VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 1, 2018

Ms. Barbara Moynan, Manager
Allenwood At Pillsbury Manor
90 Allen Road
South Burlington, VT 05403-7856

Dear Ms. Moynan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 15, 2018.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 08/29/2018
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0372	A. BUILDING: _____ B. WING _____	C 08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLENWOOD AT PILLSBURY MANOR	90 ALLEN ROAD SOUTH BURLINGTON, VT 05403

(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) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was completed on 8/15/18 by the Vermont Division of Licensing and Protection. The purpose of the survey was to investigate two complaints regarding resident care and services. The following regulatory violations were identified.	R100	R104 Revised POC accepted as attached per a 9/12/18 mBatt	
R104 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.1 Admission 5.2.a Prior to or at the time of admission, each resident, and the resident's legal representative if any, shall be provided with a written admission agreement which describes the daily, weekly, or monthly rate to be charged, a description of the services that are covered in the rate, and all other applicable financial issues, including an explanation of the home's policy regarding discharge or transfer when a resident's financial status changes from privately paying to paying with SSI or ACCS benefits. This admission agreement shall specify at least how the following services will be provided, and what additional charges there will be, if any: all personal care services; nursing services; medication management; laundry; transportation; toiletries; and any additional services provided under ACCS or a Medicaid Waiver program. If applicable, the agreement must specify the amount and purpose of any deposit. This agreement must also specify the resident's transfer and discharge rights, including provisions for refunds, and must include a description of the home's personal needs allowance policy. (1) In addition to general resident agreement requirements, agreements for all ACCS	R104	See Attached	

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R104	Continued From page 1 participants shall include: the ACCS services, the specific room and board rate, the amount of personal needs allowance and the provider's agreement to accept room and board and Medicaid as sole payment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide an admission agreement that explained to the resident/legal representative what exact services were included in the 3 stated "Stages of Care", #1. Extra Care, #2. Stage I, and #3. Stage II. Resident #2 was admitted to the Residential Care Home and based on review of the 2 week admission assessment, the resident did not meet the criteria for Stage II yet the signed admission agreement documented that the resident was to be billed for care and personal services at the Stage II level. Findings include; Per review of Resident #2's admission agreement provided by the Co-Executive Director on 8/14/18, the wording used to describe each stage of care was not specific. The Stages of Care were described as follows: "Extra Care - resident requires standby assistance up to or including medication management and ambulation. Cost - $750.00." "Stage I - resident requires care beyond the Extra Care stage which may include more in-depth assistance with ADLs, hygiene needs, ambulation, personal care and increased involvement with the resident's physician. Cost - $1,000.00" "Stage II - resident requires care beyond Stage I which MAY include regular safety checks, direct involvement with ADL functioning, cueing and/or	R104		

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R104	Continued From page 2 reorienting, bladder/bowel incontinence management and increased involvement with the resident's physician. Cost - $2,000.00 per month in addition to base rent." The admission agreement stated that "all residents undergo an initial 2 week assessment by the nursing team at Allenwood. After this 2 week assessment period, the nurse manager, resident, and family will agree to a plan of resident care services which may include some or all of the items listed. As the resident's needs change, another assessment and adjustment in residential care services may be necessary." Per review of the Resident Admission Assessment dated 6/21/18, the resident was fully cognitively intact (alert and oriented) and was independent with all decision making. The resident was coded as independent in physical functioning (ADLs [activities of daily living], including mobility, ambulation, personal care, toileting, hygiene and bathing). The resident was continent of both bladder and bowel. The resident had recent surgery and required pain management and monitoring of a healed surgical wound by nurses. The resident was assessed for the highest level of care, Stage II for the entire 4 week stay, although there was no evidence that level of care was needed. During interview on 8/15/18 at 3:30 PM, the Licensed Practical Nurse (LPN) who completed the 14 day admission assessment, stated s/he did not know why the resident was assigned Stage II level of care based on the admission assessment. S/he stated that the resident received medication administration. The LPN confirmed that s/he had not re-assessed the resident's needs after the initial 2 weeks in the	R104		

