

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Rochester Rehabilitation and Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Ballington Boulevard NW Rochester, MN 55901	
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685</p> <p>Based on observation, interview and document review the facility failed to assess for removal of an indwelling urinary catheter for 1 of 3 residents (R6) as soon as possible to restore urinary continence to the extent possible, reviewed for catheter care.</p> <p>Findings included:</p> <p>Definitions:</p> <p>Foley catheter: a flexible tube that drains urine from the bladder into a collection bag. Standard Foley catheters are two-way catheters with one port for draining urine and one for inflating the balloon. It's a type of indwelling urinary catheter (IDC) that's inserted into the urethra and left in place. The catheter is kept in place by a water-filled balloon, and urine drains through a tube connected to a collection bag.</p> <p>R6's After Visit Summary (AVS) dated 9/3/24 identified on 9/1/24 at 1:54 p.m., a 16 French double lumen Foley catheter was placed. Recommendations for provider identified to please follow-up with Urology on 09/13/24 for urinary retention. You will have foley catheter until further evaluated by urology.</p> <p>R6's hospital discharge summary dated 9/3/24, identified during R6's hospitalization from [DATE] to 9/3/24, R6 developed acute urinary retention on 9/1/24, and a Foley catheter was inserted. R6 will continue Foley catheter on discharge until further follow up with Urology on 09/13/24. R6 was recommended to have a close post hospital follow up with her primary care physician (PCP) at the facility.</p> <p>R6's Order Summary dated 9/3/24, identified Foley Catheter: DX: for catheter [stage 3 or 4 pressure area, neurogenic bladder, obstruction of GU, or cancer of urinary systems]. Foley catheter: If no acceptable diagnosis discontinue catheter after bladder retraining.</p> <p>R6's care plan dated 9/3/24 identified a focus of catheter, I have a device that required continued monitoring/treatment/laboratory. Interventions lacked appointments with urology and lacked the size needed of the Foley catheter.</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>R6's quarterly Minimum Data Set (MDS) dated [DATE], identified R6 had moderate impaired cognition and diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation, morbid obesity, and mild intellectual disabilities. MDS identified R6 did not walk and was dependent on staff with toileting and toileting hygiene. MDS further identified R6 had an indwelling catheter and was occasionally incontinent of bowel.</p> <p>During an interview on 10/28/24 at 3:00 p.m., registered nurse (RN)-A RN-A verified there was no current MD order in place for R6's size of Foley catheter to use or directions on when to change it and stated the MD should be notified for clarification of this order. RN-A indicated R6 was supposed to have a follow up appointment with urology consult on 9/13/24, to see if R6 still needed the Foley catheter. RN-A stated prolonged use of an indwelling catheter can put the resident at an increased risk of infection, bladder spasms and catheter obstruction.</p> <p>During an interview on 10/29/24 at 7:55 a.m., licensed practical nurse (LPN)-A indicated there was no current MD order in place for R6's size of Foley to use or directions on when to change it. LPN-A stated the MD should be notified for clarification of this order.</p> <p>During an observation and interview on 10/29/24 at 8:28 a.m., R6 was seated in bed and stated she never had a catheter until she was in the hospital at the beginning of the month. R6 stated she had never had a follow up appointment to her urologist since she has been here and that her catheter has not been changed. R6 stated she liked having the catheter because the staff get pretty busy and don't always have time to get me to the bathroom.</p> <p>During an interview on 10/29/24 at 10:56 a.m., DON indicated R6 missed her urology appointment on 9/13/24 and one had not been rescheduled. DON further indicated it would be important for R6 to be assessed as soon as possible for removal of the catheter to help restore continence.</p> <p>During an interview on 10/29/24 at 12:09 p.m., via phone CNP-A stated R6 developed urinary retention while she was in the hospital and a foley catheter was placed on 9/1/24, upon R6's admission to the facility on [DATE], the AVS identified R6 should follow up with urology on 9/13/24 and verified the appointment was missed with no follow up appointment rescheduled. CNP-A indicated it would be important for R6 to be assessed as soon as possible to help restore continence.</p> <p>During a phone interview on 10/30/24 at 3:48 p.m., medical director (MD)-A stated if a resident was scheduled for an outside provider visit the facility should do their best to get the resident to their appointment. MD-A verified R6 missed her urology appointment on 9/13/24. If a resident has a Foley catheter in place, there should be the correct size and how often it should be changed in the physician orders. MD-A stated it is important for staff to note this and call the provider to ensure orders are in place. MD-A further stated anytime a resident has an indwelling foley catheter there would be an increased risk for infection and staff should follow up with urology to ensure R6 was assessed as soon as possible to restore continence to the extent possible.