

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2015
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NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DR CARMEL, IN 46032
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F000000	<p>This visit was for the Investigation of Complaint IN00163721.</p> <p>Complaint IN00163721 - Substantiated. Federal/State deficiency related to the allegation is cited at F309.</p> <p>Survey dates: February 2 & 3, 2015</p> <p>Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490</p> <p>Survey Team: Mary Jane G. Fischer RN-TC</p> <p>Census Bed Type: SNF: 19 SNF/NF: 115 Total: 134</p> <p>Census Payor Type: Medicare: 25 Medicaid: 99 Other: 10 Total: 134</p> <p>Sample: 7</p> <p>This deficiency reflects State finding cited in accordance with 410 IAC</p>	F000000		
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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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F000309 SS=G	<p>16.2-3.1.</p> <p>Quality Review was completed by Tammy Alley RN on February 9, 2015.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure the necessary care for a resident with an indwelling catheter, in that when Resident "A" had an indwelling catheter placed due to urinary retention, the nursing staff failed to ensure the resident's urinary output was sufficient. This deficit practice resulted in the resident with a change in condition, which prompted the nursing staff to alert the Emergency Medical System to transport the resident to the local area hospital with a diagnoses of occluded urinary catheter, abdominal distention and sepsis for 1 of 1 resident transported to the local area hospital for immediate intervention and 6 of 6 residents who required nursing intervention to include</p>	F000309	<p>F309 Provide Care/Servicesfor highest well being</p> <p>Itis the practice of this provider to ensure that residents receive the necessarycare and treatment to maintain the highest practicable physician well-being.</p> <p>What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident A no longer resides at the facility. ·Residents G, B, C, D, E and F fluid needs have been reviewed by the RDand plans of care have been reviewed and updated by the Interdisciplinary Team. ·Staff education will be completed by 2-19-15. 	02/21/2015	

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	<p>assessments and catheterization in a sample of 7. (Resident's "A", "G", "B", "C", "D", "E", and "F").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 02-02-15 at 9:30 a.m. Diagnoses included, but were not limited to, Parkinsons disease, bladder neck obstruction, history of urinary tract infection and acute kidney failure. These diagnoses remained current at the time of the record review. The resident had recently returned to the facility form a hospitalization for urinary tract infection and dehydration.</p> <p>The resident had physician orders, dated 01-20-15 for Clorpectin (an irrigation solution for obstruction in urinary catheters), 100 ml (millimeters) - "Special instructions: Instill 100 ml into Foley/bladder, clamp and let dwell for 10 minutes, unclamp and let solution drain into Foley bag. Once an Evening on Tuesday and Saturday 3:00 p.m. - 11:00 p.m."</p> <p>An additional physician order, dated 01-20-15, instructed the nursing staff to "Change urinary catheter and drainage bag PRN [as needed] occlusion/dislodgement. Document the</p>		<p>How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <ul style="list-style-type: none"> ·All residents who have catheters have the potential to be effected. ·Licensed staff were re-educated on assessing residents with catheters by2-19-15. ·C.N.A.'s were re-educated on documenting urinary output on residents by2-19-15. <p>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?</p> <ul style="list-style-type: none"> ·Physicianorders are reviewed daily by Nursing Management to identify new orders/changesin condition. ·Administrationcompliance records will be reviewed daily by Nursing Management and by theWeekend supervisor Saturday and Sunday. ·Nurseconsultant will randomly audit identified residents who have catheters upon herweekly visit. ·Anydiscrepancies noted on the compliance report will be called to the physicianand an observation opened for resident assessment for 24 hours. 		

