

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

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345548	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5533 BURLINGTON ROAD MC LEANSVILLE, NC 27301
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<p>F 000</p> <p>F 315 SS=D</p>	<p>INITIAL COMMENTS</p> <p>No deficiencies cited as a result of the complaint investigation survey of 01/10/13. Event ID# UUX811.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents and staff, the facility failed to provide services to prevent urinary tract infection by not routinely emptying a catheter bag for 1 of 2 sampled residents with indwelling catheters (Resident #233).</p> <p>Findings include: Resident #233 was originally admitted to the facility on 11/28/12 and readmitted to the facility on 12/3/12. Resident #233 had diagnoses including urinary retention and a history of urinary tract infections.</p> <p>The facility's Indwelling Catheter policy stated that, "The facility monitors for the risk, prevention, and detection of urinary tract infections.</p>	<p>F 000</p> <p>F 315</p> <p>F 315</p>	<p>This provider submits the following plan of correction (POC) in good faith and to comply with Federal Law. This POC is not an admission of wrong doing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiency.</p> <p>1. Upon disclosure of the concern through the survey process resident #233 did not have an indwelling catheter. The indwelling catheter was discontinued on 12/15/12. The discontinuation of the indwelling was done in conjunction with the improvement of the resident's condition including the urinary tract infection that the resident was admitted with.</p> <p>2. Only one resident continues to have an indwelling catheter in the facility. Upon disclosure of the concern identified in the</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Diane Hinkle* TITLE *Administrator* (X6) DATE *3-20-13*

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 315	<p>Continued From page 1</p> <p>Specifically, the facility employs standard infection control practices in managing catheters and associated drainage system, and the facility takes measures to maintain free urine flow through any indwelling catheter."</p> <p>The care plan dated 12/3/12 indicated tasks to be completed for Resident #233 included, "Record evidence of bladder output at least once per shift."</p> <p>Resident #233's 30-day Minimum Data Set (MDS), with the Assessment Reference Date (ARD) 12/31/12, indicated the resident was cognitively intact.</p> <p>A nurse practitioner order dated 12/10/12 indicated, "Place [indwelling catheter] for urinary retention."</p> <p>A nurse's note dated 12/10/12 at 4:08pm indicated that an indwelling catheter was inserted with good results.</p> <p>A nurse's note dated 12/12/12 at 2:41pm indicated that the resident was to start taking Urechaline for urinary retention, the catheter was to be removed after taking the medication for two days, and urinary retention was to be monitored.</p> <p>The nursing assistant (NA) assignment sheets dated 12/9/12 - 12/13/12 indicated that Resident #233's care needs included using a bedside commode and offering assistance prior to leaving the resident's room.</p> <p>The care plan dated 12/14/12 indicated a potential for injury, due to a urinary tract infection,</p>	F 315	<p>statement of deficiency no other residents were found to be affected by the alleged deficiency.</p> <p>3. The facility does utilize a process and systems to assist in the prevention of urinary tract infections and ensure that Foley catheter bags are emptied routinely. Nursing staff assigned to resident #233 during the time frame of the alleged deficiency have been in serviced on catheter care and recommended practices to prevent urinary tract infections for residents with an indwelling catheter as indicated by the Lippincott Manual of Nursing Practice. Additional in service education is being provided to nursing staff on catheter care and recommended practices to prevent urinary tract infections for residents with an indwelling catheter.</p>	
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F 315	<p>Continued From page 2</p> <p>related to the indwelling catheter and a diagnosis of urinary retention. Goals included that the resident would have no signs or symptoms of a urinary tract infection for 90 days and would maintain a patent catheter drainage system. Interventions included that staff would check tubing for kinks routinely, change the catheter and bag monthly and as needed for occlusion and/or leakage, catheter care with soap and water every shift and as needed, monitor and record intake and output, report any negative fluid balance trends to the physician, and observe and document urine appearance.</p> <p>The NA assignment sheets dated 12/14/12 indicated that Resident #233's care needs included using a bedside commode, offering assistance prior to leaving the resident's room, and that the resident had an indwelling catheter.</p> <p>The Completed Care Tasks sheet dated 12/14/12 at 6:51am indicated that NA #1 documented 900 cubic centimeters (cc's) of urinary output in the resident's catheter drainage bag.</p> <p>The Completed Care Tasks sheet dated 12/14/12 at 2:35pm indicated that NA #2 documented 800cc's of urinary output in the resident's catheter drainage bag.</p> <p>The Completed Care Tasks sheet dated 12/14/12 did not indicate catheter care provided or urinary catheter output for shifts 3pm-11pm and 11pm-7am.</p> <p>A nurse's note dated 12/15/12 indicated that resident #233's indwelling catheter was discontinued at 1pm.</p>	F 315	<p>4. The Director of Nursing or designee will conduct a weekly monitor of the resident or 50% of residents with an indwelling catheter for the next 12 weeks. Results of findings will be evaluated and reported monthly to the Quality Assurance Committee. The Quality Assurance Committee will review for trends and compliance results. At the end of the 12 week monitoring process the Quality Assurance Committee will determine if continuation of monitoring or any other actions are needed as a result of continued compliance.</p>	2/7/13	

