Department of Inspections and Appeals
Health Facilities Division
Citation

Citation Number 10692			**Report date** December 19, 2024
Facility name Southfield Wellness and Community		**Survey dates** November 25, 2024 - December 4, 2024	
Facility address 2416 Des Moines Street			
City Webster City	**JB**		

Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date
58.19(2)j	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(2)** *Medication and treatment.* *j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III) **DESCRIPTION** Based on observations, interviews, and record review, the facility failed to routinely assess and provide interventions for retracting the foreskin of the penis and returning to its original position for 1 out of 3 residents reviewed (Resident #2). Resident #2 required intervention at the Urology Clinic to reduce paraphimosis (foreskin pulled back but unable to return to its original position over the head, or glans, of the penis) on 3 different occasions. This facility reported a census of 52 residents. Findings include: Resident #2's Minimum Data Set assessment dated	**Class I**	**$6250.00** **Held in Suspension**	**Upon Receipt**

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	10/1/24, listed an admission from an acute hospital stay on 9/24/24. The MDS identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Resident #2 required substantial assistance with rolling left and right, toileting hygiene, and dressing. The MDS listed Resident #2 had a catheter. The MDS included diagnoses of congestive heart failure (CHF), renal (kidney) insufficiency, chronic obstructive pulmonary disease (COPD), and paraphimosis. A list provided by the facility on 11/25/24 of residents with BIMS scoring 8 or greater reflected Resident #2's score of 13, indicating intact cognition. Resident #2's Hospital Records dated 9/24/24 listed the following physician orders: a. Admit to skilled level of care. b. Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat upon arrival. c. Urology placed a urinary catheter, recommend leaving the catheter in place until the patient is more mobile and penoscrotal (penis/scrotum) edema (swelling) has improved. The Structured Progress Note dated 9/24/24 at 1:29 PM reflected the note as the Admission Nursing Assessment. The note indicated Resident #2 had abnormalities, edema, with his genitalia. The note			

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	lacked documentation of a catheter. The Health Status Note dated 10/4/24 at 4:50 PM indicated the nurse assessed Resident #2's penis due to a report of it looking swollen. Upon assessment the nurse documented Resident #2 penis as swollen at the base of the tip on top. It looked like a crescent starting from one side and going to the other side of the tip. The note reflected the nurse attempted the doctor's suggestion to try and pull his foreskin back with lubricant, but had no success. The swelling is noted as part of the skin under the foreskin. Underneath his penis looked discolored, he denied pain to area. The doctor directed to send Resident #2 to the emergency room if he started to complain of pain and it started turning purple. The Health Status Note dated 10/6/24 at 6:16 AM written by Staff L, Registered Nurse (RN), indicated the certified nurse aides (CNAs) reported Resident #2 got up to the bathroom multiple times throughout the night. The nurse catheterized him to see if he had residual (urine left in bladder after urinating). The nurse emptied 1,025 milliliters (ml) of urine, and left the urinary catheter left in place. The day nurse would notify family and the provider. The Skilled Note dated 10/10/24 at 10:45 PM identified Resident #2's had 2 plus (+) edema.			

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	Urinary catheter remains in place. The Health Status Note dated 10/11/24 at 12:38 PM reflected the facility's Advanced Registered Nurse Practitioner (ARNP) saw Resident #2 on 10/10/24 at the facility. The ARNP wrote orders to use a secure lock for his urinary catheter to prevent pulling. In addition, related to his paraphimosis put an icepack to his groin area for 20 minutes, then try manual manipulation with KY gel. The ARNP planned to see him the next week. The Communication with the Physician Note on 10/13/24 at 9:27 PM indicated the facility faxed an update to Resident #2's primary care provider (PCP) that the current treatment didn't help his paraphimosis. The New Order Follow-Up Note dated 10/14/24 at 9:19 AM reflected Resident #2's urinary catheter drained yellow urine. His penile edema remained. The staff continued to apply ice for 20 minutes and attempted manipulation without success. Resident #2 continued to have flat affect, but compliant with care and assessment stating he'd do what the girls told him. Resident is quiet, responded when spoken to but didn't offer conversation per his usual. The Physician Visit Note dated 10/16/24 at 4:05 PM, indicated Resident #2 returned to the facility			

