STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245587	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EBENEZER CARE CENTER	2545 PORTLAND AVENUE SOUTH MINNEAPOLIS, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions with the use of an indwelling urinary catheter to help prevent complications and restore normal voiding for 1 of 3 residents (R2) reviewed for urinary catheter care. Findings include: R2's 5-Day Minimum Data Set (MDS), dated [DATE], identified R2 had intact cognition and required extensive assistance with bed mobility. Further, the MDS identified R2 used an indwelling catheter. R2's admission Ebenezer Bowel and Bladder Status V2 - V2, dated [DATE], identified R2 did not use a catheter, however, had awareness of his need to void along with some demonstrated urinary incontinence. The assessment listed a treatment plan for R2 which read, Check and Change. R2's care plan, dated 2/3/20, identified R2 had an activities of daily living (ADL) deficit and was not a candidate for bladder retraining due . to unable to inhibit urge. The care plan listed an intervention for R2 which read, TOILET USE: Assist of one to check and change upon rising, before or after getting in bed, at bedtime and during the night if awake. Provide urinal at bedside(,) empty after use. Staff to manage peri-care, incontinent product and clothing. The care plan lacked any indication or interventions pertaining to use of a Foley catheter. On 3/9/20, at 1:37 p.m. R2 was observed laying in bed in his room. R2 had a visible urinary catheter drainage bag attached to the bed rail. R2 explained he had an indwelling Foley catheter which had been in placed for a couple months since the Veterans Affairs (VA) office had placed it. The VA had since tried to remove it, however, it had to be put back in for some reason. When questioned about the management and monitoring the facility' staff were completing for the catheter, R2 responded he was unaware of anything being completed for his catheter and added, They just empty the bag. R2's urology Consultation Sheet, dated 2/14/20, identified R2 had an episode of [MEDICAL CONDITION] after surgery which resolved. However, R2 then developed an acute kidney injury (AKI) and was found to have [MEDICAL CONDITION] over a month later. A Foley catheter was placed upon discharge from the hospital. The note identified R2's catheter was removed that day (2/14/20) at the appointment and listed instructions which read, (R2) should void in 2-3 hours, if unable to void in 8 hours please straight cath X2. If unable to void after 3rd attempt please place foley catheter. If able to check residuals via bladder scan, please scan (every) shift and straight cath if residual >350 ml (milliliters). R2's progress note, dated 2/15/20, identified R2 had been straight cathed several times for residual amounts of over 350 ml. As a result, R2's Foley catheter was replaced. A subsequent Referral Form, dated 2/21/20, identified R2 had returned to the urology clinic for follow-up from his 2/14/20 appointment. The note directed, Retrial of void when balance better. Continue catheter for now. A return-to-clinic (RTC) dated was listed for, 3 mon (months). On [DATE], at 8:03 a.m. occupational therapist (OT)-A was interviewed. R2 had been on caseload for approximately two months and R2 did not have a catheter when he first admitted to the nursing home. The catheter had been removed prior, however, it needed to be replaced again. OT-A explained R2's balance had improved but was still variable, at times, however, R2 was able to sit up at the bedside and support himself. Further, OT-A stated they were looking at stopping therapy with R2 as he was reaching his maximum potential and she reiterated R2's balance had improved overall. R2's medical record lacked any evidence the facility had comprehensively assessed and care planned R2's use of the Foley catheter, including R2's normal voiding amounts, urine characteristics and/or potential complication risk of the device since it had been placed on 2/15/20, after being removed at his urology appointment. Further, there was no evidence in the record which demonstrated the facility had re-visited or assessed for the potential to remove the Foley despite R2's balance having improved per OT which was in accordance with R2's Referral Form dated 2/21/20. When interviewed on [DATE], at 8:14 a.m. nursing assistant (NA)-A stated R2 had a Foley catheter in place from the time he came here and the staff empty it and help clean it up. NA-A stated they provide catheter cares once a day. On [DATE], at 8:29 a.m. licensed practical nurse (LPN)-A was interviewed. LPN-A explained R2 had went to a urology appointment on 2/14/20, where the Foley had been removed. He returned to the nursing home without a catheter in place and the staff began doing bladder scans, however, R2 was having high residuals so the catheter had to be replaced. LPN-A stated the nurses were monitoring R2's outputs which ranged from 350 ml to 1000 ml on a daily basis, however, it depend(ed) on the day. LPN-A expressed someone using a catheter should be assessed for their urine characteristics, skin integrity and intakes and outputs. These assessments would be in the electronic medical record (EMR) which LPN-A reviewed and verified had not been completed. LPN-A stated, That's not good, as an assessment should be done to help ensure the catheter is placed for the correct reasons and it's working as intended. LPN-A expressed the care instructions for the catheter were posted in R2's room closet for the NA to reference if they had questions. LPN-A then proceeded to attempt to show these instructions to the surveyor in R2's room, however, there were none found. LPN-A stated, I don't know what happened to his. LPN-A then reviewed R2's care plan and verified it lacked any guidance or interventions pertaining to R2's use of the catheter and stated the care plan was not updated. When interviewed on [DATE], at 10:34 a.m. registered nurse (RN)-A stated he reviewed the medical record and were unable to locate a comprehensive catheter assessment for R2. RN-A explained an assessment would typically include review of the patient's history and physical (H&P) and physician orders [REDACTED]. Further, RN-A stated R2's care plan had not been updated with use of the catheter as they felt the catheter was going to be a shorter term intervention when it was initially placed. This was important to do as the care plan reflects the daily care he's receiving. A facility policy on catheter assessment and care was requested, however, none was received.

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.