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R104	Continued From page 3 facility. Per review of the progress notes and medication administration records, the nurses had provided pain management, monitoring of the surgical site and involvement with the physician for medication orders since admission. During interview with the Co-Executive Director on the afternoon of 8/15/18, s/he could not describe the specific differences for the 3 Stages of Care stated in the admission agreements and what the charges were based on. S/he also confirmed that there was no existing written policy/procedure to describe the Stages of Care. (Refer also to R 200).	R104		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide the necessary services to meet each resident's nursing and medical needs for 1 of 4 applicable residents in the sample: (Resident #1). Findings include: Per record review on 8/14/18, Resident #1 was at risk for bowel complications, including constipation, and licensed nurses failed to	R126	R126 POC accepted per addendum MB 8/29/18	

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R126	Continued From page 4 provide treatment until the surveyor brought to their attention that treatment documentation showed the resident had gone for 10 days without a bowel movement. The resident was receiving Hospice services and frequent routine and PRN (as needed) doses of Morphine to manage pain (morphine is known to contribute to constipation). The resident was diagnosed with intermittent rectal prolapse and had physician orders to monitor bowel movements and for treatment to reduce the rectal prolapse as needed. Per review of the MAR (medication administration record) for August, 2018, there was no documented bowel movement (BM) from 8/4/18 - 8/14/18. The resident had orders for Miralax 17 gm. every day and nurses and MT (medication technicians) documented refusal of the Miralax from 8/1/18 to 8/13/18. Per interview on 8/14/18 at 3 PM, the evening shift LPN was asked why the resident did not receive any medication to alleviate the constipation and lack of any bowel movement since 8/3/18. The LPN stated that there was an order for Colace (a stool softener); however the resident was no longer taking PO medications. She had not asked the pharmacy about liquid Colace although the resident was able to take liquid medications. The resident also had Hospice orders for Bisacodyl, 10 mg. suppository PR for constipation. In response to why the resident was not given a suppository, the LPN stated that s/he couldn't administer that medication due to the rectal prolapse (an intermittent issue). The Director of Nurses was also present for the interview and stated that the suppository could be given after reduction of the prolapse rectum if needed. After the conversation the LPN did an assessment of the resident's abdomen and administered the Bisacodyl PR and the resident subsequently had a bowel movement later the	R126		

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R126	Continued From page 5 same day. Regarding management of a resident's bowel functioning, the evening shift LPN stated that they do administer laxatives and stool softeners on the evening shift; any resident with 3 days of no BM, would be given medication to facilitate a bowel movement during the evening shift. Per review of the care plan, the plan for the rectal prolapse was identified and interventions included monitoring of bowel movements. A physician order dated 2/16/18 stated: 'Apply granulated sugar to rectal prolapse as needed to reduce (contact RN at MD office for further instructions'). The presence of the rectal prolapse intermittently had the potential to complicate this resident's risks related to constipation. The care plan did not address the need for on-going nurse monitoring of the rectal area and reduction of the prolapse when it occurred. Refer also to R 145.	R126		
R144 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to completed the admission assessment within 14 days of admission to the facility for 1 of 4 residents in the applicable sample. (Resident # 2), Findings include: Per review of the state required admission	R144	R144 POC accepted 9/27/18 M. Bolton RN	

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R144	Continued From page 6 assessment, Resident #2 was admitted to the facility on 6/21/18. The assessment did not have the required signature of the RN to denote that the RN had reviewed the assessment and agreed with the assessment as written and that the basement was complete. The incomplete, late assessment was confirmed during interview with the LPN and RN DNS on 8/15/18 at and 5:30 PM	R144		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RN failed to revise the care plan to address all of the identified needs for 1 of 4 applicable residents in the sample. (Resident #1). Findings include: Per record review and staff interview on 8/14/18, Resident #1 was receiving Hospice services and was treated with with opiods for pain management; opiods are known to cause constipation and nursing staff failed to revise the resident's care plan to address this need, and failed to address monitoring and reduction of a rectal prolapse in the care plan. Based on record review, the resident, who had physician orders to	R145	R145 POC accepted 9/27/18 M. Butler	