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	<p>procedure in the progress notes to include: ml. [milliliters] removed from the existing Foley bulb, the ml. placed in the new bulb, any drainage from the meatus, characteristics of the peri care, urinary return and the residents tolerance of this procedure as needed. Special instructions: Unmanageable urinary retention cannot be treated or corrected medically or surgically for which alternative therapy is not feasible and is characterized by: (1) documented PVR [post void residual] > [greater than] 200 ml (2) inability to manage retention/incontinence with I & O [intake and output] catherization."</p> <p>A review of the Nurses Progress Notes, dated 01-21-15 at 7:58 a.m., indicated, "Resident had some retention on prior shift and cath. [catheter] place <sic> with desired results. MD [Medical Doctor] notified with no new order given."</p> <p>"01-21-15 at 3:15 p.m. 500 c.c. [cubic centimeters] yellow urine emptied from res. [resident] catheter today. No c/o [complaints of] pain or discomfort. Fluids encouraged."</p> <p>"01-21-15 11:08 p.m. LATE ENTRY - During evening bath aide alerted writer that resident had blood in his undergarment . Assessed resident and</p>		<p>·All nursing staffwere re-educated on catheter care, including documentation of urinary output on2-19-15.</p> <p>How will the corrective action(s) bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place?</p> <p>·Anaudit tool will be used to ensure catheter documentation is monitored weekly x12, monthly x 3, quarterly thereafter.</p> <p>·Anyidentified areas from audits will be addressed immediately.</p> <p>·Employeesnot adhering to policy will be re-educated up to and including termination.</p> <p>·Theresults of these audits will be discussed at the monthly facility QualityAssurance Committee meeting and frequency and duration of reviews will beadjusted as needed.</p> <p>Compliance Date: February 21, 2015</p>				

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	<p>cleaned him up. Resident stated he was in no pain. No signs of trauma or swelling. Reassessed resident during bed check and no further signs of bleeding or trauma. Will continued to monitor."</p> <p>The record lacked any additional information related to the resident's catheter or further bleeding until 01-24-15 at 6:00 p.m. when the licensed nurse employee # 9 documented, "Aide was in resident's room attempting to dress him for dinner. Aide was unable to stand resident up on her own, which is unusual, so aide went to find this nurse. This nurse immediately began to ask resident yes and no questions, but resident was unable to respond. This nurse took resident's vitals (159/75, 138 bpm [beats per minute], 101.7 degrees [temperature] and 94 % [oxygen saturation level]) and called the on call NP [nurse practitioner]. Resident was sent to the hospital. Family has been notified."</p> <p>A review of the Hospital record on 02-02-15 at 11:00 a.m., indicated the resident was transported to local area hospital (#1) on 01-24-15. The emergency room documentation indicated the resident was + [positive] for fever, shock, dehydration, pneumonia and urinary tract infection - makes sounds</p>				

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	<p>like crying but no tears. HR [heart rate] 115 - sepsis with fever. Giving IV [intravenous] fluids has indwelling Foley too." The emergency room nursing documentation indicated the resident's "abd. [abdomen] was firm - bladder scanned for 999 ml [millimeters]. The catheter apparently plugged and unable to irrigate it."</p> <p>The resident's catheter was changed and a urine specimen was obtained. The nurse documented the urine was "cloudy and odorous."</p> <p>"Nursing Note; 1000 ml returned from catheter, then catheter clamped for about 30 min. [minutes], then reopened. A total of 1900 ml drained from bladder. Abd. now soft." The urinalysis indicated the resident had "abnormalities" in the urine which included "occult blood, large leukocyte esterase, cloudy in appearance, white blood cells > 100 in the urine, packed bacteria and mucus."</p> <p>The family requested the resident to be transferred to the hospital (#2) where the resident had previously been hospitalized. The transfer papers indicated the resident had a "UTI [urinary tract infection] and Foley malfunction."</p> <p>A hospital Consultation notation dated 01-25-15, indicated, "I was asked to see the patient for pyelonephritis, UTI in a</p>			

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	<p>chronic Foley Catheterized patient. He had worsening mental status at the SNF [skilled nursing facility] and fever up to 101 and tachycardia... his Foley catheter was exchanged on admission to emergency room because it was clogged with mucus and non-draining."</p> <p>The facility clinical record was reviewed for fluid intake and urinary output from the date the catheter was noted to be obstructed on 01-21-15 until the time the resident was transferred to the local area hospital due to a change in mental status. The following was noted:</p> <p>01-21-15 Fluid Intake - 2200 ml. Urinary Output at 6:54 a.m. 225 ml, 8:07 a.m. 225 ml, 2:42 p.m. "Large," 11:43 p.m. 600 ml.</p> <p>01-22-15 Fluid Intake - 1320 ml. Urinary Output at 6:18 a.m. 200 ml, 10:02 a.m. "Large," 11:00 p.m. Large/650 ml.</p> <p>01-23-15 Fluid Intake 840 ml. Urinary Output at 7:52 a.m. 950 ml, 6:13 p.m. "Large."</p> <p>01-24-15 Fluid Intake 940 ml. Urinary Output 1:36 a.m. "Medium"/700 ml, 1:34 p.m. "Large."</p> <p>The Nursing staff failed to measure and</p>				

