STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165326	A. BUILDING _____ B. WING _____	C 03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMFIELD CARE CENTER	800 NORTH DAVIS STREET BLOOMFIELD, IA 52537

(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
F 000	INITIAL COMMENTS Correction date 4-14-18 Investigation of mandatory report # 73635-M resulted in deficiency. Complaint # 74283-C was substantiated. See the Federal Code of Regulations (42-CFR) Part 483, Subpart B-C.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Newman LNHA — TITLE: Administrator — (X6) DATE: 4/16/2018

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 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The following deficiency relates to mandatory report # 73635-M: Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure residents are treated and cared for in a respectful and dignified manner and kept free from mistreatment and abuse (Resident #1). The facility reported a census of 61 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated 12/21/17, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating an intact cognitive status. Resident #1 required the assistance of one with transfers, personal hygiene, dressing and toilet use. Resident #1's diagnosis included cerebrovascular accident (stroke) depression and anxiety. The assessment documented she felt down, depressed or hopeless during the last two weeks of the assessment period.	F 550		

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F 550	Continued From page 2	F 550		

Resident #1's plan of care recorded a focus related to her fall risk with an intervention dated 12/18/17 instructing staff to assist her to bed prior to 7:00 p.m. as preferred.

In an interview on 3/12/18 at 2:40 p.m. Staff A, certified nurse aide (CNA), stated on the evening of 1/13/18, she stood behind the nurse's station. Resident #1 sat in her wheelchair in front of the nurse's station, stating she wanted to go to her room. Without provocation, Staff D stated, "Hey do you want some ice", then tossed ice at Resident #1, hitting her. Resident #1 stated, "Please don't hit me" in a crying voice as Staff D repeated her actions. Another CNA present (Staff C) was laughing and Staff A stated "I don't see how that's funny". Staff C stated "It's funny because it's Resident #1". Staff A stated they then returned to work. Staff A stated she had only worked at the facility a few weeks, did not know who the charge nurse was that evening and she didn't report the incident. Staff A stated she reported the incident the next day when she came to work.

In an interview on 3/12/18 at 3:10 p.m. Staff B, CNA, stated on the evening of 1/13/18 she and others stood behind the nurse's station. Resident #1 sat in her wheelchair, upset and crying about something. For no known reason Staff D tossed an ice cube at Resident #1. Resident #1 told Staff D she didn't want to catch anything. Staff D tossed another ice cube and hit Resident #1. Staff B stated she doesn't recall Staff D saying anything, just tossing the ice. Staff B stated she was new, didn't know what to do and felt what Staff D had done was abusive. Staff B stated later that night at around 2:00 a.m. as she passed

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F 550	Continued From page 3 a resident's room, she heard Staff D telling the resident she was not going to come in every two hours and help her to the bathroom. The following day Staff A reported the incident involving Resident #1. In an interview on 3/12/18 at 5:05 p.m. Staff C, CNA, stated on the evening of 1/13/18 she stood in the hub area near the nurse's station and Resident #1 sat in her wheelchair. Without reason, Staff D tossed an ice cube at Resident #1. Staff C stated Resident #1 turned away and appeared bothered by being hit with ice. Staff C stated she does not recall Staff D or Resident #1 saying anything. Staff C thought Staff D was just being playful and messing around. She did not interpret it as mistreatment or abuse. Staff C stated Staff D can be spastic, but she had never known her to mistreat or abuse a resident. The facility's Mandatory Reporting of Dependent Adult Abuse, Crimes and Other Notifications policy, effective 4/3/17, defined Personal Degradation as a willful act or statement by a caretaker intended to shame, degrade, humiliate or otherwise harm the personal dignity of a dependent adult or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation or harm to the personal dignity of a reasonable person. The facility's Abuse Prevention, Training and Investigations policy, revised 8/24/16 and under Identification, instructed that employees are required to report incidents at the time of occurrence to their supervisor or person in charge of the facility for further investigation, regardless of whether the incident results in	F 550		

