STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675350	A. BUILDING _____ B. WING _____	**03/27/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE INN OF ABILENE	**4934 S 7TH ST ABILENE, TX 79604**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to implement policy and procedure that prohibits neglect for one of two sampled residents (Resident #3) reviewed for Foley catheter care. The facility failed to ensure Resident #3 did not suffer from a urinary tract infection that became septic on 3/19/13. - The facility failed to properly assess Resident #3 and when she was sent to the local emergency room via Emergency Medical Services (EMS), she was in septic shock. The facility only notified the physician that she had been vomiting twice the day before, and no one at the facility had assessed her Foley catheter or urine. An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Seventy-one residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated ,physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .[MEDICAL CONDITION] patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and [MEDICAL CONDITION] .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .[MEDICAL CONDITION] patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . Record review of the local EMS (emergency medical services) Run Sheet dated 3/19/13 beginning at 1418 (2:18 p.m.) and ending at the local emergency department at 1432 (2:42 p.m.), when arrived at the local emergency department, documented .staff states patient vomited twice previously .requesting transport for possible aspiration - patient has history of severe dementia .tachypnea (rapid breathing), [MEDICAL CONDITION](rapid heart rate) [MEDICAL CONDITION] (low blood pressure) and diaphoresis (sweating) .patient transferred to EMS cot via three person lift .IV attempt twice was unsuccessful .impression - septic shock . Review of the EMS Run Sheet dated 3/19/13 at 1418 (2:18 p.m.) the first set of vital signs were documented the blood pressure as 89/53, pulse 134, respirations 20. Observation on 3/21/13 at 9:00 a.m. at the local hospital Intensive Care Unit revealed Resident #3 had a large unstageable pressure sore on her right heel. In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) the day charge nurse for the west side. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. The Administrator, DON, RNC #1 was informed 3/22/13 at 10:45 a.m. that Immediate Jeopardy was declared. Review of the facility's Abatement Plan to Remove Immediate Jeopardy dated 3/22/13 revised 3/27/13 accepted at 11:00 a.m. documented .The Immediate Jeopardy was declared at 10:45 a.m. on 3/22/13. Immediate re-education was written and staff was called in for the education. Below is the content of the re-education being presented to the facility staff nurses by the Director of Nursing/Unit Managers. - Incontinent Care - Foley Catheter Care - Foley Catheter Assessments and Documentation of color/clarity/characteristics by licensed nurse Re-education was started immediately with current staff in the facility: (copies of education provided is attached). In-service has been provided for licensed nurses for re-education regarding importance of Foley catheter care, documenting after Certified Nursing assistants provides Foley catheter care, and nurse assessment of patency of catheter, color and clarity of urine every shift. As of 3/26/13 at 11:30 a.m. all certified nursing assistants have been re-educated on incontinent care, Foley catheter care and successfully performed incontinent care observed by the Director of Nursing and/or Assistant Directors of Nursing using the skills checklist for incontinent care (sample attached). The exception is three certified nursing assistants who are prn (as needed) and are not scheduled. These three identified certified nursing assistants will not be allowed to work until they have been re-educated and successfully completed incontinent care using the skills checklist for incontinent care. All licensed charge nurses have been re-educated on Foley catheters and incontinent care including documentation. The exception is one PRN (as needed) licensed nurses who is not scheduled to work and will not be allowed to work until the re-education is completed. System Changes: There are no residents with Foley catheters in the facility as of 3/25/13 at 7:00 p.m. Future orders for Foley catheters will read: Change indwelling Foley catheters as needed prn dysfunction. Certified Nursing Assistants are required to not only document urine output of resident ' s with Foley catheters in the Kiosk with the amount of urine in cc ' s (cubic centimeters) on their shift, but also report to the nurse if they notice any changes in urine color and if there is absence of urine output at any time during their shift. At that time, the charge nurse will assess the resident for change of condition, report to family and physician and carry out any new orders received. Director of Nursing/designee reviews a report from the Kiosk Monday through Friday and the weekend RN will run report to review output of residents with Foley catheter to review urine output documentation. Any missing documentation on urine output of resident ' s with Foley catheters has been addressed and a late entry made in the chart to reflect urine output for any missing documentation. A line has been added on the Nurses ' Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. As of 3/26/13 at 11:30 a.m. all current incontinent residents have been assessed for any signs and symptoms of urinary tract infection. One resident on the east side had no change in urine odor, vital signs stable, but complained of lower back pain. Physician notified of complaint and order received for lab urinalysis and culture and sensitivity. Family has been notified of complaint and new order. One resident on the west side had vital signs within normal limits, no complaints, but did have a change in urine odor. Physician has been notified of this change. Resident is aware of the call to the physician. These assessments and findings have been documented in the resident ' s medical record. Resident on east side with Foley catheter was assessed and a physician order [REDACTED]. Family notified. Catheter has been discontinued and resident is voiding without difficulty. Post void residual of 30 cc (cubic centimeters) was obtained via straight catheter per physician's order [REDACTED]. Certified nursing assistants are toileting the resident and she is voiding on the toilet. Certified nursing assistants are reporting results to nurse. This resident will be reassessed using the Bladder Assessment to determine continence and care plans will be developed based upon results. The Medical Director has been made aware of the alleged deficient practice and plans in place to correct. The Performance Improvement Committee will review the above actions taken by the facility to correct the alleged deficient practice. The Director of Nursing will report progress to the Performance Improvement Committee monthly for three months and then quarterly until compliance has been achieved. Any areas of concern will be addressed at the time of discovery for further interventions. On 3/27/13 at 11:00 a.m. the Immediate Jeopardy was lowered to a scope and severity of actual harm that is not Immediate Jeopardy level at a pattern. CMS Form 672 dated 3/21/13 documented four residents having an indwelling urinary catheter, upon observation, there was only one resident with an indwelling urinary catheter besides Resident #3.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to implement written policy and procedure that prohibits neglect for one of two sampled residents (Resident #3) reviewed for Foley catheter care. The facility failed to ensure Resident #3 did not suffer from a urinary tract infection that became septic on 3/19/13. - The facility failed to properly assess Resident #3 and when she was sent to the local emergency room via Emergency Medical Services (EMS), she was in septic shock. The facility only notified the physician that she had been vomiting twice the day before, and no one at the facility had assessed her Foley catheter or urine. Review of the facility's Policy and Procedure Detecting and Reporting Abuse undated documented .Neglect is defined as the refusal or failure to provide a person with the necessities of life including, but not limited to, food, shelter, clothing and the provision of medical care. An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. with the Administrator, DON and RNC #1 present. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Seventy-one residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated .physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement

