STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185141	A. BUILDING _____ B. WING _____	**06/24/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF GEORGETOWN	**102 POCAHONTAS TRAIL GEORGETOWN, KY 40324**

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 0157 **Level of harm -** Actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of facility policy and review of the Lippincott Manual of Nursing Practice, it was determined the facility failed to ensure the Physician was notified when there was a change in condition, for one (1) of seven (7) sampled residents (Resident #3). On 06/19/16 at approximately 1:00 PM, Resident #3 reported leaking around his/her indwelling urinary catheter. Without informing the Physician, or obtaining procedure orders, Licensed Practical Nurse (LPN) #7 attempted to irrigate the resident's catheter, and proceeded to make multiple attempts to replace the catheter. Throughout the procedure, Resident #3 complained of pain, begged the nurse to stop, and experienced bleeding. Furthermore, when the resident's ex-wife, who sat with the resident throughout the night of 06/19/16 into 06/20/16, reported the resident did not feel well and had no urine output, staff on duty still did not notify the Physician. On 06/20/16 at approximately 10:00 AM, the nurse did obtain an order to transfer Resident #3 to the hospital at the ex-wife's insistence. Review of the hospital record revealed Resident #3 was noted by the Urologist to have scant urine output, bleeding secondary to trauma sustained during catheterization attempts at the facility, and a Urinary Tract Infection [MEDICAL CONDITION]. (Refer also to F281, F282, F315, F441, and f514) The findings include: The facility did not provide a specific written policy regarding physician notification. Interview with the Director of Nursing (DON), on 06/23/16 at 11:00 AM, revealed the facility followed nursing practice standards outlined in Lippincott and Potter & Perry manuals. She stated the facility did not have a copy of the reference manuals, but could access them on-line if information was needed. Review of the Lippincott Manual of Nursing Practice Standards, Ninth Edition, revealed professional nursing standards set minimum levels of acceptable performance for which its practitioners were accountable. Continued review revealed the failure to perform proper assessments, notify physicians of changes in condition, and obtain orders for care could result in adverse outcomes. Review of the medical record revealed Resident #3 was admitted by the facility on 05/11/16, with [DIAGNOSES REDACTED]. Review of the nursing Admission Assessment revealed the resident had an indwelling urinary catheter connected to a bedside drainage bag. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/18/16, revealed the facility assessed Resident #3 to have a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was cognitively intact, and therefore interviewable. Continued review of the MDS revealed the resident was assessed to have an indwelling catheter; however, there was no documented medical [DIAGNOSES REDACTED]. Review of the Comprehensive Care Plan, dated 05/20/16, revealed Resident #3 was at risk for complications associated with bladder elimination related to an indwelling urinary catheter. The stated goal was for the resident to have a reduced risk of complications due to the catheter through the next review date of 08/18/16. Approaches included a directive to monitor bladder status and report any changes such as low urine output, discolored urine, and pain to the Physician. Interview with State Registered Nurse Assistant (SRNA) #8, on 06/24/16 at 11:30 AM, revealed Resident #3 reported to SRNA #8, on 06/19/16, that his/her catheter was leaking. Continued interview revealed SRNA #8 informed Licensed Practical Nurse (LPN) #7 of the resident's complaint. He stated when he re-entered the resident's room, observed LPN #7 remove the indwelling catheter and proceed to insert a new catheter. SRNA #8 further stated when the nurse tried to put the new catheter in, the resident cried out, Stop! Stop!, and the SRNA noted the resident was bleeding a lot. Further interview revealed LPN #7 stated she couldn't get the catheter in, so she got another one, and inserted it. The resident was crying, and told the nurse he couldn't stand it and to take it out. According to SRNA #8, the nurse removed the newly placed catheter, handed the original catheter, which had been removed, to the SRNA and directed him to rinse it off in the bathroom. LPN #7 re-inserted the used catheter into the resident's bladder. Telephone interview with LPN #7, on 06/23/16 at 6:45 PM, regarding the catheter change for Resident #3 on 06/19/16, revealed she made a mistake and was terminated by the DON. LPN #7 acknowledged she put in the wrong size catheter without a physician's orders [REDACTED]. She further stated when she inserted the larger catheter, the resident bled and she panicked. She did not acknowledge her attempt to flush the catheter when the resident reported leaking around it, or removal of the larger catheter and re-insertion of the used catheter. Interview with the ex-wife of Resident #3, on 06/23/16 at 5:20 PM, revealed she stayed throughout the night of 06/19/16 into 06/20/16 because the resident did not feel well and she knew something was wrong. She stated the resident had no urine output all night, was very sore, reported feeling like a panic attack, and did not seem as alert as usual. Continued interview revealed the ex-wife described her concerns to the nurse on duty and expressed her feeling the resident should go to the hospital. She further stated the nurse said he didn't need to go because his vital signs were fine. Further interview revealed on the day shift of 06/20/16, the ex-wife insisted the resident be sent to the Emergency Department (ED). She reported she was informed in the ED the resident had suffered trauma due to repeated catheterization attempts, with resultant internal swelling and the presence of blood clots. Review of the Nurses Notes and nursing assessments for 06/19/16 and 06/20/16 revealed no documented evidence of the events surrounding the catheter change for Resident #3. Furthermore, there was no documented evidence of a call to the Physician related to the events, including the resident's bleeding and subsequent lack of urine output, or the receipt of any new treatment orders. Review of the Intake/Output Record, dated 06/19/16 and 06/20/16, revealed no documented evidence of any urine output for Resident #3 after 11:00 PM on 06/19/16. Review of the Nursing Home to Hospital Transfer Form, dated 06/20/16 at 10:00 AM, revealed the nurse noted Resident #3 had had no urine output for twelve (12) hours, and exhibited a decreased level of consciousness and generalized weakness. Review of the resident's physician's orders [REDACTED]. Continued review revealed a verbal order, dated 06/20/16, to transfer the resident to the hospital Emergency Department for an evaluation per family request. Further interview with the DON, on 06/23/16 at 11:00 AM, revealed when she questioned LPN #7, the nurse reported Resident #3's catheter was not draining so she tried to flush it without success. The nurse decided to replace the catheter. The DON stated LPN #7 further reported the resident bled a lot during the procedure. Continued interview revealed LPN #7 should have called the Physician and obtained an order prior to flushing or changing the indwelling catheter. The DON expressed

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 0157 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) her expectation that a nurse never flush or change a catheter without obtaining an order, and stated decisions regarding Resident #3's catheter should have been made by the Physician, not the nurse. Review of hospital records revealed Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED].#3 had remarkably infected urine and a Urology consult was ordered to address the resident's hematuria (blood in the urine). Review of the Urology consult note, dated 06/21/16, revealed the physician specialist documented the presence of gross hematuria, likely secondary to multiple traumatic attempts at catheterization at the facility. Continued review revealed the presence of a UTI, low urine output and acute renal (kidney) failure. Interview with the Administrator, on 06/24/16 at 3:30 PM, revealed he expected nursing staff to notify the Physician for changes in condition. A post-exit telephone interview with Resident #3's Physician, on 06/29/16 at 11:15 AM, revealed he would have expected the nurses to notify him of changes in the resident's urinary status, including leaking, obstruction, decreased urinary output, or the need for irrigation or replacement of the catheter. Continued interview revealed he would have expected to be immediately notified of a traumatic catheter insertion, such as occurred with Resident #3. The Physician stated he would have cultured the urine, verified placement and initiated precautions to monitor the resident for complications. Further interview revealed the Physician was not notified of any catheter problems for Resident #3 until the resident was on the way out of the facility to the hospital. He further stated the nurse re-using a catheter was bizarre behavior and showed negligence in the nurse's thought processes we don't re-use needles or catheters.
