

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/13/2015
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NAME OF PROVIDER OR SUPPLIER MILL POND HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1014 MILL POND LN GREENCASTLE, IN 46135
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for a Recertification and Stage Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00162418</p> <p>Complaint #IN00162418-Substantiated. Federal/State deficiency related to the allegation is cited at F314.</p> <p>Survey dates: January 5,6,7,8,9,12, and 13, 2015</p> <p>Facility number: 004550 Provider number: 155736 Aim number: 200526450</p> <p>Survey team: Laura Brashear, RN, TC Mary Weyls, RN Vicki Nearhoof, RN January 5, 6, 7, 8, 9, and 12, 2015 Geoff Harris, RN January 5, 6, 7, 8, 9, and 12, 2015 Jennifer Mcelwee, RN</p> <p>Census bed type: SNF: 21 SNF/NF: 35 Residential: 31 Total: 87</p>	F000000		

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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F000164 SS=D	<p>Census payor type: Medicare: 21 Medicaid: 17 Other: 18 Total: 56</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1</p> <p>Quality review completed 1/16/2015 by Brenda Marshall, RN.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another</p>			

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	<p>health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation and record review, the facility failed to ensure full visual privacy to 3 of 3 residents during provision of personal and or medical care. [Residents #102, #115, and #119]</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 1/8/15 at 3:10 p.m., CNAs #5 and #6 were observed to transfer Resident #102 from the wheelchair to bed with a mechanical lift. Once the resident was positioned on her side in bed, clothing was removed. The staff provided incontinence care to the resident. The privacy curtain was not pulled around the foot of the bed which made the resident visible to staff entering the room, and potentially to the roommate that was ambulating in the room. The door to the room was opened throughout the provision of care multiple times, which made the resident visible. On 1/9/15 at 2:45 p.m. the wound nurse provided a treatment to a pressure area on Resident #119. During the 	F000164	<p>All residents could be affected by the alleged deficient practice. All Nursing staff will be educated on resident rights and the right to personal privacy and confidentiality of his or her personal and clinical records. DHS or Designee will monitor 3 residents per hallway 3x weekly x 4 weeks. DHS or designee will monitor 3 residents per hall every two weeks x 4 weeks. Then 3 residents monthly x 4 months. Then 3 residents monthly x 6 months All audit results will be reported monthly at QA meeting x 6months.</p>	02/13/2015

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F000241 SS=D	<p>procedure the resident's roommate was in bed. The privacy curtain between the residents was pulled half way. The roommate of Resident #119 had visual view. During the treatment Resident #119's right hip and abdominal area were exposed.</p> <p>3. On 1/8/15 at 12 noon, CNAs #1 and #2 provided care to Resident #115. The resident was on her back with knees bent and legs open. The gown was above the resident's waist. The CNAs left the resident's bedside to get other items and the resident lay exposed.</p> <p>The facility provided a booklet titled "Resident Move-in Guide" on 1/12/15 at 11 a.m. identified as the facility's policy for provision of privacy in the section "Resident Rights." The section included but was not limited to "You have the right to personal privacy."</p> <p>3.1-3(p)(2) 3.1-3(p)(4)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p>			

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	<p>Based on observation, record review and interview the facility failed to ensure residents were cared for in a respectful manner for 2 of 3 residents observed requiring assistance with personal privacy issues and/or family concerns with positioning during meal services. (Resident #'s 102, and 119)</p> <p>Findings include:</p> <p>1. On 1/9/14 at 9:45 a.m., Resident #119 was observed in a lounge across from the nursing station. The resident was sitting in a wheelchair watching TV. A urinary drainage bag was attached under the resident's wheelchair. The drainage bag was not covered and urine was observed in the bag.</p> <p>The resident's clinical record was reviewed on 1/9/14 at 11:44 a.m. A current plan of care addressed the resident's use of a urinary catheter with an approach of "Cover my catheter drainage bag with a dignity cover."</p> <p>2. On 1/8/15 at 2:00 p.m. Resident #102's family member was interviewed. The family member indicated she had just come in to visit the resident after she had returned from a medical appointment. The family member indicated she found the resident in bed, positioned on her side, her coat was on</p>	F000241	<p>All residents have the potential to be affected by the alleged deficient practice. Educate nursing staff to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Monitor catheter bags to ensure they are covered properly and ensure residents are set up prior to hall meal service. Audit meal service in the dining room and hall tray service to ensure dignity is honored in regard to removal of outerware and proper seating. Monitor 3 residents per hallway x 4 weeks then 3 residents per hallway every 2 weeks x 4 weeks. Then 3 residents per month x 4 months. Then 3 residents monthly times 6 months All audit reports will be sent to QA monthly for review x 6 months</p>	02/13/2015			