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	<p>document the exact amount of output in milliliters and the record lacked documentation of the resident's urinary output for each shift.</p> <p>The record lacked the amount of urinary output on the evening shift 01-22-15, the night shift on 01-23-15 and evening shift on 01-24-15.</p> <p>The resident remained at the hospital until the time of discharge. The Discharge Summary indicated the resident had been admitted with "severe sepsis secondary to complicated UTI secondary to ESBL [Extended spectrum beat-lactamase] E.coli [Escheria coli] - which was resolved, and toxic metabolic encephalopathy."</p> <p>2. The record for Resident "G" was reviewed on 02-03-15 at 2:30 p.m. Diagnoses included, but were not limited to, neurogenic bladder, hypertension, infection and paraplegia. These diagnoses remained current at the time of the record review. The resident had an indwelling catheter.</p> <p>A review of the resident's current plan of care dated 10-29-14 prompted the nursing staff with the following interventions in regard to the catheter. "Assess the drainage of SPC [suprapubic</p>			

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	<p>catheter] every shift. Record amount, type, color, odor. Observe for leakage. Avoid obstruction in draining."</p> <p>A review of the Nurses Progress notes dated 01-7-15 indicated the super <sic> pubic catheter changed "per sterile tech. [technique]...yellow urine return.</p> <p>A review of the Intake and Output Report indicated the resident had zero output on 01-04-15, 01-05-15, 01-07-15, 01-10-15, 01-11-15, 01-15-15, 01-19-15, 01-20-15, 01-21-15, 01-22-15, 01-24-15, 01-26-15, 01-27-15 and 01-28-15.</p> <p>The Urinary Output detailed report from 01-04-15 through 02-01-15 the Certified Nurses Aides documented the output in "Details" as "Large" or "Medium," with no value or mls recorded.</p> <p>The Nursing staff failed to measure and document the exact amount of output in milliliters and the record lacked documentation of the resident's urinary output daily and for each nursing shift.</p> <p>3. The record for Resident "B" was reviewed on 02-02-15 at 11:00 a.m. Diagnoses included, but were not limited to, End Stage Renal Disease, altered mental status, hypertension, urinary tract infection, and congestive heart failure.</p>						

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	<p>These diagnoses remained current at the time of the record review.</p> <p>A review of the CNA assignment sheet indicated "In and Out catheter per nurse. Record Output."</p> <p>The resident had physician orders, dated 01-18-15 for In and Out catheterization every 6 hours.</p> <p>A review of the Nurses Progress Notes indicated the following:</p> <p>"01-17-15 at 11:40 p.m. - resident had c/o fullness and inability to urinate, contacted MD and got order for in and out cath times 1. In and out cath, per sterile procedure, tolerated well by resident 650 ml dark amber urine retrieved."</p> <p>"01-18-15 at 1:36 a.m. Order for In & Out cath. [catheter] every 6 hours obtained from [name of physician] due to patient urinary retention."</p> <p>"01-20-15 at 12:15 a.m. In et [and] out cath via sterile technique for 150 dark yellow urine. Encourage to drink."</p> <p>"01-20-15 at 5:05 a.m. In et out cath via sterile technique for 210 dark amber urine. Pt. [patient] tolerated procedure well."</p>			

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	<p>"01-21-15 at 12:15 a.m. In et out cath via sterile technique for 200 dark yellow urine. Encouraged to drink."</p> <p>"01-21-15 at 6:10 a.m. In et out cath via sterile technique for 150 dark yellow urine. Encouraged to drink."</p> <p>"01-26-15 I/O [in and out] catheter per MD order. 240 ml of dark amber urine. Resident tolerated procedure well with no discomfort noted."</p> <p>"01-29-15 at 12:45 a.m. In et out cath for 100 ml dark amber urine. Pt. tolerated procedure well."</p> <p>"01-29-15 at 7:40 a.m. In et out cath done 250 ml return dark amber urine. Pt. tolerated procedure well."</p> <p>The facility nursing staff were monitoring the resident's urinary output in addition to the frequent catheterization.</p> <p>A review of the fluid intake and urinary output from 01-16-15 through 02-01-15 indicated the resident had either "large, medium or small urinary outputs" with no specific measurements or documentation the exact amount of the resident's urinary output in milliliters.</p>			