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CARE INN OF ABILENE	4934 S 7TH ST ABILENE, TX 79604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .[MEDICAL CONDITION] patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and [MEDICAL CONDITION] .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .[MEDICAL CONDITION] patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . Record review of the local EMS (emergency medical services) Run Sheet dated 3/19/13 beginning at 1418 (2:18 p.m.) and ending at the local emergency department at 1432 (2:42 p.m.), when arrived at the local emergency department, documented .staff states patient vomited twice previously .requesting transport for possible aspiration - patient has history of severe dementia .tachypnea (rapid breathing), [MEDICAL CONDITION](rapid heart rate) [MEDICAL CONDITION] (low blood pressure) and diaphoresis (sweating) .patient transferred to EMS cot via three person lift .IV attempt twice was unsuccessful .impression - septic shock . Review of the EMS Run Sheet dated 3/19/13 at 1418 (2:18 p.m.) the first set of vital signs were documented the blood pressure as 89/53, pulse 134, respirations 20. Observation on 3/21/13 at 9:00 a.m. at the local hospital Intensive Care Unit revealed Resident #3 had a large unstageable pressure sore on her right heel. In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was the day charge nurse for the west side. Review of the facility ' s Infection Reports revealed two forms being used. One contained the questions Health Care Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) which had yes or no answers. The second Infection Report Form documented .Facility Acquired Infection developed after admission? and Community Acquired Evidence of Infection at time of admission? Both with yes or no answers. Seventeen Infection Reports of residents with UTI ' s were reviewed for whether they were marked to indicate if the UTI was an HAI or CAI. Nine of the reports had both questions marked No , seven had neither question answered, and one had HAI question left blank and answered No on the CAI question. In an interview on 3/26/13 at 10:50 a.m. with the DON, ADON #2 and RNC #1, RNC #1 stated that there were criteria for determining if a resident infection was a Healthcare Associated Infection (HAI) and ADON #2 pointed to the criteria listed on the HAI form. In an interview on 3/26/13 at 3:50 p.m. and 4:30 p.m. RNC #2 stated that on the Infection Report form the questions Healthcare Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) should be answered either yes or no. If the HAI question is answered yes , then the Healthcare Associated Infection Surveillance Report Form should be filled out. RNC #2 stated that the Infection Control Policy criteria was to determine if there was an infection and the HAI Surveillance Report Form criteria was to help determine if the infection was chronic or acute. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. The Administrator, DON, RNC #1 were informed 3/22/13 at 10:45 a.m. that Immediate Jeopardy was declared. Review of the facility's Abatement Plan to Remove Immediate Jeopardy dated 3/22/13 revised 3/27/13 accepted at 11:00 a.m. documented .The Immediate Jeopardy was declared at 10:45 a.m. on 3/22/13. Immediate re-education was written and staff was called in for the education. Below is the content of the re-education being presented to the facility staff nurses by the Director of Nursing/Unit Managers. - Incontinent Care - Foley Catheter Care - Foley Catheter Assessments and Documentation of color/clarity/characteristics by licensed nurse Re-education was started immediately with current staff in the facility: (copies of education provided is attached). In-service has been provided for licensed nurses for re-education regarding importance of Foley catheter care, documenting after Certified Nursing assistants provides Foley catheter care, and nurse assessment of patency of catheter, color and clarity of urine every shift. As of 3/26/13 at 11:30 a.m. all certified nursing assistants have been re-educated on incontinent care, Foley catheter care and successfully performed incontinent care observed by the Director of Nursing and/or Assistant Directors of Nursing using the skills checklist for incontinent care (sample attached). The exception is three certified nursing assistants who are prn (as needed) and are not scheduled. These three identified certified nursing assistants will not be allowed to work until they have been re-educated and successfully completed incontinent care using the skills checklist for incontinent care. All licensed charge nurses have been re-educated on Foley catheters and incontinent care including documentation. The exception is one PRN (as needed) licensed nurses who is not scheduled to work and will not be allowed to work until the re-education is completed. System Changes: There are no residents with Foley catheters in the facility as of 3/25/13 at 7:00 p.m. Future orders for Foley catheters will read: Change indwelling Foley catheters as needed prn dysfunction. Certified Nursing Assistants are required to not only document urine output of resident ' s with Foley catheters in the Kiosk with the amount of urine in cc ' s (cubic centimeters) on their shift, but also report to the nurse if they notice any changes in urine color and if there is absence of urine output at any time during their shift. At that time, the charge nurse will assess the resident for change of condition, report to family and physician and carry out any new orders received. Director of Nursing/designee reviews a report from the Kiosk Monday through Friday and the weekend RN will run report to review output of residents with Foley catheter to review urine output documentation. Any missing documentation on urine output of resident ' s with Foley catheters has been addressed and a late entry made in the chart to reflect urine output for any missing documentation. A line has been added on the Nurses ' Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. As of 3/26/13 at 11:30 a.m. all current incontinent residents have been assessed for any signs and symptoms of urinary tract infection. One resident on the east side had no change in urine odor, vital signs stable, but complained of lower back pain. Physician notified of complaint and order received for lab urinalysis and culture and sensitivity. Family has been notified of complaint and new order. One resident on the west side had vital signs within normal limits, no complaints, but did have a change in urine odor. Physician has been notified of this change. Resident is aware of the call to the physician. These assessments and findings have been documented in the resident ' s medical record. Resident on east side with Foley catheter was assessed and a physician order [REDACTED]. Family notified. Catheter has been discontinued and resident is voiding without difficulty. Post void residual of 30 cc (cubic centimeters) was obtained via straight catheter per physician's order [REDACTED]. Certified nursing assistants are toileting the resident and she is voiding on the toilet. Certified nursing assistants are reporting results to nurse. This resident will be reassessed using the Bladder Assessment to determine continence and care plans will be developed based upon results. The Medical Director has been made aware of the alleged deficient practice and plans in place to correct. The Performance Improvement Committee will review the above actions taken by the facility to correct the alleged deficient practice. The Director of Nursing will report progress to the Performance Improvement Committee monthly for three months and then quarterly until compliance has been achieved. Any areas of concern will be addressed at the time of discovery for further interventions. On 3/27/13 at 11:00 a.m. the Immediate Jeopardy was lowered to a scope and severity of actual harm that is not Immediate Jeopardy level at a pattern. CMS Form 672 dated 3/21/13 documented four residents having an indwelling urinary catheter, upon observation, there was only one resident with an indwelling urinary catheter besides Resident #3.
F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure services provided by the nursing facility meet professional standards of**

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) **quality** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to notify the legal representative regarding a significant change in the physical/clinical status for one of 17 residents (Resident #3) reviewed for care. http://www.hgexperts.com/article.asp?id=6237 from the Texas Board of Nursing documents .A standard of care holds a person of exceptional skill or knowledge to a duty of acting as would a reasonable and prudent person possessing the same or similar skills or knowledge under the same or similar circumstances. Standards of care may serve as guidelines when evaluating nursing care for possible negligence. They define acts that are permitted to be performed or prohibited from being performed. SOC ' s give direction to the nurse ? defining what should or should not be done for patients. An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Seventy-one residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated .physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .[MEDICAL CONDITION] patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and [MEDICAL CONDITION] .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .[MEDICAL CONDITION] patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . 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In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that

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	675350	A. BUILDING _____ B. WING _____	03/27/2013

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CARE INN OF ABILENE	4934 S 7TH ST ABILENE, TX 79604

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was the day charge nurse for the west side. Review of the facility ' s Infection Reports revealed two forms being used. One contained the questions Health Care Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) which had yes or no answers. The second Infection Report Form documented .Facility Acquired Infection developed after admission? and Community Acquired Evidence of Infection at time of admission? Both with yes or no answers. Seventeen Infection Reports of residents with UTI ' s were reviewed for whether they were marked to indicate if the UTI was an HAI or CAI. Nine of the reports had both questions marked No , seven had neither question answered, and one had HAI question left blank and answered No on the CAI question. In an interview on 3/26/13 at 10:50 a.m. with the DON, ADON #2 and RNC #1, RNC #1 stated that there were criteria for determining if a resident infection was a Healthcare Associated Infection (HAI) and ADON #2 pointed to the criteria listed on the HAI form. In an interview on 3/26/13 at 3:50 p.m. and 4:30 p.m. RNC #2 stated that on the Infection Report form the questions Healthcare Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) should be answered either yes or no. If the HAI question is answered yes , then the Healthcare Associated Infection Surveillance Report Form should be filled out. RNC #2 stated that the Infection Control Policy criteria was to determine if there was an infection and the HAI Surveillance Report Form criteria was to help determine if the infection was chronic or acute. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. Review of Resident #1 ' s clinical record Admission Record