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	<p>and lunch tray was on the bedside table. The resident held a piece of meat in her hand and was trying to eat it.</p> <p>On 1/13/15 at 3:00 p.m., the Director of Nursing (DON) was interviewed. The DON indicated the resident's coat should have been removed and staff should have positioned the resident in a comfortable seating arrangement before serving her lunch.</p> <p>The resident's Minimum Data Set assessment dated 10/17/14, coded the resident as requiring extensive assistance with bed mobility, dressing, and set-up and supervision with eating.</p> <p>On 1/12/15 at 11:00 a.m. the DON provided a booklet titled "Resident Move-in Guide" [no date] identified as included the facility's policy on dignity. The documentation included, but was not limited to: "You have the right to receive services with reasonable accommodation of individual needs and preferences. This Means That: 1. The facility provides services in a manner that will assist you in maintaining your independent functioning, dignity, and well-being.... 3. The facility will provide nursing care and accommodations that meet your needs."</p> <p>3.1-3(t)</p>						

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to provide an appropriate height toilet for 1 of 1 resident in Stage I reviewed for expressed concerns related to accommodation of needs (Resident 112).</p> <p>Finding includes:</p> <p>On 1/5/14 at 12:09 p.m., Resident #112 was interviewed. The resident indicated her roommate utilized a raised toilet seat. She indicated when the seat was in place, she had trouble getting on the raised toilet seat and her feet did not reach the floor when she sat on it. The resident indicated she urinated on the floor when trying to get on the toilet and used paper towels to wipe the urine from the floor.</p> <p>A Physical Therapy Assistant was interviewed on 1/9/15 at 10:57 a.m. The therapist indicated when a resident was admitted they were assessed for necessary durable medical equipment. The</p>	F000246	<p>2 residents have the potential to be affected by the alleged deficient practice DHS or designee will work with therapy to ensure residents are provided appropriate height toilet seats for individual rooms. Nursing staff will be educated to utilize appropriate seats for each resident DHS or designee will audit every resident with raised toilet seat daily and check three residents on each hall 3 x weekly then 3 residents on each hall every two weeks and then 3 residents monthly x 4 months. Then 3 residents monthly x 6 months All audits will be reported to QA monthly x 6 months</p>	02/13/2015

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F000314 SS=G	<p>therapist indicated a recommendation had been made for the CNAs (Certified Nurse Aides) to remove the riser when Resident #112 used the toilet. The therapist indicated the CNA indicated it was "too much work" to move the toilet seat and indicated the resident's toes touched the floor when she sat on the raised seat. The therapist indicated the resident required a toilet seat that allowed flat placement of her feet on the floor.</p> <p>The resident's clinical record was reviewed on 1/12/15 at 10:13 a.m. An initial Minimum Data Set assessment coded the resident with no cognitive impairment. Diagnoses included but were not limited to, Rheumatoid arthritis, osteoarthritis, and knee repair.</p> <p>3.1-e(v)(1)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p>			
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	<p>Based on interview, observation, and record review, the facility failed to evaluate alternate pressure reducing options and failed to ensure a timely repair/replacement of a broken recliner for a resident whose preference was to sleep in a recliner. This deficient practice resulted in stage II pressure ulcers developing on the buttocks of a resident not identified at risk for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident A).</p> <p>Finding includes:</p> <p>During interview of Resident A on 1/12/15 at 10:35 a.m., the resident indicated her "bottom" was sore. The resident indicated she slept in her recliner because her back hurt and indicated the recliner had been broken since before Christmas. She indicated she was unable to recline the chair and her son told her he would call the company where the chair had been purchased. During the interview the resident was sitting in a wheelchair without a pressure relieving cushion. She patted the seat of the recliner and indicated her bottom was sore from sitting in the recliner all night without being able to recline.</p> <p>During interview of LPN #9, on 1/12/15 at 10:35 a.m., the nurse indicated she</p>	F000314	<p>All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be inserviced to ensure residents who enter the facility without pressure sores do not develop pressure sores unless the individuals condition clinically demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. All residents will be evaluated to ensure proper use of pressure reducing devices and assessment of each resident to ensure proper prevention in place. DHS or designee will audit all pressure relieving devices daily to ensure proper position and functionality x 4 weeks then 3 residents per hall daily x 4 weeks then 3 residents monthly x 4 months. Audit results will be forwarded to QA monthly x 6 months.</p>	02/13/2015

