STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265400	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKE HAVEN HEALTHCARE	**1410 NORTH KENTUCKY AVENUE WEST PLAINS, MO 65775**

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, record review, and interview, the facility failed to maintain and monitor the indwelling urinary catheter (tubing inserted to continuously drain the bladder) tubing in a manner to prevent urinary tract infections and failed to follow physician orders [REDACTED].#59) out of 20 sampled residents. The facility census was 99. Record review of the facility's policy, titled urinary catheter care, revised October 2010, showed staff to ensure the catheter tubing and drainage bag are kept off the floor. 1. Record review of Resident #59's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated [DATE], showed the following information: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's physician order [REDACTED]. Observation on [DATE], at 2:11 P.M., showed the resident sat in a wheelchair in his/her room. His/her urinary catheter drainage bag hung underneath the chair with the tubing resting on the floor. Record Review of the POS [REDACTED]. Record review of nurses' notes from [DATE] through [DATE] did not show any documentation regarding staff beginning bladder training for the resident. Record review of the resident's care plan, showed as of [DATE], staff did not document information pertaining to an indwelling catheter. Observation on [DATE], at 1:30 P.M., showed the resident sat in his/her wheelchair in the television lounge area. His/her urinary catheter drainage bag hung underneath the chair. As the resident moved the chair, the catheter tubing dragged on the floor. Observation on [DATE], at 10:00 A.M., showed the resident rested in bed. His/her catheter drainage bag hung on the lower bed rail, with the lowest edge of the bag resting on the floor. During an interview on [DATE], at 4:19 P.M., Certified Nursing Assistant (CNA) A said staff should hang a catheter bag so that neither the drainage bag or tubing is touching the floor. If staff find the tubing touching the floor, they should change out the drainage bag and tubing. During an interview on [DATE], at 4:21 P.M., Licensed Practical Nurse (LPN) B said the floor nurse notifies the Director of Nursing (DON), Assistant Director of Nursing (ADON), or charge nurse (Registered Nurse; RN) whenever a physician order [REDACTED]. The nurses pass on the information in the report to the next shift. LPN B viewed the POS with the surveyor and said he/she did not know about the new orders for bladder training or that they were going to attempt to discontinue Resident #59's catheter. He/she did not receive that information with shift change reports since [DATE]. During the interview, CNA A also said he/she did not know about the orders to begin bladder training prior to discontinuing the resident's catheter. During an interview on [DATE], at 5:13 P.M., the ADON and the MDS/Care Plan Coordinator said catheter drainage bags and tubing should not be allowed to touch the floor. The staff member who obtains a new order should enter the orders into the electronic medical record (EMR) system, and they should print out the order for the floor nurses to view and pass on during the shift report. Staff should follow physician orders [REDACTED]. The staff receiving the bladder training and catheter DC orders did not document a clinical note and the LPN did not see the orders.

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.