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Observation on 3/22/12 at 9:15 a.m. CNA #7 providing incontinent care to Resident #1 revealed CNA #7 rubbing back and forth with the same piece of cloth on the urinary catheter. CNA #7 then cleaned stool from an incontinent episode of bowel movement from the bottom up, spreading stool to vaginal/peri area. Observation on 3/21/13 at 3:40 p.m. revealed that Resident #1 ' s urinary catheter tubing contained dark amber urine with sediment in the tubing. ADON #2 stated that she thought the urine was yellow, but when questioned, she stated that she would call the urine amber. ADON #2 stated that with the sediment in the tubing and the color of the urine, she thought that Resident #1 might have a urinary tract infection. Review of Resident #1 ' s clinical record Diagnostics dated 3/19/13 documented Resident #1 ' s urine contained the bacterium Escherichia coli (which is intestinal bacteria). Review of Resident #2 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]., hypertension and [MEDICAL CONDITION]. Review of Resident #2 ' s clinical record Diagnostics dated 1/23/13 document her urine contained Escherichia coli, [MEDICATION NAME] cloacae, and proteus mirabilis which is commonly found in the intestines or fecal material. Review of Resident #7 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #7 ' s clinical record Diagnostics dated 2/7/13 documented her urinalysis and culture and sensitivity contained Escherichia Coli which is intestinal bacteria. Review of Resident #8 ' s admission record undated documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #8 ' s clinical record Diagnostics dated 1/12/13 documented her urinalysis and culture and sensitivity contained Proteus mirabilis which is intestinal bacteria. Review of Resident #9 ' s admission record revealed she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #9 ' s clinical record Diagnostics dated 2/5/13 documented her urinalysis and culture and sensitivity contained [MEDICATION NAME] Faecalis which is intestinal bacteria. Review of Resident #11 ' s admission record revealed he was an [AGE] year old male who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #11 ' s clinical record Nurse ' s Notes documented he was admitted to the facility on [DATE] with an indwelling urinary catheter. On the date of admission (3/14/13) at 6:40 p.m. he pulled the catheter out and it was re-inserted by nursing staff. Review of Resident #11 ' s clinical record Admission Order revealed no evidence of documentation for an indwelling urinary catheter. Review of Resident #11 ' s clinical record Physician order [REDACTED]. Review of Resident #12 ' s clinical record Resident Admission Record undated documented that she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #12 ' s clinical record Nurse ' s Notes dated 3/11/13 at 0840 (8:40 a.m.) documented .hospice notified the time of resident pulling out Foley catheter on previous shift, awaiting new orders(to be) called back from hospice . There was no evidence of documentation that hospice had called back or from the physician regarding to discontinue the Foley catheter. Review of Resident #12 ' s clinical record Re-admission orders [REDACTED]. Review of Resident #12 ' s clinical record Physician order [REDACTED]. Observation on 3/22/13 at 9:50 a.m. revealed that Resident #12 did not have an indwelling urinary catheter in place. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that she had been told there was an order to discontinue Resident #12 ' s indwelling urinary catheter, but that she had not been able to find one in the clinical record. In an interview on 3/22/13 at 10:55 a.m. ADON #1 stated that she thought an order had been faxed to discontinue the indwelling urinary catheter, but that she didn ' t know what happened there. Review of Resident #12 ' s clinical record Diagnostics dated 1/4/13 documented Resident #12 ' s urinalysis, culture and sensitivity documented she had Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca in her urine. Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca are commonly found in fecal material (stool). Review of Resident #17 ' s admission record documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #17 ' s clinical record Diagnostics dated 2/3/13 documented her urine contained Proteus mirabilis which is commonly found in fecal material (stool). The Administrator, DON, RNC #1 was informed 3/22/13 at 10:45 a.m. that Immediate Jeopardy was declared. Review of the facility's Abatement Plan to Remove Immediate Jeopardy dated 3/22/13 revised 3/27/13 accepted at 11:00 a.m. documented .The Immediate Jeopardy was declared at 10:45 a.m. on 3/22/13. Immediate re-education was written and staff was called in for the education. Below is the content of the re-education being presented to the facility staff nurses by the Director of Nursing/Unit Managers. - Incontinent Care - Foley Catheter Care - Foley Catheter Assessments and Documentation of color/clarity/characteristics by licensed nurse Re-education was started immediately with current staff in the facility: (copies of education provided is attached). In-service has been provided for licensed nurses for re-education regarding importance of Foley catheter care, documenting after Certified Nursing assistants provides Foley catheter care, and nurse assessment of patency of catheter, color and clarity of urine every shift. As of 3/26/13 at 11:30 a.m. all certified nursing assistants have been re-educated on incontinent care, Foley catheter care and successfully performed incontinent care observed by the Director of Nursing and/or Assistant Directors of Nursing using the skills checklist for incontinent care (sample attached). The exception is three certified nursing assistants who are prn (as needed) and are not scheduled. These three identified certified nursing assistants will not be allowed to work until they have been re-educated and successfully completed incontinent care using the skills checklist for incontinent care. All licensed charge nurses have been re-educated on Foley catheters and incontinent care including documentation. The exception is one PRN (as needed) licensed nurses who is not scheduled to work and will not be allowed to work until the re-education is completed. System Changes: There are no residents with Foley catheters in the facility as of 3/25/13 at 7:00 p.m. Future orders for Foley catheters will read: Change indwelling Foley catheters as needed prn dysfunction. Certified Nursing Assistants are required to not only documen
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to 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 for eight of 17 residents (Resident #1, #2, #3, #7,#8, #9, #11 and #12). Forty-five facility identified incontinent residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Seventy-one residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated .physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .[MEDICAL CONDITION] patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and [MEDICAL CONDITION] .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .[MEDICAL CONDITION] patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . Record review of the local EMS (emergency medical services) Run Sheet dated 3/19/13 beginning at 1418 (2:18 p.m.) and ending at the local emergency department at 1432 (2:42 p.m.), when arrived at the local emergency department, documented .staff states patient vomited twice previously .requesting transport for possible aspiration - patient has history of severe dementia .tachypnea (rapid breathing), [MEDICAL CONDITION](rapid heart rate) [MEDICAL CONDITION] (low blood pressure) and diaphoresis (sweating) .patient transferred to EMS cot via three person lift .IV attempt twice was unsuccessful .impression - septic shock . Review of the EMS Run Sheet dated 3/19/13 at 1418 (2:18 p.m.) the first set of vital signs were documented the blood pressure as 89/53, pulse 134, respirations 20. Observation on 3/21/13 at 9:00 a.m. at the local hospital Intensive Care Unit revealed Resident #3 had a large unstageable pressure sore on her right heel. In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was the day charge nurse for the west side. Review of the facility ' s Infection Reports revealed two forms being used. One contained the questions Health Care Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) which had yes or no answers. The second Infection Report Form documented .Facility Acquired Infection developed after admission? and Community Acquired Evidence of Infection at time of admission? Both with yes or no answers. Seventeen Infection Reports of residents with UTI ' s were reviewed for whether they were marked to indicate if the UTI was an HAI or CAI. Nine of the reports had both questions marked No , seven had neither question answered, and one had HAI question left blank and answered No on the CAI question. In an interview on 3/26/13 at 10:50 a.m. with the DON, ADON #2 and RNC #1, RNC #1 stated that there were criteria for determining if a resident infection was a Healthcare Associated Infection (HAI) and ADON #2 pointed to the criteria listed on the HAI form. In an interview on 3/26/13 at 3:50 p.m. and 4:30 p.m. RNC #2 stated that on the Infection Report form the questions Healthcare Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) should be answered either yes or no. If the HAI question is answered yes , then the Healthcare Associated Infection Surveillance Report Form should be filled out. RNC #2 stated that the Infection Control Policy criteria was to determine if there was an infection and the HAI Surveillance Report Form criteria was to help determine if the infection was chronic or acute. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. Review of Resident #1 ' s clinical record Admission Record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Observation on 3/22/12 at 9:15 a.m. CNA #7 providing incontinent care to Resident #1 revealed CNA #7 rubbing back and forth with the same piece of cloth on the urinary catheter. CNA #7 then cleaned stool from an incontinent episode of bowel movement from the bottom up, spreading stool to vaginal/peri area. Observation on 3/21/13 at 3:40 p.m. revealed that Resident #1 ' s urinary catheter tubing contained dark amber urine with sediment in the tubing. ADON #2 stated that she thought the urine was yellow, but when questioned, she stated that she would call the urine amber. ADON #2 stated that with the sediment in the tubing and the color of the urine, she thought that Resident #1 might have a urinary tract infection. Review of Resident #1 ' s clinical record Diagnostics dated 3/19/13 documented Resident #1 ' s urine contained the bacterium Escherichia coli (which is intestinal bacteria). Review of Resident #2 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]., hypertension and [MEDICAL CONDITION]. Review of Resident #2 ' s clinical record Diagnostics dated 1/23/13 document her urine contained Escherichia coli, [MEDICATION NAME] cloacae, and proteus mirabilis which is commonly found in the intestines or fecal material. Review of Resident #7 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #7 ' s clinical record Diagnostics dated 2/7/13 documented her urinalysis and culture and sensitivity contained Escherichia Coli which is intestinal bacteria. Review of Resident #8 ' s admission record undated documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #8 ' s clinical record Diagnostics dated 1/12/13 documented her urinalysis and culture and sensitivity contained Proteus mirabilis which is intestinal bacteria. Review of Resident #9 ' s admission record revealed she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #9 ' s clinical record Diagnostics dated 2/5/13 documented her urinalysis and culture and sensitivity contained [MEDICATION NAME] Faecalis which is intestinal bacteria. Review of Resident #11 ' s admission record revealed he was an [AGE] year old male who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #11 ' s clinical record Nurse ' s Notes documented he was admitted to the facility on [DATE] with an indwelling urinary catheter. On the date of admission (3/14/13) at 6:40 p.m. he pulled the catheter out and it was re-inserted by nursing staff. Review of Resident #11 ' s clinical record Admission Order revealed no evidence of documentation for an indwelling urinary catheter. Review of Resident #11 ' s clinical record Physician order [REDACTED]. Review of Resident #12 ' s clinical record Resident Admission Record undated documented that she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #12 ' s clinical record Nurse ' s Notes dated 3/11/13 at 0840 (8:40 a.m.) documented .hospice notified the time of resident pulling out Foley catheter on previous shift, awaiting new orders(to be) called back from hospice . There was no evidence of documentation that hospice had called back or from the physician regarding to discontinue the Foley catheter. Review of Resident #12 ' s clinical record Re-admission orders [REDACTED]. Review of Resident #12 ' s clinical record Physician order [REDACTED]. Observation on 3/22/13 at 9:50 a.m. revealed that Resident #12 did not have an indwelling urinary catheter in place. In an interview on 3/22/13 at 10:42 a.m.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) ADON #2 stated that she had been told there was an order to discontinue Resident #12 ' s indwelling urinary catheter, but that she had not been able to find one in the clinical record. In an interview on 3/22/13 at 10:55 a.m. ADON #1 stated that she thought an order had been faxed to discontinue the indwelling urinary catheter, but that she didn ' t know what happened there. Review of Resident #12 ' s clinical record Diagnostics dated 1/4/13 documented Resident #12 ' s urinalysis, culture and sensitivity documented she had Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca in her urine. Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca are commonly found in fecal material (stool). Review of Resident #17 ' s admission record documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #17 ' s clinical record Diagnostics dated 2/3/13 documented her urine contained Proteus mirabilis which is commonly found in fecal material (stool). The Administrator, DON, RNC #1 was informed 3/22/13 at 10:45 a.m. that Immediate Jeopardy was declared. Review of the facility's Abatement Plan to Remove Immediate Jeopardy dated 3/22/13 revised 3/27/13 accepted at 11:00 a.m. documented .The Immediate Jeopardy was declared at 10:45 a.m. on 3/22/13. Immediate re-education was written and staff was called in for the education. Below is the content of the re-education being presented to the facility staff nurses by the Director of Nursing/Unit Managers. - Incontinent Care - Foley Catheter Care - Foley Catheter Assessments and Documentation of color/clarity/characteristics by licensed nurse Re-education was started immediately with current staff in the facility: (copies of education provided is attached). In-service has been provided for licensed nurses for re-education regarding importance of Foley catheter care, documenting after Certified Nursing assistants provides Foley catheter care, and nurse assessment of patency of catheter, color and clarity of urine every shift. As of 3/26/13 at 11:30 a.m. all certified nursing assistants have been re-educated on incontinent care, Foley catheter care and successfully performed incontinent care observed by the Director of Nursing and/or Assistant Directors of Nursing using the skills checklist for incontinent care (sample attached). The exception is three certified nursing assistants who are prn (as needed) and are not scheduled. These three identified certified nursing assistants will not be allowed to work until they have been re-educated and successfully completed incontinent care using the skills checklist for incontinent care. All licensed charge nurses have been re-educated on Foley catheters and incontinent care including documentation. The exception is one PRN (as needed) licensed nurses who is not scheduled to work and will not be allowed to work until the re-education is completed. System Changes: There are no residents with Foley catheters in the facility as of 3/25/13 at 7:00 p.m. Future orders for Foley catheters will read: Change indwelling Foley catheters as needed prn dysfunction. Certified Nursing Assistants are required to not only document urine output of resident ' s with Foley catheters in the Kiosk with the amount of urine in cc ' s (cubic centimeters) on their shift, but also report to the nurse if they notice any changes in urine color and if there is absence of urine output at any time during their shift. At that time, the charge nurse will assess the resid
F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure one of two residents (Resident #3) clinical condition demonstrated that urinary catherization was medically necessary. Resident #3 did not have a clinical [DIAGNOSES REDACTED]. This failure could contribute to loss of bladder control and urinary tract infections for Resident #3 and could likely affect 45 other residents identified by the facility as being frequently or occasionally incontinent of urine. An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. with the Administrator, DON and RNC #1 present. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Seventy-one residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated .physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .[MEDICAL CONDITION] patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and [MEDICAL CONDITION] .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .[MEDICAL CONDITION] patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . Record review of the local EMS (emergency medical services) Run Sheet dated 3/19/13 beginning at 1418 (2:18 p.m.) and ending at the local emergency department at 1432 (2:42 p.m.), when arrived at the local emergency department, documented .staff states patient vomited twice previously .requesting transport for possible aspiration - patient has history of severe dementia .tachypnea (rapid breathing), [MEDICAL CONDITION](rapid heart rate) [MEDICAL CONDITION] (low blood pressure) and diaphoresis (sweating) .patient transferred to EMS cot via three person lift .IV attempt twice was unsuccessful .impression - septic shock . Review of the EMS Run Sheet dated 3/19/13 at 1418 (2:18 p.m.)

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) the first set of vital signs were documented the blood pressure as 89/53, pulse 134, respirations 20. Observation on 3/21/13 at 9:00 a.m. at the local hospital Intensive Care Unit revealed Resident #3 had a large unstageable pressure sore on her right heel. In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell

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	675350	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE INN OF ABILENE	4934 S 7TH ST ABILENE, TX 79604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. Review of the facility's Policy and Procedure for when to change an indwelling urinary catheter was a handout printed off of the internet from HICPAC (Healthcare Infeciton Control Practices Advisory Committe) - Guideline for Prevention of Catheter-Associated Urinary Tract Infections dated 2009 documented .changing an indwelling catheters or drainage bags at routine, fixed intervals is not recomended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.Category II. Review of Category II documented .a weak recommendation supported by any quality evidence suggesting a tradeoff between clinical benefits and harms. This document wsa given as the facility policy and procedure for indwelling urinary catheter changes by RNC #1. RNC #1 stated that the corporation adopted this as their policy and procedure in August 2012 and the facilities had put this suggestion into place at that time. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was the day charge nurse for the west side. Review of the facility ' s Infection Reports revealed two forms being used. One contained the questions Health Care Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) which had yes or no answers. The second Infection Report Form documented .Facility Acquired Infection developed after admission? and Community Acquired Evidence of Infection at time of admission? Both with yes or no answers. Seventeen Infection Reports of residents with UTI ' s were reviewed for whether they were marked to indicate if the UTI was an HAI or CAI. Nine of the reports had both questions marked No , seven had neither question answered, and one had HAI question left blank and answered No on the CAI question. In an interview on 3/26/13 at 10:50 a.m. with the DON, ADON #2 and RNC #1, RNC #1 stated that there were criteria for determining if a resident infection was a Healthcare Associated Infection (HAI) and ADON #2 pointed to the criteria listed on the HAI form. In an interview on 3/26/13 at 3:50 p.m. and 4:30 p.m. RNC #2 stated that on the Infection Report form the questions Healthcare Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) should be answered either yes or no. If the HAI question is answered yes , then the Healthcare Associated Infection Surveillance Report Form should be filled out. RNC #2 stated that the Infection Control Policy criteria was to determine if there was an infection and the HAI Surveillance Report Form criteria was to help determine if the infection was chronic or acute. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. Review of Resident #1 ' s clinical record Admission Record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Observation on 3/22/12 at 9:15 a.m. CNA #7 providing incontinent care to Resident #1 revealed CNA #7 rubbing back and forth with the same piece of cloth on the urinary catheter. CNA #7 then cleaned stool from an incontinent episode of bowel movement from the bottom up, spreading stool to vaginal/peri area. Observation on 3/21/13 at 3:40 p.m. revealed that Resident #1 ' s urinary catheter tubing contained dark amber urine with sediment in the tubing. ADON #2 stated that she thought the urine was yellow, but when questioned, she stated that she would call the urine amber. ADON #2 stated that with the sediment in the tubing and the color of the urine, she thought that Resident #1 might have a urinary tract infection. Review of Resident #1 ' s clinical record Diagnostics dated 3/19/13 documented Resident #1 ' s urine contained the bacterium Escherichia coli (which is intestinal bacteria). Review of Resident #2 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]., hypertension and [MEDICAL CONDITION]. Review of Resident #2 ' s clinical record Diagnostics dated 1/23/13 document her urine contained Escherichia coli, [MEDICATION NAME] cloacae, and proteus mirabilis which is commonly found in the intestines or fecal material. Review of Resident #7 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #7 ' s clinical record Diagnostics dated 2/7/13 documented her urinalysis and culture and sensitivity contained Escherichia Coli which is intestinal bacteria. Review of Resident #8 ' s admission record undated documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #8 ' s clinical record Diagnostics dated 1/12/13 documented her urinalysis and culture and sensitivity contained Proteus mirabilis which is intestinal bacteria. Review of Resident #9 ' s admission record revealed she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #9 ' s clinical record Diagnostics dated 2/5/13 documented her urinalysis and culture and sensitivity contained [MEDICATION NAME] Faecalis which is intestinal bacteria. Review of Resident #11 ' s admission record revealed he was an [AGE] year old male who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #11 ' s clinical record Nurse ' s Notes documented he was admitted to the facility on [DATE] with an indwelling urinary catheter. On the date of admission (3/14/13) at 6:40 p.m. he pulled the catheter out and it was re-inserted by nursing staff. Review of Resident #11 ' s clinical record Admission Order revealed no evidence of documentation for an indwelling urinary catheter. Review of Resident #11 ' s clinical record Physician order [REDACTED]. Review of Resident #12 ' s clinical record Resident Admission Record undated documented that she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #12 ' s clinical record Nurse ' s Notes dated 3/11/13 at 0840 (8:40 a.m.) documented .hospice notified the time of resident pulling out Foley catheter on previous shift, awaiting new orders(to be) called back from hospice . There was no evidence of documentation that hospice had called back or from the physician regarding to discontinue the Foley catheter. Review of Resident #12 ' s clinical record Re-admission orders [REDACTED]. Review of Resident #12 ' s clinical record Physician order [REDACTED]. Observation on 3/22/13 at 9:50 a.m. revealed that Resident #12 did not have an indwelling urinary catheter in place. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that she had been told there was an order to discontinue Resident #12 ' s indwelling urinary catheter, but that she had not been able to find one in the clinical record. In an interview on 3/22/13 at 10:55 a.m. ADON #1 stated that she thought an order had been faxed to discontinue the indwelling urinary catheter, but that she didn ' t know what happened there. Review of Resident #12 ' s clinical record Diagnostics dated 1/4/13 documented Resident #12 ' s urinalysis, culture and sensitivity documented she had Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca in her urine. Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca are commonly found in fecal material (stool). Review of Resident #17 ' s admission record documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #17 ' s clinical record Diagnostics dated 2/3/13 documented her urine contained Proteus mirabilis which is commonly found in fecal material (stool). The Administrator, DON, RNC #1 was informed 3/22/13 at 10:45 a.m. that Immediate Jeopardy was declared. Review of the facility's Abatement Plan to Remove Immediate Jeopardy dated 3/22/13 revised 3/27/13 accepted at 11:00 a.m. documented .The Immediate Jeopardy was declared at 10:45 a.m. on 3/22/13. Immediate re-education was written and staff was called in for the education. Below is the content of the re-education being presented to the facility staff nurses by the Director of Nursing/Unit Managers. - Incontinent Care - Foley Catheter Care - Foley Catheter Assessments and Documentation of color/clarity/characteristics by licensed nurse Re-education was started immediately with current staff in the facility: (copies of education provided is attached). In-service has been provided for licensed nurses for re-education regarding importance of Foley catheter care, documenting after Certified Nursing assistants provides Foley catheter care, and nurse assessment of patency of catheter, color and clarity of urine every shift. As of 3/26/13 at 11:30 a.m. all certified nursing assistants have been re-educated on incontinent care, Foley catheter care and successfully performed incontinent care observed by the Director of Nursing and/or Assistant Directors of Nursing using the skills checklist for incontinent care (sample attached). The exception is three certified nursing assistants who are prn

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13)

F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and maintain an infection control program designed to prevent the transmission of infection. The facility failed to ensure: - Eight identified urinary tract infections in January, 2013 - Nine identified urinary tract infections in February, 2013 - Two identified urinary tract infections in March, 2013 This deficient practice could affect 45 residents, identified by the facility as being incontinent of urine placed at increased risk for infection, increase risk of unnecessary antibiotic use, and decreased quality of life. The findings included: An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. with the Administrator, DON and RNC #1 present. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Forty-five facility identified incontinent residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of the facility's Policy and Procedure Infection Preventionand Control dated 9/2011 documented .The Infection Prevention and Control/Epidemiology Program is a facility policy and Procedure.Infection Prevention and Control Programs are an integral part of the Facility's philosophy and procedures related to patient/resident care.Facility recognizes that quality Infection Prevention and Control Programs administrered by a qualified Infection Preventionist will lead to better patient/resident care, reduce healthcare acquired illness and result in resource conservation.A quality infection prevention and control program will provide direction regarding outcome monitoring, patient/resident welfare, and employee based monitoring and care, and a general overall concern for the facility community. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. In an interview on 3/21/13 at 11:30 a.m. ADON #2 stated that .evidently I really know my residents . When asked to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. There was no evidence of documentation of an order to take or leave the catheter out. Based on observation, interview and record review the facility failed to 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 for eight of 17 residents (Resident #1, #2, #3, #7,#8, #9, #11 and #12). Forty-five facility identified incontinent residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Seventy-one residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated .physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .colostomy patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and tachycardiac .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .colostomy patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . Record review of the local EMS (emergency medical services) Run Sheet dated 3/19/13 beginning at 1418 (2:18 p.m.) and ending at the local emergency department at 1432 (2:42 p.m.), when arrived at the local emergency department, documented .staff states patient vomited twice previously .requesting transport for possible aspiration - patient has history of severe dementia .tachypnea (rapid breathing), tachycardia (rapid heart rate) hypotension (low blood pressure) and diaphoresis (sweating) .patient transferred to EMS cot via three person lift .IV attempt twice was unsuccessful .impression - septic shock . Review of the EMS Run Sheet dated 3/19/13 at 1418 (2:18 p.m.) the first set of vital signs were documented the blood pressure as 89/53, pulse 134, respirations 20. Observation on 3/21/13 at 9:00 a.m. at the local hospital Intensive Care Unit revealed Resident #3 had a large unstageable pressure sore on her right heel. In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing

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	675350	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE INN OF ABILENE	4934 S 7TH ST ABILENE, TX 79604

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out . There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it .