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R145	Continued From page 7 'monitor bowel movements for rectal prolapse' failed to have documented evidence of a bowel movement for a period of 10 days, from 8/4/28 - 8/14/18, when the surveyor noted the problem and alerted the licensed nurses. The LPN for the shift confirmed that constipation was a risk to be monitored and treatment provided for this resident. When asked if s/he monitors resident BM (bowel movements) during the evening shift, the nurse replied "Not routinely" then stated "I ask (caregivers) if there are any residents with 3 days of no bowel movement". The nurse then replied that s/he was not sure how it went all this time and no staff were aware of the lack of a BM for Resident #1. Refer also to R 126.	R145		
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and staff schedule reviews, the facility failed to provide adequate licensed nurse staffing to enable Med Techs to administer a controlled medication in accordance with facility medication administration policies and procedures. This practice had the potential to affect any resident who may have required administration of a controlled medication on 1 weekend during the time period reviewed (6/28/18 - 8/8/18. Findings include:	R178	POC 178 accepted 9/27/18 M. Baltimore	

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R178	Continued From page 8 Per review of the nursing staff schedules for the time period of 6/28/18 - 8/8/18, there was no nurse on listed on duty on the day shift (6:30 AM - 3 PM) on 7/5/18. Based on a complaint received by the licensing agency, an anonymous allegation regarding a lack of charge nurses for all shifts, presented potential issues with regard to the facility's assurance of prompt, appropriate action in cases of resident injury, illness or other emergencies. The allegation alleged that Medication Technicians (MT) had been assigned as Charge staff when no nurse was available to work. Per interview with the DNS on 8/15/18, the routine staffing pattern included a charge nurse for each of the 3 shifts daily. It was noted that when the MTs are administering medications, they could be anywhere within a large environment that included 3 resident floors and 2 separate wings of the home. If there were no charge nurse, the MT would also be responsible for answering the main telephone line after 5 PM, attending to any emergent resident needs (such as falls, injuries, illness) in any of the above locations and administering medications to all of the residents of the RCH accurately and on time. The lack of a nurse on the day shift on 7/5/18 would mean that for any resident needing Morphine via oral route for pain, (for example, a Hospice resident), the MT would not be able to administer the liquid PO Morphine in accordance with the facility policy entitled: "Administration of PO Liquid Morphine by Med Techs", last updated on 3/22/17, that stated: #1, The RN oversight nurse will check the Rx order from the physician, and insure that the delegated med techs understand the order. #2. The RN oversight nurse will then pre-draw any doses that are to be given by a med tech.	R178		

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R178	Continued From page 9 There would not be a RN present to interview the MT regarding their understanding of the order or to answer any questions that they might have. Per interview with the DNS, it was h/her understanding that MTs were following an earlier P/P for controlled medications that required the MT to draw up the controlled medication and have a nurse on duty check the dose prior to administration to the resident. Then the MT and the nurse would then each initial the MAR (medication administration record). This policy titled "Medication Administration by unlicensed staff" was last reviewed on 3/5/13. Based on the interviews with nursing staff, it was not clear which P/P the MTs were required to follow. However, it was clear that both policies/procedures required the presence in the facility of the RN to assure that the dose was correct as ordered by the physician.	R178		
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to develop written policies/procedures to govern all services provided by the home, related to 1 resident in the applicable sample. (Resident #2) Finding include:	R200	R200 POC accepted 9/27/18 M. Bolton, RN	

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R200	Continued From page 10 1. Per review of a sample of admission agreements (4), the home failed to develop a written policy/procedure to address the Stages of Care as included in the resident admission agreements currently in use. Based on review of the admission agreement for Resident #2, recently admitted to the facility, there was no written evidence in the medical record to justify the assigned Stage II level of care upon admission to the home. During interview with the Co-Executive Director and the DNS on the afternoon of 8/15/18, they confirmed that there was no written policy/procedure for the assignment of the level of care for newly admitted residents of the home. (Refer also to R 104)	R200		

Allenwood at Pillsbury Manor D.A.I.L. site visit 08/15/2018

Plan of Correction **Revised 9/27/2018**

R104:

Resident #2 has had all charges in relation to care provided between 06/21/18 and 07/21/18 removed from their account.

THE "Explanation of Extra Services and Tiered Care Charges addendum" has been revised and clarified to the stratification of care charges (see attached document).

Assessments for current Residential Care Residents receiving Extra Services and Tiered Care Charges will be reviewed by the Director of Nursing or designee by October 31st 2018

New resident admission assessments will be reviewed by the Director of Nursing or designee to ensure Extra Services and Tiered Care charges are appropriate and/or if applicable within 14 days of admission.

The Director of Nursing or designee will review all Residential Care Residents reassessments to ensure Extra Services and Tiered Care charges are appropriate and/or if applicable.

