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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345530	A. BUILDING _____ B. WING _____	03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENN NURSING CENTER	619-A S MAIN STREET REIDSVILLE, NC 27320

(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=E	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 observation, staff interview and record review the facility failed to secure the indwelling urinary catheter for 3 of 3 sampled residents. (Residents #71, #148 and #59.) The facility also failed to keep the urinary drainage bag below the level of urinary bladder for 1 of 3 sampled residents. (Resident #71.) Findings Included: 1. Resident #71 admitted on 10/21/15. His diagnoses included enlargement of the prostate gland (BPH). A review of the recent Minimum Data Set (MDS), dated 1/20/16, revealed the resident ' s cognition was intact. The MDS specified Resident #71 required limited assistance with activities of daily living and used an indwelling urinary catheter. Review of Resident #71 ' s plan of care, dated 4/21/16, revealed the resident was at risk for complications from the use of an indwelling catheter, related to urinary retention. The Care plan ' s goal was to prevent urinary tract infection	F 315	Foley catheter for resident #71 and all resident's with foley catheters were *secured to resident's inner thigh.* *Catheter drainage bags on Resident #71 and all residents with foley catheters* were secured below the level of resident's bladder. On 3/9/16, education was initiated on resident's with catheters to ensure catheters are secured to the thigh using a STAT Lock and ensuring that all foley drainage bags are kept at a level below the bladder. Nurses and nurse techs were educated on securing the foley catheter to the inner thigh of resident #71 and maintaining foley drainage bag below the bladder level on Resident #71. Care plan reviewed and updated on resident #71.	3/9/16 3/9/16 3/9/16 3/9/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annette King-McNeill — TITLE: Administrator — (X6) DATE: 3/23/16

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENN NURSING CENTER	618-A S MAIN STREET REIDSVILLE, NC 27320

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F 315	Continued From page 1	F 315		

(UTI), related to catheter and drainage bag use. The approaches included keep the catheter not kinked or coiled to prevent urinary flow obstruction, and to never raise the drainage bad above the urinary bladder to prevent urine flow back into the bladder.
On 3/7/16 at 7:45 AM, Resident #71 was observed sitting in the wheelchair with a urinary drainage bag attached to the right side of the wheelchair frame, above the level of the resident ' s urinary bladder.
On 3/9/16 at 8:20 AM, Resident #71 was observed sitting in the wheelchair at the sink in his room washing his face and hands in the sink. His urinary catheter was observed without any securing devices. The urinary drainage bag was near the resident on the seat of the wheelchair, on the same level as urinary bladder.
On 3/9/16 at 9:15 AM, during an interview, Nurse #3 stated that the indwelling urinary catheter needed to be secured to the resident ' s inner thigh to prevent friction/movement. The urinary drainage bag needed to be below the bladder level all the time.
On 3/9/16 at 11:45 AM, during an interview, Nurse Aide #3 stated Resident #71 used an indwelling urinary catheter and drainage bag. She indicated the urinary catheter needed to be secured to the resident ' s leg.
On 3/9/16 at 1:00 PM, during an interview, the Director of Nursing stated that she expected the staff to maintain indwelling urinary catheters anchored to residents ' legs and to keep the urinary drainage bags below the level of urinary bladder.

2. Resident #148 admitted on 10/21/15. His diagnoses included enlarged prostate and obstructive uropathy (blockage of urine flow). A

