| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345328 | A. BUILDING ______<br>B. WING ______ | C<br>12/08/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **GIVENS HEALTH CENTER** | **600 BARRETT LANE**<br>**ASHEVILLE, NC 28803** |

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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation Event ID#8F4V11. | F 000 | | |
| F 278<br>SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, observations, and | F 278 | Disclaimer: The component elements of | 12/9/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed    TITLE    (X6) DATE: 12/22/2016

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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Continued From page 1

record reviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident with a catheter. The findings Included:
Resident #84 was admitted to the facility on 10/12/16. The diagnoses included Chronic Kidney Disease, Edema, Respiratory Failure, and Congestive Heart Disease.
The Admission MDS dated 10/19/16 indicated Resident #84 was cognitively intact, but needed extensive assistance with transfers, toilet use, and walking did not occur during the assessment period. The MDS was coded as none of the above for appliances related to the indwelling catheter.
The care area assessment of urinary incontinence showed Resident #84 had an increase of her diuretic due to an increase of congestive heart failure with the urinary catheter being placed on 10/19/16.
Nursing note dated 10/19/16 at 2:33 PM was reviewed and read as 16 French, 30 cubic centimeter catheter was inserted without difficulty.
Review of the care plan with a start date 10/21/16 focused on the risk for complications related to indwelling catheter use.
MDS nurse was interviewed on 12/08/16 at 3:28 PM and stated, "I didn't code the catheter in section H, but I discuss in the care area assessment. I will submit a modification of the assessment to include the information in section H."

During an interview on 12/08/16 at 3:58 PM, the Director of Nursing explained the expectations of MDS coding was to be done correct and accurate.

F 278

the following plan of correction are those specifically required by Section 7304 of the CMS State Operations manual. This filing does not constitute an admission that the deficiencies alleged did in fact exist. This POC is filed as evidence of the facility's desire to comply with the requirements and to provide high quality resident care. This POC constitutes written allegation of substantial compliance with written Medicare and Medicaid requirements.

Plan of Correction for Tag F0278 - 483.20(g) - (j)

During the Survey, the surveyor noted a typographical error in the MDS coding for section H0100 regarding the presence of a catheter for resident #84. The Care Area Assessment noted the presence of a catheter and the care plan addressed proper interventions for catheter care. On 12/8/16, the surveyor brought to the attention of the MDS coordinator, this typographical error on Section H0100 MDS for Resident #84. The MDS Coordinator immediately modified the MDS portion of the assessment to indicate the presence of a catheter. The CAA portion of the assessment noted the presence of the catheter and therefore did not require modification. The entire assessment, including the MDS and CAA, was then re-submitted to CMS on 12/12/16.

In order to ensure no other residents were affected in a similar manner, the MDS

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| F 278 | Continued From page 2 | F 278 | Coordinator and the Administrator checked the Section H0100 of the two (2) most recent MDS assessments of all residents with indwelling catheters. There was only one other resident with an indwelling catheter. In this additional case, the MDS coding was found to be accurate.<br><br>In order to prevent reoccurrence of this type of error in the future, the DON or ADON will verify the accuracy for the MDS coding of Section H0100 for all residents with indwelling urinary catheters for ninety (90) days or until the DON feels that consistent compliance has been achieved and then randomly thereafter.<br><br>The DON will report her findings to the QAPI Committee for ongoing monitoring and oversight until the QAPI Committee determines that ongoing, consistent compliance has been achieved. | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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. | F 315 | | 12/20/16 |