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F 0441 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 15) She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was the day charge nurse for the west side. Review of the facility ' s Infection Reports revealed two forms being used. One contained the questions Health Care Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) which had yes or no answers. The second Infection Report Form documented .Facility Acquired Infection developed after admission? and Community Acquired Evidence of Infection at time of admission? Both with yes or no answers. Seventeen Infection Reports of residents with UTI ' s were reviewed for whether they were marked to indicate if the UTI was an HAI or CAI. Nine of the reports had both questions marked No , seven had neither question answered, and one had HAI question left blank and answered No on the CAI question. In an interview on 3/26/13 at 10:50 a.m. with the DON, ADON #2 and RNC #1, RNC #1 stated that there were criteria for determining if a resident infection was a Healthcare Associated Infection (HAI) and ADON #2 pointed to the criteria listed on the HAI form. In an interview on 3/26/13 at 3:50 p.m. and 4:30 p.m. RNC #2 stated that on the Infection Report form the questions Healthcare Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) should be answered either yes or no. If the HAI question is answered yes , then the Healthcare Associated Infection Surveillance Report Form should be filled out. RNC #2 stated that the Infection Control Policy criteria was to determine if there was an infection and the HAI Surveillance Report Form criteria was to help determine if the infection was chronic or acute. Review of the facility's Policy and Procedure for when to change an indwelling urinary catheter was a handout printed off of the internet from HICPAC (Healthcare Infeciton Control Practices Advisory Committe) - Guideline for Prevention of Catheter-Associated Urinary Tract Infections dated 2009 documented .changing an indwelling catheters or drainage bags at routine, fixed intervals is not recomended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised.Category II. Review of Category II documented .a weak recommendation supported by any quality evidence suggesting a tradeoff between clinical benefits and harms. This document wsa given as the facility policy and procedure for indwelling urinary catheter changes by RNC #1. RNC #1 stated that the corporation adopted this as their policy and procedure in August 2012 and the facilities had put this suggestion into place at that time. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. Review of Resident #1 ' s clinical record Admission Record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Observation on 3/22/12 at 9:15 a.m. CNA #7 providing incontinent care to Resident #1 revealed CNA #7 rubbing back and forth with the same piece of cloth on the urinary catheter. CNA #7 then cleaned stool from an incontinent episode of bowel movement from the bottom up, spreading stool to vaginal/peri area. Observation on 3/21/13 at 3:40 p.m. revealed that Resident #1 ' s urinary catheter tubing contained dark amber urine with sediment in the tubing. ADON #2 stated that she thought the urine was yellow, but when questioned, she stated that she would call the urine amber. ADON #2 stated that with the sediment in the tubing and the color of the urine, she thought that Resident #1 might have a urinary tract infection. Review of Resident #1 ' s clinical record Diagnostics dated 3/19/13 documented Resident #1 ' s urine contained the bacterium Escherichia coli (which is intestinal bacteria). Review of Resident #2 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]., hypertension and osteoarthrosis. Review of Resident #2 ' s clinical record Diagnostics dated 1/23/13 document her urine contained Escherichia coli, [MEDICATION NAME] cloacae, and proteus mirabilis which is commonly found in the intestines or fecal material. Review of Resident #7 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #7 ' s clinical record Diagnostics dated 2/7/13 documented her urinalysis and culture and sensitivity contained Escherichia Coli which is intestinal bacteria. Review of Resident #8 ' s admission record undated documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #8 ' s clinical record Diagnostics dated 1/12/13 documented her urinalysis and culture and sensitivity contained Proteus mirabilis which is intestinal bacteria. Review of Resident #9 ' s admission record revealed she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #9 ' s clinical record Diagnostics dated 2/5/13 documented her urinalysis and culture and sensitivity contained [MEDICATION NAME] Faecalis which is intestinal bacteria. Review of Resident #11 ' s admission record revealed he was an [AGE] year old male who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #11 ' s clinical record Nurse ' s Notes documented he was admitted to the facility on [DATE] with an indwelling urinary catheter. On the date of admission (3/14/13) at 6:40 p.m. he pulled the catheter out and it was re-inserted by nursing staff. Review of Resident #11 ' s clinical record Admission Order revealed no evidence of documentation for an indwelling urinary catheter. Review of Resident #11 ' s clinical record Physician order [REDACTED]. Review of Resident #12 ' s clinical record Resident Admission Record undated documented that she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #12 ' s clinical record Nurse ' s Notes dated 3/11/13 at 0840 (8:40 a.m.) documented .hospice notified the time of resident pulling out Foley catheter on previous shift, awaiting new orders(to be) calle
F 0498 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that nurse aides show they have the skills and techniques to be able to care for residents' needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three of four Certified Nurse Aides (CNA's) were able to demonstrate competency in skills and techniques necessary to care for resident's needs for two of two resident's (Residents #12 and #16) reviewed for incontinent care. The facility failed to ensure: a. CNA's were able to demonstrate quality and safe incontinent care to residents who require incontinent care services b. Provide recent in-services for providing quality and safe incontinent care This deficient practice could affect any of the 45 residents who were frequently incontinent of bladder and/or the 34 residents who were frequently incontinent of bowel resulting in cross contamination and risk for bacteria into the urinary tract causing infection. The findings included: An Immediate Jeopardy was identified on 3/22/13 at 10:45 a.m. While the Immediate Jeopardy was removed 3/27/13 at 11:00 a.m. the facility remained out of compliance at a scope of pattern and a severity level of actual harm because the facility had not had time to evaluate its own action plan for effectiveness. Forty-five incontinent residents could be placed at risk for an untreated life threatening medical event if the deficient practice continued. Findings included: In an interview on 3/25/13 at 10:20 a.m. ADON #2 stated that the nurse who had been doing infection control left in January 2013 and that she (ADON #2) had been trying to keep up with it . She said she was not aware that Proteus Mirabalis was a fecal bacterium. She was not aware of any recent in-services on incontinent care. Review of Resident #3 ' s clinical record Resident Admission Record documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/29/11 documented she was admitted to the facility with an indwelling Foley catheter with a wound vac to her coccyx. Review of Resident #3 ' s clinical record Nurse ' s Notes dated 6/8/12 documented her Stage IV pressure ulcer to her coccyx had closed. Review of Resident #3 ' s clinical record there was no evidence of documentation of any calls to her physician or attempts to remove the Foley catheter since wound healing. Review of Resident #3 ' s clinical record Minimum Data Set (MDS) dated 2/17/13 documented under Speech Clarity Resident #3 was documented as having no speech - absence of spontaneous speech. Under Cognitive Skills for Daily Decision Making, it was documented as severely impaired - never/rarely made decisions. Under Functional Status, Bed Mobility, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Transfer, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Locomotion on Unit, Dressing, Toilet Use, Personal Hygiene, Resident #3 was documented as total dependence - full staff performance every time during entire 7 day period. Under Bladder and Bowel, Resident #3 was documented as having an indwelling Foley catheter for urine elimination and Ostomy for bowel movements. Review of Resident #3 ' s clinical record Care Plan dated 2/28/13 documented under Problem documented .I have a potential for compromised

