STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235488	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST BLOOMFIELD HEALTH AND REHABILITATION CENTER	6445 W MAPLE WEST BLOOMFIELD, MI 48322

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 -** 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** This citation pertains to intake # 9 Based on interview and record review the facility failed to ensure appropriate catheter care was provided for one resident (R#701) of three residents reviewed for catheter care, resulting in pain, acute transfer to hospital and subsequent needle aspiration of the catheter bulb through the skin. Findings include: On 3/11/20 at approximately 10:09 a.m., during a conversation with complainant A (CA), CA indicated that R#701 had been sent to the hospital because the facility Nurse B had inflated their catheter balloon while the catheter was not yet in the bladder and still in the Urethra. CA further indicated that Nurse B was supposed to have used a straight catheter(a soft, thin tube used to pass urine from the body. Straight catheters are usually made of plastic and are only used one time and then thrown away) but had told them that they couldn't find one in the facility and so they ended up using a Foley indwelling catheter (a tube with a balloon that drains urine from your bladder into a bag outside your body). On 3/11/20 the medical record for R#701 was reviewed and revealed the following: R#701 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#701 MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/20/19 revealed R#701 had impairments of upper and lower extremities and had an indwelling catheter. A nursing note dated 12/20/19 at 12:09 a.m., revealed the following: Resident complaint <sic> on lower abdominal pain at about 10:43 PM just as skin assessment was being performed, scaled pain 10/10. Call (Physician) and new orders obtained to performed PVR (Post Void Residual) and insert 16Fr (French) Foley (indwelling catheter) if Urine is above 250cc (cubic centimeters) in the bladder, PVR was performed and 378cc Urine retained in Bladder, Catheter inserted and Procedure explained to resident and he verbalize understanding, Catheter placed all the way inside till resistance was felt, no returns noted, 10cc fluid pump in to catheter to encourage returns as resident continues to complain of pain, still no Urine returns, Unable to retract 10cc fluid, call (Physician) and resident ordered to be sent out to (local hospital) Out Via 911 as regular ambulance ETA (estimated time of arrival) was over 2 hours and resident was in excruciating pain. A hospital transfer form dated 12/20/19 revealed the following: Key Clinical Information-ABD (abdominal) and back pain 10/10 spasms .Reason for transfer: Urinary catheter balloon malfunction placement by covering nurse catheter in urethra unable to insert or d/c (discontinue) catheter . A hospital emergency room report dated 12/20/19 revealed the following: History-Patient (R#701 demographics) who is currently residing at (name of nursing home) facility after sustaining compression fractures from a fall. Tonight he was complaining of suprapubic pressure with noted decreased urine output. He was noted to be retaining urine with bladder scan shower <sic> 357cc .Foley was placed but no output was appreciated. Staff inflated balloon with 10 cc of fluid with no urine return. Staff was apparently unable to deflate the balloon or remove the Foley. He was complaining of increased pain so was sent to the ED (emergency department) for further evaluation .ED course .Patient with noted Foley unable to move and with inflated bulb of around 30 cc's verified on imaging of pelvis recommendations by Urology for bedside needle aspiration of the Foley catheter bulb .Review of other clinical data .CT abdomen pelvis without IV contrast: Impression-1. A Foley catheter appears to terminate at the bulbar urethra. Repositioning is recommended .Patient was sent from rehab facility after unsuccessful Foley placement for [MEDICAL CONDITION]. Per patient staff was unable to deflate the balloon catheter or remove the Foley catheter. Patient started experiencing increased pressure and pain in the suprapubic area .CT abdomen and pelvis shows a Foley catheter appears to terminate at the bulbar urethra .Discussed with (name of Physician) recommended palpate the balloon catheter and sticking the balloon with 25 gage needle though the skin .palpated the balloon and confirmed with ultrasound, ER (emergency room) physicians were able to deflate the balloon under aseptic technique sticking 25 gage needle through the skin . On 3/11/20 at approximately 3:35 p.m., during a conversation with Nurse B, Nurse B was queried regarding the catheter insertion procedure for R#701. Nurse B indicated that R#701 was having pain and they asked one of the nursing aides if R#701 had been toileted and they reported they hadn't. Nurse B indicated they called the Doctor and the Doctor ordered PVR and if they were over a certain amount then to insert a catheter. Nurse B reported a bladder scan was done and R#701 had retained urine over the parameter set by the Physician. Nurse B then reported they inserted a Foley indwelling catheter up R#701's Urethra until they felt resistance. At that time no urine output was noted. Nurse B indicated they had 1-2 inches left of the catheter outside the penis. Nurse B then indicated that since no urine output was observed they pumped approximately 10cc of fluid into the catheter to stimulate the bladder. Nurse B was queried if that was a standard procedure for stimulating the bladder when no output was observed and they reported that there were multiple ways to stimulate the bladder and that was the one they had tried. On 3/12/20 at approximately 8:48 a.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding their knowledge of the procedure that Nurse B used when inserting R#701's catheter and what happened that caused R#701 to be sent to the hospital. The DON stated he inflated the balloon. The DON was queried if Nurse B should have inflated the balloon when no urine return was observed and they had felt resistance and they stated, that's not standard procedure. The DON was queried what Nurse B should have done instead of inflating the catheter balloon when no return was observed and resistance was felt and they indicated they would not have inflated the balloon if no return was observed and resistance was felt. The DON further indicated they would not have inflated the balloon and would have withdrawn the catheter. The DON was queried if any education or inservices on appropriate catheter care was provided to Nurse B and the DON indicated that Nurse B was inserviced on general catheter care and so were the rest of the nurses. The DON was queried if Nurse B was inserviced on not inflating the balloon when no urine return and resistance was felt and they stated, that's nursing 101. At that time the DON was queried for documentation of the education/inservices for catheter care. On 3/12/20 at approximately 9:50 a.m., the DON indicated they knew Nurse B was inserviced on catheter care after R#701's catheter incident but did not have any documentation. On 3/12/20 a facility document titled Facility Infection Control Manual dated 9/26/17 was reviewed and did not reveal any information pertaining to the deficient practice. A reivew of a Nursing Process Manual titled Taylor's Clinical Nursing Skills-5th Edition was reviewed and revealed the following: Insert indwelling catheters to the catheter bifurcation (the 'y' level created by the balloon filling and urinary drainage ports) to assure the balloon is within the bladder to avoid inadvertent inflation of the balloon in the urethra (ANA, 2014; Suna, 2015c) .inproper inflation can cause patient discomfort and malpositioning of catheter .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE