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	175468	A. BUILDING _____ B. WING _____	C 12/03/2019

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PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

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F 000	INITIAL COMMENTS The following citations represent the findings of Complaint Investigation #148064. The 2567 was electronically sent to the facillity on 12/16/19.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 40 resident, with three residents selected for review. Based on observation, interview, and record review the facility failed to ensure quality of care for one Resident (R) 1 when staff failed to follow physician orders for bladder irrigations and the resident had blood in his urine. Findings included: - Resident (R) 1's electronic medical record revealed he admitted to the facility on 12/17/15 with diagnosis including renal and ureteral calculous obstruction, urinary tract infection, and retention of urine per the 10/31/19 physician orders. The 04/15/19 admission "Minimum Data Set"	F 684		

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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(MDS), documented a Brief Interview for Mental Status (BIMS) score of 14, indicating cognition was intact. The resident did not walk and required total assistance of two for transfers and required extensive assistance with most of the remaining areas. The resident had an indwelling urinary catheter.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 04/15/19, revealed the resident diagnosis' included hydronephrosis (excess fluid in the kidney due to a backup of urine, caused by a blockage in the tube that connects the kidney to the bladder) with an indwelling suprapubic catheter (a tube inserted through the skin directly into the bladder that drains urine into a bag outside the body).

Differences identified with the 10/04/19 quarterly MDS included BIMS score was12, indicating moderately impaired cognition and he required extensive assistance with transfers.

The care plan documented as follows:

02/19/19, during transfers, the Foley catheter should be clamped to ensure no urine back flow, should the bag be carried/placed above bladder level.

10/07/19, Geri-recliner wheelchair used to assist me where I need to go.

11/27/19, check him every 2 hours and change for bowel incontinence with repositioning. Provide catheter care, empty urinary catheter drainage bag every shift and provide perineal and scrotal care too as he still has drainage from his penis.

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Physician orders, dated 07/04/19 at 12:25 PM, evidenced the following order for Renacidin Solution (a sterile solution made of Citric Acid that prevents encrustations in urethral catheters and dissolves certain bladder stones) use 30 cc via irrigation two times a day, every day, for irrigation for continued sediment.
Progress notes, dated 07/18/19, from a visit to a Urology Clinic revealed:
Assessment:
Suprapubic catheter dysfunction.
General measures as discussed:
1.) plenty of fluids.
2.) keep catheter dependent to drain.
3.) change catheter routinely as scheduled.
4.) Normal Saline flushes as needed (PRN).
Use Renacidin twice daily (BID) for 2-3 days in a row as long as no active infection if sediment.
Then use on Tuesdays/Thursdays for maintenance. (two times a week).

The treatment administration records (TARs) revealed the resident received the Renacidin Solution flush more than two times weekly, after the 07/18/19 orders, as follows:
July 2019: from 7/21-31/19, twice daily.
August 2019: from 8/1-31/19, twice daily.
September 2019: from 9/1-14/19, twice daily (In hospital 9/15-21/19) 9/22- 30/19, twice daily.
October 2019: from 10/1-31/19, twice daily.
November 2019: from 11/1-6/19, twice daily.

Nurses notes and Physicians Orders, dated 11/06/19, documented R1 returned from a doctor's appointment with the following orders:

1.) Renacidin flushes to be done on Tuesday and Thursday.only and normal saline flushes between

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as needed.

On 12/2/19 at 10:44 AM, R1's unidentified family member reported, R1 received unnecessary catheter flushes. She said R1 was having problems with his catheter being clogged and saw the physician extender at the facility on 07/4/19. The PA ordered the suprapubic catheter flushed with Renacidin solution twice daily and to follow up with a urologist. The family member reported she knew it was a citric acid solution, used to help dissolve sediment in the catheter, and helped with the crusting that forms in the tubing at times. She reported she was with R1 when he went for his follow-up appointment on November 06, 2019 and she read on his medical record for the 07/18/19 visit, the Renacidin flushes were only ordered twice daily for 2-3 days and then to be two times a week, on Tuesdays and Thursdays, but the facility continued to flush the catheter two times a day, every day from July until the first part of November 2019.

On 12/2/19 at 10:20 AM, the resident reported the staff took good care of him, and reported when staff flushed his catheter it did not cause pain or burning.