</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>Facility policy, Incontinence management, revised December 11, 2023, identified urinary incontinence, the involuntary loss of urine, can affect all patients. Contrary to popular opinion, urinary incontinence is neither a disease nor a part of normal aging. It isn't inevitable and can sometimes be avoided or reversed with support and interventions. Urinary incontinence may be caused by childbirth, confusion, dehydration, fecal impaction, and restricted mobility. It's also a sign of various disorders, such as prostatic hyperplasia, bladder calculus, bladder cancer, urinary tract infection (UTI), stroke, diabetic neuropathy, Guillain-Barre syndrome, multiple sclerosis, prostate cancer, prostatitis, spinal cord injury, and urethral stricture. It can also result from urethral sphincter damage after prostatectomy. In addition, certain medications-including diuretics, hypnotics, sedatives, anticholinergics, antihypertensives, and alpha antagonists-may trigger urinary incontinence. Urinary incontinence can be either acute or chronic. Acute urinary incontinence results from disorders that are potentially reversible, such as delirium, dehydration, urinary retention, restricted mobility, fecal impaction, infection or inflammation, medication reactions, and polyuria .A practitioner should carefully assess a patient with urinary incontinence for underlying disorders. Most underlying disorders are treatable, and some are even curable. Treatment aims to control the condition through bladder management techniques, diet modification, medication therapy, pessaries and, possibly, surgery. Corrective surgery for stress urinary incontinence in patients assigned female at birth includes various types of mid-urethral slings and bladder neck slings. Corrective surgery for urinary incontinence in patients assigned male at birth includes the injection of transurethral bulking agents, a perineal sling, and an artificial urinary sphincter implant .</p> <p>CORRECTING URINARY INCONTINENCE WITH BLADDER MANAGEMENT A patient with incontinence typically feels frustrated, embarrassed, and hopeless. Fortunately, the patient usually can correct the problem with the use of a bladder management program-a process that aims to reestablish a regular voiding pattern. Follow these guidelines. Assess elimination patterns First, assess the patient's intake and voiding patterns and the reason for each accidental voiding (such as a coughing spell). Use a bladder management record. Establish a urinary voiding schedule Encourage the patient to void regularly-for example, every 2 hours. When the patient can stay dry for 2 hours, increase the interval by 30 minutes every day until the patient achieves a 3- to 4-hourvoiding schedule. Teach the patient to practice relaxation techniques, such as deep breathing, which help decrease the sense of urgency.</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>Facility policy, Indwelling urinary catheter (Foley) care and management, revised December 11, 2023, identified Introduction The Centers for Disease Control and Prevention estimates that 15% to 25% of hospitalized patients have an indwelling urinary (Foley) catheter inserted at some time during their hospitalization . Catheter insertion for inappropriate indications is common. Consider alternatives to indwelling urinary catheterization when appropriate, such as external catheter application, bladder ultrasonography, intermittent catheterization, use of optimal incontinence products, prompted toileting, urinal and bedside commode use, and daily weight, as methods to collect and measure urine and monitor fluid balance. Appropriate indications for catheter use include: perioperative use for selected surgical procedures, such as urologic surgery or surgery on contiguous structures of the genitourinary tract prolonged surgery (with removal of catheters inserted for this purpose in the post anesthesia care unit) surgery requiring large-volume infusions or diuretic use continuous bladder irrigation for clot retention or intravesical drug infusion administration of drugs directly into the bladder, such as chemotherapy intraoperative urine output monitoring prolonged immobilization, such as for an unstable thoracic or lumbar spine or multiple trauma injuries, including pelvic fractures need for accurate hourly urine output measurement in critically ill patients acute urinary retention or urinary obstruction assistance in the healing of open pressure injuries or skin grafts in selected patients with urinary incontinence improved comfort during end-of-life care. Inappropriate or unnecessary use of an indwelling urinary catheter can result in catheter-associated urinary tract infection (CAUTI). CAUTIs are the most common type of health care-associated infection in adult patients. Researchers estimate that as many as 70% of these infections are preventable by following evidence-based practices. Hospital-acquired condition alert: Keep in mind that the Centers for Medicare and Medicaid Services considers CAUTI a hospital-acquired condition because it can be reasonably prevented using a variety of best practices. Make sure to follow evidence-based CAUTI prevention practices-such as performing hand hygiene before and after any catheter manipulation; maintaining a sterile, continuously closed drainage system; maintaining unobstructed urine flow; emptying the collection bag regularly; replacing the catheter and drainage system using sterile technique when breaks in sterile technique, disconnection, or leakage occurs; and discontinuing the catheter as soon as it's no longer clinically indicated-when caring for a patient with an indwelling urinary catheter to reduce the risk of CAUTI . Complications associated with indwelling urinary catheter care and management may include: CAUTI, genitourinary trauma, epididymitis, retained balloon fragments, bladder fistula (with prolonged use), bladder stone formation and incontinence.</p>		