morphotypes have been isolated, none of which is a predominant pathogen. &quot;No other workup or identification will be performed.&quot; Results of a blood culture collected on 12/22/11 were no growth at both 24 hours and 5 days.</td>
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On 12/22/11 the Physician's Telephone Orders and MAR indicate IV Zosyn was discontinued and IV Clindamycin was initiated for 10 days.

Review of the Significant Change MDS dated 12/28/11 revealed changes since the 11/9/11 MDS. These changes included in part, Resident #1 required the assistance of two people for bed mobility and dressing, instead of one person, and was being transferred from bed to chair less frequently. Resident #1 was also coded as having an indwelling catheter and an active UTI.

Resident #1's recorded temperatures from 1/8/12 - 1/11/12 were:
1/8/12 7:36 PM 99.1 (oral)
1/10/12 9:22 PM 100.5 (axilla)
1/11/12 4 PM 103 (axilla)

A 1/11/12 Change in Condition Note, indicated that Resident #1 was: diaphoretic and had a dusky facial color, along with a cough, change in breathing pattern, fever and decreased fluid intake. It read, in part: "Pt (patient) lying in bed with eyes open, HOB (head of bed) elevated. Respiration even and labored. Diaphoretic with grey hue to skin. Axillary temperature 102.0. Staff unable to draw blood for ordered labs or infuse ordered IVF's (intravenous fluids). G-tube clogged continuous feedings unable to be given."

The Physician's Telephone Orders dated 1/11/12 at 8:50 AM revealed "May send pt for PICC (peripherally inserted central catheter) line and PEG if okay (with daughter) and the following labs were ordered: comprehensive metabolic profile and complete blood count with..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** 316

**DEFICIENCY:** Resident #1 was not readmitted to the nursing home facility following this.

**PLAN OF CORRECTION:**

1. Review of the medical record from 10/11/12 revealed no order or progress note to initiate the indwelling catheter, or to leave an indwelling catheter placed at the hospital, and no medical indication for an indwelling catheter.

2. According to the 11/1/12 Hospital History and Physical (H&P) Resident #1 presented to the ER with a high fever and clogged G-tube for replacement. The H&P also revealed that a urinalysis showed 3+ bacteria and that Resident #1 had a chest x-ray which did not show any convincing evidence of pneumonia.

3. According to the Hospital Discharge/Transfer Summary dated 11/1/12, Resident #1's discharge diagnosis included "Septicemia from acute pyelonephritis with multifactorial drug resistant Escherichia coli (E coli) from both bottles of blood culture. Septicemia is a bacterial infection in the bloodstream, pyelonephritis is a kidney infection and E coli is a bacteria found in the digestive tract. E coli infections are caused by contact or contamination with feces.

4. On 11/12 at 12:24 PM, interview with Nurse #1 revealed she was the nursing supervisor on duty, on 11/11, when Resident #1 was sent to the ER. She stated that Resident #1 was hot natured so she tended to sweat. She also stated that the resident was on IV fluids and
### Statement of Deficiencies and Plan of Correction

| (K4) ID Prefix TAG | SUMMARY STATEMENT OF DEFICIENCIES
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<td>Continued From page 5 antibiotics for a UTI but that her G-tube was not functioning and the PICC line was not infusing. Nurse #1 revealed that the resident had been discussed in the Interdisciplinary Team meeting that day and was already going to be sent out for the G-tube and PICC when she became diaphoretic fever, so she was sent out for that as well. Nurse #1 indicated that Resident #1 had an indwelling catheter that had been inserted at the hospital on a previous visit there. She added that when resident’s return with an indwelling catheter the practice is to leave it in for a few days and then remove it but she did not know why Resident #1’s catheter had not been removed. On 1/20/12 at 12:30 PM, interview with Administrative Nurse #1 revealed that indwelling catheters are only kept in if the resident has urinary retention or a neurogenic bladder. She was not certain of the reason for Resident #1 having an indwelling catheter. She stated that Resident #1 had severe contractures and it was painful for the resident to have her legs moved for perineal care, so she thought that may have been the physician’s rationale. On 1/20/12 at 1:00 PM, interview with the attending physician revealed that many resident’s come back from the hospital with indwelling catheters inserted and “we usually take them out right away unless there is a need like urinary retention or a skin issue.” He further indicated that he did not know why Resident #1’s indwelling catheter had not been discontinued but stated that it should have been. He also pointed out that on a previous readmission in May 2011; Resident #1 was readmitted with an indwelling...</td>
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catheter which was removed on her readmission to the facility.

On 1/20/12 at 1:15 PM, during interview with 
Administrative Nurse #2, she stated "we always 
discontinue catheters went they come back from 
the hospital with them." She added that she did 
not know why Resident #1 's indwelling catheter 
was not discontinued as it was not facility practice 
to keep them in without an underlying reason.