

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/10/2017
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NAME OF PROVIDER OR SUPPLIER STARMOUNT HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 109 S HOLDEN ROAD GREENSBORO, NC 27407
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F 282 SS=D	<p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii)</p> <p>(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews the facility failed to follow the resident's care plan and secure the indwelling urinary catheter to prevent urinary complications for 1 of 3 resident's reviewed for activities of daily living (Resident #1).</p> <p>The findings Included: Resident #1 was admitted to the facility on 3/4/17 with the diagnosis of neurogenic bladder dysfunction, dementia and history of urinary tract infections. Review of a quarterly Minimum Data Set (MDS) dated 10/2/17 revealed Resident #1 was moderately cognitively impaired. The resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had an indwelling urinary catheter and did not have a Urinary Tract Infection (UTI) in the last 30 days. Review of the care plan last updated 10/06/17 revealed Resident #1 had a care plan in place for an indwelling urinary catheter. Interventions</p>	F 282	<p>1. Resident #1 catheter is currently being secured per resident's individualized care plan.</p> <p>2. Indwelling catheters are to be secured to prevent excess tension and urinary complications. Comprehensive care plans are to reflect the resident's current status. The Director of Nursing, in conjunction with the Unit Managers, compiled a list of residents who have indwelling catheters. Care plans for residents who have indwelling catheters were reviewed and updated, as needed, by the MDS Coordinator. Director of Nursing and Unit Managers validated that residents who have indwelling catheters have their catheter tubing secured to prevent urinary complications.</p> <p>3. The Director of Nursing, Unit Managers, Staff Development Coordinator, MDS Coordinator and Nursing Supervisors in-serviced nursing staff that indwelling catheters are to be secured as indicated in residents' care plans.</p>	10/12/17
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 10/19/2017
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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 282	<p>Continued From page 1</p> <p>included that the catheter be anchored to prevent excess tension and that the resident would be observed for sign or symptoms of a Urinary Tract Infection (UTI).</p> <p>During an observation on 10/10/17 at 9:41 AM, 2 nurse aides (NAs) took Resident #1 to the bathroom to provide incontinence care. Resident #1 stood up holding on to the grab bar in the bathroom with the assistance of NA #1 and NA #2. Urinary catheter care was provided. Resident #1 did not have a securing device to hold the catheter in place.</p> <p>The Nurse Practitioner was interviewed on 10/10/17 at 12:04 PM. She stated Resident's #1 urine was always colonized with bacteria but the resident did have symptoms of a UTI in August, 2017. At that time, the resident was running a fever and was treated for a UTI. The resident had not had any signs or symptoms of a UTI since then.</p> <p>Nurse #1 was interviewed on 10/10/17 at 1:19 PM. She stated Resident #1 moved around a lot and sometimes just wasn't careful the urinary catheter. She also added that the securing leg strap for the urinary catheter comes in a separate package than the urinary catheter kit and they have to get it separately. She stated she thought Resident #1 had a urinary catheter securing device in place.</p> <p>Resident #1 was observed again on 10/10/17 at 1:31 PM with Nurse #1 and the Unit Manager present. The resident was placed in bed and there was no strap/device securing the urinary catheter in place. Nurse #1 stated "there wasn't a strap". The Unit Manager went to get a strap to</p>	F 282	<p>specific care plan.</p> <p>4. The Unit Managers will conduct observation audits on four residents with indwelling catheters weekly to validate indwelling catheters are secured per resident's individualized care plan. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Unit Managers monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing.</p>		

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F 282	Continued From page 2 secure the urinary catheter. Nurse Aide #2 was interviewed on 10/10/17 at 2:59 PM. She stated that Resident #1 had a urinary catheter securing device at one point but it got messed up the other day so she had to take the strap off due to an incontinent accident the Resident had while in the bed. The Administrator was interviewed on 10/10/17 at 3:41 PM and stated she would expect that the urinary catheter was secured appropriately.	F 282			
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; (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	F 315		10/12/17	