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	without incident from seeing the Urology Clinic Provider ARNP. They ordered medication and directed to follow-up at his appointment on 11/20/24 at 3:00 PM. The nurse updated the Medication Administration Record (MAR), faxed the pharmacy, updated the calendar, and notified his daughter. The Urology Progress Notes dated 10/16/24, identified Resident #2 had urethral (urinary tract opening at end of penis) erosion (breakdown of tissue surrounding the urethra) and paraphimosis. The Urology staff reduced the paraphimosis in the clinic. The Urology team would provide education to the nursing staff at his care facility. The Impression/Plan listed they reduced the paraphimosis at the bedside. They provided education to the nursing home (NH) staff to ensure they retract the foreskin back over the head of the penis after catheter care. The New Order Follow-up Note dated 10/17/24 at 12:43 PM, reflected Resident #2 appeared more tired than usual and would see the facility ARNP the next day on rounds. The Urology Clinic Provider and facility ARNP discontinued the treatment of ice and manipulation. The Communication – with Outside Vendor dated 10/18/24 at 2:06 PM reflected the facility received			

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	a fax from the Urology Clinic Provider. The fax identified the Urology clinic would do the next couple catheter changes. Resident #2 would follow up in the office on 10/20/24 at 3:00 PM. The provider gave a new order to apply bacitracin to tip of penis/urethra twice a day (BID) and ensure the foreskin is not behind the head of penis. The note instructed to pull the foreskin back and clean it daily then pull it back over the penile head to prevent edema paraphimosis. A Clinical Physician's Order dated 10/18/24, directed to apply bacitracin (antibiotic ointment) to the tip of the penis twice a day. The order directed the nurses to ensure the foreskin is not behind the head of the penis. The note instructed to pull the foreskin back and clean it daily then pull it over the penile head, twice a day for paraphimosis. In a Urology Clinic Conversation between a Urology Clinic Nurse and the Urology Clinic Provider dated 10/18/24, the provider instructed the Clinic Nurse to make sure the NH staff know they need alternate the catheter so it didn't cause tension. The NH needs an order to apply bacitracin to the end of the penis/urethra twice daily on the sore area. In addition, make sure they know when they do catheter care they must make sure the foreskin is not left behind the head of the penis. Resident #2 had significant swelling/paraphimosis when they			

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	saw him from this. They should pull the foreskin back daily and clean with catheter care but the foreskin needed returned over the penile head. The Health Status Note dated 10/28/24 at 12:23 AM reflected Resident #2's penis remained enlarged. The attempts to apply cooling packs and ointment to get the foreskin over the head of penis without success. Resident #2 became very tearful at times. The Health Status Note dated 10/28/24 at 10:03 PM indicated Resident #2's penis remained full of fluid. Resident #2 denied discomfort or pain. The Health Status Note dated 10/30/24 at 11:01 PM, reflected the nurse applied triple antibiotic to tip of Resident 2's penis. The head of his penis remained enlarged. The staff provided peri-care and attempted to pull his foreskin over his penis without success. The Physician Visit Note dated 10/31/24 at 2:43 PM identified the facility ARNP saw Resident #2 and ordered labs. The Communication – with Physician dated 10/31/24 at 2:54 PM, indicated the facility called the Urology Clinic to report edema to Resident #2's foreskin of his penis. The Urology Clinic Provider			

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	would see Resident #2 the next day on 11/1/24 at 9:00 AM. The Health Status Note dated 10/31/24 at 11:36 PM reflected the staff provided catheter care. His penis remained swollen and they couldn't to pull foreskin over the penis head. The Appointment Note dated 11/1/24 at 8:15 AM identified Resident #2 left the facility via van to an appointment with his Urology Clinic Provider. The Appointment Note dated 11/1/24 at 9:55 AM, indicated Resident #2 returned to the facility. The Communication Sheet lacked notes, transportation reported the clinic would call. A Urology Clinic Progress Note dated 11/1/24, reflected the reason for Resident #2's visit as his foreskin retracted and the NH unable to get it back in place. It caused pain and paraphimosis. The clinic saw Resident #2 that day for penile pain and swelling. The NH called the previous day and reported his foreskin was retracted and they couldn't get it back over the head of his penis. The Urology Clinic Provider managed to manipulate the foreskin back. The clinic called the NH and gave instructions to Staff G, Licensed Practical Nurse (LPN). The instructions were to avoid fully retracting the foreskin all the way behind the glans, only pull			