F 0281 **Level of harm** - Actual harm **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and review of the Lippincott Manual of Nursing Practice, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of seven (7) sampled residents (Resident #3). When the resident had leakage of urine from around an indwelling urinary catheter on 06/19/16, the nurse did not notify the Physician of the resident's change in condition, attempted to flush the catheter, and ultimately replaced the catheter without a physician's orders [REDACTED]. When the resident cried in pain, experienced bleeding, and insisted the nurse remove the catheter, she instructed the State Registered Nurse Assistant (SRNA) to rinse the original catheter which had been removed, then reinserted the non-sterile, used catheter into the resident's bladder. Later that night, and into the morning of 06/20/16, the resident's ex-wife noticed a decline in the resident, including lethargy and a lack of urine output, and expressed her concerns to the nurse, who did not address the concerns. On the day shift of 06/20/16, at the insistence of the ex-wife, Resident #3 was sent to the hospital. Review of the Emergency Department (ED) record revealed the resident had minimal or no urine output since the urinary catheter was changed the day before, and lab results revealed a severe urinary tract infection [MEDICAL CONDITION]. According to the Urology Consult report, Resident #3 had gross hematuria (large amount of blood in the urine), most likely caused by multiple, traumatic catheterizations at the facility, with subsequent low urine output and acute renal (kidney) failure. (Refer also to F157, F282, F315, F441 and F514) The findings include: Review of the facility's policy titled Catheterization Policy, undated, revealed catheterizations should be completed using sterile technique. Continued review revealed if problems were encountered during the procedure, the nurse should stop and notify the Physician. Interview with the Director of Nursing (DON), on 06/23/16 at 11:00 AM, revealed the facility did have a written policy regarding nursing standards of care; however, the facility followed nursing practice standards outlined in the Lippincott and Potter & Perry nursing manuals. She stated the facility did not have a current copy of the nursing reference. Further interview with the DON revealed the facility followed the Centers for Disease Control (CDC) recommendations for changing indwelling urinary catheters. She stated catheters were changed as ordered by the Physician. Review of the Lippincott Manual of Nursing Practice Standards, Ninth Edition, revealed professional nursing standards of practice were minimum levels of acceptable performance for which its practitioners were accountable. Continued review revealed patients were at risk for adverse outcomes when nurses failed to assess properly, failed to notify the Physician of changes and obtain orders for care, failed to adhere to facility policy or procedure, and failed to document relevant information in the medical record. Further review of the Lippincott Manual, related to Standards for Catheterization, revealed irrigation of the catheter and catheterization should be performed using sterile technique, utilizing the smallest catheter capable of draining the bladder adequately. Continued review revealed the Physician should be notified if bloody urine developed. Review of the medical record revealed the facility admitted Resident #3 on 05/11/16 with [DIAGNOSES REDACTED]. Review of the nursing Admission Assessment revealed Resident #3 had an indwelling urinary catheter connected to a bedside drainage bag. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/18/16, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was assessed to be cognitively intact and interviewable. Continued review of the MDS revealed the resident was assessed to have an indwelling catheter; however, continued review revealed no medical [DIAGNOSES REDACTED]. Telephone interview with Resident #3's ex-wife, on 06/23/16 at 5:20 PM, revealed the resident came to the facility from the hospital with the urinary catheter in place because Resident #3 was very obese, could only urinate when standing up, and was too weak to stand while in the hospital. Review of the Comprehensive Care Plan, dated 05/20/16, revealed Resident #3 was at risk for complications associated with bladder elimination related to an indwelling urinary catheter. The stated goal was for the resident to have a reduced risk of complications due to the catheter through the next review date of 08/18/16. Approaches included an intervention to monitor bladder status and report any changes such as low urine output, discolored urine, and pain to the Physician. Interview with SRNA #8, on 06/24/16 at 11:30 AM, revealed on 06/19/16 at approximately 1:00 PM, Resident #3 told him that his/her catheter was leaking. The SRNA reported to the Charge Nurse/Licensed Practical Nurse (LPN) #7, who gathered supplies and entered the resident's room. When SRNA #8 returned to the room, LPN #7 had taken the old catheter out and was in the process of inserting a new one. SRNA #8 said he noticed the new catheter was larger in diameter than the old one, and asked the nurse about it. He said LPN #7 stated the resident required a larger catheter because there was leaking around the smaller one. When the nurse tried to put the new catheter in, the resident cried out, Stop! Stop! and began bleeding. The nurse stopped, obtained another catheter and inserted it. Resident #3 started crying and told the nurse to take it out because he/she couldn't stand it. SRNA #8 stated, LPN #7 removed the newly placed catheter and handed the original catheter to the SRNA and directed him to rinse it off in the bathroom. The nurse then, reinserted the used catheter and secured it, and left the resident's room. SRNA #8 knew the pain and the bleeding wasn't right and stated he meant to report the incident to the DON, but he got busy and did not report it. Telephone interview with LPN #7, on 06/23/16 at 6:45 PM, regarding the catheter change for Resident #3 on 06/19/16, revealed she made a mistake and was terminated by the facility. LPN #7 stated she put in the wrong size catheter without a physician's orders [REDACTED]. She further stated when she inserted the larger catheter, the resident bled and she panicked. She did not acknowledge her attempt to flush the catheter when the resident reported leaking around it, or removal of the larger catheter and re-insertion of the used catheter. Review of the Job Description for Position of Charge Nurse, signed by LPN #7, revealed essential duties and responsibilities included notifying the Physician when there was a change in a resident's condition. Interview with SRNA #7, on 06/23/16 at 4:00 PM, revealed the SRNA was familiar with Resident #3, and had provided direct care to the resident on the 06/19/16 evening shift. The SRNA stated Resident #3 complained of being dirty and not feeling well. SRNA #7 stated at about 9:00 PM, she assisted the resident's ex-wife to clean the resident up. SRNA #7 further stated the resident had old, dried blood on his/her abdomen. Interview with LPN #6, on 06/24/16 at 1:00 PM, revealed she cared for Resident #3 from 7:00 PM to 11:00 PM on 06/19/16. She stated she noted the resident had a blue indwelling catheter which was the type present when the resident was admitted by

