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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interview the facility failed to provide privacy for residents so that their exposed body parts could not be observed from the hallway or by roommates during care for 2 of 3 residents sampled for dignity (Resident #201 and Resident #103). The findings included: 1. Resident #201 was admitted 9/25/14 and readmitted 10/10/14 with cumulative diagnoses including: cardio vascular accident, depression, urinary tract infection and anemia. Resident #201 also had a nephrostomy tube and an indwelling urinary catheter. Review of the Quarterly Minimum Data Set (MDS) assessment dated 2/26/15 revealed Resident #201 was cognitively impaired but could understand others and could usually be understood by others when communicating. According to the assessment Resident #201 was totally dependent for toileting and bathing and required extensive assistance for toileting. In addition, the MDS revealed the resident had an indwelling catheter and was always incontinent of bowel. On 3/26/15 at 12:45 PM Nursing Assistant #1 NA #1 was observed to enter the room of Resident	F 241	Filing this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F 241 1. Corrective action has been accomplished in relation to the alleged deficient practice for Residents # 201 and 102. Resident # 201 receives incontinent care in a manner that provides privacy and promotes dignity, limiting exposure to others. The privacy curtain is closed between resident # 201 and his/her roommate during care. Resident # 103 is provided restorative services in a manner that limits the resident□s exposure to the hallway and others. The resident□s room door is closed and or privacy curtain is closed to provide privacy during exercises. Nursing Assistant #1 and Restorative Aide #1 were provided one to one education / counseling related to providing care and services that promote dignity while providing privacy for	4/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/23/2015

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 241	Continued From page 1 #201 and close the door behind her. On 3/26/15 at 12:48 PM NA #1 exited the room of Resident #201 and closed the door behind her. She then went to the linen cart to obtain towels and wash cloths. NA #1 was observed to knock and then open the door. While the door was open Resident #201 was visible from the hallway; none of the curtains in the room had been drawn. Resident #201 was lying on her bed with her pants pulled down. She had a brief on which was visible and was holding her left leg up in the air. The resident had loose stool down the back of her leg and on her catheter tubing. The resident ' s roommate was in the bed at the window side of the room with her back to the resident. The curtain between the two beds was not closed. The Resident #201 gave consent to be observed for incontinent care and the door was closed by NA #1. Once she had her supplies ready NA#1 closed the privacy curtains. Interview with Resident #201 on 3/26/15 at 12:55 PM indicated that she was aware the curtain was left open and should have been closed so no one would see her while walking by when the door was open. Resident #201 did not express any concerns about privacy in regards to her roommate. On 3/26/15 at 1:26 PM NA #1 was interviewed. She acknowledged she should have closed the privacy curtains before removing any of the Resident ' s clothing, and that the curtain should have been pulled all the way around, even though the resident ' s roommate was not cognitively intact. On 3/26/15 at 5 PM the Assistant Director of	F 241	residents. 2. Facility residents who require assistance with activities of daily living including toileting and residents receiving restorative nursing services have the potential to be affected by the same alleged deficient practice. The Interdisciplinary Team (IDT) will review resident concerns during morning meeting, Monday through Friday and review Resident Council care concerns as they occur to identify residents on an on-going basis. Individual interviews with alert and oriented residents have been conducted with current facility residents to identify privacy concerns. Identified concerns will be addressed as identified. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: Mandatory re-education for nursing staff regarding the importance of providing care in a manner that promotes dignity and respect, ensuring staff provides privacy during care where there is an opportunity for exposure; ensuring doors, curtains, blinds are closed as appropriate for the activity and ensuring residents are covered as much as possible during care to limit exposure to others. Random privacy observations will be conducted by the Director of Nursing (DON, Assistant Director of Nursing (ADON) Clinical Care Coordinator, Staff Development Coordinator or other designated staff members during care	

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Nursing was interviewed. She stated that she expected staff to close privacy curtains when a Resident ' s body part was going to be exposed.

On 3/27/15 at 5:15 PM the Director of Nursing was interviewed. She stated that she expected privacy curtains to be used, and closed all the way around the bed, when incontinent care was going to be provided. She further indicated resident ' s should not be exposed and be able to be seen from the hall or by roommates even if residents are not cognitively intact.

2. Resident #103 was admitted 9/15/09 with cumulative diagnoses including paralysis, seizure disorder, anxiety and depression.

Review of the Quarterly Minimum Data Set (MDS) assessment dated 2/1/15 revealed Resident #103 was cognitively impaired, totally dependent for all activities of daily living and had range of motion for one upper extremity and bilaterally for his lower extremities.