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	<p>The Nursing staff failed to measure and document the exact amount of urinary output in milliliters for each shift.</p> <p>During an interview on 02-02-15 at 3:30 p.m., Administrative staff verified there was no facility policy which instructed the staff to document "large, medium or small" in regard to urinary output.</p> <p>4. The record for Resident "C" was reviewed on 02-02-15 at 1:05 p.m. Diagnoses included, but were not limited to, Epilepsy, hypertension, acute respiratory failure and wounds to buttocks. The resident had an indwelling catheter.</p> <p>A review of the CNA assignment sheets prompted the nursing staff "resident has Foley catheter. Empty after each shift record output."</p> <p>The resident had a physician order dated 01-20-15, which indicated: "Special instructions: Unmanageable urinary retention cannot be treated or corrected medically or surgically for which alternative therapy is not feasible and is characterized by: (1) documented PVR [post void residual] > [greater than] 200 ml (2) inability to manage retention/incontinence with I & O [intake and output] catherization."</p>						

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	<p>A review of the Fluid Intake and Urinary Output report indicated the following:</p> <p>01-20-15 Fluid Intake 2640 mls. Urinary Output 1085 mls.</p> <p>01-21-15 Fluid Intake 2280 mls. Urinary Output - no documentation related to mls.</p> <p>01-22-15 Fluid Intake 2680 mls. Urinary Output 1020 mls.</p> <p>01-23-15 Fluid Intake 2520 mls. Urinary Output "Medium - no documentation related to amount of mls."</p> <p>01-24-15 Fluid Intake 2700 mls. Urinary Output "Large" - no documentation related to amount of mls, and "Medium 900 mls."</p> <p>01-25-15 Fluid Intake 3060 mls. Urinary Output 600 mls.</p> <p>01-26-15 Fluid Intake 2480 mls. Urinary Output 900 mls.</p> <p>01-27-15 Fluid Intake 2500 mls. Urinary Output 2625 mls.</p> <p>01-28-15 Fluid Intake 2520 mls. Urinary Output - no documentation</p>			

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	<p>related to mls.</p> <p>01-29-15 Fluid Intake 2900 mls. Urinary Output "Medium 640 mls/ Large 1200 mls."</p> <p>01-30-15 Fluid Intake 2650 mls. Urinary Output "Medium - no documentation related to the amount, Medium 200 mls."</p> <p>01-31-15 Fluid Intake 1380 mls. Urinary Output 1100 mls, "Medium 440 mls."</p> <p>02-01-15 Fluid Intake 2580 mls. Urinary Output 900 mls.</p> <p>02-02-15 Fluid Intake 1680 mls. Urinary Output "Large 1200 mls, and 600 mls.</p> <p>The Nursing staff failed to measure and document the exact amount of output for each shift.</p> <p>5. The record for Resident "D" was reviewed on 02-02-15 at 1:50 p.m. Diagnoses included, but were not limited to Parkinsons disease, urinary retention and acute respiratory failure. These diagnoses remained current at the time of the record review. The resident had an indwelling urinary catheter.</p>				

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	<p>A review of the CNA assignment sheets instructed the nursing staff "Foley catheter empty each shift - record output."</p> <p>A review of the Nurses Progress notes lacked documentation related to the resident's urinary catheter or ongoing assessment for urinary retention.</p> <p>A review of the Fluid Intake and Urinary Output report indicated the following:</p> <p>01-25-15 Fluid Intake 1434 mls. Urinary Output. No documentation for day shift or night shift. Evening shift - Large/Medium 1600 mls.</p> <p>01-26-15 Fluid Intake 1637 mls. Urinary Output. No documentation for day shift. Evening shift and night shift only. Large - 1600 mls.</p> <p>01-27-15 Fluid Intake 1197 mls. Urinary Output. No documentation for day shift or night shift. Evening shift - Large/Medium 1650 mls.</p> <p>01-28-15 Fluid Intake 1591 mls. Urinary Output. No documentation for night shift. Day shift and evening shift Large 1900 mls.</p>			