The Director of Nursing or designee will monitor for compliance.

Completion date will be October 31 2018

R104 POC accepted 9/27/18 M. Bolton, RN

R126:

Resident #1 no longer resides in the facility.

Each Residential Care Resident will receive a written plan of care that is based on their abilities and needs as identified in the resident assessment.

All Residential Care Residents' care plans will be reviewed by the Director of Nursing or designee to ensure care needs and services are care planned appropriately and services are being met to meet each resident's identified needs by October 31 2018.

The Director of Nursing or designee will audit a sample 10 Residential Care Residents' care plans x60 days to ensure resident care needs and services are care planned appropriately and services are being provided to meet the resident's identified needs by October 31 2018., then quarterly.

Reeducation will be provided to nursing staff and care providers regarding care plans and appropriate documentation along with new policy education by September 30t, 2018.

The Director of Nursing or designee will monitor for compliance.

Completion date will be October 31 2018

R126 POC accepted 9/27/18 M. Bolton, RN

R144:

All Residential Care state required assessments will be signed by the Director of Nursing within 14 days of admission.

The Director of Nursing or designee will review all current Residential Care Residents' assessments to ensure n that assessments are completed and signed by the Director of Nursing or RN designee within 14 days by October 31, 2018.

The Director of Nursing or designee will audit a sample of 10 Residential Care Residents' assessments monthly x 90 days to ensure resident care needs and services are care planned appropriately and services are being provided to meet the residents identified needs, then quarterly.

The Director of Nursing or designee will monitor or compliance.

R144 POC accepted 9/27/18 M. Bolton RN

Completion date will be October 31' 2018.

R145:

Resident #1 no longer resides in the facility.

Each Residential Care Resident will receive a written plan of care that is based on their abilities and needs as identified in the resident assessment.

All Residential Care Residents' care plans will be reviewed by the Director of Nursing or designee to ensure care needs and services are thoroughly and appropriately care planned to meet each resident's identified needs by October 31' 2018.

The Director of Nursing or designee will audit a sample 10 Residential Care Residents' care plans monthly x 90 days to ensure resident care needs and services are care planned appropriately and services are being provided to meet each resident's identified needs by October 31' 2018,, then quarterly.

Reeducation will be provided to nursing staff and care providers regarding care plans and appropriate documentation by September 30[t, 2018]

R145 POC accepted 9/27/18 M. Bolton RN

The Director of Nursing or designee will monitor for compliance.

Completion date will be October 31' 2018

R178:

The facility will ensure sufficient staffing to administer medications per physician's orders.

The policy and procedure regarding the administration of Morphine by Medication Technicians has been revised. (Please see revised policy dated 8/2018). .

Reeducation will be provided to nursing staff and medication technicians regarding new or revised policy and appropriate documentation by September 30, 2018.

The Director of Nursing or designee will audit the MAR (Mediation Administration Record) for all Residential Care Residents receiving Morphine for policy compliance by September 30' 2018.

R178 POC accepted 9/27/18 M. Bolton RN

The Director of Nursing or designee will monitor or compliance.

Completion date will be 9September 30, 2018.

R17 accepted 9/27/18 M. Bates, RN

R200:

THE "Explanation of Extra Services and Tiered Care Charges" policy has been revised and clarified to the stratification of care charges (see attached document).

New resident admission assessments will be reviewed by the Director of Nursing or designee to ensure Extra Services and Tiered Care charges are appropriate and/or if applicable in accordance with the facility's policy and procedure within 14 days of admission.

The Director of Nursing or designee will review all current resident assessments to ensure Extra Services and Tiered Care charges are appropriate and/or if applicable for the level of care by October 31st 2018.

The Director of Nursing or designee will monitor for compliance.

Completion date will be October 31' 2018

R 200 poc accepted 9/27/18 M. Bates

Allenwood At Pillsbury

Extra Services and Tiered Care Pricing

Extra Services:

Any one Service can be added to an independent resident agreement Ala carte. Greater than one service will necessitate entrance to the residential care program and adoption of tiered care plan.

Assist – Shower & Dress: $350.00 monthly: Resident will receive assistance from a trained caregiver in bathing and dressing a minimum of 2/times weekly.