On 12/2/19 t 11:10 AM, LN H and CNA M entered R1 's room to provide wound care. and then staff repositioned the resident to his left side. The urine appeared dark brownish/reddish in color, and the catheter was anchored to upper right leg.

On 12/2/19 at 3:00 PM, LN I reported when a new order comes the nurse that receives it documents in the nurses' notes and calls the pharmacy to order the medication and notifies the family of the

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new order. LN I said she was not sure what happened with R1. LN I added R1 got Renacidin flushes twice a day until November. LN I reported in July his catheter was clogging and not draining right and she called physician extender LL and received an order to flush it with normal saline for clogging, but it was still had a lot of sediment in it. Physician extender LL gave another order, for the Renacidin Solution flush twice a day. LN I added she later read about the Renacidin and knew it could cause problems, but had seen it used daily before at another facility. LN I said the facility did change it to twice a week on Tuesday and Thursday in November. LN I reported the facility recently changed the way they did new orders. Now new orders were checked by the administrative nurses, and on the weekend the facility had 2 nurses' so the orders were doubled checked by each one. LN I reported she did not remember any changes when he went to the urologist later in July.

On 12/2/19 at 3:50 PM, LN G reported she worked 1:00PM to 11:00 PM on 07/04/19 and on 07/18/19, and she was probably the nurse in charge when R1 returned from the doctor. LN G reviewed the order and said she did not remember seeing any changes and said they might have been sent later. LN G reported the usual procedure was to note orders when a resident returned and call the pharmacy and notify the family. LN G added the other nurses did the same. LN G reported on 11/06/19 she requested clarification from the urologist office related to the Renacidin flush, whether it was to be BID or daily on Tues and Thurs.

On 12/3/19 at 12:15 AM, administrative nurse D reported a medication error report was done on

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LNG related the R1 catheter flushes. Administrative Nurse D reported she discovered the Renacidin flush was given BID when it was supposed to be for only 2-3 days, then changed to Tues. and Thursdays for maintenance. The order was written on the back page of the progress notes and was not noted by a nurse. The extra flushes could have caused bleeding in the urine. The flush was changed to every Tues and Thurs. staring on 11/12/19. Education was given to the nurses to review all progress notes for orders and follow up.

On 12/3/19 at 12:45 PM, Physician Extender MM reported he saw R1 on 11/06/19 and was made aware the Renacidin flushes had been done twice daily since July. When asked if the excess flushes caused the resident's bleeding in the urine, Physician extender MM It was a mild acid that can irritate the bladder tissue and probably contributed to the blood in the urine.

On 12/3/19 at 1:40 PM, physician extender LL , reported he talked with physician extender MM about R1. He commented the excess Renacidin flushes probably didn't help the resident due to the blood in the urine but did not caused any real damage. Physician extender LL reported he was aware the orders for the flush was written wrong on the MAR, however, he did not know how staff missed the order.

The facility lacked a policy and procedure related to bladder irrigations/flushes.

The facility failed to provide quality of care for this resident who was experiencing blood in the urine when facility staff failed to accurately transcribe and follow physician's orders for bladder flushes.

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: The facility reported a census of 40 resident, with three residents selected for review. Based on observation, interview, and record review the facility failed to administer medication ordered by	F 755		

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the physician to assist in clearing blood from the resident's urine, until 4 days after it was ordered.

Findings included:

- Resident (R) 1's electronic medical record revealed he admitted to the facility on 12/17/15 with diagnosis including renal and ureteral calculous obstruction, urinary tract infection, and retention of urine per the 10/31/19 physician orders.

The 04/15/19 admission "Minimum Data Set" (MDS), documented a Brief Interview for Mental Status (BIMS) score of 14, indicating cognition was intact. The resident did not walk and required total assistance of two for transfers and required extensive assistance with most of the remaining areas. The resident had an indwelling urinary catheter.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 04/15/19, revealed the resident diagnosis' included hydronephrosis (excess fluid in the kidney due to a backup of urine, caused by a blockage in the tube that connects the kidney to the bladder) with an indwelling suprapubic catheter (a tube inserted through the skin directly into the bladder that drains urine into a bag outside the body).

Differences identified with the 10/04/19 quarterly MDS included BIMS score was12, indicating moderately impaired cognition and he required extensive assistance with transfers.

The care plan documented as follows:

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02/19/19, during transfers, the Foley catheter should be clamped to ensure no urine back flow, should the bag be carried/placed above bladder level.