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F 550	Continued From page 4 obvious or visible injury. Under Protection, the policy directed that employees are required to immediately intervene to distract, halt or prevent harm to the extent that they can do so without placing themselves at risk of injury if they observe what they suspect is abuse or criminal behavior to be occurring. They are also required to report allegations or suspicions of mistreatment, abuse or other crimes perpetrated by any person, including staff, resident, volunteer or visitor immediately and without hesitation directly to the person in charge of the facility at that time.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		

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F 580	Continued From page 5 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint # 74283-C. Based on clinical record review and staff, physician and family interviews, the facility failed to immediately consult with a resident's physician and notify a resident's representative of an accident which resulted in injury and had the potential for requiring physician intervention for one of four residents reviewed (Resident #3). The facility reported a census of 61 residents. Findings include:	F 580		

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F 580	Continued From page 6 According to the Minimum Data Set (MDS) assessment dated 2/13/18, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired memory and cognition. Resident #3 required the assistance of two with transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnoses included Non-Alzheimer's dementia, seizure disorder and chronic lung disease. A faxed physician order dated 1/19/18 instructed staff to obtain a follow up urinalysis (UA) for Resident #3. In an interview on 3/13/18 at 4:18 p.m. Staff E, licensed practical nurse (LPN), stated on the afternoon of 1/19/18 she received an order to straight cath Resident #3 for a urinalysis. Staff E asked her co-workers what size of catheter should be used for that procedure and they all agreed a 16 french would be appropriate. Staff E went in with Staff F and proceeded to insert the catheter using sterile technique. Staff E stated she got a little return of urine and started to inflate the balloon when she noticed blood return through the tubing. Staff E deflated the balloon and removed the catheter. Resident #3 started bleeding profusely and she went and got help. Staff E stated she has been a nurse since October 2017 and has some experience with straight catherizations, but primarily with females. When asked why she would inflate the balloon for a straight cath, which is an in and out procedure, Staff E stated she was not sure. In an interview on 3/14/18 at 9:09 a.m. Staff F, certified nurse aide, stated she assisted Staff E with the catherization of Resident #3 on 1/19/18.	F 580		

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F 580	Continued From page 7 Staff F stated she held Resident #3's knees. As Staff E inserted the catheter, she then began to inflate the balloon and almost immediately there was blood flowing back through the catheter. Staff E deflated the balloon and pulled the catheter out and blood squirted out everywhere. Staff F assisted with applying pressure and Staff E left to get help. Staff F stated during the catherization process, she never saw a return of urine in the catheter tubing. The Emergency Nursing Record dated 1/19/18 documented that upon an RN doing a UA via straight cath, the resident's meatus started bleeding. The nurse at the care center did a straight cath on the patient to try to get a UA for recent UTI (urinary tract infection). She noticed acute bleeding after inserting the catheter. The record documented the clinical impression of urethral bleeding and a suspected urethral tear (the report contained no indication the facility disclosed the likely cause for the bleeding/injury). In an interview on 3/13/18 at 11:45 a.m. the Assistant Director of Nursing (ADON) stated in mid January Resident #3 received an order for a straight cath urinalysis. While inserting the catheter, Resident #3 sustained trauma to his urethra resulting in excessive bleeding. The ADON stated straight caths on males are usually done with a regular 16 french Foley catheter. The procedure is an in-and-out to obtain a urine sample and there would be no reason on a straight cath to inflate the balloon. When asked if the ADON was aware Staff E had inflated the balloon during the straight cath procedure on Resident #3 on 1/19/18, the ADON stated she had consulted with Resident #3's physician and the physician did not believe the urethra tear was	F 580		

