STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015189	A. BUILDING _____ B. WING _____	07/24/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVING CENTER - PELL CITY	510 WOLF CREEK ROAD, NORTH PELL CITY, AL 35125

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 -** Actual harm **Residents Affected -** Few	**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 interviews, record review and review of the facility's Admissions Orders, the facility failed to ensure Resident Identifier (RI) #1, a resident with a history of UTI's (Urinary Tract Infections), Foley Catheter (F/C) was changed in a timely manner after the resident was readmitted to the facility with a F/C on 05/20/14. On 06/23/14 an order was written to change RI #1's F/C. On 07/10/14, 17 days after the order had been written to change the F/C, and 51 days after RI #1 had been readmitted to the facility, the resident was noted to have dark amber urine and sediment in the F/C tubing. RI #1 began to experience pain by crying out when urinating and the F/C was changed at that time. This affected RI #1, one (1) of three (3) residents sampled for the use of an indwelling catheter. Findings Include: RI #1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with a [DIAGNOSES REDACTED]. A review of RI #1's care plans revealed the resident had a care plan titled Alteration in elimination of bowel and bladder . History of UTI's (Urinary Tract Infections), [MEDICAL CONDITION] with use of foley . The care plan had an initiated date of 1/24/2014. A review of a facility form titled Clinical Health Status revealed RI #1 was readmit to the facility again on 05/20/14. Under Section F Urinary Incontinence, it was documented has foley and History of catheter use last 48 hours. A review of RI #1's May 2014 MAR (Medication Administration Record) revealed no order had been written for the resident's F/C to be changed. RI #1's progress notes documented the following: 5/20/2014 20:15 (8:15 p.m.) . Note Text: Resident arrived on a stretcher by (name of EMTS (Emergency Medical Transport Service)) . Foley catheter remains intact . 5/27/2014 20:58 (8:58 p.m.) . Note Text: . Foley catheter patent and draining dark yellow urine . 6/3/2014 23:09 (11:09 p.m.) . Note Text: . Foley patent and draining dark urine . 6/5/2014 22:59 (10:59 p.m.) . Note Text: . Foley catheter patent and draining dark urine . 6/7/2014 22:14 (10:14 p.m.) . Note Text: . Foley catheter patent and draining dark urine . 6/8/2014 23:32 (11:32 p.m.) . Note Text: . Foley catheter patent and draining dark urine . 6/9/2014 01:38 (1:38 a.m.) . Note Text: . foley intact draining dark urine . 6/10/2014 00:19 (12:19 a.m.) . Note Text: . Foley catheter patent and draining dark urine . 6/10/2014 04:22 (4:22 a.m.) . Note Text: . Foley catheter patent and draining dark urine . 6/11/2014 03:06 (3:06 a.m.) . Note Text: . Foley catheter patent and draining dark urine . 6/15/2014 14:22 (2:22 p.m.) . Note Text: . Catheter in place and draining dark amber urine into cath bag . 6/20/2014 15:44 (3:44 p.m.) . Note Text: . Foley in place . small amount of sediment noted . A review of RI #1's June 2014 MAR revealed an order which documented: Change foley every month . every 30 day(s) . According to the order RI #1's F/C was to be changed on June 23, 2014. After reviewing the MAR, there was no indication on the MAR that the F/C was changed at this time. RI #1's progress notes documented the following: 7/10/2014 22:31 (10:31 p.m.) . Note Text: . Resident crying out in pain when urinating. Urine dark amber in color. Sediment noted in tubing. Removed existing catheter, replaced catheter without difficulty with #18 fr (french) foley catheter . On 07/23/14 at 7:37 a.m., the surveyor conducted an interview with Employee Identifier (EI) #1, a LPN (Licensed Practical Nurse) who provided care for RI #1 on the 11-7 shift. The surveyor asked EI #1 when a resident has a F/C how often is it changed. EI #1 replied every 30 days. The surveyor asked EI #1 which shift changed the F/C. EI #1 said she was pretty sure it was the 11-7 shift. When asked who would have been responsible for changing RI #1's F/C on 6/23/14, EI #1 said she thought it would have been EI #5 (the nurse assigned to care for RI #1 on the 11-7 shift on 06/23/14). EI #1 said when a F/C was changed, it usually would be documented on the MAR. EI #1 said she did not see where it was documented on RI #1's MAR that the F/C had been changed. On 07/23/14 at 11:40 a.m., the surveyor conducted an interview with EI # 2, a LPN who provided care for RI #1 on the 7-3 shift. The surveyor asked EI #2 how often were residents F/C changed. EI #2 replied the F/C was to be changed on the night shift every 30 days or once a month. The surveyor asked EI #2 had RI #1's family ever approached him about RI #1's F/C not being changed. EI #2 said RI #1's sponsor did ask him when the last time it was changed. EI #2 said (when he looked at RI #1's records) he could not find where it had been changed. EI #2 said when the sponsor asked him about the F/C, RI #1's urine was very cloudy. On 07/23/14 at 11:40 a.m., the surveyor conducted an interview with EI #3, the RN (Registered Nurse) MDS (Minimum Data Set) Coordinator. EI #3 said RI #1 came back from the hospital on [DATE] with the F/C. The surveyor asked EI #3 how often were F/C changed. EI #3 replied