STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Ridge Health and Rehab	5430 Boone Avenue North New Hope, MN 55428

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** 43367 Based on observation, interview and record review, the facility failed to provide appropriate catheter care and services to minimize the risk for urinary tract infections for 1 of 3 (R1) residents. Additionally, the facility failed to follow provider's orders when catheter required to be flushed for 1 of 1 (R1) residents reviewed with indwelling catheter. Findings included: R1's quarterly Minimum Data Set (MDS) dated [DATE], identified intact cognition and no behaviors. R1 required partial to moderate assistance for personal hygiene, substantial to maximal assistance for repositioning, upper body dressing, and dependent upon staff for all transfers. R1 was unable to ambulate and used a motorized wheel chair for mobility. R1 had an indwelling urinary catheter and always incontinent of bowel. R1 diagnoses included neurogenic bladder (a condition that affects bladder control due to nerve damage or brain disorders), diabetes mellitus, multiple sclerosis (autoimmune disease in which the insulating covers of the nerve cells in the brain and spinal cord are damaged), hemiplegia/hemiparesis (one sided muscle weakness), anxiety, and depression. R1's Care Area Assessment (CAA) dated 1/8/24, identified history of urinary tract infections (UTI), visual impairment, and poor memory. R1's physician orders identified: -9/21/24 at 8:00 p.m., Sodium Chloride Irrigation (NS) Solution (GU Irrigate). Use 60 ml (milliliters) via irrigation two times a day for sediment to affected area BID (two times a day), hand irrigate 60 ml NS, and as needed. -9/22/24 at 8:00 a.m., Ertapenem Sodium Injection Solution (antibiotic to treat urinary tract infections caused by bacteria) reconstituted 1 GM (gram). Use 1 gram intravenously one time a day for UTI until 10/01/2024 at 11:59 p.m. (continued on next page)

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's care plan dated 9/13/24, identified R1 had an indwelling foley catheter related to a neurogenic bladder and directed staff to monitor/record/report to MD for s/sx (signs and symptoms) of 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 observation on 9/23/24 at 1:30 p.m. nursing assistant (NA)-A applied gown, mask, and gloves then entered R1's room. NA-A placed a paper towel on the floor, grabbed a graduate container located on the back of the toilet counter in R1's bathroom, and placed it on the paper towel. NA-A removed R1's indwelling urinary collection bag from the lower side of the bed and laid it onto the floor. NA-A asked R1 if she had an alcohol swab and R1 replied yes it was located on that table and pointed. NA-A grabbed the alcohol swab, picked up collection bag from the floor, and pulled the end of drain tube out of the pouch located on the outside of the collection bag. NA-A held onto the catheter bag as it hung over the graduate container and the end of the drain tube rested on the bottom inside of the graduate. NA-A attempted many times to release the clamp and end of drain tube touched the inside of the container at least five times. NA-A stated this one was from the hospital and different than what we had here, much harder to open the clamp. NA-A drained 900 cubic centimeters (cc) yellow urine out of the collection bag, clamped the tubing, wiped off the end of drain tube, then placed it into the clamp holder. NA-A dumped urine into toilet, rinsed out graduate, placed it onto the toilet counter, removed gown, mask, gloves, and exited the room. During an observation on 9/23/24 at 1:50 p.m., NA-A entered R1's room, carried a new catheter bag wrapped in original packaging and stated she had to change the tubing and collection bag on her catheter. R1 laid on her back with head of bed up at approximately 45 degrees, NA-A lowered R1's head of bed down approximately 30 degrees. NA-A removed new bag/tubing from package and cap from end of drain tube. NA-A pulled apart the connection of the tubing attached to the collection bag from the catheter end that remained inside R1's bladder. NA-A let go of the open catheter end and hung between R1's inner thighs. R1 reached down between her thighs and searched for the catheter end stating that was not draining urine on me was it? R1 grabbed the catheter held it with her fingers and touched the end and sides of of it. NA-A reached down and stated to R1 let go of that tube and grabbed the catheter end from R1's fingers, without end of catheter tubing being wiped off, connected to the new tubing with collection bag attached. NA-A was unable to secure the catheter tubing back in to the cassette holder located on R1's thigh and R1 stated here let me do that. R1 reached down and without being able to visibly see what she had done, felt around, placed the tubing in the cassette, and snapped the holder closed. R1's hands were not sanitized /cleaned prior to when NA-A exited room. During an observation on 9/24/24/ at 9:40 a.m., registered nurse (RN)-B and NA-A applied gown, gloves, and masks and entered R1's room. R1 requested indwelling urinary catheter be flushed. RN-B grabbed a sterile syringe, opened a new container of normal saline (NS) poured into a plastic cup, then opened syringe package, removed cover from end of syringe, and drew up 60 milliliters (ml). R1 stated a towel would need to be placed under the tubing before you flushed tubing. R1 asked RN-B if she had any alcohol wipes and she stated yes there are right there on the table. An alcohol wipe was not used prior to when RN-B attached the syringe to the catheter tubing that remained inside the R1's bladder. RN-B flushed R1's indwelling catheter with 60 ml of NS slowly then asked R1 is she wanted another 60 ml. R1 stated well, ok. RN-B left syringe attached to the catheter and drew up another 60 ml of NS with a new sterile syringe from the plastic cup. RN-B removed the syringe from the catheter, did not wipe off catheter end, attached the new syringe, and flushed with an additional 60 ml. RN-B wiped off the end of the catheter tubing with an alcohol swab attached to the collection bag, removed the syringe from catheter, and without being wiped off attached catheter tubing to collection bag catheter end. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/23/24 at 2:49 p.m., floor manager (RN)-A stated once the indwelling catheter tube and the collection bag tube were pulled apart the catheter tubing would be expected to be wiped off with an alcohol swab prior to attachment of the new tube. RN-A indicated this helped with sanitary measure and prevention of a UTI and infection. During an follow up interview on 9/24/24 at 10:21 a.m. RN-A stated staff were expected to have wiped the end of the catheter tubing prior to attachment of a syringe to flush catheter in order to prevent spread of bacteria into a sterile system and infection. RN-A verified staff were expected to review physician orders prior to the indwelling catheter flushes so they the orders were followed. RN-A stated facility nurses are expected to follow the physician orders. RN-A stated it was not ok to have administered twice as much of NS than was ordered. During an interview on 9/23/24 at 10:00 a.m. RN-B stated she had flushed R1's indwelling catheter first with 60 ml and then another 60 mg for a total of 120 ml. RN-B stated R1 had not always tolerated a total of 120 ml and the reason why she flushed with 60 ml at one time then offered another 60 ml. RN-B reviewed the physician's orders during interview and identified R1 was only to have received 60 ml NS total. RN-B verified she had not checked R1's order for this, prior to her hospitalization was 120 ml and assumed it was still the same. RN-B stated would be important order was verified prior to completion of the flush so that the correct amount was used. RN-B stated was not necessary to wipe off the the catheter end of the tube that remained inside R1's bladder with an alcohol swab prior to flush or attaching the collection bag tubing and catheter tubing together. RN-B also stated just the tubing attached to the bag to keep it clean was required to be wiped off with an alcohol swab. During an interview on 9/23/24 at 12:50 p.m. R1 stated usually asked a lot of questions when staff worked with her urinary catheter because did not want another UTI. R1 stated she had asked staff many times where their alcohol swab was and if the tubing was cleaned off. R1 stated there were times when staff were not good, forgot to wipe off the catheter tubing, and she had reminded them to grab an alcohol wipe. R1 verified staff had laid the urinary collection bag on her bed to empty it and she had reminded them to hang in below her bladder. R1 stated had also reminded staff to not place urinary collection bag on the floor. During an interview on 9/24/24 at 9:35 a.m., NA-A stated had not noticed the end of the catheter bag drain tube had touched the inside of the collection container. NA-A stated R1 held the end of the catheter and thought she had wiped it off prior to when she connected the new tubing. NA-A also stated she was unable to snap the catheter tubing cassette (located on R1's right inner thigh) closed, to hold tubing in place. NA-A stated R1 felt with her fingers due to her position in bed (laid on back) and snapped cassette holder together. NA-A verified she had not wiped off R1's hands prior to leaving her room after she held the end of the urinary catheter with her fingers. NA stated would be expected to have wiped off the end of the tube and R1's hands for infection control. During an interview on 9/24/24 at 10:25 a.m., infection control RN-D stated staff had the option of searching for a policy on Policy Stat icon located on their desk top computers for more information regarding changing catheter tubing collection bags and flushing the catheter tubing. RN-D stated their biggest resource would be the nurse manager. RN-D stated when an indwelling catheter was flushed it would be required to be sterile. RN-D indicated more bacteria could be pushed into the bladder if the end of the tube was not wiped off with an alcohol swab prior to connection or reconnection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/24/24 at 10:39 a.m. RN-C stated there were no policies currently in place to guide staff on how to have flushed the urinary indwelling catheter and/or catheter bag changed. RN-C stated staff would be expected to rely on information they were given during orientation demonstration, return demonstration to a preceptor, computer education called Relias, and a nurse manager that was always on duty for each shift. RN-C stated a really great resource for staff would be education department where they could have gone down there and skills reviewed. During an interview on 9/24/24 at 12:15 p.m., director of nursing (DON) stated staff received education upon hire on indwelling urinary catheters. DON stated after the end tubing of a urinary collection bag touched the bottom and/or the inside of the container would be considered contaminated. DON stated not sure why the facility policy for indwelling catheters reads never disconnect the drainage bag from the catheter there were cases where that would have not been accurate. DON indicated we would look at each situation on a case by case bases and what resident needs were. DON stated R1's situation would be one of those cases. DON verified staff would be expected to have wiped off the end of the catheter tubing to prevent infection. DON stated expected staff nurse to have looked over the physician orders prior to the urinary catheter being flushed so that the appropriate amount of solution was used. DON verified staff nurse should have flushed R1's catheter with 60 ml of NS and best practice was to have cleaned catheter end that goes to the bladder with an alcohol swab prior and after the flush to avoid infection. Requested facility policy change of the urinary catheter tubing and urinary catheter flush and was not provided. Facility skills checklist titled Emptying a Urinary Drainage Bag dated and signed by nursing assistant (NA)-A on 12/2/23, identified checklist identified steps needed to empty a urinary drainage bag and rationales to explain why these steps are performed. Place the urine bag below the level of the bladder but do not allow it to touch the floor. Place a graduate container on the floor on top of a disposable pad. Remove the port from the protective sleeve. Place the port over the graduate container and do not let the port touch any surfaces. Facility policy Emptying a Urine Drainage Bag dated 10/2023, identified do not allow the drain spout to come into contact with the measuring container, hands, or any other object (Note: if accidental contamination occurs, wipe the drain spout with an alcohol sponge or swab). Never disconnect the drainage bag from the catheter. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. Facility policy Indwelling Urinary Catheters dated 6/2022, identified to prevent catheter associated urinary tract infections empty drainage bag regularly using a separate, clean collection container for each resident. Avoid splashing and prevent contact of the drainage spigot with the nostril container. Changing indwelling catheters or drainage bags at routine, fixed intervals was not recommended and based on clinical indications such as infection, obstruction, or when the closed system is compromised.