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	<p>01-29-15 Fluid Intake 1591 mls. Urinary Output. No documentation for day shift. Night shift and evening shift - Large no documentation of mls. obtained and a subsequent entry - Medium 250 mls.</p> <p>01-30-15 Fluid Intake 3171 mls. Urinary Output. No documentation for day shift or night shift. Evening shift only - Large no documentation of mls. large 900 mls.</p> <p>01-31-15 Fluid Intake 2754 mls. Urinary Output. No documentation for day shift or night shift. Evening shift - Medium 350 mls.</p> <p>02-01-15 Fluid Intake 1911 mls. Urinary Output. No documentation for day shift or night shift. Evening shift - Large no documentation of mls. obtained, and a subsequent entry - Large 2525 mls.</p> <p>The Nursing staff failed to measure and document the exact amount of output in milliliters and the record lacked documentation of the resident's urinary output for each shift.</p> <p>6. The record for Resident "E" was reviewed on 02-02-15 at 2:40 p.m. Diagnoses included, but were not limited to, suprapubic catheter for urinary retention, gross hematuria, neurogenic bladder, and history of urinary tract</p>						

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	<p>infection. These diagnoses remained current at the time of the record review.</p> <p>A review of the CNA assignment sheet prompted the nursing staff to "empty Catheter bag every shift - report amount."</p> <p>During an observation on 02-03-15 at 10:00 a.m., the resident was seated in his wheelchair and the urinary drainage bag was suspended from the arm of the wheelchair.</p> <p>A review of the resident's current plan of care, dated 09-24-14 indicated interventions for the catheter included, "assess the drainage every shift. record the amount, type color, odor and observe for leakage."</p> <p>The record indicated the resident's catheter was changed during a recent appointment at the Urologist office.</p> <p>A current physician order instructed the nursing staff to record the output from the drainage bag every shift.</p> <p>A review of the Fluid Intake and Urinary Output report indicated the following where the output was less than the intake amount:</p> <p>01-02-15 Fluid Intake 2640 mls. Output</p>				

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	<p>1800 mls. 01-03-15 Fluid Intake 1880 mls. Output 890 mls. 01-05-15 Fluid Intake 1080 mls. Output 500 mls. 01-06-15 Fluid Intake 1440 mls. Output "0." 01-07-15 Fluid Intake 2680 mls. Output 1700 mls. 01-09-15 Fluid Intake 1100 mls. Output 600 mls. 01-15-15 Fluid Intake 2680 mls. Output 1250 mls. 01-17-15 Fluid Intake 2320 mls. Output 1050 mls. 01-18-15 Fluid Intake 600 mls. Output 375 mls. 01-19-15 Fluid Intake 1100 mls. Output 650 mls. 01-20-15 Fluid Intake 640 mls. Output 450 mls. 01-21-15 Fluid Intake 2417 mls. Output 1650 mls. 01-23-15 Fluid Intake 1110 mls. Output 820 mls. 01-28-15 Fluid Intake 2440 mls. Output 700 mls. 01-30-15 Fluid Intake 7360 mls. Output 700 mls. 01-31-15 Fluid Intake 960 mls. Output 350 mls. 02-01-15 Fluid Intake 1480 mls. Output 750 mls. 02-02-15 Fluid Intake 1150 mls. Output</p>				

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	<p>975 mls.</p> <p>In addition, the Nurses Progress Notes lacked documentation or assessment of the drainage, color, odor of urine or leakage.</p> <p>7. The record for Resident "F" was reviewed on 02-02-15 at 3:00 p.m. Diagnoses included, but were not limited to, bladder disorder with urinary retention, anxiety pain and hypertension. These diagnoses remained current at the time of the record review. The resident had an indwelling urinary catheter.</p> <p>A review of the CNA assignment sheet did not identify this resident with a catheter.</p> <p>A review of the resident's current plan of care, dated 01-28-15, indicated the resident had the indwelling catheter related to bladder outlet syndrome and urinary retention.</p> <p>A physician order dated 01-27-15 instructed the nursing staff to "Flush f/c [Foley catheter] with 300 c.c. saline PRN, sluggishness/non-patency as needed."</p> <p>The resident had a physician order dated 02-02-15 which indicated, "Special</p>				