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F 580	Continued From page 8 caused by inflating the balloon while still in the urethra. In an interview on 3/14/18 at 9:45 a.m. Resident #3's physician stated she had not been informed until this morning that a nurse had inflated the catheter balloon while still in the urethra of Resident #3 on 1/19/18 which resulted in the urethra tear. The physician stated at the time of the incident she suspected a possible stricture in the urethra or enlarged prostate, but noted the bleeding in those cases is generally minimal. In light of now knowing that a nurse inflated the balloon while in the urethra and that there was excessive bleeding, she had no doubt the inflated balloon caused the urethra tear. The physician stated she was very upset with the facility for not informing her of the inflated balloon issue. The physician stated the ADON called her this morning and informed her of the details involving Resident #3's catherization on 1/19/18. In an interview on 3/14/18 at 10:55 a.m. Resident #3's sister and power of attorney stated she had been informed of Resident #3 going to the hospital on 1/19/18 related to a urethra tear, but was not informed of the accident which caused it.	F 580		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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F 690	Continued From page 9 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: The following deficiency relates to complaint # 74283-C. Based on clinical record review and staff, physician and family interviews, the facility failed to ensure staff used correct technique when inserting a catheter to obtain a urine specimen for one of four residents reviewed (Resident #3). The facility reported a census of 61 residents. Findings include:	F 690		

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F 690	Continued From page 10 According to the Minimum Data Set (MDS) assessment dated 2/13/18, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderately impaired memory and cognition. Resident #3 required the assistance of two with transfers, dressing, toilet use and personal hygiene needs. Resident #3's diagnoses included Non-Alzheimer's dementia, seizure disorder and chronic lung disease. The Interdisciplinary progress notes revealed: On 1/19/18 at 1:45 p.m., indicated the nurse went to Resident #3's room to obtain urine per order with 16 French Foley catheter with sterile technique, no resistance, upon insertion, moderate amount of bright red blood came out of the urethra, pressure applied, clot visualized at meatus resident no complaint of pain, resident alert per usual self. On 1/19/18 at 2:15 p.m., indicated nurse called to Resident #3's room due to resident bleeding copious amounts of blood bright red. Pressure was applied without any blood stopping. Primary care physician contacted and requested to apply ice and send Resident #3 to emergency room. On 1/19/18 at 5:45 p.m., Resident #3 returned back to the facility from emergency room with three way catheter. The resident's urine was pink-tinged urine and some bleeding around catheter. Resident obtained urethral tear if bleeding continuous send back to emergency room. On 1/24/18 at 5:45 p.m., Resident #3 catheter's drainage bag had 450 milliliters of bright red	F 690		

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F 690	Continued From page 11	F 690		

tinged blood urine. And small amount of blood around penis. Resident did not have leg strap on and certified nursing assistant retrieved one to prevent pulling. Physician requested staff keep leg strap on and to update her before the removal of the catheter on 1/26/2018.

On 1/26/2018 at 6:30 a.m., resident had no urine output.

On 1/26/2018 at 6:35 a.m., Resident #3's penis was swollen and that foreskin would not go down over head of penis. The small amount of urine in catheter bag was white and cloudy and had foul smell.

On 1/26/18 at 7:15 a.m. Resident #3 was transferred to emergency room and later hospital called to indicate the Resident #3 was being admitted for urinary tract infection and sepsis.

A faxed physician order dated 1/19/18 instructed staff to obtain a follow up urinalysis (UA) for Resident #3.

In an interview on 3/13/18 at 4:18 p.m. Staff E, licensed practical nurse (LPN), stated on the afternoon of 1/19/18 she received an order to straight cath Resident #3 for a urinalysis. Staff E asked her co-workers what size of catheter should be used for that procedure and they all agreed a 16 french would be appropriate. Staff E went in with Staff F and proceeded to insert the catheter using sterile technique. Staff E stated she got a little return of urine and started to inflate the balloon when she noticed blood return through the tubing. Staff E deflated the balloon and removed the catheter. Resident #3 started bleeding profusely and she went and got help.

