STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505515	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Olympia Rehabilitation and Nursing Center	1811 East 22nd Avenue Olympia, WA 98501

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** 44739 Based on interview and record review, the facility failed to ensure timely action was taken when a resident's indwelling urinary catheter (a small flexible tube inserted into the bladder to drain urine) showed abnormal urine characteristics indicating an infection for 1 of 1 sampled resident (Resident 1) reviewed for catheter care. This resulted in Resident 1 experiencing harm when the potential infection was not treated/evaluated timely and the resident required a transfer to the hospital where she was diagnosed with a kidney infection. This failure placed residents at risk of acquiring catheter associated infections, delay in care, pain and a diminished quality of life. Findings included . Review of the facility's Catheter Care Policy and Procedure, revised 04/2018, documented residents with long term indwelling catheter use will have care plan interventions developed to prevent complications including urinary tract infections and urethral irritation. Section 6 noted residents with indwelling urinary catheters will have interventions in place to maintain urinary drainage including, G. Monitor urine drainage for four odor, sediment, color change or hematuria [blood in urine]. Resident 1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes without complications, retention of urine, and diarrhea. The Minimum Data Set assessment, dated 10/28/2024, documented Resident 1 was alert and oriented, and was dependent on staff for activities of daily living associated with catheter care. Physicians' orders, dated 10/24/2024, documented the following: --Indwelling catheter: 16FR [French indicates the diameter], 10cc [cubic centimeter] balloon, to gravity drainage. Change Monthly and PRN [as needed] every day shift starting on 10/24/2024. --Change catheter bag and tubing as needed. --Monitor for signs and symptoms of skin breakdown related to catheter tubing/strap every shift. --LN [License Nurse] to ensure, catheter system is secured, catheter strap in place, covered appropriately (privacy bag) and catheter care was provided every shift and as needed. (continued on next page)