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F 315	Continued From page 2 review of the recent Minimum Data Set (MDS), dated 1/21/16, revealed the resident ' s cognition was severely impaired. The MDS specified Resident #148 required extensive assistance with ADLs and used an indwelling urinary catheter. Review of Resident #148 ' s plan of care, dated 1/26/16, revealed the resident was at risk for complications from the use of an indwelling catheter, related to urinary retention. The goal was to prevent urinary tract infections, related to catheter and drainage bag use. The approaches were to keep the catheter not kinked or coiled to prevent the urinary flow obstruction and to never raise the drainage bag above the urinary bladder to prevent urine flow back into the bladder. On 3/8/16 at 1:40 PM, during Resident #148 ' s wound care observation, provided by Nurse #2 and Nurse Aide #2, the indwelling catheter was not secured to the leg. On 3/8/16 at 1:45 PM, during an interview, Nurse #2 confirmed that the catheter was not secured. She added that the catheter needed to be secured to the resident ' s thigh all the time. On 3/8/16 at 1:55 PM, during an interview, Nurse Aide #2 confirmed that the urinary catheter was not secured to the resident ' s leg. The aide indicated that the catheter needed to be secured all the time. On 3/9/16 at 8:45 AM, Resident #148 was observed in his room. The indwelling catheter was not secured to the thigh. The Nurse #3 was called to the resident ' s room and she confirmed that the catheter was not secured to the resident ' s leg. On 3/9/16 at 11:45 AM, during an interview, Nurse Aide #3 stated that Resident #148 used indwelling urinary catheter and drainage bag. She did not observe any devices to hold the urinary catheter in place.	F 315	Foley catheter for resident #148 and all resident's with foley catheters were *secured to resident's inner thigh.* On 3/9/16, education was initiated on resident's with catheters to ensure catheters are secured to the thigh using a STAT Lock. Nurses and nurse techs were educated on securing the foley catheter to the inner thigh of resident #148. 3/9/16 Care plan reviewed and updated on resident #148.	3/9/16 3/9/16 3/9/16

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F 315	Continued From page 3 On 3/9/16 at 1:00 PM, during an interview, the Director of Nursing stated that she expected the staff to maintain indwelling urinary catheters anchored to residents ' legs and to keep the urinary drainage bags below the level of urinary bladder. 3. Resident #59 was admitted on 2/8/16, with a diagnoses of stage III pressure ulcer and paraplegia. The most recent minimum data set (MDS) dated 2/25/16, revealed the resident ' s cognition was moderately impaired, and he used an indwelling urinary catheter. He had not rejected care Review of Resident #59 ' s care plans dated 2/17/16, revealed no documentation to use a device to secure the urinary tubing to the thigh, and no care plan indicating Resident #59 chose not to use a catheter stabilizing device. During wound care observation on 03/08/2016 at 11:11 AM, there was no device to secure the indwelling catheter tubing to Resident #59 ' s thigh. During an observation on 03/09/2016 at 9:30 AM of Resident #59 ' s catheter tubing, Nurse Aide #1 indicated there was no device to secure the tubing to the thigh. She revealed catheters were required to be secured to a resident ' s thigh. During the observation, Resident#59 indicated he had never had device on his catheter tubing since he had been admitted. He stated, that he laid with it on his thigh and tried not to tug it. During an interview on 3/9/16 at 1:00 PM, the Director of Nursing indicated she expected the staff to use a device on indwelling urinary catheters to secure the tubing to the resident ' s	F 315	Care plan reviewed and updated on resident #59 to include securing foley catheter to resident's thigh. Foley catheter for resident #59 and all residents with foley catheters were *secured to resident's inner thigh.* Nurses and nurse techs were educated on securing the foley catheter to the inner thigh of resident #59. Facility policy regarding Urinary Catheter Care will be reviewed and updated. All nurses and nurse techs will be educated on the Urinary Catheter Care policy. All nurses and nurse techs will be educated on properly securing foley cathethers to resident's inner thigh. All nurses and nurse techs will be educated on proper placement of catheter drainage bags below the level of resident's bladder.	3/9/16 3/9/16 3/9/16 4/5/16 4/5/16 4/5/16 4/5/16

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F 315	Continued From page 4 thigh.	F 315	Nurses will monitor residents with foley catheters every shift to ensure the catheter is secured properly to resident's thigh and to ensure placement of drainage bag below the level of resident's bladder. Nurses will verify compliance by signing off for each individual resident. RN/Charge Nurse will monitor residents with foley catheters daily x 3 months to ensure compliance of proper drainage bag placement and to ensure the foley catheter is properly secured to resident's thigh. RN/Charge Nurse will ensure compliance by signing a Foley Catheter Monitoring Log daily X 3 months verifying proper placement of drainage bag and properly secured foley catheter. DON will monitor RN/Charge Nurse's Foley Catheter Monitoring Log weekly X 3 months to ensure compliance. Care plans of all resident's with foley catheters will be reviewed and updated appropriately for interventions related to proper placement of catheter drainage bag, proper securement of foley catheter to resident's thigh, and any individual resident preferences. All audits and findings will be Reported and re-evaluated In quarterly QA meeting for 3 months for F315.	4/5/16 4/5/16 4/5/16 4/5/16 4/5/16 4/5/16