STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF DURHAM	411 S LASALLE STREET DURHAM, NC 27705

(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 secure a urinary catheter to prevent excessive tension on the catheter for 1 of 1 sampled resident with a urinary catheter. (Resident # 6). Findings include: Record review revealed Resident # 6 was admitted to the facility on 3/14/11 and the latest Minimum Data Set (MDS) dated 3/15/12 indicated the resident was cognitively intact, was dependant on staff for activities of daily living, was incontinent of bowel and had an indwelling urinary catheter. Records indicated the resident acquired a Stage 3 pressure ulcer on the back, upper left thigh. An indwelling urinary catheter was ordered and inserted to promote wound healing. The indwelling urinary catheter was removed on 6/6/12 prior to a physician examination and was	F 315	1. The Director of Nursing assessed resident # 6 on 06/14/12. The catheter was securely anchored by the license nurse on 06/14/12. 06 2. A 100% audit of resident's who have indwelling foley catheters was conducted by the Wound Care Nurse on 06/14/012 to ensure that catheters were securely anchored. No other residents were found to be affected. 06 3. An in-service was conducted by the Staff Development Coordinator for licensed nurses and certified nursing assistants regarding Urinary Catheter Use in Long-term care on 06/14/12. Licensed nurses and certified nursing assistants are required to attend. 6/20/12 4. An audit of residents with indwelling foley catheters to ensure securement of indwelling foley catheters will be conducted by the Director of Nursing and/or Unit Coordinators, Wound Care Nurse and Nursing Supervisors every day for 14 days, then three times a week for four weeks, then weekly for four weeks and /or 100% compliance. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Committee Performance Improvement as they arise and the plan will be revised to ensure continued compliance. The Quality	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Freda Wright	Administrator	6/26/12

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 315	Continued From page 1 re-inserted on 6/7/12 as ordered. The resident ' s care plan included on 3/13/12, a problem of a Stage 3 pressure ulcer on the left upper thigh and established a goal that the wound would remain free of infection through the next review. Approaches included in part the use of and indwelling urinary catheter which was to be secured to the resident ' s leg with a Velcro strap. A copy of the facility ' s Nursing Services Policy and Procedure Manual on Urinary Catheter Care was provided for review. On page 13 of the policy, item number 15 reads; " Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident ' s inner thigh.) " On 6/14/12 at 10:00 am, Treatment Nurse # 1 (TN # 1) entered Resident # 6 ' s room to provide a treatment. Resident # 6 was observed to have an indwelling urinary catheter. The urinary catheter drainage tubing was attached to the indwelling catheter and extended up and over the resident ' s left thigh, across the mattress and down the left side of the bed where the tubing was attached to a drainage bag secured to the bed frame. TN # 1 instructed Resident # 6 to turn from her back onto her right side. Resident # 6 followed the instructions and with the assistance of TN # 1 and Nursing Assistant # 1 (NA # 1), Resident # 6 turned to the right side away from the side of the bed where the catheter drainage bag was anchored. The catheter drainage bag remained attached to the left bed frame. When the resident turned, the catheter tubing pulled taught up and over the resident ' s left thigh. Once	F 315	Assurance Performance Improvement Committee consist of the Administrator, Director of Nursing , Staff Development Coordinator , MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Director of Maintenance/Environmental Services, Dietary Manager, and the Activities Director	

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F 315	Continued From page 2	F 315		

the resident was turned, it was observed that no leg strap was used to anchor the catheter drainage tubing to the thigh to prevent excessive tension and pulling at the catheter insertion site.

On 6/14/12 at 10:20 am, TN # 1 was asked about the urinary catheter tubing. TN #1 stated the tubing was not anchored and that it was facility policy to anchor urinary catheter tubing.

On 6/14/12 at 10: 21 am, Resident # 6 stated a leg band was in place at one time on the catheter tubing and she had not had any objection to it being used.

On 6/14/12 at 10:22 am, NA # 1 stated she had not noticed the catheter tubing was not anchored and that it should have been anchored with a leg band. NA # 1 stated sometimes the leg bands got soiled and she thought the leg band may have been sent to be washed, and that she would let the nurse know there was no leg band on the catheter.

On 6/14/12, at 10:25 am the Staff Development Coordinator indicated a leg strap should be used on an indwelling urinary catheter if the catheter pulled and provided a copy of the facility ' s Nursing Services Policy and Procedure Manual on Urinary Catheter Care for review.

On 6/14/12 at 10:28 am, the Director of Nursing (DON) was interviewed regarding use of a leg strap to anchor an indwelling urinary catheter. The DON stated an indwelling urinary catheter was typically anchored, and if it was not, the nursing assistant should have reported this to the nurse. She indicated a leg strap anchor should

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F 315	Continued From page 3 have been placed on Resident # 6 ' s urinary catheter tubing when the catheter was inserted. On 6/14/12, at 10:33 am Nurse # 1 was interviewed regarding Resident # 6 ' s indwelling urinary catheter. Nurse # 1 stated she re-inserted the catheter as ordered on 6/7/12 after the catheter had been removed for a physician examination on 6/6/12. Nurse # 1 stated she applied a leg strap to anchor the catheter tubing when the catheter was inserted on 6/7/12. Nurse # 1 stated the leg strap was disposable, and was supposed to be discarded if soiled. She indicated if it was removed because it was soiled, it should have been replaced.	F 315		