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	back enough to clean, apply ointment, and place back. Staff G verbalized understanding and thanks. The Health Status Note dated 11/6/24 at 11:13 PM identified Resident #2's penis didn't have redness. The staff applied ointment as ordered. The catheter patent (in place and working) at the time with urine in the drainage bag. The Health Status Note dated 11/11/24 at 11:03 PM indicated Resident #2's penis remained swollen. The staff completed his treatments as ordered. The New Order Follow-Up Note dated 11/12/24 at 7:02 AM reflected Resident #2's penile edema remained. Resident #2 denied complaints of pain/discomfort. The Skin Condition Note dated 11/14/24 at 4:00 PM identified the facility completed the weekly skin assessment. The note lacked information regarding Resident #2's penis or scrotum. The Health Status Note dated 11/15/24 at 7:42 PM indicated Resident #2 didn't have a sore on his penis. The Health Status Note dated 11/18/24 at 10:17 PM reflected Resident #2 continued to have large amounts of edema in his lower body, as well as			

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	penile edema. The New Order Note dated 11/20/24 at 4:37 PM identified Resident #2 returned from his urology appointment. The instructions directed to continue with routine monthly catheter changes. In addition, nursing must pull the foreskin back over the head of penis after peri-cares. The Health Status Note dated 11/20/24 8:00 PM indicated Resident #2's penis remained swollen. The attempt to bring his foreskin over the penis failed. The Urology Progress Notes dated 11/20/24 identified Resident #2 as well since his last visit, but again noted to have paraphimosis. The clinic has instructed the staff at his nursing facility on 2 separate occasions to make sure they pull the foreskin back over the penile head with peri-care, however, it appeared that didn't happen. The clinic would reach out again to the facility with proper instructions. Resident #2's October 2024 and November 2024 Treatment Administration Records (TARS) reflected the nurses started signing on 10/18/24 at his hour of sleep (HS) that they applied bacitracin to the tip of the penis twice a day. The documentation reflected the nurses signed they ensured the			

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	foreskin wasn't behind the head of the penis, it should be pulled back, and cleaned daily then pulled forward over the penile head. On 11/25/24 at 10:32 AM, the Urology Clinic Nurse stated they saw Resident #2 three times at their Urology Clinic. She stated all 3 times Resident #2 had paraphimosis that the clinic's provider had to reduce. The Urology Clinic Nurse stated she talked with the NH's Director of Nursing (DON) on 10/16/24 and discussed the clinic's concerns. The Urology Clinic Nurse stated at the 11/20/24 visit, it took approximately 10 minutes to reduce the paraphimosis. She described the reduction of the paraphimosis (pulling the foreskin back into place over the penile head) as painful and almost like torture for him. On 11/25/24 at 10:44 AM, the Urology Clinic Provider stated the first visit they had with Resident #2 happened on 10/16/24, he had a catheter in place. Resident #2 had erosion of the penis, edema, and paraphimosis. The Urology Clinic Provider stated the erosion looked like it started from the catheter tension to the urethra. On 11/1/24, Resident #2 had paraphimosis again and the Provider was able to reduce it. The Provider called and told them to only pull the foreskin back enough to clean the head and apply ointment then put foreskin back over the glans penis. On 11/20/24 the			