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	<p>thought the resident's son was going to get a new chair for her. The nurse indicated the resident had a concern with her "bottom" and indicated the resident refused the waffle seat cushion that was offered.</p> <p>During interview of LPN #8, on 1/12/15 at 12:05 p.m., the LPN indicated "some time before Christmas" the resident's son indicated the chair's foot rest would not come up when he tried to recline the chair. The LPN indicated the son told him he was going to get the chair fixed and indicated he had not told any other staff about the broken chair.</p> <p>During interview of the wound nurse on 1/12/15 at 11:25 a.m., the nurse indicated the resident's chair was broken and she thought the resident's son was going to take care of fixing it. The wound nurse stated "I gave her a waffle cushion to sit on while in the wheelchair and in the recliner but she refused to use it. She also refused the offer of a bed."</p> <p>During observation on 1/12/15 at 11:25 a.m., the wound nurse assessed the resident's buttocks, the resident was observed with an open area on the upper, right, inner gluteal fold and another open area on the left buttock. The wound nurse indicated the areas were stage 2</p>			

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	<p>pressure ulcers (Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. May also present as an intact or open/ruptured blister.)</p> <p>Prior to the observation, the resident was sitting in a wheelchair without a cushion. The resident stood to allow the observation.</p> <p>Resident A's clinical record was reviewed on 1/12/15 at 2 p.m. A diagnosis was noted of, but not limited to Diabetes Mellitus. A quarterly assessment dated, 8/20/14, indicated the resident was cognitively intact, required limited assist of one person for toileting and not at risk for developing a pressure ulcer.</p> <p>A form titled "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" was noted, dated 12/29/14, indicating a stage 1 [Stage I - An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: - Skin temperature (warmth or coolness); - Tissue consistency (firm or boggy); - Sensation (pain, itching); and/or - A defined area of persistent redness in lightly pigmented skin, whereas in darker</p>			

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	<p>skin tones, the ulcer may appear with persistent red, blue, or purple hues.] pressure area on the sacrum measuring 4 cm (centimeter) length by 11 cm width by 0 cm depth.</p> <p>A nurse's note, dated 12/30/14 at 10:00 a.m., indicated the resident was noted with a red area on the coccyx. The note indicated the wound nurse assessed the area and suggested the resident sleep in a bed instead of a recliner to relieve pressure from the coccyx area. The documentation indicated the resident refused and stated she couldn't sleep in a bed because it hurt her back. The record indicated the resident was given a waffle cushion to sit on while in recliner and/or wheelchair to relieve pressure.</p> <p>Documentation on 1/6/15 indicated a stage 1 pressure area on the resident's left buttocks measuring 2.0 cm by 2.0 cm by 0 cm and a stage 1 area on right buttocks measuring 2.0 cm by 2.0 cm by 0 depth.</p> <p>Documentation on 1/12/15 indicated a stage 2 pressure area on the right inside gluteal fold measuring 1 cm length by 0.2 cm width by 0.1 cm depth., a stage 2 pressure area on the left buttock measuring 1 cm length by 1 cm width by less than 0.1 cm depth. and a stage 1 pressure area to the right buttock</p>			

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F000315 SS=E	<p>measuring 1 cm length by 1 cm width by 0 depth.</p> <p>During interview of the wound nurse on 1/13/15 at 10 a.m., the wound nurse indicated she had called the company where the resident purchased her recliner, and indicated the company planned to deliver a recliner for the resident on that date. The wound nurse indicated the only pressure reducing interventions offered since the stage one pressure area was identified on 12/30/14, were a waffle cushion and a bed.</p> <p>During review of a facility policy and procedure titled "WOUND STAGING AND IDENTIFICATION EDUCATIONAL INFORMATION" received on, 1/13/15 at 3 p.m., from the wound nurse, documentation indicated possible causes for non-healing wounds as "Continued pressure".</p> <p>This Federal tag relates to complaint IN00162418.</p> <p>3.1-40(a)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a</p>				

