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 03/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - CHARLOTTE	3223 CENTRAL AVENUE CHARLOTTE, NC 28205

(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 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff, family member and nurse practitioner interviews, and record review, the facility failed to notify the nurse practitioner of	F 157	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.** F 157: *Resident #1 was sent to ER 3/5/2016 and has not returned to facility **Resident with potential:** *One on one education completed with both Nurse #1 and Nurse #2 on 3/14/16 regarding family and MD notification of change in resident condition.	

DHSR NH L&C Black Mountain WRO
Received
MAR 23 2016
by: ucl

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	3/22/16

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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F 157	Continued From page 1 failure to insert a urinary catheter into the bladder prior to balloon inflation and flush attempt which resulted in pain, bleeding and emergency hospitalization and the facility failed to notify an interested family member of intravenous (IV) fluids and urinary catheterization implementation for 1 of 3 sampled residents with urinary catheters (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/14/16 with diagnoses which included chronic kidney disease stage 3, congestive heart failure, diabetes mellitus type 2 and history of deep vein thrombosis. Review of Resident #1's medications revealed the physician ordered daily administration of Xarelto 15 milligrams (mg.) and aspirin 81 mg upon admission. (Both of these medications thin blood.) Review of Resident #1's admission Minimum Data Set (MDS) dated 01/21/16 revealed an assessment of intact cognition. Review of nurse practitioner's (NP) telephone orders for Resident #1 dated 03/04/16 revealed direction to insert an indwelling urinary catheter for inability to urinate and begin intravenous fluids for an elevated blood urea nitrogen level. Review of nursing notes dated 03/04/16 at 9:33 AM revealed Nurse #1 documented urinary catheter placement "without any difficulties, some blood noted at penis and in bag, no trauma noted at this time."	F 157	*All licensed nurses were/will be re-educated by Staff Development Coordinator or other Administrative Registered Nurse, on need for family and MD notification when there is a change in resident condition. **Measure and changes to practice:** *The facility policy titled "Change in Resident's Condition or Status" was reviewed. *All nurses will be re-educated regarding need for family and MD notification of resident change in condition. *Nurses who are not available (i.e. LOA, Vacation, etc.) will be educated upon their return to an assignment	

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F 157	Continued From page 2 Review of the NP note dated 03/04/16 revealed Resident #1 complained of pain from the catheter. The NP documented "he has noted hematuria (blood in the urine)" and ordered a urinalysis with culture and sensitivity. The NP ordered removal of the urinary catheter with catheter replacement if Resident #1 was unable to void within a few hours. Review of a nursing note dated 03/04/16 at 1:43 PM revealed Resident #1 complained of penile pain with blood tinged urine. Nurse #1 documented an urinalysis with culture and sensitivity was obtained with urinary catheter removal. Review of a nursing dated 03/05/16 at 4:22 AM revealed Resident #1's incontinent brief "saturated with bright red blood." Resident #1 received emergency transportation to the hospital. Review of Resident #1's emergency department physician's note dated 03/05/16 revealed Resident #1 arrived "bleeding profusely from penis with clots." The physician documented "a three-way catheter was placed and irrigated. Urine remained clear with no more active bleeding." The physician noted Resident #1 would require 2 units of packed red blood cells to treat anemia secondary to acute blood loss from hematuria, treatment for a urinary tract infection and bladder irrigations for 24 hours. Interview with Nurse #1 on 03/14/16 at 11:10 AM revealed the NP was notified when Resident #1 complained of inability to urinate on 03/04/06. Nurse #1 explained she inserted the urinary catheter and inflated the balloon. Nurse #1	F 157	*A lesson plan was developed addressing notification of all appropriate persons when there is a change in the resident's condition. **Monitoring Performance:** 1. An audit tool was developed which addresses: a.) Identify resident with change in condition b.) Documented notification of Responsible Party c.) Documented notification of MD/NP	

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F 157	Continued From page 3 reported there was no urine flow from the urinary catheter upon insertion of the catheter and inflation of the balloon. Nurse #1 reported she asked Nurse #2 for assistance to see if the catheter was correctly placed in the bladder. Nurse #1 reported Nurse #2 pushed the catheter up higher and urine began to flow. Nurse #1 reported a small amount of bleeding occurred at the tip of Resident #1's penis. Nurse #1 explained the urine in the catheter bag was slightly red and Resident #1 complained of pain from the catheter. Nurse #1 reported she notified the NP of the pain but did not notify the NP regarding the difficulty with catheterization. Telephone interview with Resident #1's family member on 03/14/16 at 11:40 AM revealed she received a telephone call on 03/05/16 from the facility regarding Resident #1's bleeding and need for emergency transportation to the hospital. The family member reported the facility did not notify her of the IV and attempt at catheterization until the call regarding Resident #1's blood loss. A second interview with Nurse #1 on 03/05/16 at 12:01 PM revealed she attempted to notify Resident #1's family member once but "the day got busy and I forgot." Nurse #1 explained she thought Resident #1 could notify the family member. Nurse #1 explained she forgot to ask the oncoming shift nurse to attempt to notify Resident #1's family member. Nurse #1 could not provide a reason for the lack of notification to the NP regarding the urinary catheter difficulty. Interview with Nurse #2 on 03/14/16 at 12:04 PM revealed Nurse #1 asked for assistance with Resident #1's catheter since it was not draining urine. Nurse #2 explained a small amount of	F 157	2. Audits will continue as follows: 10% of residents with change in condition will be audited weekly for 4 weeks, then bi-weekly for 2 months, then monthly for 3 months. Ongoing audits will be determined by the results of the last 6 months of audits **QAPI:** The results of the audits will be reviewed at QAPI meetings monthly for 6 months. Date of Compliance: 3/29/2016	

