| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245499 | A. BUILDING _____ B. WING _____ | 05/05/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| CALEDONIA REHABILITATION & RETIREMENT CENTER | 425 NORTH BADGER STREET CALEDONIA, MN 55921 |

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) |
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| F 0690<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and document review the facility failed to ensure proper urinary indwelling catheter care was performed to prevent and/or reduce the risk for urinary tract infections [MEDICAL CONDITION] and other catheter related complications for 1 of 1 residents (R1) and failed to monitor for signs and symptoms of UTI for 2 of 2 residents (R1,R2) reviewed who had an indwelling catheter. Finding include A vulnerable adult report submitted to the state agency on 4/30/2020, alleged improper care of indwelling urinary catheter and alleged staff were not educated or knowledgeable on catheter cares/management. During an observation on 5/5/2020, at 9:35 a.m. R1 laid in bed with nightgown on with no covers. R1's urinary catheter collection bag dated 4/29 laid on the floor next to the bed; the drainage bag tubing was not coiled and secured to have optimal drainage, tension, and comfort. In R1's shared bathroom, on the towel rack, right next to the hand sink, hung a leg bag with 125 milliliters of a light yellow liquid, the drainage tube that touched the wall was not capped in order to prevent contaminants from entering. R1's Admission Record dated 5/6/2020, included [DIAGNOSES REDACTED]. The [DIAGNOSES REDACTED]. R1's care plan dated 4/28/2020, indicated R1 had an indwelling catheter related to [MEDICAL CONDITION]. The associated interventions for catheter management included, the size of the catheter 16 FR (French), monitor and document intake and output, monitor for signs and symptoms of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter, and monitor/record/report to physician signs and symptoms of UTI. R1's progress note dated 4/28/2020, indicated the physician ordered the insertion of indwelling urinary catheter and in a subsequent note indicated the catheter was inserted without difficulty. During an observation and interview on 5/5/2020, at 9:52 a.m. nursing assistant (NA)-A indicated she was going to assist R1 with personal cares and registered nurse (RN)-A would be performing catheter cares. NA-A indicated she had not worked with R1 since she got her catheter. NA-A observed R1's catheter bag that laid on the floor and stated it should not be on the floor. NA-A then observed collection leg bag in the bathroom, stated should not be hanging from the towel rack, should have a cap on the end of the tubing, and was not sure what the liquid was in the bag but guessed it was water or urine. NA-A stated she had received education upon hire and completed an orientation checklist. During an observation on 5/5/2020, at 10:00 a.m. RN-A and NA-A entered into R1's room. RN-A stated about a week ago an indwelling catheter was ordered because R1 could no longer tolerate intermittent catheterization due to large amounts of retained urine. RN-A stated an unawareness of any problems as a result of the insertion and R1 has not had any symptoms of UTI. R1 was assisted by NA-A to remove nightgown; R1 had a brown piece of tape approximately 2-3 inches wide by 4-5 inches long on her right mid-thigh, the same color tape was also wrapped around the connection of the catheter to the drainage tube. RN-A stated the tape was double sided and was used to anchor the catheter tubing, RN-A did not know why tape was used instead of a proper catheter tubing holder. RN-A went into the bathroom, verified the placement of the undated leg drainage bag, thought the unknown liquid in the bag was vinegar, stated it should have been rinsed out, and verified the tubing should have had a cap on it. RN-A drained the liquid into the toilet, walked back over to R1, disinfected the uncapped end of the tubing with alcohol swab, disconnected the overnight drainage bag from R1's catheter, disinfected the catheter tubing, then connected the leg bag that had unknown liquid in it and had been without a cap since it was last removed. During an interview on 5/5/2020, at 1:01 p.m. NA-C stated she had worked the evening shift the day R1's catheter was inserted (4/28/2020). NA-C stated the brown tape had been on her leg to hold the catheter, she did not know why tape was used instead of a proper holder. NA-C stated shortly after her shift started at 2:00 p.m. R1 had a very large loose bowel movement that got inside of the catheter drainage bag tubing, and was instructed by a nurse (could not remember which nurse) to disconnect the catheter tubing from the collection bag tubing, use an incontinent wipe to remove the stool from inside the tubing which she had never been instructed to do before. NA-C stated she had received catheter care education. During an interview on 5/5/2020, at 2:30 p.m. NA-F stated he had worked on the evening shift on 4/28/2020, and confirmed R1's had a large loose stool that had gotten all over the outside of the catheter tubing and a small amount had gotten into the collection bag tubing. NA-F indicated that a nurse (could not recall which nurse) directed the NA's to disconnect the drainage bag tubing from the catheter and use an incontinent wipe to remove the stool from the inside of the tubing. Interviews were conducted on 5/5/2020, during the survey with RN-B, RN-C, RN-D, RN-E, and the director of nursing (DON) who all worked on 4/28/2020. RN-B, RN-E were aware of R1's loose stool however denied instructing NA's to disconnect and clean the inside of the catheter tubing and stated had they been aware of infiltration into the drainage system they would have changed the catheter and drainage bag. RN-C and RN-D stated an unawareness of any R1's loose stool or the catheter contamination and both stated they would never instruct NA's to clean the inside of the catheter tubing and would change the catheter and drainage bag. DON stated an unawareness of any complications or concerns with R1's catheter. R2 During an interview on 5/5/2020, at 9:36 a.m., NA-E stated that R2 had a catheter Review of R2 [DIAGNOSES REDACTED]. Review of R2 physician orders [REDACTED]. Change catheter PRN decreased urinary output or leaking for [DIAGNOSES REDACTED]. Review of R2 care plan dated indicated care plan indicated the resident will show no signs or symptoms of urinary infection; Monitor and document intake and output as per facility policy; Monitor for signs and symptoms of discomfort on urination and frequency; Monitor/document for pain/discomfort due to catheter; Monitor/record/report to MD for signs and symptoms UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. During an interview on 5/5/2020 at 9:36 a.m. NA-E stated to her knowledge R2 has not had any complications or concerns with the catheter. NA-E had proper catheter care and reporting procedures for complications and/or changes. NA-E stated catheter bags were changed weekly. NA-E stated they document output. NA-E stated there is yearly training. During an interview on 5/5/2020, at 9:57 a.m., licensed practical nurse (LPN)-D stated R2 wore a foley catheter bag all the time and did not use a leg bag. LPN-D said received the appropriate catheter care, necessary monitoring, and change in condition procedures. LPN-D stated vinegar is placed in catheter bags when not in use and if a protective cap went missing, she would replace it. LPN-D stated catheter supplies are located by nurse station or in central supply. During an interview on 5/5/2020, at 10:29 a.m., NA-D stated he had training on catheter care during his nurse aide training and the facility use to provide yearly competency. NA-D stated he used wet wipes not alcohol wipes for cleaning catheter bag drainage tube. NA-D stated he would report redness, odor, bloody urine, low output, leaking, or anything out of ordinary. NA-D stated they recorded output. NA-D stated bags are changed weekly. During an interview on 5/5/2020, at 2:16 p.m. director of nursing (DON) stated the catheter bag should not have been on the floor and the tubing should have been secured to the bed. DON stated the proper catheter tubing holder should have been used. DON stated the leg bag should not have had liquid in it, after it was rinsed with vinegar allowed to air dry and stored in a plastic bag with the cap on. DON then stated the leg bag should not have been reused because the cap was left off and |

