

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Davenport Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1130 W 53rd Street Davenport, IA 52806	

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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>26529</p> <p>Based on observation, clinical record review, and staff and resident responsible party interviews, the facility failed to complete appropriate assessments of urinary catheter function in a timely manner, and have needed catheter replacement supplies in the facility, resulting in a residents discomfort and transfer to a local hospital for 1 of 2 residents reviewed for urinary catheter (Resident #3). The facility reported a census of 73 residents.</p> <p>Findings reveal:</p> <p>The 3/7/24 Minimum Data Set (MDS) Assessment tool revealed Resident #3 had diagnoses that included benign prostatic hyperplasia (enlarged prostate) with lower urinary tract symptom, cerebrovascular accident (a stroke) with hemiplegia (paralysis on 1 side of the body). The assessment identified Resident #3 required the assistance of at least one staff for transfers to and from bed or chair, dressing and toileting, and a urinary catheter used for elimination.</p> <p>An Indwelling Catheter related to Urinary Retention problem initiated 3/7/24 on the Nursing Care Plan directed nursing staff:</p> <ol style="list-style-type: none"> 1. Use a leg bag with a tubing extender during the day and a large drainage bag overnight. 2. Change Foley catheter monthly and catheter bag and tubing twice monthly to decrease risk for infection. 3. Monitor urinary output every shift. Record the amount, type, color, and odor. Observe for leakage. 4. Provide catheter care every shift and as needed. <p>A review of Physician Orders revealed a lack direction for staff to replace the urinary catheter routinely, or to flush the catheter for obstruction or signs of obstruction such as no urine output.</p> <p>A Nursing Progress Note transcribed by Staff B, Registered Nurse (RN) on 3/13/24 at 3:47 a.m. stated:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Report given to this nurse at 10:00 p.m. that resident's catheter was not draining. This nurse assisted another nurse (Staff A, Licensed Practical Nurse, LPN) in flushing Foley catheter. Foley catheter blocked. This nurse attempted to reposition resident, resident was obviously in discomfort as he was grimacing with facial flushing. It was determined to replace Foley catheter with a new catheter. When deflating balloon less than 5 milliliters (ml) was released. Foley catheter came out very easy with a large blood clot. Bloody thick mucus urine was dripping from the penis, resident's responsible party stated the resident was injured sometime earlier. This nurse gathered all items to reinsert catheter, resident's responsible party continued to state the resident was injured and this nurse determined the best practice at this time was to send the resident to the hospital emergency room to evaluate further and reinsert catheter.</p> <p>A hospital emergency room physician progress note dated 3/12/24 described the resident presented from the nursing home related to urinary catheter problems/obstruction, and over 1000 ml of urine drained from the bladder when the physician inserted a urinary catheter.</p> <p>The facility's Urethral Foley Catheter Care policy dated as last reviewed 2/2/24 directed staff:</p> <ol style="list-style-type: none"> Catheters are replaced by nurses as prescribed by the physician. Catheter bags should be emptied at least once a shift and the amount recorded on the CNA care sheets. <p>Staff interviews revealed:</p> <p>On 7/9/24 at 2:05 p.m. Staff B, RN, stated she worked in the facility's locked dementia unit on the 10 p.m. to 6 a.m. night shift that began on 3/12/24, and was summoned to the long-term care facility that night by Staff A, LPN, who reported the resident had no urine in his drainage bag, and the resident had 100 cc urine output on the day shift that day (at 2:00 p.m.). When she assessed the resident there was no urine in the drainage bag, his abdomen was firm and distended, he had grimacing and non-verbal symptoms of pain, she attempted to flush the catheter but was unable to as there was an obstruction in the catheter, she repositioned the resident and did not observe urine output in the catheter after the resident was repositioned. When she deflated the balloon to remove the catheter there was only a small amount of fluid in the balloon, and there was bloody drainage as she removed the catheter with ease. The resident had a Coude type of catheter (specialty catheter for prostatic hypertrophy), the facility didn't have Coude catheters in stock, the resident's responsible party stated they had one at their home and left to retrieve it. The resident continued to have pain and bloody drainage from his penis, she determined it would be best to send him to the hospital for assessment and further care, and the resident was transferred at that time.</p> <p>On 7/10/24 at 3:18 p.m., Staff A, LPN, stated she worked the evening shift (2 p.m. to 10 p.m.) on 3/12/24, the resident's responsible party questioned her about the resident's urine output when they visited after 9 p.m., there was no urine in his drainage bag and she went to get Staff B, RN, because she thought she would know more about what to do with the resident's catheter. Staff A denied that she had assessed the resident's urine output, or for symptoms of catheter complications prior to the resident's responsible party visit that evening.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/11/24 at 8:02 a.m., the Director of Nursing (DON) stated if a resident had a urine output of 100 ml for a shift, the CNA should report that to the nurse, and the nurse should check the catheter for placement, function, problems, and notify the physician for directives for care if the issue isn't resolved with routine care/problem-solving techniques such as unkinking the tubing. The DON stated the facility should have had a replacement catheter at the facility for the resident.</p> <p>During an interview 7/8/24 at 4:08 p.m., the resident's responsible party stated the resident had a urinary catheter and they had cared for the resident at his home for several years. When they visited the resident around 9:30 p.m. on 3/12/24, there was no urine in his drainage bag, asked staff and they had not emptied the catheter, could tell the resident was uncomfortable and asked the nurse about it. The responsible party thought the resident had experienced some kind of trauma related to the catheter that day, such as having it pulled on, the catheter tip was pulled into the shaft of the penis and why it wasn't working that evening, the facility didn't have a catheter to replace it and why he was sent to the hospital that night.</p>		