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F 157	Continued From page 4 bleeding was on the penis tip which he would estimate to be approximately 10 cc. (cubic centimeters). Nurse #2 reported he attempted to inject normal saline as a flush. Nurse #2 explained he injected "about 1 cc. in" and Resident #1 complained of severe pain. Nurse #2 reported he stopped immediately, deflated the balloon and advanced the catheter until urine began to flow. Nurse #2 reported he inflated the balloon and secured the leg strap. Nurse #2 explained notification of Resident #1's family member and NP was Nurse #1's responsibility since he worked on the other hall. Interview with the NP on 03/14/16 at 1:25 PM revealed she was not aware of the balloon inflation and flush attempt prior to bladder placement of the urinary catheter. The NP reported she was not aware bleeding occurred upon insertion of the urinary catheter. The NP explained she examined Resident #1, observed his hematuria and suspected a urinary tract infection. The NP explained her orders would have included catheter irrigations and close monitoring since Resident #1 received anticoagulant medication and trauma with insertion occurred. The NP explained she expected staff to notify her of possible trauma during the catheterization. Telephone interview with Nurse #3 on 03/14/16 at 2:10 PM revealed she immediately called emergency transportation, Resident #1 ' s family member and Resident #1's physician when Resident #1 began bleeding. Nurse #3 reported she informed Resident #1's family member of the IV fluids and attempt at catheterization on 03/04/16.	F 157	**Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements.** F 315: Resident # 1 was sent to the Emergency room 3/5/2016 and has not returned to the facility.	

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F 157	Continued From page 5 Interview with the Director of Nursing (DON) on 03/14/16 at 3:15 PM revealed she expected staff to notify Resident #1's family member of the IV and catheterization orders. The DON reported nurses should continue to attempt to contact family members. The DON reported she expected Nurse #1 and Nurse #2 to notify the NP of the catheterization difficulty when it occurred.	F 157	Resident with potential: All residents in the facility who currently have a Foley catheter have been assessed for proper placement of the Foley catheter.	
F 315 SS=G	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 staff and nurse practitioner interviews, and record review, the facility failed to insert a urinary catheter into the bladder prior to balloon inflation and flush attempt which resulted in pain, bleeding and emergency hospitalization for 1 of 3 sampled residents with urinary catheters (Resident #1). The findings included: Review of the facility's procedure for catheter insertion of a male resident revised August 2002 revealed direction included: "Insert the catheter	F 315	One to one education was completed with both nurse # 1 and #2 on 3/14/16. All licensed nurses will be in serviced regarding proper insertion of a Foley catheter. Any nurse who is not available for this instruction (LOA, etc.) will be educated on Foley catheter insertion prior to accepting an assignment.	

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F 315	Continued From page 6 into the meatus (approximately 5-7 inches) until urine begins to flow from the bladder. When urine begins to flow, advance the catheter another 2 inches. Inflate the balloon slowly with 5 cc. (cubic centimeters) normal saline. If resident complains of any pain or pressure while inflating the balloon, stop, deflate the balloon and advance the catheter another inch. If the resident complains of any pain or pressure, stop, deflate the balloon and call for assistance." Resident #1 was admitted to the facility on 01/14/16 with diagnoses which included chronic kidney disease stage 3, congestive heart failure, diabetes mellitus type 2 and history of deep vein thrombosis. Review of Resident #1's medications revealed the physician ordered daily administration of Xarelto 15 milligrams (mg.) and aspirin 81 mg upon admission. (Both of these medications thin blood.) Review of Resident #1's admission Minimum Data Set (MDS) dated 01/21/16 revealed an assessment of intact cognition. The MDS indicated Resident #1 was frequently incontinent of urine. Review of nurse practitioner's (NP) telephone orders for Resident #1 dated 03/04/16 revealed direction to insert an indwelling urinary catheter for inability to urinate. Review of nursing notes dated 03/04/16 at 9:33 AM revealed Nurse #1 documented urinary catheter placement "without any difficulties, some blood noted at penis and in bag, no trauma noted at this time."	F 315	Measure and changes to practice: A lesson plan was developed titled "Catheter Care and Placement" All licensed nurses were/will be educated regarding the insertion and care of a Foley catheter. This will be done by the Staff Development Nurse or other administrative Registered Nurse. Nurses were provided with "Bladder Care: Step by Step Process" handout. The facilities procedure for insertion of a catheter of a male resident was reviewed.	