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F 0281 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) the facility. She further stated the facility did not have blue catheters, only tan ones, so she knew it was the same catheter. However, she revealed, LPN #7 had reported she had tried to change Resident #3's catheter without success, so she flushed the catheter because it was clogged, and just changed the bag. Continued interview revealed Resident #3 told LPN #6 the day shift nurse (LPN #7) tried to put in a new catheter multiple times and couldn't, so she put the old catheter back in. The resident further reported LPN #7 took a syringe out of the trash can and tried to flush the catheter. Further interview with LPN #6 revealed the facility had no policy for flushing or changing catheters; however, she stated, neither procedure should be performed without a physician's orders [REDACTED].#3's catheter. Telephone interview with Registered Nurse (RN) #1, on 06/24/16 at 12:30 PM, revealed on 06/19/16 at change of shift for the 11-7 shift, LPN #6 reported LPN #7 tried to change Resident #3's catheter, but replaced the used catheter. LPN #7 stated she cleaned it first, but RN #1 didn't know how, since the facility had no sterilizing machine. Continued interview revealed Resident #3 had the same blue indwelling catheter in place, and RN #1 confirmed the facility did not stock blue catheters. Further interview with Resident #3's ex-wife, on 06/23/16 at 5:20 PM, revealed she was very upset about the problems resident had regarding the catheter. She stated the resident told her the nurse hurt him/her when she changed the catheter. He/she reported the catheter was leaking urine bad, and after the catheter was changed, there was blood all over his/her belly, the diaper, the towel and the pad underneath him/her. The ex-wife further stated she did not know why the catheter was changed; the resident was not having any pain until after the nurse tried to change it. Continued interview revealed Resident #3 told the ex-wife he/she kept telling the nurse she was hurting him/her but she continued. According to the ex-wife, after the incident Resident #3 said he/she felt the needed to urinate, but it hurt, and he/she thought the catheter was clogged. Further interview with the ex-wife revealed she stayed with the resident all night, and the resident had no urine output. She stated the resident reported feeling shaky, like he/she was having a panic attack. Furthermore, Resident #3 complained of pain in his/her chest, arm and back, and wasn't as alert as normal. The ex-wife reported the resident acted the same way before when he/she had kidney failure; she kept telling the night nurse something was wrong, but the nurse said the resident's vital signs were fine and did not need to go out to the hospital. The ex-wife decided if the facility did not call the doctor, she would. She reported the day shift nurse on 06/20/16 did call the Physician and made arrangements to send the resident to the hospital. She further stated in the Emergency Department (ED), the nurse told her the catheter from the nursing home was not working and had to be replaced. The ex-wife also stated she was told the resident was very swollen inside, and had blood clots. Review of the Intake/Output Record, dated 06/19/16 and 06/20/16, revealed no documented evidence of any urine output for Resident #3 after 11:00 PM on 06/19/16. Review of the Nurses Notes and nursing assessments for 06/19/16 and 06/20/16 revealed no documented evidence of the events surrounding the catheter change for Resident #3. Furthermore, there was no documented evidence of a call to the Physician related to the events, including the resident's bleeding and subsequent lack of urine output, or the receipt of any new treatment orders. Telephone interview with LPN #3, on 06/24/16 at 1:15 PM, revealed he worked the day shift on 06/20/16. He stated he was told in shift report that Resident #3's catheter was changed the day before. He further stated the resident's ex-wife had been at the facility all night and she told LPN #3 about the circumstances surrounding the catheter change, and that the resident had not had any urine output all night and she wanted the resident sent to the hospital. Continued interview revealed LPN #3 asked Resident #3 how he/she was feeling and Resident #3 said he/she wasn't peeing. Further interview revealed LPN #3 called the Physician to let him know the resident's ex-wife wanted Resident #3 sent to the hospital, and he gave a verbal order to send the resident out. LPN #3 stated Resident #3 left the facility at approximately 10:00 AM on 06/20/16, for transport to the Emergency Department (ED) by the ambulance service. Review of the resident's physician's orders [REDACTED]. Continued review revealed a verbal order, dated 06/20/16, to transfer the resident to the hospital Emergency Department for an evaluation per family request. Review of the Transfer Form, dated 06/20/16 at 10:00 AM, revealed the nurse noted Resident #3 had had no urine output for twelve (12) hours, and exhibited a decreased level of consciousness and generalized weakness. Review of the hospital History and Physical, signed by the admitting Physician and dated 06/20/16, revealed in the ED, Resident #3 was moderately distressed with increased respiratory effort. The resident required intubation and mechanical ventilation, and was transferred to the Intensive Care Unit (ICU), where Resident #3 continued with low urine output that was very bloody in nature. Continued review revealed a [DIAGNOSES REDACTED]. Review of the Urology consult note, dated 06/21/16, revealed the Physician specialist documented the presence of gross hematuria, likely secondary to multiple traumatic attempts at catheterization at the facility. Continued review revealed the presence of a UTI, low urine output and acute renal (kidney) failure. Interview with Licensed Practical Nurse (LPN)/Assistant Director of Nursing (ADON), on 06/23/16 at 11:10 AM, in regards to a urinary catheter that was not working properly, or not draining, revealed she would not flush or change a catheter without a physician's orders [REDACTED]. She further stated if she was unable to insert a catheter without difficulty, she would notify the Physician. Interview with the DON, on 06/23/16 at 11:00 AM, revealed Resident #3 came to the facility from the hospital with an indwelling catheter. The DON stated she questioned LPN #7 about the events on 06/19/16, who reported the resident's catheter was not draining. She said LPN #7 reported to her that she tried unsuccessfully to flush the catheter, and made the decision to replace it. LPN #7 told the DON she must have broken through a clot because there was a lot of blood. Continued interview with the DON revealed LPN #7 should have called the Physician and obtained an order prior to flushing or changing the indwelling catheter, and the nurse should not have reinserted the used catheter, because catheterization should be completed under sterile technique. The DON expressed her expectation that a nurse never flush or change a catheter without a physician's orders [REDACTED].#3's catheter should have been made by the Physician, not the nurse. Interview with the Administrator, on 06/24/16 at 3:30 PM, revealed he expected nursing staff to notify the Physician for changes in condition, obtain Physician orders [REDACTED]. A post-exit telephone interview with Resident #3's Physician, on 06/29/16 at 11:15 AM, revealed he would have expected the nurse to notify him of changes in the resident's urinary status, including leaking, obstruction, decreased urinary output, or the need for irrigation or replacement of the catheter. Continued interview revealed he would have expected to be immediately notified of a traumatic catheter insertion, such as occurred with Resident #3. The Physician stated he would have cultured the urine, verified placement and initiated precautions to monitor the resident for complications. Further interview revealed the Physician was not notified of any catheter problems for Resident #3 until the resident was on the way out of the facility to the hospital. He further stated the nurse re-using a catheter was bizarre behavior and showed negligence in the nurse's thought processes we don't re-use needles or catheters.