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	Urology Clinic Nurse described Resident #2's penis as significantly swollen again with the foreskin stuck behind the glans. Resident #2 didn't have his catheter connected properly to the leg and caused tension. It was very painful for him. The Urology Clinic Provider stated they didn't have any way to know how long he had his foreskin pulled back. The Urology Clinic Provider stated Resident #2 already had CHF so he would already have more swelling to that area. Resident #2 told the clinic staff that he had pain since the last time he came to the clinic. The Urology Clinic Provider reported they had a lot more difficulty with getting his foreskin back in place on that visit then his prior visits and he had extreme pain. The Urology Clinic Provider described Resident #2 as not one to complain. The Urology Clinic Provider stated she called the facility and gave education every time and sent orders. She didn't know if the facility needed more education or what. The Urology Clinic Provider reported it as concerning that he had paraphimosis on all of 3 of his visits. On 11/25/24 at 1:30 PM, Resident #2 and his wife sat in their room together. They gave permission to enter the room and close the door. Resident #2 stated he didn't have any pain. He nodded in agreement when asked about the 3 times the Urology Center had to move the foreskin back over the head of his penis. He said the girls do a good job			

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	at the facility and the only time he had pain happened when they cleaned him up down there. He stated they did those cares in the morning and in the evening. He stated he believed his foreskin was, at this time, over the head of his penis and his wife agreed. Resident #2 gave permission to observe peri-care in the morning. On 11/25/24 at 7:32 PM, Staff E, LPN, stated she knew Resident #2 returned with a doctor's order instructing the aides only to pull the foreskin back so far. Staff E stated they used ice packs and ointment to try to get the foreskin back over the glans penis. Staff E stated Resident #2 didn't say anything about being in pain. She described his foreskin as just a tiny bit past the head of the penis. She stated the penis didn't change colors at all. Staff E reported to her knowledge the Urology Clinic didn't ever get the foreskin back over the head of the penis. She stated the past week was the first time the Urology clinic ever got the foreskin back over the head of the penis. Staff E said she never saw Resident #2's foreskin pulled back into place until the prior week. Staff E said to her knowledge the other 2 times Resident #2 went to Urology, they couldn't get the foreskin back into place. When they said they did, Staff E said she never saw it. When asked when would it be considered urgent to send Resident #2 out, Staff E replied if his penis turned blue or something like that. Staff E said they			

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	tried to make the swelling go down with an ice pack and putting the lubrication on it. She said the TAR included that treatment. Staff E stated they checked his penis and foreskin every night. Staff E said she taught a new CNA how to do it appropriately. Staff E said the CNA told her they never learned how to pull the foreskin back in place in school. So, Staff E showed the CNA how to do it. Staff E couldn't remember the name of the CNA. Staff E couldn't believe they didn't teach the CNA that in school. On 11/25/24 at 7:41 PM, Staff F, LPN, reported she knew when Resident #2 first came to the facility he had a fluid filled (edema) area on the shaft of his penis. Staff F described it as hard to get the foreskin to retract and go back over the head of Resident #2's penis. Staff F stated Resident #2 always had sensitivity down there. She said it didn't look like the swelling came from trauma. Staff F stated she always could get the foreskin retracted back from the head of his penis and then back over the head of the penis. Staff F said Resident #2 never complained (of pain) to her. Staff F stated she only worked at the facility as needed (PRN), like 2 or 3 times a month. She only worked with Resident #2 a couple of times. Staff F never saw any of the moments where the foreskin couldn't be pulled back into place over the head of the penis. Staff F never saw any difficulties with the CNAs being able			

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	to replace the foreskin back over the head of the penis. Staff reported they went with the CNAs because they had to apply the bacitracin on to the tip of Resident #2's penis. Staff F stated it took a few more steps to get the foreskin retracted and then pulled back over into place related to the swelling. Staff F stated Resident #2 could voice his concerns and he would voice if he had pain. On 11/26/24 at 7:15 AM, observed Staff H, Certified Medication Aide (CMA)/CNA, and Staff I, CNA, provide morning care for Resident #2. Observed edema in his lower legs and feet. During the peri-care/catheter care witnessed Resident #2's foreskin retracted half way down the head of his penis, they cleaned the penile head, and returned the foreskin back in place. The observation showed no redness, discharge, or swelling. The DON applied the bacitracin to the penis after retracting the foreskin and then she pulled the foreskin back over the glans. On 11/26/24 at 8:00 AM, Staff H and Staff I stated they both received training on how to do peri care on an uncircumcised resident. They both said they had to corrected their peers at times for not pulling the foreskin back over the head of the penis and/or not retracting the foreskin to clean the head of the penis. Staff I explained if they don't retract the foreskin to clean, then discharge can build up under			