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	<p>instructions: Unmanageable urinary retention cannot be treated or corrected medically or surgically for which alternative therapy is not feasible and is characterized by: (1) documented PVR [post void residual] > [greater than] 200 ml (2) inability to manage retention/incontinence with I & O [intake and output] catherization."</p> <p>A review of the nurses progress notes indicated the following:</p> <p>"01-16-15 at 6:49 a.m. - Res. co <sic> urinary retention, requesting I & O cath. states urinary frequency with scant o/p [output]. I & O preformed <sic>. cath met resistance - res. states he has an enlarged prostate. resident tolerated procedure well - small amt. [amount] of blood to the end of cath when removed. 400 c.c. o/p res also stated he had a hx [history] with [name of physician]. NP notified. n.o. [new order] reced [received] for appt. [appointment] to be made with [name of physician]."</p> <p>"01-20-15 at 10:00 p.m. Resident also c/a <sic> not able to urinate enough. NP notified. This writer I/O cath. resident, 750 ml output. Resident tolerated well."</p> <p>"01-22-15 at 11:59 p.m. Resident came to the nursing station c/o not able to</p>			

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	<p>urinate. this write reassessed bladder for distention, tenderness was observed. PRN I/O cath. performed, 600 c.c. clear yellow urine received. Resident tolerated procedure well."</p> <p>"01-24-15 at 3:56 p.m. Res. c/o not urinating all day, resident catheterized and returned 400 c.c. of clear yellow urine."</p> <p>"01-25-15 4:50 a.m. Res. was catheterized at 0100 [1:00 a.m.] for urine retention, 400 c.c. were obtained. Will continue to monitor."</p> <p>"01-25-15 at 12:33 p.m. Resident was I & O cath this a.m. 300 mls received, resident expressed now that he wants to be cath again, original <sic> order states every 8 hours, NP notified, states to follow original <sic> order, resident notified."</p> <p>"01-25-15 at 11:22 p.m. Resident I & O cathed at approx. [approximately] 1600 [4:00 p.m.] per sterile technique, with 400 mls cl. [clear] yellow urine out at this time."</p> <p>"01-26-15 at 1:27 a.m. This writer I/O cath. Resident, per his request for urinary retention. 200 c.c. urinary output of clear yellow urine."</p>						

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	<p>"01-26-15 1:37 a.m. Resident continues c/o not able to urinate per usual, requesting to be cath frequently NP aware. Resident has an appointment with Urologist on Tuesday."</p> <p>"01-27-15 at 1:29 a.m. Res. co [complained of] urinary retention. noted abdominal distention. I & O cath per PRN order. O/P 500 c.c. clear yellow urine. Expressed relief when completed."</p> <p>The record indicated the resident returned from the Urologist appointment 01-27-15 with recommendation for I & O cath every 4 - 6- hours. States urologist discussed other options such as chronic Foley vs. [versus] SP [supra pubic] tube. New DX. [diagnosis] bladder outlet obstruction and urinary retention. NP notified...received order to anchor Foley cath. for DX bladder outlet syndrome, flush and f/c [Foley catheter] change orders...catheter placed at 1330 [1:30 p.m.]. Res. tolerated well...immediate return of 350 c.c. clear/yellow urine."</p> <p>A review of the Nurse Practitioner note dated 01-31-15, indicated: "Plan" bladder outlet obstruction and BPH: Resident seen by Urology, given the option for Foley catheter vs. I/O cath. 6 times a day. Resident requesting staff to I/O cath 3 - 4 times during an 8 hour</p>			

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	<p>shift. Therefore Foley catheter was placed. Unable to bladder scan...."</p> <p>During an interview on 02-03-15 at 10:40 a.m. the resident indicated, "I don't like it [in regard to the indwelling catheter] but they told me I have to have it. Sometimes it gets kinked and the urine doesn't flow. The nurses don't seem worried about it."</p> <p>A review of the Fluid Intake and Output Report from 01-27-15 indicated the following:</p> <p>01-27-15 Fluid intake 1360 mls. Output 350 mls. 01-28-15 Fluid intake 1920 mls. Output 900 mls. 01-29-15 Fluid intake 1460 mls. Output 800 mls. 01-31-15 Fluid intake 1720 mls. Output 420 mls. 02-01-15 Fluid intake 2080 mls. Output 450 mls. 02-02-15 Fluid intake 720 mls. Output 500 mls.</p> <p>Further review of the Urinary Output documentation indicated the certified nurses aide documented the following:</p> <p>01-27-15 at 1:49 a.m. "Medium", 12:05 p.m. "Large."</p>				