monthly, usually on the night shift. The surveyor asked EI #3 where it would be documented that the F/C had been changed. EI #3 replied, sometimes in the nurses notes. A review of RI #1's Progress Notes (nurses notes), dated 6/23/2014 (the day the MAR indicated RI #1's F/C was to be changed), did not reveal any evidence that the F/C had been changed. On 07/23/14 at 3:45 p.m., the surveyor conducted an interview with EI #4, a LPN who provided care for RI #1 on the 3-11 shift. The surveyor asked EI #4 if she had ever changed RI #1's F/C. EI #4 replied she changed the F/C on the 10th of July (2014). EI #4 said the F/C had a lot of sediment and it was cloudy and RI #1 said it hurt. When asked how often the facility changed the F/C of residents, EI #4 replied monthly. EI #4 said the night shift usually changed the F/C out once a month. EI #4 said RI #1's F/C was due to be changed on the 23 rd of June (2014) but she didn't see a signature (on the MAR) where it had been changed. The surveyor asked EI #4 why she changed RI #1's F/C on 07/10/14. EI #4 said RI #1's sponsor said RI #1 wanted a pain pill and the F/C changed. EI #4 said RI #1's sponsor said she did not believe RI #1's F/C had been changed since the resident had come back from the hospital (5/20/14). EI #4 said RI #1's F/C was changed because the resident was pretty uncomfortable. EI #4 said after the F/C was changed, RI #1 was better. On 07/23/14 at 5:00 p.m., the surveyor conducted a phone interview with EI #5, the RN who provided care for RI #1 on the 11- 7 shift on 06/23/14 (the date and shift RI #1's F/C was scheduled to be changed). The surveyor asked EI #5 if she had ever changed RI #1's F/C. EI #5 replied she had never changed RI #1's F/C. The surveyor asked EI #5 how often were the residents F/C scheduled to be changed. EI #5 said at least every 30 days. The surveyor asked EI #5 if she recalled if she checked RI #1's MAR on 06/23/14 to see if the F/C was scheduled to be changed. EI #5 said she didn't remember if she had checked the MAR or not. EI #5 said if she changes a F/C she would put it on the MAR or in the nurses notes. On 07/24/14 at 3:26 p.m., the surveyor conducted an interview with the DON (Director of Nursing), EI #6. The surveyor asked EI #6, when a resident is admitted to the facility with a F/C, are orders for the care and the changing of the F/C written at that time. EI #6 replied yes. The surveyor asked EI #6 why this was not done for RI #1 when he was readmitted on [DATE]. EI #6 said the nurse who did the assessment was not the one who put the orders in. The surveyor asked EI #6 why an order was written for RI #1's F/C to be changed every 30 days on 06/23/14. EI #6 said the order was written because the nurse, EI #7, the Assistant Director of Nursing (ADON), was reviewing the chart and noticed that there was no order for RI #1's F/C. The surveyor asked EI #6 should RI #1's F/C have been changed at that time. EI #6 replied it depended on what RI #1's F/C looked like at that time. The surveyor asked EI #6 why EI #7 had written the order for the F/C to be changed every 30 days. EI #6 said that was a facility protocol. The surveyor asked EI #6 did she think leaving a F/C in for 51 days was too long.

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 0315 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) EI #6 replied no. The surveyor asked EI #6 if she thought 51 days was not to long to have a F/C in, why did the facility have a protocol for the F/C to be changed every 30 days. EI #6 replied that was just what the nurses did. On 07/24/14 at 4:40 p.m., the surveyor conducted an interview with EI #7, the ADON. The surveyor asked EI #7 how often were residents F/C changed. EI #7 replied the F/C was usually changed once a month and as needed. The surveyor asked EI #7 should orders be written for the F/C to be changed when a resident is admitted to the facility. EI #7 replied yes. The surveyor asked EI #7 why this was not done when RI #1 was readmitted to the facility on [DATE]. EI #7 said she did not know RI #1 was readmitted back to the facility with a F/C. EI #7 said when she wrote the order for RI #1's F/C to be changed every 30 days she thought she was updating the order to include the size of the F/C. The surveyor asked EI #7 if she thought 51 days was too long for a F/C to be in if there was orders for it to be changed every days. EI #7 replied if there was an order yes. The surveyor showed RI #7 a copy of the facility's Admission Order and asked whose admission order were they. EI #7 said the orders are the ones the facility uses when a resident is admitted to the facility. The surveyor asked EI #7 did RI #1 had a history of [REDACTED].#7 replied yes. A review of the facility's admission orders [REDACTED] The Following orders are needed when admitted to the facility . Foley Cath (Catheter) Orders . They must be changed monthly . On 07/24/14 at 5:35 p.m., the surveyor conducted the exit conference with the Administrator and the DON, EI #6. When asked if there were any questions, EI #6 stated she would like to change her statement given to the surveyor earlier. EI #6 said she wanted to change her answer to yes when the surveyor asked if she felt 51 days was too long for leaving a F/C in. This deficiency was written as a result of the investigation of complaint/report #AL 464.