Medication Management: $750.00 monthly: Resident will cede management of medication to the nursing and med tech staff at Allenwood, who will be responsible for administering and monitoring all medication needs.

Management of Foley Catheter: $400.00 monthly: Resident will have Foley Catheter changed by nursing staff per MD orders. Assistance will be provided as needed with emptying the Foley Cather and changing from the day time drainage bag to the night time drainage bag.

Resident Check daily: $350 monthly: Resident will receive a daily status check by a member of the Allenwood nursing and care team.

Incontinence Management Program: $1000.00 monthly: Resident will receive checks from a member of the nursing and care team every two hours to prompt resident. Resident will receive assistance with incontinence supplies but be responsible for providing said supplies. The nursing and care team may assist with the ordering of supplies if necessary.

Variance of Care services: $1,500.00 month in addition to Stage II care: If a resident's care needs exceed that of stage II services, and a variance has been authorized by DAIL for the continued housing of the resident, an additional charge will be added to accommodate the increase in personnel or time necessary for the housing and care of the resident.

Stage I Care Services: $1,000.00 Monthly

Stage one care services will necessitate full entrance onto the residential care program at Allenwood. This includes 3 provided hot meals per day, personal laundry service, and unlimited use of the pendant system. Please note that utilization of the pendant system multiple times in subsequent weeks may necessitate re-assessment and potential movement to Stage II services.

Any two extra services excluding incontinence management program, will prompt the nursing team to begin an assessment and place the resident onto Stage I care program.

Stage II Care Services: $2,000.00 Monthly

Stage II care services will be required for any resident where the nursing assessment shows behavioral or cognitive interventions are needed. These could include but are not limited to mood disturbances, wandering, negative or combative interactions with staff or other residents.

If there are no behavioral or cognitive concerns, residents will be placed on stage II care services when they need incontinence management and one other service, or 3+ of any of the extra services outlined above.

Pricing shows as the maximum that we will charge for any given service, but accommodations may be made in the presence of financial hardship, or minimal assistance needed in a given area.

Bowel Management

Purpose

To insure resident safety and comfort related to bowel function

for residential care residents.

Policy

Residential Care residents at Pillsbury Senior Communities will be monitored for bowel movements to avoid pain, discomfort or injury secondary to constipation. This includes resdients on the residential care program as well as Hospice residents.

General Information

Constipation may cause:

- pain
- delirium
- changes in behavior
- urinary retention
- fecal impaction, or
- fecal incontinence.

There are many factors that predispose residents to constipation which may include:

- medications especially opioid analgesics and anticholinergic medications
- limited mobility
- immobile, GI tract transit time may be up to 3 weeks (normal is 3 days).
- not recognizing urge to defecate
- neurological Illnesses especially dementia, strokes, depression, Multiple Sclerosis and Parkinson's Disease
- general disability, and
- decreased caloric and fluid intake due to reduced appetite.

Useful Tip

Morphine is a useful analgesic, but it commonly causes constipation. A laxative should always be considered when morphine is commenced.

Procedure

1. Each resident receiving residential care services will have a monthly calendar placed in the Care Providers documentation binder as part of the monthly change over.

2. Care Providers will document a resident's bowel movements including amount. Consistency, and color.
3. Evening Charge Nurse will be responsible for reviewing the bowel binder. If a resident has not had a bowel movement in **3 days** the Charge Nurse will ensure the resident receives a laxative or suppository as ordered by the physician.
4. If no bowel movement occurs by the next day, the Charge Nurse will notify the physician for further recommendations.
5. Documentation in the resident's medical record will denote the plan of action.

Administration of PO Liquid Morphine by Med Techs

In order to insure quality nursing care and pain management of our residents that have a Liquid form of Morphine prescribed by their physician, the following steps are to be taken for med techs that have been delegated to pass medications:

1. The RN oversight nurse will check the Rx order from the physician, and insure that the delegated med techs understand the order.
2. The RN oversight nurse will then pre-draw any doses that are to be given by a med tech. The syringes will be labeled and initialed by the RN. The doses will be subtracted from the narcotic count sheet, and cosigned by another licensed nurse. If the resident has hospice services, the hospice RN may predraw the doses in place of the RN oversight.
3. The predrawn syringes will then be kept in the locked narcotic box, and accounted for during the count at each shift change. These syringes will have their own narcotic count sheet.

