STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385229	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE REHABILITATION OF JUNCTION CITY	**530 BIRCH STREET JUNCTION CITY, OR 97448**

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 record review it was determined the facility failed to provide adequate catheter care for 2 of 3 (#s 1 and 4) residents reviewed for catheterization. This placed residents at risk for unmet catheter needs. Catheter Care, Urinary Level III dated 10/2010 Policies and Procedures revealed to document the following in the resident's medical record. 1. The date and time catheter care was given. 2. The name and title of the individual giving catheter care. 3. All assessment data obtained while giving catheter care. 4. Character of urine such as color, clarity, and odor. 5. Any noted problems at catheter-urethral junction during care such as drainage, redness, bleeding, irritation, crusting or pain. 6. Problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure. 9. Signature and title of the person recording the data. 1. Records indicated Resident 1 admitted to the facility in 8/2020 with a [DIAGNOSES REDACTED]. An 8/6/20 care plan revealed Resident 1 had an indwelling catheter with interventions including catheter care, change foley catheter PRN for obstruction/occlusion, and contact hospice for catheter related concerns. An 8/12/20 Urinary Indwelling Catheter CAA revealed Resident 1 was at risk for infection, due to indwelling catheter, the goal of the care plan was to maintain urine flow, avoid UTIs, and catheter related trauma. a. The 8/2020 Documentation Survey Report revealed on the following days catheter care was not completed: -8/7/20 evening shift -8/11/20 day shift -8/18/20 day shift -8/20/20 day shift -8/22/20 evening shift -8/27/20 day shift An 8/6/20 Nursing Care Note revealed Resident 1's Foley catheter was patent, draining amber colored urine. 8/8/20 and 8/14/20 Progress Notes revealed Resident 1's indwelling catheter was draining to gravity. No additional documentation was found for Resident 1's catheter care in clinical records for 8/2020. The 9/2020 Documentation Survey Report revealed on the following days catheter care was not completed: -9/12/20 day shift -9/13/20, day shift -9/14/20 day shift. No additional documentation was found for Resident 1's catheter care in clinical records for 9/1/20 through 9/9/20. An observation on 9/18/20 at 10:23 AM revealed Resident 1 lying in her/his bed with the catheter bag uncovered attached to the side of the bed; the privacy curtain was drawn. On 9/24/20 at 10:26 AM Staff 1 (Administrator) and Staff 2 (DNS) stated they expected staff to complete catheter care every shift and document in Resident 1's clinical records. b. An 8/2020 TAR instructed staff to change the catheter bag PRN for leakage or drainage, and to change the Foley catheter to prevent obstruction or occlusion. Neither the catheter or bag was changed in 8/2020. On 9/17/20 at 8:23 AM Witness 1 (Hospice) stated on 9/10/20 she observed Resident 1's catheter and it was completely clogged and draining around the sides. Witness 1 stated the catheter bag was dated 7/27/20 and she changed the bag. On 9/17/20 Staff 3 (Charge Nurse) stated there was no order to change Resident 1's catheter and the last time it was changed was in 7/2020. Staff 3 stated the orders for the catheter were not clarified with hospice regarding who was responsible. An observation on 9/18/20 at 10:23 AM revealed Resident 1 lying in her/his bed with the catheter bag uncovered attached to the side of the bed; the privacy curtain was drawn. On 9/21/20 Witness 2 (Hospice) stated she was late on completing the catheter bag change which was dated 7/27/20 for Resident 1. On 9/24/20 at 10:26 AM Staff 1 (Administrator) and Staff 2 (DNS) stated there was a communication concern between hospice and the facility which they needed to correct. 2. Resident 4 was admitted to the facility in 5/2020 with a [DIAGNOSES REDACTED]. A 5/13/20 Admission Nursing Database revealed Resident 4's Foley catheter was patent and draining A 5/20/20 Urinary Incontinence and Indwelling Catheter CAA revealed Resident 4 was at risk for infection, injury and loss of dignity due to the indwelling catheter. The Foley catheter was placed prior to admission by Hospice for comfort. A 5/26/20 care plan revealed Resident 4 had an indwelling catheter with the goal to show no signs of UTI and trauma. Interventions included catheter care and catheter placement per physician orders. No Physcian orders were found in clinical records for Resident 4's Foley catheter for 5/2020 or 6/2020 A 7/2020 TAR instructed staff to change Resident 4's catheter bag PRN for leakage and drainage and to change the Foley catheter PRN for blockage with a start date of 7/16/20. An 8/27/20 Hospice care plan revealed starting 5/14/20 Resident 4 had a urinary catheter due to [MEDICAL CONDITION] with goals of managing the urinary catheter within two weeks, to perform a urethral catheter change every eight weeks and to change PRN for dysfunction or dislodgment. A 9/18/20 draft progress note revealed Hospice's care plan and physician orders [REDACTED]. The facility did not know if the catheter was changed by the Hospice nurse or by the facility nurse. On 9/24/20 Staff 1 (Administrator) and Staff 2 (DNS) stated they were aware of the issue of lack of communication between Hospice and the facility in regard to catheters. Staff 1 stated the standard of practice was every time there was communication between Hospice and the facility it was documented. Staff 1 stated there was no documentation in 5/2020 or 6/2020 Hospice was providing daily catheter care for Resident 4.

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.