On 3/25/14 at 10:23 AM resident #103 was observed in bed. He could be seen from the hallway while walking past the door to his room. Restorative Aide #1 was observed providing passive range of motion to the Resident ' s right leg at this time. Resident #103 was wearing a hospital gown and with each raise of his right leg, his bare leg was exposed to passersby in the hall. The Restorative Aide continued with passive range of motion while talking to the surveyor at the doorway.

On 3/26/15 at 5:00 PM the Assistant Director of Nursing (ADON) was interviewed. She indicated that she did not think closing the privacy curtain

F 241

times and at other times when exposure is possible. Privacy observations will be conducted on going on a random basis. The Social Worker will conduct resident interviews with alert and oriented residents. Identified issues or concerns regarding privacy will be followed up within 2 weeks to ensure residents feel quality care is being provided in a dignified manner.

4.
The Director of Nursing will review the results of privacy observations and resident interviews, analyze for patterns/trends and report findings to the Quality Assurance meeting monthly for four months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement, additional interventions as needed to ensure continued compliance.

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F 241	Continued From page 3 was necessary during passive range of motion as long as the resident ' s body parts were not being exposed. The ADON said that since Resident #103 only had a hospital gown on the privacy curtain should have been closed. On 3/27/15 at 5:15 PM the Director of Nursing was interviewed. She stated that resident ' s body parts should not be exposed during passive range of motion and they were looking into getting pajama bottoms for Resident #103.	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications;	F 272		4/25/15

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F 272	Continued From page 4 Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to conduct a comprehensive assessment regarding a hearing deficit for 1 of 17 sampled residents to identify how condition affected each resident's function and quality of life (Resident #2). The findings included: Resident #2 was admitted to the facility on 02/25/15 with diagnoses which included a recent fracture of the femur and dementia. Review of Resident #2's admission Minimum Data Set (MDS) dated 03/04/15 revealed an assessment of moderately impaired cognition. The MDS indicated Resident #2 was understood by others and sometimes understood others with moderate hearing difficulty. The MDS indicated Resident #2 did not use a hearing aid. Review of the Communication Care Area assessment (CAA) dated 03/04/15 revealed	F 272	F272 1. The alleged deficient practice has been corrected for Resident #2. The resident□s Minimum Data Set (MDS) including Communication CAA were reviewed by the MDS Coordinator and Interdisciplinary Team. The CAA related to Communication was modified to reflect how the resident□s hearing deficit affected the resident. The Care Resident # 2 was discharged from the facility home on April 10, 2015. 2. Facility residents have the potential to be effected by the same alleged deficient practice. 3. Measures implemented to ensure the same alleged deficient practice does not	

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F 272	Continued From page 5 Resident #2's communication impairment triggered due to hearing impairment and impaired ability to understand others through verbal content. Further review of the Communication CAA revealed there was no documentation of an analysis of the findings with a description of the problem, causes and contributing factors, and risk factors related to the care area. There was no documentation of a hearing aid. Interview with Resident #2 on 03/25/15 at 9:26 AM revealed she used a hearing aid prior to her admission to the facility. Resident #2 explained the hearing aid needed batteries. Resident #2 reported she could not always understand others' speech when she did not have the hearing aid but the left ear was the "good ear." Observation during the interview revealed Resident #2 required the speaker to talk with a very loud volume into Resident #2's left ear. Interview with Nurse Aide (NA) #4 on 03/26/15 at 12:16 PM revealed Resident #4 was very hard of hearing. NA #4 reported Resident #2 did not use a hearing aid. Interview with Social Worker (SW) #1 on 03/26/15 at 3:20 PM revealed she assessed Resident #2's communication ability. SW #1 reported the lack of the hearing aid and request for the family to bring it in should have been included in the assessments. Telephone interview with Resident #2's family member on 03/26/15 at 5:05 PM revealed he was not aware a hearing deficit impacted cognition. Resident #2's family member explained the	F 272	recur are: The Regional Care Manager conducted inservice education on April 3, 2015 for the Interdisciplinary Team regarding developing a comprehensive care plan utilizing information entered about the resident in the MDS and then triggered information in the Care Area Assessment (CAA). Examples of CAAs were reviewed and discussed during the training to ensure understanding by the team. Beginning the week of April 23, 2015, the Regional Care Manager, Regional Nurse, Director of Nursing or other designated staff will conduct a random audit to ensure accuracy and follow through of two residents CAAs weekly for 4 weeks, then four residents monthly for 2 months. Continuation of random audits will be based on outcomes obtained. 4. The results of the audits will be reviewed by Director of Nursing / Assistant Director of Nursing or other designated staff member, analyzing for trends and report to the Quality Assurance Committee monthly times 3 months. The Quality Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement, additional interventions as needed to ensure continued compliance.	

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F 272	Continued From page 6 hearing aid could receive batteries and be delivered to Resident #2. Interview with Minimum Data Coordinator #1 on 03/27/15 at 10:34 AM revealed the hearing deficit should be documented in the CAA and part of the analysis of findings which impact Resident #2.	F 272		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to wet the old dressing before attempting to remove it for 1 of 1 resident. (Resident # 109). The findings included: Resident # 109 was admitted to the facility on 10/28/14 with medical diagnosis peripheral vascular disease, cellulitis/abscess of toe and diabetes mellitus. The Minimum Data Set (MDS) dated 03/25/15 coded Resident # 109 required total dependence with bed mobility and two person with support, transfer two person assist, and extensive assistance with dressing, total dependence with	F 309	F 309 1. Corrective action has been accomplished related to the alleged deficient practice in regards to Resident #109. Resident # 109 was discharged from the facility on March 27, 2015 for a pre-scheduled surgery related to the wound. Resident # 109 was readmitted to the facility on March 31, 2015 following surgery. Post-surgical treatment orders were received and implemented. Treatment orders will continue until surgical site is healed. Resident #109 will be medicated for pain as ordered by his/her physician. Resident #109 will be assessed for pain every shift, with verbalized complaints of pain and when	4/25/15

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eating and toilet use and personal hygiene.

Resident # 109 care plan dated 03/04/15 addressed resident at risk for alterations in comfort related to peripheral vascular disease and wound.

Review of Resident #109 March 2015 electronic Medication Administration Record (eMAR) revealed orders, dated 03/06/15, pain medication Hydrocodone-acetaminophen 5-325 milligram (mg) one (1) tablet by mouth every 8 hours; Hydrocodone-acetaminophen one (1) tablet by mouth daily one hour before wound dressing.

A review of the monthly Treatment Record dated 02/06/15 indicated cleanse the dark area on 2nd left toe with wound cleanser, dry completely, paint with betadine, separate toes with polymem foam that is cut in half, then apply blue bootie every day.

Observation on 03/26/15 at 9:25 AM revealed Nurse # 1 verified the treatment on the monthly treatment record and carried supplies for a dressing change into Resident #109's room and washed her hand and put on gloves. Nurse # 1 began to remove the dry dressing on the 2nd left toe and Resident # 109 jerked back when first touched and then held left foot up. Nurse # 1 verified Resident # 109 was administered pain medication prior to the dressing change.

Interview with the Nurse #1 on 03/26 /15 at 9:36 AM stated she acknowledged she should have applied wound cleanser to the old dressing before removing it.

Interview with the Director of Nursing (DON) on

F 309

non-verbal symptoms of pain are observed. Treatments will be stopped and pain addressed if identified during treatment. The resident will be assessed for effectiveness of the ordered pain medication and the physician notified for additional orders as needed. The licensed nurse was provided with one to one education related to removal of dressings on April 16, 2015 by the Director of Nursing (DON).

2. Facility residents with wounds have the potential to be affected by the same alleged deficient practice. The Director of Nursing (DON) Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), Treatment Nurse or other assigned staff will conduct an audit to identify residents with wounds that may result in pain during treatment to be completed on or before April 21, 2015. The interdisciplinary team will review the events/24 hour report during daily morning meeting Monday through Friday, to identify residents with new pressure ulcers/ wounds, new reports of pain or a change in the effectiveness of pain management. The Clinical Care Coordinator will review the event reports to ensure prompt notification of the residents□ physician and follow-through.

3. Measures put into place to ensure that the alleged deficient practice does not recur include directed mandatory in-services for licensed nurses entitled Wound Care & Pain Management conducted by a Registered Nurse with

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F 309	Continued From page 8 03/26/15 at 4:30 PM revealed she expected staff to thoroughly soak the dressing prior to removal in order to eliminate or minimize Resident # 109 pain to ensure it is controlled before and after treatment.	F 309	Wound Care Certification from Medipack Pharmacy conducted on April 7 and April 10, 2015. Content of the directed in-service training included but was not limited to: factors to improve the management of pain, epidemiology of pain and actions that decrease the incidence of pain during wound treatment. Additional training dates will be scheduled as deemed necessary. A component will be added to physicians orders for residents with wet to dry dressings or other dressings that may dry out. The SDC or other designated staff members will conduct training for licensed nurses regarding the addition of the order component of saturating or soaking the old dressing with saline prior to attempting removal to prevent pulling, causing discomfort/ pain or dislodging new tissue. Minimizing pain during wound dressing removal and treatment education will be incorporated as part of the new hire orientation for licensed nurses. The interdisciplinary team will review the new events / 24-hour report during daily morning meeting Monday through Friday, to identify residents with new wounds, new reports of pain or a change in the effectiveness of pain management. The Director of Nursing (DON) or other designated administrative nurse will conduct random order audits to ensure the presence of the order component weekly for 4 weeks and then then monthly thereafter. Beginning April 23, 2015, the DON, ADON, SDC or other designated licensed nurse will conduct random treatment observations for 1 week of at	

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F 309	Continued From page 9	F 309	least 1 resident daily and then twice weekly for at least 2 residents for 4 weeks and then once weekly for 4 weeks for 2 residents to ensure adequate pain management during treatments. 4. The DON/ADON will review the data obtained during the order audit and treatment observations, analyzing for patterns/trends and reporting in the Quality Assurance meeting. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement, additional interventions as needed to ensure continued compliance.	
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 observation, record review and staff interview the facility failed to provide hygienic incontinent care by using a back to front cleansing motion for 1 of 2 residents observed for incontinent care (Resident #201) and failed to	F 315	F 315 1. Corrective action has been accomplished in relation to the alleged deficient practice for Resident # 201 Resident # 201 receives incontinent care	4/25/15

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secure a catheter for 1 of 1 residents (Resident #201) sampled for an indwelling urinary catheter. The findings included:

1a. Resident #201 was admitted 9/25/14 and readmitted 10/10/14 with cumulative diagnoses including: cardio vascular accident, depression, urinary tract infection (UTI) and anemia. Resident #201 also had a nephrostomy tube and an indwelling urinary catheter.

Review of the Quarterly Minimum Data Set (MDS) assessment dated 2/26/15 revealed Resident #201 was cognitively impaired but could understand others and could usually be understood by others when communicating. According to the assessment Resident #201 was totally dependent for toileting and bathing and required extensive assistance for toileting. In addition, the MDS revealed the resident had an indwelling catheter and was always incontinent of bowel.

Review of the Care Plan updated 1/12/15 revealed the following problem statement " Resident has a history urinary tract infections with prophylactic antibiotic use. " The goal was " Resident will not exhibit complications of urinary tract infection. " The approaches listed included: administer antibiotic as ordered, assess for UTI, encourage fluids, encourage prompt, complete bladder emptying, " ensure meticulous personal hygiene, especially after elimination. Keep perineal area clean and dry. Use front to back wiping technique " and " if resident is incontinent, provide peri care as soon as possible after incontinent episode per facility policy being sure to cleanse well and cleanse from front to back. "

F 315

in a hygienic manner that limits contamination from bacteria. Resident # 201s catheter is secured to prevent injury, avoid tugging and inadvertent catheter removal. Nursing Assistant #1 was provided one to one education / counseling related to ensuring incontinent care is provided in a hygienic manner.

2.
Facility residents who are incontinent and those with indwelling catheters have the potential to be affected by the same alleged deficient practice. Residents who are incontinent and those with catheters have been identified. Infections over the past 90 days will be reviewed for incidence of infections related to catheters.

3.
Measures put into place to ensure that the alleged deficient practice does not recur include: Mandatory re-education for nursing staff regarding the importance of providing incontinent care in a manner that minimizes bacterial migration into the urethra and bladder and to provide care and services to prevent complications related to indwelling catheters including to ensure the catheter is secured to prevent movement that could result in injury or inadvertent removal of the catheter. An observation tool was developed to monitor staff compliance with incontinent care including placement of catheter securement device. Incontinent care observations will be conducted with currently employed ancillary staff