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F 690	Continued From page 12 Staff E stated she has been a nurse since October 2017 and has some experience with straight catherizations, but primarily with females. When asked why she would inflate the balloon for a straight cath, which was an in and out procedure, Staff E stated she was not sure. In an interview on 3/14/18 at 9:09 a.m. Staff F, certified nurse aide, stated she assisted Staff E with the catherization of Resident #3 on 1/19/18. Staff F stated she held Resident #3's knees. As Staff E inserted the catheter, she then began to inflate the balloon and almost immediately there was blood flowing back through the catheter. Staff E deflated the balloon and pulled the catheter out and blood squirted out everywhere. Staff F reported, Resident #3 stated, "That hurt god dammit that hurt." Staff F assisted with applying pressure and Staff E left to get help. Staff F stated during the catherization process, she never saw a return of urine in the catheter tubing. In an interview on 3/13/18 at 3:32 p.m. Staff G, LPN, stated on 1/19/18 Staff E received an order to straight cath Resident #3 for a urinalysis. Staff G stated she was not in the room during the catherization. Staff E exited the room stating Resident #3 was bleeding; Staff E stated she had inserted the catheter and inflated the balloon. When she deflated the balloon, Resident #3 started bleeding excessively from his penis. Staff G assisted with providing care and getting Resident #3 sent to the emergency room. Staff G stated she was concerned when Staff E stated she had inflated the balloon because a straight cath procedure wouldn't require the balloon to be inflated. Staff G believed Staff E may have inflated the balloon while it was still in the urethra	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165326	A. BUILDING _____ B. WING _____	C 03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMFIELD CARE CENTER	800 NORTH DAVIS STREET BLOOMFIELD, IA 52537

(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
F 690	Continued From page 13 (the tube leading through the penis to the bladder), resulting in the tear. In an interview on 3/13/18 at 3:17 p.m. Staff H, LPN, stated on 1/19/18 Staff E went into Resident #3's room to do a straight catherization. Staff H stated she was not present in the room during the procedure, but Staff E told her what happened. Staff E stated she had inserted the catheter, but not all the way to the "Y". Staff E stated she inflated the balloon and didn't get any urine return. When Staff E deflated the balloon, Resident #3 had an excessive amount of bleeding. Staff H stated a straight cath would not require the balloon to be inflated. Staff H believed Staff E likely inflated the balloon while it was still in the urethra, causing the tear. Emergency Nursing Record dated 1/19/18 documented that upon an RN doing a UA via straight cath, the resident's meatus started bleeding. The nurse at the care center did a straight cath on the patient to try to get a UA for recent UTI (urinary tract infection). She noticed acute bleeding after inserting the catheter. The record documented the clinical impression of urethral bleeding and a suspected urethral tear (the report contained no indication the facility disclosed the likely cause for the bleeding/injury). In an interview on 3/13/18 at 11:45 a.m. the Assistant Director of Nursing (ADON) stated in mid January Resident #3 received an order for a straight cath urinalysis. While inserting the catheter, Resident #3 sustained trauma to his urethra resulting in excessive bleeding. The ADON stated straight caths on males are usually done with a regular 16 french Foley catheter. The procedure was an in-and-out to obtain a	F 690		

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F 690	Continued From page 14	F 690		

urine sample and there would be no reason on a straight cath to inflate the balloon. When asked if the ADON was aware Staff E had inflated the balloon during the straight cath procedure on Resident #3 on 1/19/18, the ADON stated she had consulted with Resident #3's physician and the physician did not believe the urethra tear was caused by inflating the balloon while still in the urethra.

In an interview on 3/14/18 at 9:45 a.m. Resident #3's physician stated she had not been informed until this morning that a nurse had inflated the catheter balloon while still in the urethra of Resident #3 on 1/19/18 which resulted in the urethra tear. The physician stated at the time of the incident she suspected a possible stricture in the urethra or enlarged prostate, but noted the bleeding in those cases is generally minimal. In light of now knowing that a nurse inflated the balloon while in the urethra and that there was excessive bleeding, she had no doubt the inflated balloon caused the urethra tear. The physician stated she was very upset with the facility for not informing her of the inflated balloon issue. The physician stated the ADON called her this morning and informed her of the details involving Resident #3's catherization on 1/19/18.