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	<p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interview, the facility failed to ensure services were provided to prevent possible urinary tract infections for 4 of 4 residents reviewed with urinary catheters. (Residents #'s 65,102,115,119)</p> <p>Findings include:</p> <p>1. On 1/6/15 at 10:06 a.m., Resident #65 was observed self propelling in a wheelchair and a urinary catheter drainage tubing was dragging the floor. The catheter tubing became wrapped under the wheel of the wheelchair. The resident picked up the tubing and held it while he propelled himself in the wheelchair.</p> <p>On 1/8/15 at 11:22 a.m., the resident was observed lying in his bed sleeping. The resident's urinary catheter bag was not anchored on the bed and was sitting on the floor.</p> <p>On 1/8/15 at 12:24 p.m., the resident was observed exiting the bathroom in his</p>	F000315	<p>residents with an indwelling catheter have the potential to be affected by the alleged deficient practice. DHS or designee will inservice staff to ensure residents receive appropriate treatment and services to prevent urinary tract infections DHS or disignee will monitor catheter bag placement and monitor catheter tube placement. DHS or designee will audit 6 residents weekly x 4 weeks then 3 residents every two weeks x 4 weeks and then 3 residents monthly x 4 months. Then 3 residents monthly x 6 months Audits will be reviewed monthly x 6 months at QA meeting</p>	02/13/2015

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	<p>room. He was holding his urinary catheter tubing in his right hand while he propelled himself in the wheelchair.</p> <p>On 1/8/15 at 11:16 a.m., during interview with RN #7, she indicated the resident had been treated for a Urinary Tract Infection (UTI), "a while back." She indicated the physician ordered an antibiotic (ATB) but the ATB course was completed. She indicated the CNAs performed urinary catheter care every shift.</p> <p>On 1/9/15 at 9:27 a.m., during an interview with Resident #65, he indicated he had always had an issue with his catheter tubing dragging the ground and having to hold it when propelling in the wheelchair. He stated, "they try to fasten it to my leg but it never stays fastened." The resident indicated the catheter tubing pulled tightly at times and it did cause discomfort to him when it happened. He indicated he had tried a leg bag in the past but it had not worked well for him. At the same time the urinary catheter tubing was observed under his wheelchair and was in contact with the floor.</p> <p>On 1/9/14 a.m., at 11:54 a.m., during and interview with CNA #10, and CNA #11 the CNAs indicated they performed</p>			

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	<p>urinary catheter care every shift and as needed. They indicated they emptied and measured the output in the urinary catheter bag, cleansed the urinary catheter tubing and the area around the urinary catheter tubing, each time they provided the care.</p> <p>On 1/8/15 at 9:49 a.m., Resident # 65's medical record was reviewed. The record indicated the resident was originally admitted on 11/14/14 and did not have a urinary catheter at the time of his admission.</p> <p>A form titled "Change in Condition Form," dated 12/5/14, included documentation that the resident had mild confusion and stated he did not know "why things are happening." A urine analysis (UA) was obtained. The results of the UA indicated abnormal values included but were not limited to, a pH of 7.5, Ketones-trace, Blood 2+ and Bacteria-few. A physician's order dated 12/5/14 was noted for Doxycycline (antibiotic) 100 mg twice daily for 10 days.</p> <p>A physician's order, dated 12/6/14, was obtained to send the resident to the emergency room (ER) for evaluation and treatment. The resident was admitted to the hospital under observation status on</p>			

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	<p>12/6/14. The resident was discharged back to the facility on 12/7/14. The discharge diagnoses included, but were not limited to UTI and benign prostatic hyperplasia (BPH) with urinary tract obstruction. The resident was readmitted to the facility with a urinary catheter.</p> <p>A document titled "Elimination Circumstance, Reassessment, and Intervention," dated 12/7/14, indicated the resident had an insertion of a urinary catheter related to urinary retention and bladder trauma. Approach/Interventions included but were not limited to, encourage fluids, assess for sign and symptoms of UTI, and provide catheter care.</p> <p>A current copy of Resident #65's care plan was received from the Director of Nursing (DON) on 1/8/15 at 10:40 a.m. The care plan problem areas included but were not limited to, having a UTI and having an indwelling urinary catheter.</p> <p>A review of the 14-day Minimum Data set assessment (MDS) dated 12/21/14, coded the resident with a mild cognitive deficit..</p> <p>2. On 1/8/15 at 9:45 a.m., Resident #115 was in bed. The resident's urinary drainage tubing extended out from the</p>			