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(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	Continued From page 11 On 3/26/15 at 12:48 PM Nursing Assistant #1 (NA #1) was observed while providing incontinent care to Resident #201. Resident #201 had a large amount of loose stool that was not contained by the brief she had been wearing and the stool had gone down the back of her left leg to the back of her knee. After washing the catheter tubing from the top down and washing the back of the resident ' s leg NA #1 was observed to use a clean soapy washcloth and wring the excess moisture out over top of the Resident ' s perineal area. NA #1 then used the washcloth to remove the loose stool from the Resident ' s outer perineal area by using repetitive back to front motions. With a clean, wet cloth NA #1 then used a front to back motion to rinse the center of the Resident ' s perineal area. After washing the resident ' s buttocks using a back to front motion, and applying a brief, NA #1 stated that she was finished with the incontinent care and would get the resident dressed in clean clothes and settled into bed as the resident requested. NA #1 stated that the brief she applied to the resident was too small for her but it was all that had been available in the room and she didn ' t want the resident to have to wait to get cleaned up. NA #1 was asked to check behind the Resident ' s left knee and when she did she saw stool that she then washed off. On 3/26/13 at 1:26 PM NA #1 was interviewed. She acknowledged that when she provided incontinent care to Resident #201 she used a back to front motion to wash the stool from the Resident ' s perineal area. NA #1 stated she was aware that incontinent care was supposed to be done in a front to back motion to prevent infection.	F 315	beginning April 10, 2015 until completed. In addition, incontinent skills validation will continue to be a part of the new hire orientation for ancillary staff and as part of the annual review process. Infections will be reviewed monthly for urinary tract infections and catheter related infections by the Staff Development Coordinator. Events will be reviewed during morning meeting Monday through Friday to identify catheter related incidents. 4. The Director of Nursing will review the results of observations and infection / incident information, analyze for patterns/trends and report findings to the Quality Assurance meeting monthly for four months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement, additional interventions as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345013	A. BUILDING ______ B. WING ______	C 03/27/2015

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F 315	Continued From page 12 On 3/26/15 at 5:00 PM the Assistant Director of Nursing was interviewed and indicated that she expected staff to provide incontinent care using a front to back motion and to open the area (labia, buttocks, skin folds) to provide thorough cleansing to aide in preventing infection. On 3/27/15 at 5:15 PM the Director of Nursing was interviewed. She stated that it was her expectation that staff use a front to back motion when providing incontinent care and said that in this case with Resident #201 she thought a shower should have been given. 2b. Resident #201 was admitted 9/25/14 and readmitted 10/10/14 with cumulative diagnoses including: cardio vascular accident, depression, urinary tract infection and anemia. Resident #201 also had a nephrostomy tube and an indwelling urinary catheter. Review of the Quarterly Minimum Data Set (MDS) assessment dated 2/26/15 revealed Resident #201 was cognitively impaired but could understand others and could usually be understood by others when communicating. According to the assessment Resident #201 was totally dependent for toileting and bathing and required extensive assistance for toileting. In addition, the MDS revealed the resident had an indwelling catheter and was always incontinent of bowel. Review of the Care Plan initiated 10/23/14 revealed the following problem statement " Indwelling catheter. Resident requires nephrostomy tube. " (A nephrostomy tube is tube that is surgically inserted into the kidney via the	F 315		

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F 315	Continued From page 13 Resident ' s back). The goal was " Resident will have nephrostomy tube care managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma. " (Nephrostomy tubes do not pass through the urethra). The approaches listed included: administer medication, assess for continued need of nephrostomy, avoid obstructions in drainage, change catheter per orders, do not allow any part of the system to touch the floor, encourage fluids, as much as possible keep nephrostomy tube system closed, measure and record intake and output, obtain ordered labs, use proper hand washing, provide nephrostomy tube care as needed, report signs of UTI. Resident #201 also had an indwelling catheter inserted through her urethra into her bladder. Further review of the care plan from 10/10/14 through 3/27/15 revealed there was not a Plan of Care for this indwelling catheter. On 3/26/15 at 12:48 PM Nursing Assistant #1 (NA #1) was observed providing incontinent care to Resident #201. The leg strap to secure the Resident ' s indwelling urinary catheter to her leg was soiled with stool. NA #1 explained to Resident #201 that she would remove the leg strap since it was soiled and said that she would provide the resident with a new one. On 3/27/15 at 4 PM Nursing Assistant #2 (NA #2) was asked to check to see if Resident #201 had a leg strap to secure her indwelling urinary catheter, with the Resident ' s consent. Observation at this time revealed Resident #201 did not have a leg strap to secure her urinary catheter. NA #2 acknowledged that she had just provided personal care to Resident #201 but stated that she had not noticed the leg strap was not	F 315		

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F 315	Continued From page 14 present. She also said that she was aware indwelling urinary catheters should be secured with a leg strap. On 2/27/15 at 5:15 PM the Director of Nursing was interviewed. She indicated that it was her expectation that staff replace missing leg straps to secure indwelling urinary catheters to prevent tugging or urethral injury.	F 315		