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| F 315 | Continued From page 3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews, and staff interviews, the facility failed to prevent an indwelling urinary catheter bag from resting on the floor for one of one resident, Resident #84, reviewed for indwelling urinary catheter care.<br>Findings included:<br>Resident #84 was admitted to the facility on 10/12/16. The diagnoses included Chronic Kidney Disease, Heart Failure, and Edema.<br>The Admission MDS dated 10/19/16 indicated Resident #84 was cognitively intact, but needed extensive assistance with bed mobility, personal hygiene, transfers, toilet use, and walking did not occur during the assessment period.<br>The care plan dated 10/21/16 focused on the risk for complications related to indwelling catheter use. One of the interventions included was to provide catheter care per protocol to minimize risks of complications from chronic use.<br>Nursing assistant (NA) orientation checklist provided by the Director of Nursing (DON) on 12/08/16 showed catheter care being part of employee training. The policy provided by the DON named Catheter care, urinary version 2001 Med-Pass read in part, be sure the catheter tubing and drainage bag are kept off the floor.<br>Resident #84 was observed at 8:14 AM on 12/08/16, resting in the bed with a catheter bag near the foot of the bed placed directly on the floor. There was a small amount of urine left in the bag. A second observation at 9:37 AM revealed the catheter bag located near the footboard area being attached underneath the bed and touching the floor.<br>NA #1 was interviewed on 12/08/16 at 9:38 AM, acknowledged the catheter bag should not be touching the floor and stated, "It was probably | F 315 | Plan of Correction for Tag F 0315 - 483.25(d)<br><br>When the Surveyor notified the DON that she had noted the catheter bag of Resident #84 on the floor, the DON immediately removed the bag from the floor, and attached it properly to the bed beside the resident□s chair. Please note that the 4:00 p.m. - 12/8/16 interview with DON noted in the Observations, on the 2567 inaccurately indicates that the NA had placed the bag on the floor. What was actually reported was that the NA told the DON that the resident had placed the bag on the floor which was her habit.<br><br>To better enable the resident to hang the bag on her own, the DON immediately attached a large hook to the bedframe. The resident involved was educated as to the risks of putting the bag on the floor and she was also instructed how to use the hook and demonstrated the ability to use it. Facility staff members continue to investigate other methods that might better enable the resident to more easily store her catheter bag.<br><br>In order to ensure no other residents were affected in a similar manner, all residents with indwelling catheters were checked by Supervisory Nurses on the day of the survey, to ensure catheter bags were properly stored, and was found in compliance. There was only one other resident with an indwelling catheter. | |

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| F 315 | Continued From page 4<br>placed that way by the night shift."<br>Nurse #1 was interviewed on 12/08/16 at 2:00 PM explained the expectation of catheter care provided to include, the catheter bag should hang below the waist and not touch the floor.<br>DON was interviewed on 12/08/16 at 2:33 PM. The DON stated that her expectations were for the NAs to, empty the catheter and measure output, provide perineal care daily and as needed, report abnormal urine odors and/or color, to ensure a closed system with no leakage, to make sure the tubing was secured on the leg, and that the bag doesn't touch the floor. A second interview at 4:00 PM with the DON revealed the NA had told her he placed the catheter bag underneath the bed touching the floor. | F 315 | Additionally, nursing staff were re-educated on catheter care protocols during the 12/8/16 afternoon staff huddle. Nursing staff continued to be re-educated in shift staff huddles from 12/8/16-12/20/16. Further, Resident #84□s catheter bag placement has been monitored each shift by the nurse assigned to her. Ongoing monitoring now continues at least once per day. There have been no further instances noted of this catheter bag being stored improperly. However, if there are any further instances of improper storage of catheter bags , this will be will be corrected immediately, and the resident and staff members will be re-educated as indicated.<br><br>Additionally, the Infection Preventionist has been monitoring twice daily, on her scheduled work days, to ensure compliance. She will continue to spot monitor on her infection control rounds in the future. Any instances of non-compliance will be corrected immediately and reported to the DON and continued re-education will occur. This will be monitored for ninety (90) days by the DON and the Infection Preventionist to ensure compliance is achieved and randomly thereafter. The DON will additionally, report all findings to the QAPI Committee until the QAPI Committee has determined that ongoing, consistent compliance has been achieved. | |