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

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F 0690 Level of Harm - Actual harm Residents Affected - Few	--Irrigate catheter as needed if plugged or leaking. Resident 1's admission assessment, dated 10/24/2024 at 12:48 PM, documented a 16FR catheter with a 10cc balloon was in place for diagnosis of urinary retention. Catheter was patent (open and draining freely) and draining clear urine. The facility form Skilled Charting Evaluation, dated 10/25/2024 at 1:46 PM, was initiated for Resident 1 and showed Section E of the form was designated to the assessment of urinary status. Sections 5a., 5b., and 5c. were designated to describe urine characteristics for color, clarity, and odor consecutively. The Skilled Charting Evaluation, dated 10/25/2024, showed no characteristics were documented. The Skilled Charting Evaluation, dated 10/26 at 8:31 PM and 10/27/2024 at 8:30 PM, showed urine characteristics were described as yellow, clear, and no odor. The Skilled Charting Evaluation, dated 10/28/2024 at 10:15 AM, 10/29/2024 at 11:54 AM, 10/30/2024 at 8:06 AM, and 10/31/2024 at 10/35 AM, showed urine characteristics were not documented. Physician order, dated 11/01/2024 at 2:00 PM, noted the following: Encourage fluid intake. Monitor urine for color, sediment, and blood. May collect U/A (urinalysis, a urine test) C&S (culture and sensitivity involves a urine sample checked type of bacteria and the recommended antibiotic treatment) if symptomatic. This order was for every shift for two weeks with a start date of 11/01/2024. Lab work, dated 11/01/2024, for BMP (basic metabolic panel)/CBC with diff (complete blood count with diff measures the number and types of cells in the blood) showed no elevated white blood cell count. The Skilled Charting Evaluation, dated 11/01/2024 at 1:50 PM and 11/02/2024 at 8:24 PM, showed urine characteristics were described as dark yellow, sediment in catheter tubing, and no odor. A Nurse Progress Note, dated 11/02/2024 at 4:41 AM, documented no blood was noted in urine. A small amount of sediment was noted. Resident 1 was encouraged to drink water. Resident 1 had no complaints of discomfort. A Nurse Progress Note, dated 11/02/2024 at 11:13 PM, documented sediment was noted in amber colored urine, but no blood noted. Resident 1 encouraged to drink more fluid. A Nurse Progress Note, dated 11/03/2024 at 4:48 AM, documented no blood noted in urine. Some sediment noted. Urine was a light tea color. Resident 1 had no discomfort. No signs or symptoms of a urinary tract infection. Foley catheter was draining. Resident 1 was afebrile (free of fever). The Skilled Charting Evaluation, dated 11/03/2024 at 8:56 PM, showed urine characteristics were described as tea colored, clear with sedimentation, and no odor. A Skilled Charting Evaluation for 11/04/2024 was not located in the medical chart. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The Skilled Charting Evaluation, dated 11/05/2024 at 2:05 PM, 11/06/2024 at 3:33 PM, and 11/07/2024 at 10:25 AM, showed urine characteristics were not documented. A Skilled Charting Evaluation for 11/08/2024 was not located in the medical chart. The Skilled Charting Evaluation, dated 11/09/2024 at 4:06 PM, showed urine characteristics were not documented. The Skilled Charting Evaluation, dated 11/10/2024 at 9:20 PM, showed urine characteristics were described as amber in color, with mucous, and strong odor (per their policy and procedures, and standard nursing practice this would indicate a change of condition and the need to notify the provider). A Skilled Charting Evaluation for 11/11/2024 was not located in the medical chart. The Skilled Charting Evaluation, dated 11/12/2024 at 10:50 AM, 11/13/2024 at 10:27 AM, and 11/14/2024 at 4:15 AM, showed urine characteristics were not documented. Lab work, dated 11/13/2024, for BMP was physician reviewed and showed no signs and symptoms of dehydration. A Skilled Charting Evaluation for 11/15/2024 was not located in the medical chart. The Skilled Charting Evaluation, dated 11/16/2024 at 3:33 PM, showed urine characteristics were not documented. The Skilled Charting Evaluation, dated 11/17/2024 at 9:38 PM, 11/18/2024 at 11:05 PM, and 11/19/2024 at 11:19 AM, showed urine characteristics were described as amber in color, clear with sediment, and strong odor (per their policy and procedures, and standard nursing practice this would indicate a change of condition and the need to notify the provider). The Skilled Charting Evaluation, dated 11/20/2024 at 9:35 AM and 11/21/2024 at 12:25 PM, showed urine characteristics were not documented. A Skilled Charting Evaluation for 11/22/2024 was not located in the medical chart. Resident 1's October 2024 and November 2024 Medication Administration Record did not show any new medications were ordered for urinary infections from 10/24/2024 to 11/23/2024. The Skilled Charting Evaluation, dated 11/23/2024 at 4:32 PM, showed urine characteristics were not documented. A Progress Note, dated 11/24/2024 at 10:33 AM, documented Resident 1 was sent to the emergency department due to complaints of pain to bladder, no output in urinary drainage bag since start of shift (6:00 AM), and inability to flush catheter or reinsert after removing. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The Skilled Charting Evaluation documentation for 11/24/2024, charting completed on 11/24/2024 at 4:24 PM, showed Resident 1's urine characteristics were not documented. Section 6 dedicated to notable changes to bladder function documented the following: No urine output. Staff unable to flush catheter. Staff unable to reinsert catheter after removal due to pain and swelling of the urethra. Sent to Emergency Department for evaluation. Section M noted resident sent to hospital due to urinary retention. Has foley catheter. Attempted to change but unable to reinsert the catheter. Resident reported increased pain to the bladder and vaginal area. Resident visibly in distress; crying and inconsolable. A Progress Note, dated 11/24/2024 at 6:20 PM, documented staff was informed by hospital Resident 1 had been admitted for a kidney infection. A Progress Note, dated 12/01/2024, documented Resident 1 was discharged to her family's home on hospice services. On 01/13/2025 at 3:18 PM, Staff C, Registered Nurse (RN), said if Resident 1 was on Medicare there should be daily Medicare documentation that talks about urine color, consistency, and odor. Staff C said she thought there had been an order to collect a U/A with culture and sensitivity if indicated. Staff C said she was not sure if a U/A with culture and sensitivity was obtained. At 4:48 PM, Staff B, Director of Nursing Services and RN, said staff had not identified signs and symptoms of a urinary tract infection and she did not think a U/A with culture and sensitivity had been obtained. Reference WAC 388-97-1060 (3)(c)