**Wayne Care Nursing Home**

**Summary Statement of Deficiencies**

- **F 279**
  - DEVELOP COMPREHENSIVE CARE PLANS

  A facility must use the result of the assessment to develop, review and revise the resident's comprehensive plan of care.

  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

  This REQUIREMENT is not met as evidenced by:

  Based on medical record review and interview, it was determined the facility failed to develop a comprehensive care plan for urinary tract infections (UTI) for 1 of 3 (Resident #40) sampled residents reviewed of 13 included in the stage 2 review with a history of UTI.

  The findings included:

  Medical record review for Resident #40 documented an admission date of 6/29/12 with diagnoses of Osteoarthritis, Hypertension, and the facility failed to develop a comprehensive care plan for UTI.

  The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

  A comprehensive care plan was developed for resident #40 for urinary tract infections by Joann Statom, RN/DON (see attached). The ADON will monitor care plans on an ongoing basis and update as needed.

**Signature**

**Title**
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Chronic Obstructive Pulmonary Disease, Asthma, Anxiety, Depression, Gastro Esophageal Reflux Disease, Hyperlipidemia and Hiatal Hernia.

Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/10/12 revealed section C was coded with a Brief Interview for Mental Status (BIMS) score of 14; indicating the resident is independent in cognitive skills, section C -Functional / Personal Hygiene was coded a 3-3 and toilet use was coded 3-3 indicating required extensive assistance and two person physical assist, section H - O300 -Urinary Continence was coded as 0 and H0400 Bowel Continence was coded as 0- indicating always continent. Review of the MDS with an ARD of 1/4/13 section C was coded as 06 indicating severely impaired cognition, section G - Toilet use was coded 4/3 - indicating totally dependent and personal hygiene was coded 3/2 - indicating required extensive assistance and one person physical assist, section H0300 was coded as 3- indicating always continent and section 0400 bowel continence was coded 3 - indicating always continent.


Review of a laboratory (lab) report dated 11/21/12 documented, "...Organism 1... Gram Negative"
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Rods...

Review of a physician's order dated 11/28/12
documented, "Rocephin 1gm [gram] IM
[intramuscular] daily x [times] 7 days for UTI..."

Review of a lab report dated 12/6/12
documented, "organism 1-Enterococcus
faecium... VANCOMYCIN RESISTANT
ENTEROCOCCUS..."

Review of a physician's order dated 1/5/13
documented, "ClariFication Order: DC Foley
Cath R/T unable to irrigate and heavy
sediment..."

Review of the current care plan dated 1/9/13 did
not address Resident #40's urinary tract
infections.

During an interview in the MDS office on
2/28/13 at 29 AM, the MDS nurse was asked about
a care plan for UTI for Resident #40. The MDS
Coordinator stated, "I don't see one either. There
should be one for recurrent UTI..."