4. These syringes are to be given ONLY by the med techs. All licensed nurses will continue to give the liquid morphine from the original bottle as Rx by the physician.
5. The med tech will need to follow up with the resident and document the effectiveness for prn doses.
6. Med Techs are responsible to inform the RN oversight nurse or the Administrator, when more pre drawn syringe doses are needed.

*policy based on reg 5.10.d, 4 - FMS
Last updated 3/22/17- FMS

Foley Catheter Care Policy

An indwelling Foley catheter increases the risk of developing a bladder infection. However, you can prevent or at least control infection by taking the following precautions.

- Drink at least eight 8-ounces glasses of fluids a day. Include cranberry juice which keeps urine acidic
- Wash the catheter area with soap and water twice a day. Also wash the rectal area after a bowel movement. Dry skin gently but thoroughly.
- Make sure a leg strap is in place to preventing pulling
- Check and empty drainage bag every 2-3 hours if needed. Record amount, color, clarity and if any sediment.
- Make sure drainage bag is below bladder level
- Report any symptoms to MD indicating UTI: Foul odor, sediment, fever, increased confusion or decreased output, leaking or discharge around catheter

Emptying the drainage bag (leg or bedside)

- Wash your hands and put on gloves.
- Remove the stopper on the leg bag or pull out tubing at the bottom of bedside bag **DO NOT TOUCH THE TIP**
- Drain urine into a graduated container, measure amount and any other information (color, odor etc.)
- Wipe end of drainage tip with alcohol swab and replace tip or close clamp tightly
- Flush urine, rinse container with antibacterial soap.

Attaching the bedside drainage bag

- When resident is going to bed the leg bag needs to replaced to the bedside drainage bag **GLOVES**
- Empty leg bag following above procedure
- Clamp(pinch off with gloved hand) the catheter and wipe the connection with an alcohol wipe(Make sure that you are not holding the tubing up after clamping or pinching you do not want any urine to flow back into bladder)
- Disconnect the leg bag and connect the catheter to the bedside drainage bag-Unclamp the catheter
- Make sure that the tubing is secure(leg band strap) to the thigh that the bag will be hanging from on the bed
- Make sure to leave some slack so that the tube will not be pulled
- Make sure that the tubing is not kinked, it should be secured on the inner thigh and then the tubing should come up and over the top of the thigh.
- The bag on the bed should be below the bladder level and never be place on the floor it needs to be secured on the side of the bed

Reattaching the leg bag

- When you are attaching the leg bag(**GLOVES**) empty the bedside drainage bag follow the proper procedure
- Clamp the Foley catheter off disconnect from overnight bag
- Swab connections attach to leg bag unclamp tubing
- Make sure that the tubing is secure with band and bag is below bladder

Attaching the bedside drainage bag

- When resident is going to bed the leg bag needs to replaced to the bedside drainage bag **GLOVES**
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- When you are attaching the leg bag(**GLOVES**) empty the bedside drainage bag follow the proper procedure
- Clamp the Foley catheter off disconnect from overnight bag
- Swab connections attach to leg bag unclamp tubing
- Make sure that the tubing is secure with band and bag is below bladder

Cleaning the drainage bags

- The bedside drainage bag and the leg bag needs to be cleaned daily with antibacterial soap, rinsed well and then hang to air dry.
- The Foley catheter and the drainage bags should be changed monthly. Bags should be dated and initialed then reflected on treatment sheet.
- Catheter care should be signed for on treatment sheet daily.

Morphine-Administration of PO Liquid Morphine by Medication Technicians

Purpose

To insure safe and accurate administration of PO liquid morphine prescribed by a physician by medication technicians (MT's).

Policy

It is the policy of Pillsbury Senior Communities to safely and accurately administer medications to residents requiring assistance with medication management.

Procedure

1. The Charge person will receive and transcribe the physician order.
2. The Charge person will review the physician order with the MT to insure understanding and clarify any questions.
3. The MT will draw up each dose **at the time of administration.** No pre-draws of Morphine are permitted.
4. Prior to the administration of Morphine the Charge person must verify the correct resident, correct drug, correct dose and co-sign in the EMAR.
5. The Charge person is to review the physician order in the EMAR along with the morphine container in order to check the concentration and dose of the morphine.
6. All other medication administration policies apply (narcotic sheet signature, document effectiveness, etc.).