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F 0498 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 16) psychosocial well-being due to being a bed bound resident in the facility I reside in . Problem documented .Due to my health status I stay in my room. I like to listen to music or the TV. I need assistance turning the TV on, or on the radio, occasionally I attend to special events, and also I enjoy my family visits . Problem documented .I am bedfast and my cognitive status/decision making skills are impaired .I require extensive to total assistance with ADL ' s (Activities of Daily Living) .Under Goal documented .I will have my needs anticipated and met by staff for 90 days . Review of Resident #3 ' s clinical record Physician ' s Progress Notes dated 3/19/13 untimed, documented .staff reported patient vomited twice over night .up in wheelchair .alert, no fever, no acute distress, will watch .[MEDICATION NAME] (anti-emetic used for nausea/vomiting) prn (as needed) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/18/13 at 2310 (11:10 p.m.) documented by LVN #7 .resident vomited times one, [MEDICATION NAME] as needed 25 mg po (by mouth) given .HOB (head of bed) elevated .physician notified . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0300 (3:00 a.m.) documented by LVN #7 .feeding resident, vomited again and physician ' s office notified .order hold feeding and give [MEDICATION NAME] 25 mg po (per oral or by mouth) . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 0800 (8:00 a.m.) documented by LVN #2 .resident resting in bed with eyes closed .respirations regular and non-labored, lung sounds clear to auscultation in front and back .abdomen soft and non-distended .bowel sounds in four quadrants .[DEVICE] (an artificial opening on the abdomen that enters the stomach for the purpose of liquid feeding formula) patent and intact .no signs/symptoms of aspiration noted .Placement checked, no residual noted .breakfast feedings held due to patient ate 50% of meal .family called and notified about resident vomiting last night . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 10:00 a.m. documented by LVN #2 .resident resting in bed with eyes open, respirations regular and non-labored, lung sounds clear to auscultation in front and back .[DEVICE] patent and intact .Foley catheter patent and draining clear yellow urine .[MEDICAL CONDITION] patent with soft stool in bag .HOB elevated .no distress noted at this time . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 12:35 p.m. documented by LVN #2 .physician here to assess resident .see progress notes . Review of Resident #3 ' s clinical record Nurse ' s Notes dated 3/19/13 at 1340 (1:40 p.m.) documented by LVN #2 .resident resting in bed with eyes closed .HOB elevated .Vital Signs (VS) blood pressure 118/54, heart rate 135, respirations 36, temperature 96.5, oxygen saturation 96%.accu-check (a finger stick used to collect blood to measure blood glucose (sugar) levels) 235 .responding slightly to verbal stimuli .diaphoretic and [MEDICAL CONDITION] .lung sounds clear to auscultation, no nausea/vomiting noted .Foley catheter patent draining clear yellow urine, [DEVICE] patent .[MEDICAL CONDITION] patent with soft stool present .send resident to emergency department for evaluation and treatment .physician and family notified . Record review of the local EMS (emergency medical services) Run Sheet dated 3/19/13 beginning at 1418 (2:18 p.m.) and ending at the local emergency department at 1432 (2:42 p.m.), when arrived at the local emergency department, documented .staff states patient vomited twice previously .requesting transport for possible aspiration - patient has history of severe dementia .tachypnea (rapid breathing), [MEDICAL CONDITION](rapid heart rate) [MEDICAL CONDITION] (low blood pressure) and diaphoresis (sweating) .patient transferred to EMS cot via three person lift .IV attempt twice was unsuccessful .impression - septic shock . Review of the EMS Run Sheet dated 3/19/13 at 1418 (2:18 p.m.) the first set of vital signs were documented the blood pressure as 89/53, pulse 134, respirations 20. Observation on 3/21/13 at 9:00 a.m. at the local hospital Intensive Care Unit revealed Resident #3 had a large unstageable pressure sore on her right heel. In an interview on 3/22/13 at 1:10 p.m. the Emergency Department Registered Nurse that received Resident #3 into the emergency department stated that when she received Resident #3 from the emergency medical services, Resident #3 was not alert, her rectal temperature was elevated and her Foley catheter was draining thick gray pus. She stated that Resident #3 was in a very bad state, diaphoretic (soaked in sweat) and had a general bad odor about her. She stated that Resident #3 was very dirty when she arrived to the emergency room . In an interview on 3/21/13 at 8:15 a.m. Intensive Care Unit (ICU) nurse (ICU nurse #1) that had care for Resident #3 when she was first admitted to the ICU stated that when she received Resident #3 from the emergency room , that Resident #3 was filthy and her Foley catheter had sludge in the tubing clotting off the urine from going into the drainage collection bag. She described the urine as cloudy, nasty green/gray in color and when she removed the Foley that she came to the hospital with from the facility, the tubing was stained and dirty. ICU nurse #1 described that when she removed the old Foley, there were three ICU nurses in the room assisting and two of the ICU nurse ' s had to leave the room vomiting from the overwhelming odor of the urine that saturated the bedding of Resident #3. She stated that after placing a new Foley catheter in Resident #3 and after Resident #3 urinated and soaked the entire bed, Resident #3 voided almost 500 cc (cubic centimeters) of cloudy, dark, thick urine. She stated that Resident #3 had dried stool on her buttocks and abdomen. She stated that she had given Resident #3 two head to toe bed baths during her shift and Resident #3 still was not clean when she turned over care to the oncoming nurse. In an interview on 3/25/13 at 10:50 a.m. Intensive Care Unit (ICU) nurse #2 that took over care of Resident #3 stated that she also gave Resident #3 two complete head to toe bed baths and finally got her cleaned up. She stated that she had called the facility asking when Resident #3 ' s Foley catheter was last changed and the DON told her that it was 2/25/13. The ICU nurse stated that she also informed the DON at the facility that when Resident #3 arrived, she was filthy and her urine was thick, gray sludge and wanted to know how Resident #3 had been cared for. In an interview on 3/21/13 at 8:30 a.m. Resident #3 ' s four daughters were present and stated that the first time they heard of their mother being admitted to the intensive care unit (ICU) was 3/19/13 at night (they were not sure at what time, but it was late evening) when the ICU nurse called them to come see their mother, that she was in critical condition and was not expected to survive. The daughters stated that they had called the facility and spoken with the Administrator and DON about their care concerns for Resident #3. The daughters stated that they had placed a sign above their mother ' s bed with times to be up in the Geri-chair and when to be placed back in bed. They stated that often times their mother would be in the same clothes for several days at a time, that her eyes were frequently matted and the CNA ' s would often leave her dirty frequently. They also stated that there was one CNA that manually picked their mother up from the Geri-chair by herself and placed their mother onto the bed. They stated that their mother was to be transferred by the Hoyer lift only and with two person assist. Review of the local hospital ' s medical records for Resident #3 documented by the first ICU nurse on 3/19/13 at 2100 (9:00 p.m.) documented .Patient Diagnosis: [REDACTED].catheter removed and replaced on admission .Patient voided a large amount of urine incontinently immediately after catheter was removed .urine foul smelling, dark, cloudy and concentrated .New Foley catheter inserted . Review of the local hospitals medical records for Resident #3 documented by the first ICU nurse on 3/21/13 at 8:00 a.m. .I received the patient 3/19/13 and her Foley catheter appeared extremely dirty .urine was very cloudy, a grey-amber color and had an overwhelmingly foul odor .There was minimal urine output in the bag and urine was stationary in the tubing .Upon taking out the Foley catheter, patient voided a great amount of urine described above .after inserting the new catheter, patient immediately had out 450cc of urine described above .patient was very unclean . Review of the hospital ' s Patient Results dated 3/19/13 at 1531 (3:51 p.m.) documented the culture and sensitivity (C&S) results as Proteus Mirabilis and Escherichia Coli (both are bacteria commonly found in feces {stool}). Observation on 3/21/13 at 7:50 a.m. at the local hospital Intensive Care Unit (ICU) revealed that Resident #3 had an Indwelling Foley Catheter draining thick, dark amber urine. The ICU nurse caring for Resident #3 stated that the urine looked so much better than when she first received her. At this time, Resident #3 was being transferred to another unit at the hospital. Observation on 3/21/13 at 8:45 a.m. at the local hospital in a regular hospital room revealed Resident #3 had an unstageable pressure ulcer located on her right heel that the facility had no evidence of documentation. Also she had two stage II pressure ulcers on the lateral aspect of her right foot. In an interview on 3/22/13 at 10:10 a.m. LVN #3 stated that she had changed the indwelling urinary catheter on Resident #3 on 2/25/13 when she was still working nights. She stated that the nurse working on the west side stated she did not know how to change an indwelling urinary catheter on a resident that was contracted. LVN #3 stated that the old urinary catheter had sediment in the tubing clogging off the flow of urine into the collection bag. LVN #3 stated that when she placed the new indwelling urinary catheter it immediately began draining without any difficulties. LVN #3 stated that she did not detect any odor about Resident #3 or the urine when she changed the catheter on 2/25/13. LVN #3 stated that she did not notify the physician due to the amount of sediment in the catheter tubing. LVN #3 stated that in her professional opinion indwelling urinary catheters should be changed at least once a month or more often if needed. LVN #3 stated in her professional opinion that it would take a very long time for urine to go from clear yellow to thick gray sludge, she was unable to give an estimate on how long it would take. In an interview on 3/21/13 at 11:30 a.m. ADON #2 accompanied this investigator to see the residents that was on the CMS Form 672 dated 3/21/13 that documented the facility having four residents in the facility as having a Foley catheter. Observation at this time revealed only one other resident (Resident #1) as having an indwelling urinary catheter. Resident #12 had not had a Foley catheter .for the past three weeks, she pulled her catheter out and hospice said to leave it out .

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	675350	A. BUILDING _____ B. WING _____	03/27/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE INN OF ABILENE	4934 S 7TH ST ABILENE, TX 79604