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	<p>01-29-15 at 1:19 a.m. "Large." 02-01-15 4:00 a.m. "Medium," 2:31 p.m. "Large." 02-02-15 12:04 p.m. "Large."</p> <p>The Nursing staff failed to measure and document the exact amount of output in milliliters and urinary output for each shift.</p> <p>8. During interviews on 02-03-15 the following information was obtained in regard to the documentation, observation and responsibilities of the nursing staff in regard to indwelling catheters.</p> <p>CNA #5 - The CNA's record if the amount is "large, medium or small. Then we report the amount to the nurses and they put that in the nurses computer."</p> <p>CNA #6 - "I look at the bag and do it in thirds for large medium or small. I chart the amount of mls - the nurses don't do it because I saw it."</p> <p>LPN #7 - "The CNA's don't mess with the catheter bags only the nurses can do that - we empty it and document the amount."</p> <p>LPN #8 - "Only the nurses can do the catheters especially if a resident is on a fluid restriction. I guess if the resident is</p>						

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	<p>not on a fluid restriction anyone can do it."</p> <p>During an interview on 02-02-15 at 3:30 p.m., the Administrator indicated the facility did not have a device to scan the resident's bladder as in a post void residual amounts.</p> <p>9. Review of the facility policies in regard to resident's with catheters, or who required catheterization indicated the following:</p> <p>9a. A review of the nursing skills check list on 02-02-15 at 12:15 p.m., titled "In & Out Cath. [catheter] procedure," undated - "measure and dispose of urine (observe characteristics of urine.)"</p> <p>9b. A review of the facility policy on 02-02-15 at 1:00 p.m., titled "Catheter Irrigation, Open System, dated as revised October 2010, indicated the following:</p> <p>"Purpose - The purpose of this procedure is to maintain patency of the catheter... General Guidelines: ... 3. Check the urine for unusual appearance. Record findings... 6. Maintain an accurate record of the resident's daily fluid intake and output if indicated...Documentation The following information should be recorded in the resident's medical record: 1. The</p>				

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	<p>date and time the procedure was performed... 3. The amount of solution used to irrigate, the amount returned as drainage, and the amount of urine drained. 4. The character and color of urine/drainage. 5. Any observation of obstruction: evidence of blood, pus; presence of sediment, change in output, amount or color; patency of catheter, etc."</p> <p>9c. A review of the facility policy on 02-03-15 at 9:45 a.m., titled "Catheterization, Residual," dated as revised October 2010, indicated the following:</p> <p>"Purpose: The purpose of this procedure is to assess the amount of urine left in the bladder after a resident voids."</p> <p>"Documentation: The following information should be recorded in the resident's medical record: 6. The amount of residual urine obtained. 7. The character (i.e. color, clarity, etc.) of the residual urine obtained."</p> <p>9d. A review of the facility policy on 02-03-15 at 9:45 a.m., titled "Emptying a Urinary Drainage Bag," dated as revised October 2010, indicated the following:</p> <p>"Purpose: The purpose of this procedure</p>						

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	<p>are to prevent the drainage bag from becoming full and allowing urine to flow back into the bladder, to measure output, and to obtain a sterile specimen."</p> <p>"General Guidelines: 1. Empty the urinary drainage bag at least every eight (8) hours or more often if needed to keep the bag from becoming full... 5. Observe the character of the urine such as color (straw-colored, dark, or red), clarity (Cloudy, solid particles, or blood), and odor."</p> <p>"Steps in the Procedure: 7. Open the drainage bag and let the urine flow into the measuring container."</p> <p>"Reporting: 2. Notify the physician of the amount of residual urine,if any, and if there are any abnormalities in the character of the urine."</p> <p>9e. A review of the faciity policy on 02-02-15 at 1:00 p.m., titled "Catheterization, Intermittent," dated as revised October 2010, indicated the following:</p> <p>"Purpose: The purpose of this procedure is to provide guidelines for the aseptic insertion of an intermittent catheter."</p> <p>"Documentation: The following</p>			

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	<p>information should be recorded in the resident's medical record: 3. The amount of urine drained. 4. The character, clarity and color of urine. 5. Any observation of obstruction: evidence of blood, pus etc. 6. Any change in the resident's condition (e.g. swelling, discomfort etc... 9. All assessment data obtained during the procedure."</p> <p>"Reporting: 2. Notify the physician of any abnormalities (i.e. urine output greater than 800 mls, obstruction of catheter, etc."</p> <p>This Federal tag relates to Complaint IN00163721.</p> <p>3.1-37(a)</p>				