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F 315	Continued From page 7 Review of the NP note dated 03/04/16 revealed Resident #1 complained of pain from the catheter. The NP documented "noted hematuria (blood in the urine)" and ordered a urinalysis with culture and sensitivity. The NP ordered removal of the urinary catheter with catheter replacement if Resident #1 was unable to void within a few hours. Review of a nursing note dated 03/04/16 at 1:43 PM revealed Resident #1 complained of penile pain with blood tinged urine. Review of a nursing dated 03/05/16 at 4:22 AM revealed Resident #1's incontinent brief "saturated with bright red blood." Resident #1 received emergency transportation to the hospital. Review of Resident #1's emergency department physician's note dated 03/05/16 revealed Resident #1 arrived "bleeding profusely from penis." The physician documented "a three-way catheter was placed and irrigated. Urine remained clear with no more active bleeding." The physician noted Resident #1 would require 2 units of packed red blood cells to treat anemia secondary to acute blood loss from hematuria, treatment for a urinary tract infection and bladder irrigations for 24 hours. Interview with Nurse #1 on 03/14/16 at 11:10 AM revealed Resident #1 complained of inability to urinate on 03/04/06. Nurse #1 explained she inserted the urinary catheter and inflated the balloon. Nurse #1 reported there was no urine flow from the urinary catheter upon insertion of the catheter and inflation of the balloon. Nurse	F 315	Monitoring Performance: An audit tool was developed which addresses: All Foley catheters have an appropriate diagnosis. Residents Foley catheter is draining urine. The collection bag is properly placed below the bladder The Foley catheter is secured with a securing device to minimize dislodging of the Foley catheter.	

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F 315	Continued From page 8 #1 reported she asked Nurse #2 for assistance to see if the catheter was correctly placed in the bladder. Nurse #1 reported Nurse #2 pushed the catheter up higher and urine began to flow. Nurse #1 reported a small amount of bleeding occurred at the tip of Resident #1's penis. Nurse #1 explained the urine in the catheter bag was slightly red and Resident #1 complained of pain from the catheter. Nurse #1 reported the pain to the NP. Interview with Nurse #2 on 03/14/16 at 12:04 PM revealed Nurse #1 asked for assistance with Resident #1's catheter since it was not draining urine. Nurse #2 explained a small amount of bleeding was on the penis tip which he would estimate to be approximately 10 cc. (cubic centimeters). Nurse #2 reported he attempted to inject normal saline as a flush. Nurse #2 explained he injected "about 1 cc. in" and Resident #1 complained of severe pain. Nurse #2 reported he stopped immediately, deflated the balloon and advanced the catheter until urine began to flow. Nurse #2 reported he inflated the balloon and secured the leg strap. Interview with the NP on 03/14/16 at 1:25 PM revealed she was not aware of the balloon inflation and flush attempt prior to bladder placement of the urinary catheter. The NP reported she was not aware bleeding occurred upon insertion of the urinary catheter. The NP explained she examined Resident #1, observed his hematuria and suspected a urinary tract infection. The NP explained her orders would have included catheter irrigations and close monitoring since Resident #1 received anticoagulant medication and trauma with insertion occurred. The NP explained both	F 315	The nurses caring for the resident can verbalize the proper procedure for inserting the Foley catheter. Resident is free of s/s of pain related to catheter. A post-test for the in-service title "Catheter Care and Placement" was developed to evaluate the licensed nurses understanding of the in-service education provided regarding Foley catheter insertion. Audits will continue as follows: 100% of resident with a Foley catheter Weekly	

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F 315	Continued From page 9 balloon inflation and flush attempt should not occur until bladder placement is confirmed with urine flow. Telephone interview with Nurse #3 on 03/14/16 at 2:10 PM revealed Resident #1's disposable brief was filled with bright red blood when checked on regular rounds between 3:00 and 3:45 AM. Nurse #3 explained the blood amount was large and she was not able to tell the origin of the bleeding. Nurse #3 reported she immediately called emergency transportation, Resident #1's family member and Resident #1's physician. Telephone interview with Nurse #4 on 03/11/16 at 3:00 PM revealed she received report regarding Resident #1's inability to void and pain from catheter when she arrived on duty at 3:00 PM on 03/04/16. Nurse #4 explained Resident #1 voided during the evening shift with no visible blood in the urine and did not complain of pain. Interview with the Director of Nursing (DON) on 03/14/16 at 3:15 PM revealed she expected nurses to follow the facility procedure for urinary catheterization. The DON explained staff should make certain the catheter is in the bladder prior to balloon inflation and flush attempt.	F 315	for 4 weeks, 100% of resident with a Foley catheter every other week for 8 weeks. 100% of resident with a Foley catheter monthly for 3 months. Ongoing audits will be determined by the results of the last 6 months of audits. QAPI: The results of the audits will be reviewed at the QAPI meeting monthly for 6 months. Date of Compliance: 3/29/2016	