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F 315	<p>Continued From page 3</p> <p>The Occupational Therapy (OT) note dated 12/15/12 at 1:20pm stated, "[Patient] reports nursing had not emptied [indwelling catheter] bag overnight and urine had been sitting in bladder for unknown amount of time. Pt reports pain and feeling bad (overall) and unable to participate in OT."</p> <p>The Completed Care Tasks sheet dated 12/15/12 at 4:37pm indicated that NA #3 documented 1500cc's of urinary output in the resident's catheter drainage bag.</p> <p>A nurse's note dated 12/16/12 at 4:48am indicated that resident #233 requested and was given pain medication for abdominal and back discomfort.</p> <p>The 24-Hour Report/Change of Condition Reports indicated that on 12/20/12 at 11:30pm Resident #233 requested pain medication and was given Percocet. The report also stated that the resident had been complaining of urinary discomfort, stated that she could not continue taking pain medication, planned to tell her [family member], and needed "the other" medication. The on-call practitioner was notified and gave orders for one dose of Pyridium for bladder pain and to obtain a urine specimen.</p> <p>A nurse's note dated 12/21/12 at 6:42am indicated that Resident #233 had been complaining of urinary discomfort and wanted something done immediately, that an order for one dose of Pyridium was received, urine was collected and placed in the lab refrigerator to be picked up and tested.</p>	F 315		
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F 315	<p>Continued From page 4</p> <p>A nurse's note dated 12/21/12 at 3:08pm indicated that Resident #233 was started on Pyridium 100mg every 8 hours as needed for painful urination.</p> <p>Laboratory results dated 12/25/12, from urine collected 12/21/12, indicated resident #233 had a urinary tract infection. On 12/25/12, the resident was started on Amoxicillin 500mg by mouth two times a day for 14 days.</p> <p>The December 2012 Treatment Administration Record (TAR) for Resident #233 did not include monitoring or care for the indwelling catheter.</p> <p>At 10:25am on 1/8/13, Resident #233 stated, "2nd [3pm to 11pm] and 3rd [11pm-7am] shift nurses did not even know that I had a catheter. I don't remember names, but the aide got out her piece of paper, showed me that it was not on there that I had a catheter. It had gone 2 shifts without being emptied."</p> <p>At 2:06pm on 1/9/13, the Assistant Director of Nursing (ADON) was interviewed and stated, "The nurses and treatment nurse monitor [indwelling catheters] [every] shift. It is documented in the treatment record and nurse's progress notes. [NAs] empty the [indwelling catheters] [every] shift and document the output on the care task sheet."</p> <p>When interviewed at 3:00pm on 1/9/13, about the December 2012 TAR that did not indicate an indwelling catheter was in place from 12/10/12 to 12/15/12 Treatment Nurse #1 stated, "It is not on here for the month of December, but this is where</p>	F 315		
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F 315	<p>Continued From page 5</p> <p>it would be documented that she had one. The nurse would also document assessments of the [indwelling catheter] [every] shift and put it in her notes."</p> <p>At 4:38pm on 1/9/13, Resident #233 was interviewed further regarding her indwelling catheter and stated, "When they finally emptied the catheter bag they emptied it into a container to the top, then filled it half full again. When they came in to empty the bag, the urine was in the catheter all the way up to where it went in to me. There were no bubbles or anything in the tubing. It seems like the amount was about 2000 but I don't remember an exact number. Before they emptied it I was in miserable pain, burning from my urinary tract up in to my bladder. I believe that I had asked for pain medicine it was so bad. It was horrible and was scary. I thought they can't get anything right. It got me frightened thinking that I was dependent on them to do the right thing."</p> <p>At 9:40am on 1/10/13, NA #3 was interviewed and stated, "The [NAs] empty the [indwelling catheters]. Most of the time it is on the assignment sheet who has an [indwelling catheter]. That is how we know who to check." When asked about the incident with Resident #233's [indwelling catheter], she stated, "I know exactly what you are talking about. I didn't know she had an [indwelling catheter] that day. The previous weekend she did not have one and it was not on my assignment sheet that she had one. I came in at 7 that morning and she kept complaining of burning and pain. I tried to help her to the restroom and then saw the bag. I got another [NA] to come in there and help me empty</p>	F 315		
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F 315	<p>Continued From page 6</p> <p>the bag. It was about 7:30-8am. I recorded the amount. We had to empty 1000mls (milliliters) and then go back and empty more. The urine was in the tubing. She was in pain and then told me that she felt better once the urine was drained. I believe by the end of the day the catheter was taken out. She did say that it had not been emptied for a long time. When it happened she said to me that she did not want to speak to her [family member] because it would upset her [family member], but that she did want to speak to someone in charge. I told my charge nurse. He went in to speak with her. I am not sure if he told anyone else what happened."</p> <p>At 11:05am on 1/10/13, the Staff Development Coordinator (SDC) was interviewed. The SDC stated that, "[NAs] are trained to empty [indwelling catheter] drainage bags [every] shift and [as needed]." When asked about how NAs knew who had an [indwelling catheter] she stated, "The kiosk in the hallway and the assignment sheets tell who has [indwelling catheters]. The assignment sheet is the most accurate. It is updated every day by the supervisors and the careguide on the kiosk comes from MDS information."</p> <p>At 1:00pm on 1/10/13, Resident #233's physician was interviewed regarding [indwelling catheter] care and urinary tract infections. She stated, "Backup of urine may cause an infection. There is a standing order at the facility to send urine if the resident is symptomatic for UTI (urinary tract infection) or complains of pain, pressure, burning - any signs of UTI." Regarding Resident #233, the physician stated, "I remember that I spoke to the [family member] after the incident with the</p>	F 315		
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F 315	<p>Continued From page 7</p> <p>resident's [indwelling catheter]. The [family member] contacted me and was upset."</p> <p>At 1:15pm on 1/10/13pm, the Director of Nursing (DON) was interviewed regarding her expectations of when [indwelling catheter] bags should be emptied and who would document the output. She stated, "[Indwelling catheter] bags are emptied at the end of each shift and output is documented by the [NAs]." Regarding who updates the assignment sheets, she stated, "The ADON, supervisors, and myself are the only ones who update the [NA] Assignment Sheets."</p>	F 315		
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