11/27/19, check him every 2 hours and change for bowel incontinence with repositioning. Provide catheter care, empty urinary catheter drainage bag every shift and provide perineal and scrotal care too as he still has drainage from his penis.

November 2019: from 11/1-6/19, twice daily.

Nurses notes and Physicians Orders, dated 11/06/19, documented R1 returned from a doctor's appointment with the following orders:

1.) Renacidin flushes to be done on Tuesday and Thursday only and normal saline flushes between as needed.

2.) Cephalexin (an antibiotic medication) 500 milligrams (mg.) 1 tablet by mouth twice daily for 7 days.

3.) Finasteride (medication used to treat benign prostatic hyperplasia which enlarged prostate which can cause a weak urine stream and, in some cases, lead to infection or bladder stones) 5 mg. by mouth daily.

Review of the November, 2019, Medication Administration Record (MAR) revealed facility staff failed to begin the administration of the Finasteride medication until 11/10/19 (4 days after ordered.)

On 12/2/19 at 10:44 AM, R1's unidentified family member reported R1 failed to receive medication

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timely after it was ordered, because the nurses failed to get the orders straight when R1 returned from an appointment on 11/06/19. She reported she was with R1 when he went for his follow-up appointment on November 06, 2019 and the urologist ordered Cephalexin, an antibiotic and Finasteride, and the facility failed to start the Finasteride.

On 12/2/19 at 10:20 AM, the resident reported the staff took good care of him, and reported when staff flushed his catheter it did not cause pain or burning.

On 12/2/19 t 11:10 AM, LN H and CNA M entered R1 's room to provide wound care. and then staff repositioned the resident to his left side. The urine appeared dark brownish/reddish in color, and the catheter was anchored to upper right leg.

On 12/2/19 at 3:00 PM, LN I reported when a new order comes the nurse that receives it documents in the nurses' notes and calls the pharmacy to order the medication and notifies the family of the new order.

On 12/2/19 at 3:50 PM, LN G reported the usual procedure was to note orders when a resident returned and call the pharmacy and notify the family. LN G added the other nurses did the same. LN G reported she would have called the pharmacy to order the medication and might have pulled the antibiotic from the E-kit, if needed. LN G verified she worked Monday thru Thursday and said the facility recently began a new check for medications. Administration nurses checked the orders and on the weekends orders were double checked by the 2 nurses working. LN G added R1 received catheter flushes twice a day but

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added she did not do the catheter flushes usually. LN G reported on 11/06/19 she requested clarification from the urologist office related to a diagnosis for Cephalexin and the Finasteride.

On 12/2/19 at 4:55 PM, LN J, reported on a weekend in November 2019, a card of medication was found, Finasteride for R1, but the medication was not on his medication administration record (MAR.) LN J checked his orders and it was on his orders. LN J called Administrative Nurse D and she told me to add it to the computer. LN J said the nurse that receives the order was the one responsible to put in in the computer for the MAR but it was missed.

On 12/3/19 at 12:15 AM, administrative nurse D reported a medication error report was done on LN G related to the missed Finasteride. Education was given to the nurses to review all progress notes for orders and follow up. Also, re-education to chart all in/out appointments in the record. LN G reported she wrote the medication, Finasteride on the MAR and ordered it from the pharmacy, but staff could not find it. Administrative Staff D stated she was not sure what happened. The Finasteride ordered on 11/06/19 was not started until 11/10/19 when the medication was found by another nurse.

On 12/3/19 at 12:45 PM, Physician Extender MM reported he saw R1 on 11/06/19 and was made aware the Renacidin flushes had been done twice daily since July instead of twice weekly. He said he ordered an antibiotic, Cephalexin 500 mg. for 7 days and Finasteride 5 mg. daily. When questioned about what the Finasteride was ordered for, he said it was to help with the blood in the urine. He further reported the missed

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doses of Finasteride would cause the urine to take longer for the blood to clear.

On 12/3/19 at 1:40 PM, physician extender LL reported he talked with physician extender MM about R1. Physician extender LL reported he was aware of the missed Finasteride, however, he did not know how facility staff missed the order.

The undated facility policy and procedure, "Physician Orders for Medications and Treatments," evidenced all medications will be admisistered as ordered by a health care professional.

The facility failed to administer medication which would aide in the decrease of the blood in the resident's urine, as ordered by the physician.