F 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care, for two (2) of seven (7) sampled residents (Residents #1 and #3). The nursing staff did not follow the Care Plan when they failed to inform the Physician of a change in the condition of Resident #3 related to his urinary status and an indwelling urinary catheter. Resident #3 experienced leaking around the catheter. Without notifying the Physician and obtaining care orders, the nurse attempted to flush the catheter, then changed the catheter. Furthermore, the nurse did not notify the Physician when the resident had pain and bleeding related to her attempts to insert a catheter. The following day, Resident #3 was admitted to the hospital with [REDACTED]. In addition, Resident #1 was assessed to be require two (2) staff for assistance with transfers; however, the resident was transferred by one staff member on two (2) occasions on 06/08/16. The resident complained of pain and a bruise was observed on the left shoulder. Resident #1 sustained a fracture to the left humerus (upper arm). (Refer also to F157, F281, F315, F441, and F514) The findings include: Interview with the Director of Nursing (DON), on 06/24/16 at 2:45 PM, revealed the facility did not have a written policy related to following the Care Plan. She stated it was her expectation for the nurses to follow the Care Plan as it had been developed.

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F 0282 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) Review of the Job Description for Position of Charge Nurse (LPN or RN), revealed Essential Duties and Responsibilities included review of the Care Plan daily to confirm that appropriate care was being delivered. 1. Review of the medical record revealed the facility admitted Resident #3 on 05/11/16 with [DIAGNOSES REDACTED]. Review of the nursing Admission Assessment revealed Resident #3 had an indwelling urinary catheter connected to a bedside drainage bag. Review of the resident's Admission Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was assessed to be cognitively intact and interviewable. Continued review of the MDS revealed the resident was assessed to have an indwelling urinary catheter. Review of the Comprehensive Care Plan, dated 05/20/16, revealed Resident #3 was at risk for complications related to bladder incontinence and an indwelling urinary catheter. The stated goal was for the resident to have a reduced risk of complications due to the catheter through the next review date of 08/18/16. Specific interventions included the following: report changes in bladder status to the Physician; and monitor and report any symptoms of a Urinary Tract Infection [MEDICAL CONDITION], such as discolored urine, pain on urination, and [MEDICAL CONDITION] (low urine output). Telephone interview with Licensed Practical Nurse (LPN) #7, on 06/23/16 at 6:45 PM, regarding the catheter change for Resident #3 on 06/19/16, revealed she made a mistake and was terminated by the DON. She stated the resident told her he was wet and a towel underneath the resident was soaked, and there was no urine in the bag. LPN #7 further stated the drainage bag was hazy and discolored and needed to be changed. The nurse acknowledged she did not notify the Physician of the condition change related to Resident #3's catheter and urinary status, as directed by the Care Plan, and did not obtain any orders because she knew he would okay it. Interview with LPN #3, on 06/23/16 at 11:20 AM, revealed the nurse should follow the Care Plan related to urinary catheters, and notify the Physician if symptoms indicated a problem, and obtain an order before proceeding to other interventions. Review of hospital records revealed Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED].#3 had remarkably infected urine and a Urology consult was ordered to address the resident's hematuria (blood in the urine). Review of the Urology consult note, dated 06/21/16, revealed the physician specialist documented the presence of gross hematuria, likely secondary to multiple traumatic attempts at catheterization at the facility. Continued review revealed the presence of a UTI, low urine output and acute renal (kidney) failure. Post-Survey Interview by phone with the Physician for Resident #3, on 06/29/16 at 11:15 AM, revealed he would have expected to be notified, (as directed by the Care Plan), when the resident developed problems associated with his catheter. He stated if he had been made aware of the leaking, bleeding, low urine output and difficulty flushing and changing the catheter, he would have cultured the resident's urine, verified placement and taken precautions to monitor the resident for further complications. 2. Review of the medical record revealed the facility admitted Resident #1 on 09/05/12 with [DIAGNOSES REDACTED]. Review of the Annual MDS Assessment, dated 04/06/16, revealed the facility assessed Resident #1 to have a BIMS score of (0), which indicated the resident was severely cognitively impaired. Continued review of the MDS revealed Resident #1 required extensive physical assistance of two persons for transfers. Review of the comprehensive Care Plan, dated 04/19/16, revealed Resident #1 was at risk for complications related to a self-care deficit. Continued review revealed interventions included staff assist of two (2) for transfers. Review of the care directives utilized by the SRNAs, for June 2016, revealed Resident #1 required the assistance of two (2) staff when transferring. Review of the Nurses Notes, dated 06/09/16 at 5:54 AM, revealed Resident #1 complained of left arm pain, and had a bruise on the left shoulder. Continued review revealed a portable x-ray was obtained, which showed a [MEDICAL CONDITION] humerus (upper arm). Review of the hospital radiology report, dated 06/09/16, revealed Resident #1 sustained a proximal left humerus fracture. Record review of the documented interview between the facility's Assistant DON (ADON) and SRNA #1, dated 06/09/16, revealed SRNA #1 acknowledged she had provided care to Resident #1 during her 3:00 PM to 11:00 PM shift on 06/08/16. Further review revealed the SRNA also acknowledged she transferred Resident #1 without other staff assistance on two (2) occasions during the 06/08/16 shift. The SRNA described the transfer as standing in front of the resident, wrapping her arms around the resident, grabbing the back of the the resident's pants, and lifting and pivoting the resident. Continued review revealed SRNA #1 did not ask other staff for assistance. Telephone interview with SRNA #1, on 06/23/16 at 3:11 PM, revealed she was assigned to care for Resident #1 on 06/08/16. She acknowledged she transferred the resident by herself, and without the use of a gait belt. She further stated the other SRNA was at lunch, so she just picked the resident up by the back of her pants and moved her, from the bed to the chair, and from the chair to the bed. Interview with the DON, on 06/24/16 at 2:45 PM, revealed SRNA #1 did not transfer Resident #1 appropriately when she did not obtain assistance. She stated the Care Plan was not followed regarding the directive to transfer with the assist of two (2) staff. The DON further stated the SRNA reported she thought she could do it by herself because the resident was little. Interview with the Administrator, on 06/24/16 at 3:30 PM, revealed once the Care Plan is developed by the Interdisciplinary Team, he expected staff to follow it. Regarding Resident #1, the Administrator stated the stakeholder transferred the resident improperly. Further interview revealed the SRNA did a return demonstration of that transfer and it was improper. The Administrator additionally stated the x-ray ruled out the resident's fracture was caused from impact because it was a [MEDICATION NAME] fracture, so it must have occurred during the transfer. Continued interview revealed the Administrator expected the nursing staff to follow the Care Plan for each resident, to ensure all needs were met.