In an interview on 3/14/18 at 10:55 a.m. Resident #3's sister and power of attorney stated she had been informed of Resident #3 going to the hospital on 1/19/18 related to a urethra tear, but was not informed of the accident which caused it.

Bloomfield Care Center

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Provider # 165326

Plan of Correction in response to the DIA survey completed on 3/14/18 at Bloomfield Care Center.

Preparation and implementation of the plan of correction should not be construed as an admission of the deficiencies cited or an admission of the accuracy or truthfulness of any statements, findings, facts, or conclusions that form the basis of the alleged deficiencies. This plan of correction is prepared solely because it is required under federal or state law.

F550: Resident Rights/Exercise of Rights CFR(s): 483.10 (a)(1)(2)(1)(2)
The facility will continue to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life; recognizing each resident' s individuality. The facility will continue to protect and promote the rights of the resident.

F 550 – Correction Date: 04/14/2018

1. Following the occurrence the facility reported the incident to the state agency within 24 hours and completed an internal investigation. Psychosocial assessment and support was provided to Resident #1, although he/she could not recall the incident.
2. The facility has systems in place to educate and train newly hired certified nursing assistants (CNAs). CNAs receive topic-specific in-service education, orientation to facility procedures and practices and the specific needs of the residents upon hire. Training includes completion of an extensive orientation checklist which encompasses resident rights, dignity, communication, chain of command and aspects and accountability of reporting requirements. A written acknowledgement of receipt of training and understanding of policies and procedures for "Mandatory Reporting of Dependent Adult Abuse" and "Abuse Prevention Training and Investigations" is obtained from the employee. This will continue to be our practice. The Assistant DON provided verbal re-education on 1/15/18 to CNAs regarding timely communication with supervisory staff present in the building, as well as supervisors available by phone 24/7. CNAs may utilize any nurse on duty, as well as on-call staff to obtain information and guidance regarding issues or concerns if they are unsure who the "charge nurse" is. The CNAs verbalized knowledge of the importance of accountability regarding these procedures.
3. A staff in-service conducted on 04/10/2018 included re-education focusing on potential alleged or suspected abuse reporting procedures.

4. To ensure that facility solutions are permanent, the Director of Nursing (DON) or designee will conduct follow up audits of staff knowledge of mandatory reporting procedures monthly x 4 months.

F580: Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483 .10(G)(14)(i)-(iv)(15)
The facility will continue to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment).

F 580 – Correction Date: 04/14/2018

1. Resident #3's physician was notified immediately of complications of bleeding after a urinary catheter insertion procedure on 1/19/18 and again approximately 30 minutes later, as documented in the resident's chart.
2. To ensure appropriate notification of resident condition changes nursing staff was educated by the DON on 04/13/2018. The presentation included review of facility policy, "Family and Physician Notification Relating to Accident or Change in Medical Condition."
3. To ensure facility residents/families/physicians are appropriately notified, the DON or designee will perform random audits of condition changes/incidents monthly x 3 months.

F690: Bowel/Bladder Incontinence, Catheter, UTI CFR(s) 483.25(e)(1)-(3)
The facility ensures that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

F 690 – Correction Date: 04/06/2018

1. Resident #3 no longer has a urinary catheter. Staff will continue to monitor resident for signs altered urinary elimination and urinary tract infections.
2. Professional staff was provided re-education related to urinary catheter insertion techniques and equipment with a focus on individual resident risk factors that could contribute to a higher incidence of complications vs. avoidable iatrogenic injuries.
3. The professional staff will be observed by the charge nurses during catheter insertion procedures randomly for 6 months. The DON will review the results of the audits through the quality assurance process. The frequency of audits thereafter will be based on outcomes.