**NAME OF PROVIDER OR SUPPLIER**

MIDSOUTH HEALTH AND REHABILITATION CENTER

<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F315</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>Based on the resident's comprehensive assessment, the facility must ensure that a 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.</td>
<td>F315</td>
<td>This plan constitutes our credible Plan of Correction. However, the submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. This plan represents our ongoing pledge to provide quality care that is rendered in accordance with all regulatory requirements.</td>
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This REQUIREMENT is not met as evidenced by:

Intakes: TN000296995

Based on medical record review, observation and interview, it was determined the facility failed to develop a care plan, follow the care plan, or use appropriate infection control practices for 3 of 5 (Residents #1, 2 and 4) sampled residents with indwelling urinary catheter.

The findings included:

1. Closed medical record review for Resident #1 documented an admission dated of 7/2/09 with a readmission dated of 4/5/11 with diagnoses of Alzheimer's, Stage 4 Sacral Pressure Ulcer, Osteoarthritis and Osteomyelitis. Review of a physician's order dated 1/23/12 documented, "...insert Foley catheter... Stage 4 sacral wound..." Review of the annual Minimum Data Set (MDS) dated 4/10/12 documented, "...Section H Bladder and Bowel... Appliances... Indwelling catheter..." Review of the care plan dated 4/18/12.

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 patient. (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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and last updated 1/18/12 documented no care plan for a urinary catheter.

During an interview in the conference room on 5/2/12 at 6:20 PM, the Director of Nursing (DON) was asked if a care plan had been developed and implemented for Resident #1's catheter. The DON stated, "...No... There should be a care plan for the Foley catheter... If [the care plan] should of been updated along with the instructions of what we [staff] were going to do..."

2. Medical record review for Resident #2 documented an admission date of 2/18/10 with a readmission date of 9/11/11 with diagnoses of Neurogenic Bladder, Hypertension, Cardiac Dyshrhythmia and Diabetes. Review of a physician's order dated 4/22/11 documented a diagnosis of Neurogenic Bladder and the insertion of a urinary catheter. Review of the quarterly MDS dated 7/18/11 and the annual MDS dated 4/12/12 documented, "...Section H Bowel and Bladder... Appliances... Indwelling catheter..." Review of the care plan dated 4/12/12 documented, "...Potential for urinary tract infection related to presence of indwelling catheter d/t [due to] residual urine... Observe and record urine appearance at least q [every] shift. Report any abnormalities to physician..." The facility could not provide documentation that the care plan was being followed.

Observations on 5/1/12 at 10:46 AM, 11:30 AM, 12:35 PM and 2:15 PM and on 5/2/12 at 1:05 PM and 3:45 PM, revealed Resident #2 with an indwelling urinary catheter draining to a privacy bag.

F -315 – The facility must ensure all residents receive appropriate services and treatment to prevent urinary tract infection and restore as much normal bladder function as possible.

MidSouth Health and Rehabilitation Center will develop, review and revise a plan of care for all residents with an indwelling urinary catheter. We will follow our plan of care and use appropriate infection control practices.

Resident #1 - all medical records for residents with an indwelling urinary catheter have been reviewed and all have an appropriate plan of care.

Resident #2 and #4 plans of care have been revised and the interventions updated to more accurately reflect the nursing documentation.

Resident #4 catheter tubing has been properly positioned over the thigh and downward toward the Foley bag to ensure proper drainage. The Foley bag is covered with a privacy cover and hangs appropriately below the level of the bladder.
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During an interview in the conference room on 5/2/12 at 6:45 PM, the DON confirmed that the nurses were not following the care plan for recording urine appearance at least every shift.

3. Medical record review for Resident #4 documented an admission date of 12/8/11 with a readmission date of 1/18/12 with diagnoses of Late Effect Femoral Neck Fracture, Joint Pain - Pelvis, Osteoarthritis, Heart Disease and Hypertension. Review of a physician's order dated 4/26/12 documented, "...Place Foley Catheter RE: [regarding] Breakdown on buttock... will re-evaluate in 14 days." Review of the care plan dated 4/25/12 documented, "...Potential for urinary tract infection related to presence of indwelling catheter due to breakdown of buttocks... Position catheter tubing below level of bladder... Observe and record urine appearance at least every shift. Report any abnormalities to physician." The facility could not provide documentation of urine appearance at least every shift.

Observations in Resident #4's room on 5/1/12 at 3:45 PM, revealed Resident #4 was sitting up in the wheelchair, the catheter tubing was placed over her left thigh and draped up and over the back of the left arm rest. The catheter bag was out of the privacy bag and laying on the floor.

During an interview in the resident's room on 5/2/12 at 3:50 PM, Nurse #1 was asked if the catheter tubing and bag were in the proper position. Nurse #1 stated, "...It [catheter] shouldn't be like that... it should always drain downward toward the bag and be kept off the floor..."

The MDS nurse will be responsible for developing a plan of care for each resident that is admitted with or receives an order to receive an indwelling urinary catheter. The interventions will be reflective of each resident's needs.

The MDS nurse will in-service the nursing staff on updating the comprehensive plan of care. The MDS nurse placed generic care plans for indwelling urinary catheters at each nurse's station. This was completed on 5/7/2012 (See attached in-service record)

The nursing staff and therapy department have been in serviced on proper placement of urinary catheter tubing and covering and placement of the urinary bag. This was completed by the unit manager on 5/1/2012 and is ongoing. (See attached in-service record).

Quality assurance will be monitored by the director of nursing/designee. All residents with indwelling urinary catheters will be monitored weekly for a month then monthly times three using the quality assurance monitoring tool attached to ensure compliance.
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During an interview in the conference room on 5/2/12 at 7:30 PM, the DON confirmed that urinary catheter tubing should always drain downward toward the collection bag and be kept off the floor. The DON confirmed that the nurses were not following the care plan for recording urine appearance at least every shift. | F 315 | All finding will be reviewed at the QA meeting. | |