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 observation, interview, record review, review of the facility's policy and the Resident Assessment Instrument (RAI) Manual, it was determined the facility failed to ensure an indwelling urinary catheter was not used unless there was valid medical justification. In addition, the facility failed to ensure services were provided to prevent Urinary Tract Infections (UTIs), and restore or improve normal bladder function to the extent possible, for one (1) of seven (7) sampled residents (Resident #3). On 05/11/16, Resident #3 was admitted to the facility with an indwelling urinary catheter without a supportive medical [DIAGNOSES REDACTED].#3's catheter. Furthermore, there was no evidence of re-assessment or bladder training in an attempt to restore or improve normal bladder function. On 06/19/16, Resident #3 developed complications related to the catheter which were exacerbated by the nurse's improper management and failure to notify the Physician. Resident #3 experienced pain, bleeding, and decreased urine output, which required admittance to the hospital, with gross hematuria (large amount of blood in the urine), UTI and Acute Kidney Failure. (Refer also to F157, F281, F282, F441, and F514) The findings include: The facility provided no written policy related to assessment and management of residents admitted to the facility with an indwelling urinary catheter. Interview with the Director of Nursing (DON), on 06/24/16 at 2:45 PM, revealed the facility uses the Resident Assessment Instrument (RAI) Manual to assess residents who are admitted to the facility with an indwelling urinary catheter. Review of the RAI Manual, Version 3.0, revealed indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of the catheter, the anticipated duration of use, and consideration of complications, which can include an increased risk of UTI, blockage of the catheter, pain and bleeding. Review of the facility's Policy titled Bladder Retraining & Toileting, dated 09/17/2015, revealed guidelines included the following: assess the resident to determine if the resident is capable of retraining and will cooperate with retraining; fill out the retraining document; and include the retraining on the Care Plan.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF GEORGETOWN	102 POCAHONTAS TRAIL GEORGETOWN, KY 40324

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F 0315 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) Review of the medical record revealed the facility admitted Resident #3 on 05/11/16 with [DIAGNOSES REDACTED]. Review of the nursing Admission Assessment revealed Resident #3 had an indwelling urinary catheter connected to a bedside drainage bag on admission; however, the section titled Indwelling Catheter Evaluation was not completed by the nurse. Continued medical record review revealed no documented medical justification for the urinary catheter, and no documented bladder retraining assessment completed according to facility policy. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/18/16, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was assessed to be cognitively intact and interviewable. Continued review of the MDS revealed the resident was assessed to have an indwelling catheter; however, there was no documented evidence of a supporting medical diagnosis. Review of the physician's orders [REDACTED]. Telephone interview with Resident #3's ex-wife, on 06/23/16 at 5:20 PM, revealed the resident came to the facility from the hospital with the urinary catheter in place. She stated the catheter was placed at the hospital because the resident was too weak to stand up to urinate, and no one ever took the catheter out. Review of the Comprehensive Care Plan, dated 05/20/16, revealed Resident #3 was at risk for complications related to bladder elimination and presence of an indwelling urinary catheter. The care plan goal stated the resident would have reduced risk of complications from the catheter through the next review date. Approaches included to monitor and report any changes in bladder status. Continued review of the Care Plan revealed no individualized interventions related to a medical justification for the catheter, no interventions for determining if the underlying reason for the catheter could be reversed, and no plan for bladder retraining and possible removal of the catheter. Telephone interview with Licensed Practical Nurse (LPN) #5, on 06/24/16 at 2:15 PM, revealed the process for determining if a urinary catheter was medically necessary was to read the resident's History and Physical to see why the catheter was placed. She stated there were various reasons for a catheter, e.g. wounds, [MEDICAL CONDITION] and immobility, but she could not provide the medical justification for Resident #3's catheter. Interview with LPN #2, on 06/24/16 at 2:00 PM, revealed she and LPN #5 had completed the admission process and paperwork for Resident #3. She stated the admitting nurse should take report from the hospital, and ask questions regarding the catheter, e.g. what size it was, when and why it was placed. She further stated the information should be documented. Continued interview revealed the facility had a protocol for bladder retraining, but Resident #3 did not have an order for [REDACTED].>Further interview with the DON, on 06/24/16 at 2:45 PM, revealed a resident admitted with an indwelling catheter was assessed and care planned with interventions for maintaining the catheter, or the catheter was discontinued if there was not a [DIAGNOSES REDACTED]. The DON stated the IDT looked for supporting [DIAGNOSES REDACTED]. If the Physician did not provide a diagnosis, the facility followed their protocol for bladder retraining. Further interview revealed Resident #3 should have been re-assessed for a medical reason to continue the catheter. She acknowledged there was no documented evidence the resident was re-assessed since admission. Regarding the nursing Admission Assessment, the DON stated it was the responsibility of the admitting nurse to ensure the Indwelling Catheter Evaluation section was completed and documented. She stated the evaluation should identify exclusions; if there were no exclusions, the resident should be re-assessed for discontinuing the catheter. Post-survey telephone interview with the MDS nurse, on 06/28/16 at 11:40 AM, revealed residents admitted with an indwelling urinary catheter were evaluated by the IDT to identify the