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0498 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 17) There was no evidence of documentation of a physician order [REDACTED]. Resident #6 had not had a catheter since before 10/5/13 when hospice performed an in and out catherization to obtain urine for a urinalysis and culture and sensitivity for a suspected urinary tract infection. ADON #2 stated sarcastically .evidently I really know my residents . There was no evidence of documentation of an order to take or leave the catheter out. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that in her professional opinion Foley catheters should be changed monthly. She also stated that some nurse aides measure the urine and document it and some aides only document urine amounts as small, medium or large. In an interview on 3/22/13 at 10:45 a.m. ADON #2 stated that the assessment completed on Resident #3 was a wrong assessment because the nurse did not do a head to toe assessment and the documentation on the assessment documented Resident #3 ' s urine as clear yellow urine. She stated that LVN#2 did not do a complete assessment of Resident #3 due to the fact that LVN #2 had not documented in Resident #3 ' s clinical record regarding the color and clarity of Resident #3 ' s urine until 3/19/13. In an interview on 3/25/13 at 11:39 a.m. CNA #3 stated that she had emptied Resident #3 ' s drainage bag on 3/19/13 before she went off shift at 6:00 a.m. and at that time the urine in the drainage bag was yellow and had bacteria in it. She explained that by having bacteria in the urine she meant that the urine was white and cloudy and to her it looked like this white cloudy stuff was clogging the tubing. She stated that she reported it to the day nurse who was LVN #2. In an interview on 3/22/13 at 11:00 a.m. LVN #2 stated that Resident #3 had vomited twice the night before (3/18/13) she was sent to the hospital. He stated that Resident #3 ate breakfast in bed but did not eat any lunch. The physician saw her and said she was fine. A few hours later (approximately 55 minutes) she started sweating a lot and her pulse rate got fast. LVN #2 stated that Resident #3 was mumbling and not doing the stuff she normally does. After lunch she was not responding, was breathing fast and was sweaty. LVN #2 described Resident #3 ' s urine as being yellow, clear and draining, but he was unable to state how much he observed in the bag at the time of the transfer. In an interview on 3/22/13 at 11:10 a.m. LVN #1 stated that if a resident with a urinary catheter had appeared to have a urinary tract infection it would be best to go ahead and change the catheter, even if waiting on a urinalysis. In an interview on 3/22/13 at 11:15 a.m. LVN #1 stated there were no open areas on Resident #3 ' s feet and that he had assess her skin the morning prior to her being sent to the emergency department and that he did not look at her urine. In an interview on 3/22/13 at 12:20 p.m. the Medical Director for the facility stated that he was unaware that the facility had changed their policy of changing indwelling urinary catheters monthly to as needed. He stated that in his professional medical opinion, urinary catheters needed to be changed at least once a month or sooner if needed. He stated that .I just don ' t know what to do with that facility . In an interview on 3/22/13 at 3:05 p.m. the DON stated that she tracks bowel movements, oral and [DEVICE] administered intakes. She stated that she does not see anything on outputs (such as urine). She stated that the system goes down every day at 2:00 a.m. and 2:00 p.m. but it does not stay down for very long (she was unable to give an estimated amount of time the system would be down). She stated that she had been training staff on fluid intake. In an interview on 3/22/13 at 3:15 p.m. CNA #5 stated that when she worked with Resident #3 on 3/18/13 the urine was dark yellow and she did not think anything of it because since her employment began in August 2012, Resident #3 ' s urine had always been dark yellow with stuff in the tubing. CNA #5 stated that the reason she did not tell any of the charge nurses about the color and clarity of Resident #3 ' s urine was because the urine hadn ' t changed since she had begun working in August, 2012. In an interview on 3/22/13 at 3:25 p.m. CNA #6 stated that she would go and ask the nurse how to input color, consistency and amount of urine into the kiosk. She stated that it was very important to keep the catheter clean and to be very careful while completing peri-care because it they didn ' t want to give the residents who have indwelling urinary catheters an infection. In an interview on 3/24/13 at 8:20 a.m. RN #1 stated that she worked weekends, but had been off and had not worked with Resident #3 for over a month. During the interview she said that in her professional opinion indwelling urinary catheters should be change done a month or sooner if needed. RN #1 was no aware of any facility criteria for changing out urinary catheters. In an interview on 3/25/13 at 1:30 p.m. CNA #2 stated that the last time she had taken care (which was documented on the kiosk as 3/10/13) of Resident #3 she reported to the nurse that the urine was a dark brown color and that she did inform the charge nurse, but was unable to state which nurse she had reported this to. CNA #2 stated that it was the day charge nurse for the west side. Review of the facility ' s Infection Reports revealed two forms being used. One contained the questions Health Care Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) which had yes or no answers. The second Infection Report Form documented .Facility Acquired Infection developed after admission? and Community Acquired Evidence of Infection at time of admission? Both with yes or no answers. Seventeen Infection Reports of residents with UTI ' s were reviewed for whether they were marked to indicate if the UTI was an HAI or CAI. Nine of the reports had both questions marked No , seven had neither question answered, and one had HAI question left blank and answered No on the CAI question. In an interview on 3/26/13 at 10:50 a.m. with the DON, ADON #2 and RNC #1, RNC #1 stated that there were criteria for determining if a resident infection was a Healthcare Associated Infection (HAI) and ADON #2 pointed to the criteria listed on the HAI form. In an interview on 3/26/13 at 3:50 p.m. and 4:30 p.m. RNC #2 stated that on the Infection Report form the questions Healthcare Associated Infection (HAI)? (Generally occurs after 72 hours from the time of admission) and Community Associated Infection? (Present or incubating at time of admission, or develops within 72 hours of admission) should be answered either yes or no. If the HAI question is answered yes , then the Healthcare Associated Infection Surveillance Report Form should be filled out. RNC #2 stated that the Infection Control Policy criteria was to determine if there was an infection and the HAI Surveillance Report Form criteria was to help determine if the infection was chronic or acute. In an interview on 3/27/13 at 9:30 a.m. ADON #2 stated that she had no instruction on how to fill out the Infection Control Log. Review of Resident #1 ' s clinical record Admission Record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Observation on 3/22/12 at 9:15 a.m. CNA #7 providing incontinent care to Resident #1 revealed CNA #7 rubbing back and forth with the same piece of cloth on the urinary catheter. CNA #7 then cleaned stool from an incontinent episode of bowel movement from the bottom up, spreading stool to vaginal/peri area. Observation on 3/21/13 at 3:40 p.m. revealed that Resident #1 ' s urinary catheter tubing contained dark amber urine with sediment in the tubing. ADON #2 stated that she thought the urine was yellow, but when questioned, she stated that she would call the urine amber. ADON #2 stated that with the sediment in the tubing and the color of the urine, she thought that Resident #1 might have a urinary tract infection. Review of Resident #1 ' s clinical record Diagnostics dated 3/19/13 documented Resident #1 ' s urine contained the bacterium Escherichia coli (which is intestinal bacteria). Review of Resident #2 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]., hypertension and [MEDICAL CONDITION]. Review of Resident #2 ' s clinical record Diagnostics dated 1/23/13 document her urine contained Escherichia coli, [MEDICATION NAME] cloacae, and proteus mirabilis which is commonly found in the intestines or fecal material. Review of Resident #7 ' s admission record undated documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #7 ' s clinical record Diagnostics dated 2/7/13 documented her urinalysis and culture and sensitivity contained Escherichia Coli which is intestinal bacteria. Review of Resident #8 ' s admission record undated documented she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #8 ' s clinical record Diagnostics dated 1/12/13 documented her urinalysis and culture and sensitivity contained Proteus mirabilis which is intestinal bacteria. Review of Resident #9 ' s admission record revealed she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #9 ' s clinical record Diagnostics dated 2/5/13 documented her urinalysis and culture and sensitivity contained [MEDICATION NAME] Faecalis which is intestinal bacteria. Review of Resident #11 ' s admission record revealed he was an [AGE] year old male who was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #11 ' s clinical record Nurse ' s Notes documented he was admitted to the facility on [DATE] with an indwelling urinary catheter. On the date of admission (3/14/13) at 6:40 p.m. he pulled the catheter out and it was re-inserted by nursing staff. Review of Resident #11 ' s clinical record Admission Order revealed no evidence of documentation for an indwelling urinary catheter. Review of Resident #11 ' s clinical record Physician order [REDACTED]. Review of Resident #12 ' s clinical record Resident Admission Record undated documented that she was a [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #12 ' s clinical record Nurse ' s Notes dated 3/11/13 at 0840 (8:40 a.m.) documented .hospice notified the time of resident pulling out Foley catheter on previous shift, awaiting new orders(to be) called back from hospice . There was no evidence of documentation that hospice had called back or from the physician regarding to discontinue the Foley catheter. Review of Resident #12 ' s clinical record Re-admission orders [REDACTED]. Review of Resident #12 ' s

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F 0498 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 18) clinical record Physician order [REDACTED]. Observation on 3/22/13 at 9:50 a.m. revealed that Resident #12 did not have an indwelling urinary catheter in place. In an interview on 3/22/13 at 10:42 a.m. ADON #2 stated that she had been told there was an order to discontinue Resident #12 ' s indwelling urinary catheter, but that she had not been able to find one in the clinical record. In an interview on 3/22/13 at 10:55 a.m. ADON #1 stated that she thought an order had been faxed to discontinue the indwelling urinary catheter, but that she didn ' t know what happened there. Review of Resident #12 ' s clinical record Diagnostics dated 1/4/13 documented Resident #12 ' s urinalysis, culture and sensitivity documented she had Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca in her urine. Proteus mirabilis and [DIAGNOSES REDACTED] oxytoca are commonly found in fecal material (stool). Review of Resident #17 ' s admission record documented she was an [AGE] year old female originally admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Review of Resident #17 ' s clinical record Diagnostics dated 2/3/13 documented her urine contained Proteus mirabilis which is commonly found in fecal material (stool). The Administrator, DON, RNC #1 was informed 3/22/13 at 10:45 a.m. that Immediate Jeopardy was declared. Review of the facility's Abatement Plan to Remove Immediate Jeopardy dated 3/22/13 revised 3/27/13 accepted at 11:00 a.m. documented .The Immediate Jeopardy was declared at 10:45 a.m. on 3/22/13. Immediate re-education was written and staff was called in for the education. Below is the content of the re-education being presented to the facility staff nurses by the Director of Nursing/Unit Managers. - Incontinent Care - Foley Catheter Care - Foley Catheter Assessments and Documentation of color/clarity/characteristics by licensed nurse Re-education was started immediately with current staff in the facility: (copies of education provided is attached). In-service has been provided for licensed nurses for re-education regarding importance of Foley catheter care, documenting after Certified Nursing assistants provides Foley catheter care, and nurse assessment of patency of catheter, color and clarity of urine every shift. As of 3/26/13 at 11:30 a.m. all certified nursing assistants have been re-educated on incontinent care, Foley catheter care and successfully performed incontinent care observed by the Director of Nursing and/or Assistant Directors of Nursing using the skills checklist for incontinent care (sample attached). The exception is three certified nursing assistants who are prn (as needed) and are not scheduled. These three identified certified nursing assistants will not be allowed to work until they have been re-educated and successfully completed incontinent care using the skills checklist for incontinent care. All licensed charge nurses have been re-educated on Foley catheters and incontinent care including documentation. The exception is one PRN (as needed) licensed nurses who is not scheduled to work and will not be allowed to work until the re-education is completed. System Changes: There are no residents with Foley catheters in the facility as of 3/25/13 at 7:00 p.m. Future orders for Foley catheters will read: Change indwelling Foley catheters as needed prn dysfunction. Certified Nursing Assistants are required to not only document urine