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	<p>top of the urinary drainage bag that was hanging from the lower bed frame, then looped down and along the floor before extending up to the top of the bed.</p> <p>On 1/8/15 at 12 noon, CNA #'s 1 and 2 were observed providing care to Resident #115. Prior to providing care and/or repositioning, the resident's urinary drainage tubing was observed attached to a urinary catheter and positioned under the resident's thigh. The urinary catheter was pulled taunt at least two times during care.</p> <p>On 1/8/15 at 2 p.m., the resident was observed in bed. The resident's urinary drainage tubing was observed to be extending out from under her thigh.</p> <p>During interview of the DON (Director of Nursing) and wound nurse on 1/8/15 at 3:09 p.m., the DON indicated staff should have positioned the urinary drainage tubing over a resident's thigh.</p> <p>On 1/8/15 at 4 p.m., with the wound nurse present, the resident's urinary drainage tubing was laying under the resident's thigh. The tubing extended down to, and along the floor. The urine in the tubing was observed to be mixed with a white substance. The wound nurse did not address the urinary drainage tubing</p>			

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	<p>on the floor.</p> <p>During review of Resident #115's clinical record on, 5/12/15 at 10 a.m., a diagnosis was noted of ovarian cancer, and indicated the reason for a urinary catheter was the terminal illness.</p> <p>3. During initial tour on 1/5/15 at 10:20 a.m., Resident #119 was observed sitting in a wheel chair in the hallway. The resident was observed to have a urinary drainage bag hanging from the bottom of the wheelchair with the urinary drainage tubing coiled on the floor.</p> <p>On 1/8/15 10:45 a.m. the resident was observed sitting in a wheelchair with the urinary drainage tubing on the floor. CNA #'s 3 and 4 were observed to transfer the resident from a wheelchair to the bed with a mechanical lift. During the transfer, CNA #4 held the resident's urinary drainage bag above the resident's bladder. Urine was observed backing up in the tubing. After transferring the resident to the bed, the CNA placed the urinary drainage bag on the bed. The drainage bag was left on the bed during incontinence care. While providing the incontinence care, the resident's urinary catheter was observed to be pulled taunt several times. During incontinence care the resident complained I'm peeing and</p>				

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	<p>it's hot" CNA #3 indicated the resident's Foley catheter was leaking. While removing the resident's slacks the CNAs indicated the slacks were wet.</p> <p>During review of Resident #119's clinical record on 1/9/14 at 11:44 p.m., a plan of care was noted addressing the resident with a "Urinary Foley Catheter". The plan of care identified an approach of, "Please make sure my catheter is below the level of the bladder".</p> <p>4. On 1/8/15 at 3:10 p.m., Resident #102 was observed to be transferred from the wheelchair to the bed by CNAs #6 and #7. The resident had an indwelling foley catheter. The drainage bag was hung on a handlebar of the lift above the resident's bladder level. The bag remained there while the resident was lifted from the wheelchair seat, transported, and lowered into bed. Urine was observed in the tubing and drainage bag. After the resident was positioned in bed, the drainage bag and tubing were placed next to the resident on the mattress while bowel incontinence care was provided. The catheter was not secured to the resident's thigh and was kinked.</p> <p>A policy titled "Guidelines for Urinary Catheter Care" (no date) provided as current by the Director of Nursing on 1/12/15 at 12:00 p.m. included but was</p>			

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	<p>not limited to, "Purpose: To prevent infection of the resident's urinary tract. Procedure: 3. The urinary drainage bag should be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. 5. Check the resident frequently to be sure he/she is not lying on the catheter and to keep the catheter and tubing free of kinks. 11. Be sure the catheter tubing and drainage bag are kept off the floor. 14. Ensure the catheter remains secured. A leg strap may be used to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.) ...</p> <p>3.1-41(a)(2)</p>						