medical justification for the catheter. She explained if there was not an appropriate diagnosis, the doctor was notified to ensure the catheter was medically necessary. She stated our doctor (Resident #3's doctor) would not write a [DIAGNOSES REDACTED]. Continued interview revealed the IDT followed up for re-evaluations of the need for a catheter, and stated there was not a specific timeframe for follow-up because every resident was different. The MDS nurse responded, No, an inability to urinate unless standing up was not a qualifying [DIAGNOSES REDACTED]. Post-survey telephone interview by phone with the Staff Development Coordinator (SDC), on 07/01/16 at 1:00 PM, revealed she was not an official part of the IDT. She stated her responsibilities were predominantly related to staff orientation and training, and she had little involvement in the resident admission evaluation process. She further stated she was aware an indwelling catheter required a medical diagnosis, and the IDT had to take further steps if there was not a qualifying reason for the catheter, but she could not say what the exact process was. Interview with SRNA #8, on 06/24/16 at 11:30 AM, revealed on 06/19/16 at approximately 1:00 PM, Resident #3 reported his/her catheter was leaking. The SRNA informed LPN #7, who gathered supplies and entered the resident's room. When SRNA #8 returned to the room, he observed LPN #7 had taken the old catheter out and was having a difficult time inserting a new one. He stated when the nurse tried to put the new catheter in, the resident cried out, Stop! Stop! and began bleeding. The nurse stopped, obtained another catheter and inserted it. Resident #3 started crying and told the nurse to take it out because he/she couldn't stand it. SRNA #8 stated, LPN #7 removed the new catheter and handed the original catheter to the SRNA and directed him to rinse it off in the bathroom. The nurse reinserted the used catheter and secured it, and left the resident's room. Telephone interview with Licensed Practical Nurse (LPN) #7, on 06/23/16 at 6:45 PM, revealed Resident #3 reported being wet. She stated a towel underneath the resident was soaked, and there was no urine in the drainage bag. LPN #7 further stated the drainage bag was hazy and discolored and the catheter needed to be changed. The nurse acknowledged she did not notify the Physician of the condition change related to Resident #3's catheter leaking, and did not notify the Physician when the resident had bleeding associated with repeated attempts by the nurse to flush the catheter, and change the catheter. Post-Survey telephone interview with Resident #3's Physician, on 06/28/16 at 11:15 AM, revealed if a resident was admitted to the facility with an indwelling catheter, he would rely on the Discharge Summary from the prior facility to determine the medical justification for continuing the catheter. He stated the resident should be care planned based on the diagnosis, and re-assessment determined if bladder training was possible. Continued interview revealed he would have expected the nurses to notify him of changes in the resident's urinary status, including leaking, obstruction, decreased urinary output, or the need for irrigation or replacement of the catheter. Furthermore, he would have expected to be immediately notified of a traumatic catheter insertion, such as occurred with Resident #3. The Physician stated he would have cultured the urine, verified placement and initiated precautions to monitor the resident for complications. Further interview revealed the Physician was not notified of any catheter problems for Resident #3 until the resident was on the way out of the facility to the hospital. Review of the hospital History and Physical, signed by the admitting Physician and dated 06/20/16, revealed a [DIAGNOSES REDACTED]. Review of the Urology consult note, dated 06/21/16, revealed the Physician specialist documented the presence of gross hematuria, likely secondary to multiple traumatic attempts at catheterization at the facility. Continued review revealed the presence of a UTI, low urine output and acute renal (kidney) failure. Interview with the Administrator, on 06/24/16 at 3:30 PM, revealed he expected nursing staff to follow facility policy and adhere to accepted standards of practice as it related to residents with indwelling urinary catheters.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and review of the facility's policy,it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for one (1) of seven (7) sampled residents (Resident #1). The findings include: Policy review of the facility's Incident Reporting policy (effective Dec. 2010) revealed under the Guideline - the facility was to ensure the resident's environment was as free of accident hazards as possible and each resident was to receive adequate supervision and assistive devices to reduce accidents. Further review of the policy revealed the Charge Nurse/designee was to add interventions to the plan of care as needed. Record review the facility admitted Resident #1 on 09/05/12 with [DIAGNOSES REDACTED]. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment, completed 04/04/16 revealed the resident was assessed as

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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) requiring extensive assistance with transfers and required two (2) persons to physically assist. Review of Resident #1's plan of care, dated 04/19/16, related to self care deficit, revealed an intervention for assistance of two (2) staff for transfers. Review of Resident #1's June 2016 Care Directive Record, utilized by State Registered Nursing Assistants (SRNA), directed nursing staff to use two (2) staff persons when transferring the resident. Record review of Nurses Notes, dated 06/09/16 at 5:54 AM, revealed Resident #1 complained of left arm pain, and had a bruise on the left shoulder, the facility assessed the resident and a portable x-ray was done. The x-ray revealed a transverse fracture of the proximal left humerus. Review of the emergency room report, dated 06/09/16 revealed these types of fractures are suspicious in a non-mobile adult. Treatment recommendations included a sling and swath to keep the arm immobilized and pain control medication. Record review of the 06/09/16 interview between the facility's Assistant Director of Nursing (ADON) and SRNA #1 revealed SRNA #1 acknowledged she had provided care to Resident #1 during her 3:00 PM to 11:00 PM shift on 06/08/16. Further review of the documented interview revealed SRNA #1 also acknowledged she had self transferred Resident #1 on two (2) occasions during the 06/08/16 shift. The SRNA described the transfer as standing in front of the resident, wrapping her arms around the resident, grabbing the back of the pants, lifting and pivoting the resident. According to the documented interview, SRNA #1 did not ask other staff members for transferring assistance on 06/08/16. Interview conducted, on 06/23/16 at 3:12 PM, with SRNA #1 revealed the she was assigned to Resident #1 on 06/08/16. SRNA #1 stated she transferred the resident by herself and without the use of a gait belt. SRNA #1 described how she transferred the resident from the Broada Chair to the bed and from the bed to the Broada Chair. When asked why no assistance with the transfer was requested, SRNA #1 stated the other SRNA was at lunch so she just picked Resident #1 up by the back of the pants and moved Resident #1. Review of the facility's investigation revealed the following corrective actions had occurred prior to the State Survey Agency entering the facility on 06/23/16: 1. An incident of a fracture of unknown origin was reported to the Office of the Inspector General on 06/13/16. The facility's investigation of the incident was initiated on 06/09/16 and included the following: The alleged perpetrator, SRNA #1's employment was terminated, re-education continues for all the nursing staff on following residents' plan of care and random audits being completed for appropriate care as stated on resident care plans. 