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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| | **245499** | A. BUILDING _____ B. WING _____ | **05/05/2020** |

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| **CALEDONIA REHABILITATION & RETIREMENT CENTER** | **425 NORTH BADGER STREET CALEDONIA, MN 55921** |

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| F 0690<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>because of the unknown liquid left in the bag. DON verified R1's record lacked evidence of monitoring for UTI and complications associated with catheters, and expected the staff to follow documentation standards and follow the care plan. DON then indicated that had there been stool inside the tubing, the catheter should have been changed and not wiped out with an incontinent wipe. DON stated she started her employment with the facility at the beginning of March this year and was not aware of what catheter education was historically provided nor aware of how staff were tested for competency. DON provided completed orientation checklist for nursing staff and education that was provided in December of 2019, stated unfortunately could not find specific documentation of staff competency testing. Facility policy Urinary Catheter Care dated dated 10/2010, included the following:, -General Guidelines: if breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment as ordered. -Input/Output: Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor Maintain an accurate record of the resident's daily output, per facilty policy and procedure. -Infection Control: Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag. Be sure the catheter tubing and drainage bag are kept off the floor. .Avoid splashing, and prevent contact of drainage spigot with the non sterile container. -Changing Catheters: It is suggested to change catheters and drainage bags based on clincial indications when the closed system is compromised, infection or obstruction. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site (NOTE: catheter tubing should be strapped to the resident's inner thigh. -Documentation: The following information should be recorded in the resident's medical record: date and time that catheter care was given. all assessment data obtained when giving catheter care. character of urine, clarity, and odor. Any problems at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irrigation, crusting or pain. How the resident tolerated the procedure. Facility policy Emptying a Urinary Drainage Bag dated 10/2010, included Do not allow the drain spout to come into contact with the measuring container, hand, or any other object. Always attach the drainage bag to the bedframe, never to the side rails. Never disconnect the drainage bag from the catheter. 9) Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. The policy also had the same instructions for what documentation should be in the record. |