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F 315	<p>Continued From page 3 and</p> <p>(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.</p> <p>(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 record review, observations and staff interviews the facility failed to secure the resident's indwelling urinary catheter and failed to ensure that the catheter bag was off of the ground to prevent complications of an indwelling urinary catheter for 1 of 3 resident's reviewed for activities of daily living (Resident #1).</p> <p>The findings Included:</p> <p>Resident #1 was admitted to the facility on 3/4/17 with the diagnosis of neurogenic bladder dysfunction, dementia and history of urinary tract infections.</p> <p>Review of a quarterly Minimum Data Set (MDS) dated 10/2/17 revealed Resident #1 was moderately cognitively impaired. The resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident had an indwelling urinary catheter and did not have a Urinary Tract Infection (UTI) in the last 30 days.</p>	F 315	<ol style="list-style-type: none"> 1. Resident #1 catheter is currently being secured per resident's individualized care plan. 2. Indwelling catheters are to be secured to prevent excess tension and urinary complications. Indwelling catheters should not touch the floor in order to prevent complications. Comprehensive care plans are to reflect the resident's current status. The Director of Nursing, in conjunction with the Unit Managers, compiled a list of residents who have indwelling catheters. Care plans for residents who have indwelling catheters were reviewed and updated, as needed, by the MDS Coordinator. Director of Nursing and Unit Managers validated that residents who have indwelling catheters have their catheter tubing secured to prevent urinary complications. Director of Nursing and Unit Managers observed residents with indwelling catheters to validate indwelling catheters or catheter 		

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F 315	<p>Continued From page 4</p> <p>A nursing note dated 10/3/17 revealed Resident #1 was noted to be lying in the bed with the urinary catheter's balloon deflated and the urinary catheter was in the resident's bed. The urinary catheter was replaced and yellow urine was noted.</p> <p>Review of the care plan last updated 10/06/17 revealed Resident #1 had a care plan in place for an indwelling urinary catheter. Interventions included that the catheter be anchored to prevent excess tension and that the resident would be observed for sign or symptoms of a Urinary Tract Infection (UTI).</p> <p>During an observation on 10/10/17 at 9:41 AM, 2 nurse aides (NAs) took Resident #1 to the bathroom to provide incontinence care. Resident #1 stood up holding on to the grab bar in the bathroom with the assistance of NA #1 and NA #2. NA #1 unhooked the catheter bag from the wheelchair and placed it on the bathroom floor. Urinary catheter care was provided. Resident #1 did not have a securing device to hold the catheter in place. Resident #1 had a small amount of stool on her buttock, which was cleaned properly. A clean brief was placed on the resident and the resident sat back in the wheelchair with the assistance of 2 NAs. The urinary catheter bag was picked up off the floor and placed back on the Resident's #1 wheelchair.</p> <p>The Nurse Practitioner was interviewed on 10/10/17 at 12:04 PM. She stated Resident's #1 urine was always colonized with bacteria but the resident did have symptoms of a UTI in August, 2017. At that time, the resident was running a fever and was treated for a UTI. The resident had not had any signs or symptoms of a UTI since</p>	F 315	<p>tubing are not in contact with the floor.</p> <p>3. The Director of Nursing, Unit Managers, Staff Development Coordinator, MDS Coordinator and Nursing Supervisors in-serviced nursing staff that indwelling catheters are to be secured as indicated in residents' specific care plan and are not to come in contact with the floor in order to prevent complications.</p> <p>4. The Unit Managers will conduct observation audits on four residents with indwelling catheters weekly to validate indwelling catheters are secured per resident's individualized care plan and are not in contact with the floor. The audits will be conducted weekly for a minimum of twelve weeks or until the Quality Assurance and Performance Improvement Committee determines the audits remain necessary to sustain compliance ongoing. The audits will be presented by the Unit Managers monthly, for a minimum of three months, in the Quality Assurance and Performance Improvement Committee Meeting to determine recommendations and further actions indicated. At the end of the three months, the Quality Assurance and Performance Improvement Committee will determine any further actions needed to sustain compliance ongoing.</p>		

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F 315	<p>Continued From page 5 then.</p> <p>Nurse #1 was interviewed on 10/10/17 at 1:19 PM. She stated Resident #1 moved around a lot and sometimes just wasn't careful the urinary catheter. She also added that the securing leg strap for the urinary catheter comes in a separate package than the urinary catheter kit and they have to get it separately. She stated she thought Resident #1 had a urinary catheter securing device in place.</p> <p>Resident #1 was observed again on 10/10/17 at 1:31 PM with Nurse #1 and the Unit Manager present. The resident was placed in bed and there was no strap/device securing the urinary catheter in place. Nurse #1 stated "there wasn't a strap". The Unit Manager went to get a strap to secure the urinary catheter.</p> <p>Nurse Aide #2 was interviewed on 10/10/17 at 2:59 PM. She stated that Resident #1 had a urinary catheter securing device at one point but it got messed up the other day so she had to take the strap off due to an incontinent accident the Resident had while in the bed. She also added "yeah, they took it (catheter bag) off the wheelchair" when they stood the resident for incontinent care this morning.</p> <p>The Administrator was interviewed on 10/10/17 at 3:41 PM. She stated she would expect that the urinary catheter was secured appropriately and the urinary bag was placed in the appropriate area (not on the floor) while providing care to the resident.</p>	F 315			