2. Record review of the facility's Termination Information form revealed SRNA #1's employment was terminated by the facility on 06/14/16 following an internal incident investigation. 3. The physician was notified on 06/09/16 of Resident # 1's complaints of pain in her left arm. A portable x-ray was ordered. 4. Resident #1 was transferred to a local Acute Care Hospital Emergency Department for further evaluation and prior to the results of the portable x-ray were available for review. 5. The Acute Care Hospital informed the facility Resident #1 had sustained a fracture of his/her left arm. 6. Staff completed resident interviews of the current resident population to ensure their needs were being met and they didn't feel any staff member was abusive. 7. A Witness Statement was conducted on 06/09/16 with SRNA #1. SRNA #1's employment was terminated by the facility on 06/14/16. 8 . SRNA's last day worked was 06/08/16, the date of the alleged incident. 9. Re-education of Gait Belt competency, Sit to Stand Lift-Bedside to Wheelchair competency and Transferring to Wheelchair competency was provided to all of the facility's direct care staff, by the Director of Nursing on 06/16/16 and 06/17/16 with return demonstration for competency. 10 Interviews conducted with SRNA #9 and #10, on 06/24/16 at 5:30 PM and 5:35 PM, confirmed facility staff received the re-education by the Director of Nursing on 06/16/16. 11. The facility's Director of Nursing and ADON documented and per interview on 06/23/16, revealed they were conducting daily transfer observations on 06/18/16 and 06/19/16 to ensure competency of the education and ensure direct care staff was following care plans related to transfers.
F 0441 **Level of harm -** Actual harm **Residents Affected -** Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's policy and review of the Centers for Disease Control (CDC) Guidelines, it was determined the facility failed to ensure safe and sanitary practices to prevent the development and transmission of disease and infection for one (1) of seven (7) sampled residents (Resident #3). Licensed Practical Nurse (LPN) #7 did not follow professional nursing standards on 06/19/16 when Resident #3 had a change in bladder status and leakage of urine from around the indwelling urinary catheter. After attempting to irrigate the catheter with no success, LPN #7 removed the existing urinary catheter, and attempted to insert another, larger catheter. When that failed, the nurse instructed the State Registered Nurse Assistant (SRNA) to wash the old catheter, and the nurse re-inserted the un-sterile, used catheter into the resident's bladder. Later that night, and into the morning of 06/20/16, the resident's ex-wife, who visited the resident often, noticed a decline in the resident and expressed her concerns to the nurses on duty. On 06/20/16, at the insistence of the ex-wife, Resident #3 was sent to the hospital. Review of the hospital emergency room (ER) record revealed the resident had minimal or no urine output since the urinary catheter was changed the day before, and lab results revealed a severe urinary tract infection (UTI). Resident #3 was diagnosed in sepsis and septic shock, which is a serious medical condition where organs are injured or damaged in response to infection. The primary infection is most commonly caused by bacteria, and can be located in any part of the body, but most commonly in the lungs, brain, urinary tract or abdominal organs. It can cause multiple organ failure and death. Resident #3 experienced a rapid decline in the ER which resulted in not being able to breathe on independently. Resident #1 was intubated, (which means a tube was placed down the throat into the lungs) and was put on a mechanical ventilator machine. According to the Urology Consult report, Resident #3 had gross hematuria, which is a large amount of blood in the urine. The report stated this was mostly likely caused by multiple, traumatic catheterizations, which was followed by low urine output, difficulty breathing and sepsis. (Refer also to F157, F281, F282, F315, and F514) The findings include: Review of the facility's policy titled Catheterization Policy, undated, revealed steps which included Open the sterile catheterization tray and establish a sterile field, and Open the catheter of proper diameter and balloon size and drop it on the sterile field. The facility did not provide a policy for Infection Control. The facility provided a sheet of paper with the statement Infection Control Program. Signature Healthcare of Georgetown follows CDC Guidelines and Heaton manual for Infection Control Policies and Procedures. Review of the CDC Guideline recommendations regarding catheter changes revealed only properly trained persons who knew the correct technique of aseptic, or sterile method, of catheter insertion were given the responsibility to perform catheterizations. Continued review revealed sterile technique and equipment was necessary to prevent harmful organisms from entering the body and causing infection. Review of Resident #3's medical record revealed the resident was admitted by the facility on 05/11/16, with [DIAGNOSES REDACTED]. Review of the nursing admission assessment revealed the resident had an indwelling urinary catheter connected to a bedside drainage bag. Review of Resident #3's Admission Minimum Data Set (MDS) Assessment, dated 05/18/16, revealed Resident #13 was assessed to have a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was cognitively intact and interviewable. Continued review of the MDS revealed the resident was assessed to have an indwelling catheter, but no documented medical [DIAGNOSES REDACTED]. Review of the Transfer Form, dated 06/20/16 at 10:00 AM, revealed the nurse noted Resident #3 had had no urine output for twelve (12) hours, and exhibited a decreased level of consciousness and generalized weakness. Review of the hospital History and Physical, signed by the admitting Physician and dated 06/20/16, revealed in the ED, Resident #3 was moderately distressed with increased respiratory effort. The resident required intubation and mechanical ventilation, and was transferred to the Intensive Care Unit (ICU), where Resident #3 continued with low urine output that was very bloody in nature. Continued review revealed a [DIAGNOSES REDACTED]. Review of the Urology consult note, dated 06/21/16, revealed the Physician specialist documented the presence of gross hematuria, likely secondary to multiple

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F 0441 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) traumatic attempts at catheterization at the facility. Continued review revealed the presence of a UTI, low urine output and acute renal (kidney) failure. Interview with State Registered Nurse Assistant (SRNA) #8, on 06/24/16 at 11:30 AM, regarding the catheter change Licensed Practical Nurse (LPN) #7 performed for Resident #3 on 06/19/16, revealed the resident had urine leakage from around the catheter. LPN #7 removed the existing catheter, attempted to replace it with a bigger catheter and was unsuccessful, had the SRNA wash off the used catheter in the bathroom. The nurse then reinserted the used, un-sterile catheter into the resident's bladder and connected to the bedside drainage bag. Interview by phone with Registered Nurse (RN) #1, on 06/24/16 at 12:30 PM, regarding Resident #3's catheter change revealed on 06/19/16, the evening shift nurse/LPN #6 said in shift report, that LPN #7 tried to change the catheter, but ended up putting the same catheter back in. She stated LPN #7 said she cleaned the used catheter before she put it back in. RN #1 further stated, I wondered how she did it, because we don't have an autoclave (sterilizing machine). Interview with the Director of Nursing (DON), on 06/24/16 at 2:45 PM, revealed the facility followed the CDC Guidelines for infection control and frequency of changing catheters. The DON stated she expected nurses to follow Professional Standards and facility policy, and nurses should never re-use a catheter. Interview with the Administrator, on 06/24/16 at 3:30 PM, revealed he expected the nurses to follow Professional Standards and absolutely not re-use a catheter that had been removed. A post-exit interview by phone with Resident #3's Physician, on 06/28/16 at 11:15 AM, revealed he would have expected the nurses to notify him of any changes in resident's urinary status, which would have included leakage, obstruction, decreased urinary output and need for irrigation or catheter change orders. Continued interview revealed the physician would have expected to be notified immediately of an improper catheter insertion, such as occurred with Resident #3. The physician stated, he would have cultured the urine, verified placement and took precautions to monitor the resident for complications. He stated the nurse re-inserting a catheter that had been in the trash is bizarre behavior, and shows the nurse was negligent in her thought processes. He stated you should never re-use needles or catheters.
F 0514 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of the Lippincott Manual of Nursing Practice, it was determined the facility failed to maintain clinical records on each resident in accordance with acceptable professional standards of practice that were complete and accurately documented, for one (1) of seven (7) sampled residents (Resident #3). On 06/19/16 at 6:00 PM, Licensed Practical Nurse (LPN) #7 tried to irrigate Resident #3's catheter but could not, so she changed Resident #3's indwelling urinary catheter and failed to document the event in the resident's clinical record in accordance with acceptable professional standards. On the resident's Daily Skilled Nurse Note dated 06/19/16 and timed 6:00 PM, LPN #7 documented the resident had a urinary catheter and was incontinent of bladder. Further record review revealed incomplete or incorrect historical information related to Resident #3's indwelling urinary catheter on other nurses notes and Physician's Progress notes. The findings include: The facility did not provide a specific policy regarding documentation in the clinical record. Interview with the Director of Nursing (DON), on 06/23/16 at 11:00 AM, revealed the facility followed nursing practice standards outlined in the nursing manuals Lippincott and Potter & Perry. Continued interview with the DON revealed the facility did not have a current copy of the nursing reference, but if needed they would just look them up on-line and print them off. Review of the Lippincott Manual of Nursing, Ninth Edition dated 2010, revealed professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable. Patients can suffer adverse outcomes when nurses fail to assess the patient properly, notify physicians of changes, obtain orders for care, adhere to facility policy or procedure, and fail to document information in the medical record. Review of Resident #3's medical record revealed the facility admitted the resident on 05/11/16, with [DIAGNOSES REDACTED]. Review of the nursing Admission Assessment revealed the resident had an indwelling urinary catheter connected to a bedside drainage bag; however, review of the Indwelling Catheter Evaluation section, revealed it was not completed by the nurse. Review of the resident's Admission Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of twelve (12), which indicated the resident was assessed to be cognitively intact and interviewable. Continued review of the MDS revealed the resident was assessed to have an indwelling catheter, but no medical [DIAGNOSES REDACTED]. Continued review of Resident #3's clinical record revealed no documentation of an indwelling urinary catheter, or a [DIAGNOSES REDACTED]. Review of Resident #3's clinical record nurses notes, revealed on 05/11/16 at 5:00 PM, Licensed Practical Nurse (LPN) #5 did not document the size of the indwelling Foley (urinary) catheter or the bulb size on the Nursing Admission Assessment. On 06/06/16 at 11:50 AM, Registered Nurse (RN) #2 did not document the presence of a catheter, and documented Resident #3 was continent of bladder with incontinent episodes. On 06/19/16 at 6:00 PM, LPN #7 changed Resident #3's indwelling urinary catheter and did not document the event in the resident's clinical record. In addition, LPN #7 did not document the resident's change in condition which included leaking around the catheter, pain, bleeding and decreased urine output. An attempt to interview RN #2 by phone regarding not documenting the urinary catheter was unsuccessful. Interview by phone with LPN #7, on 06/23/16 at 6:45 PM, regarding the catheter change done 06/19/16, revealed she made a mistake. She stated she put in the wrong size catheter and didn't know what size to put in. She stated she didn't see the size in the chart or on the catheter, and didn't chart it because she was too busy. She stated she planned on charting it the next morning, 06/20/16, but was terminated from her position by phone before she could complete the documentation. Interview by phone with LPN #5, on 06/24/16 at 2:15 PM, regarding Resident #3's Nursing Admission Information note dated 05/11/16, revealed she should have documented about the catheter in the notes. Interview with the Director of Nursing (DON), on 06/24/16 at 2:45 PM, regarding documentation by the staff, revealed the DON expected staff to document all resident care, including a urinary catheter change. Interview with the Administrator, on 06/24/16 at 3:30 PM, revealed he expected staff to follow their training and facility policy related to documenting in the clincial record.