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	the foreskin, which could result in it becoming cheesy and yellow. They didn't see anything recently where they needed to intervene with the staff. Staff H stated Resident #2 came into the facility with the foreskin retracted and the head of his penis swollen. She stated she thought he went to have it taken care of about 1 week after he got to the facility. On 11/26/24 at 8:25 AM, Staff J, CNA, stated she received training on how to clean an uncircumcised penis. She stated when Resident #2 first came into the facility, Staff J couldn't tell if Resident #2 was circumcised or not because of the swelling in his penis. In addition, she couldn't tell if he even had a foreskin. Staff J stated Resident #2 retained a lot of water. She stated she gave him a bath the previous Sunday (11/24/24) and his penis looked swollen but he had the foreskin pulled over the head of his penis. On 11/26/24 at 8:40 AM, Staff K, CMA/CNA, reported she learned how to provide peri care to uncircumcised males. She explained the process as you need to pull the foreskin back, cleanse the penis, and then replace the foreskin back over the penis. She described Resident #2's penis as swollen. Staff K saw him with his foreskin pulled back behind the head of the penis, when they couldn't pull it back over the penis. She estimated it was probably			

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	the previous week, but she didn't know a certain day. She stated when she realized this she went and told the nurse. She stated she didn't observe any of her peers leaving the foreskin down. She stated they used to be able to take the foreskin down, clean the head of the penis, and then pull the foreskin back up, but then his penis started swelling. She didn't know when or who pulled the foreskin down and didn't get it back up over the head of his penis. On 11/26/24 at 11:46 AM, the DON reported he didn't document the conversation she had with the Urology Clinic on 11/20/24 and 11/21/24 as it just happened. She stated she would document the conversation. When asked about the admission order to remove the catheter after his penile and scrotal swelling decrease, but his clinical record lacked documentation of penile and scrotal swelling until 10/4/24 with exception of a mention in an admission note, she responded it would be in the daily skilled documentation. When asked about Resident #2 having paraphimosis on 10/16/24, she replied she would look into it more. When asked how the nurses signed that they applied the bacitracin BID to the tip of his penis and ensured they pulled the foreskin back over the head of his penis, but, Resident #2 went out again on 11/1/24 and 11/20/24 with paraphimosis, the DON responded she needed to look into it more. She			

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	stated that since changing corporations, they updated the systems and they are looking into getting information that the survey team requested. She reported she understood the concern with the lack of documentation of assessments and interventions. On 12/3/24 at 3:55 PM, Staff L, RN, stated Resident #2 had a lot of edema to his penis in general as well as the foreskin and the shaft. Staff L stated Resident #2 had an issue with his foreskin for a long time. The staff pulled it back to perform peri-care and then they couldn't get it back over because of the swelling. She stated this already happened when she started working with him. Staff L said her first encounter with Resident #2 happened when she catheterize him on 10/4/24. Staff L noticed his foreskin retracted and they couldn't pull it back over the head of the penis. Staff L stated if his penis was like that prior to Staff L putting the catheter in, she didn't know of it. Staff L didn't recall when they put the bacitracin order in place. After the beginning of November, when Staff L went back to day shift, he already had the order to apply bacitracin to his penis in place. Staff L stated she applied the bacitracin to Resident #2 multiple times. He had foreskin retracted where it couldn't be pulled back over, except right before he moved to the back on 11/26/24, somebody did get it back over the penis head. The majority of the time his			

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	penis had too edema and it hurt him, the facility staff couldn't get the foreskin back over. Staff L noticed one time he had his foreskin back over the head of his penis. Luckily on that day she could pull the foreskin back, do his treatment, and replace the foreskin back over the penis. Staff L stated she didn't recall if the bacitracin order directed to pull the foreskin back over the head of the penis. Staff L said she didn't remember his penis being discolored at all. Staff L stated she didn't know if anyone reported it to the Provider. Staff L stated he already had the issue when she went to the day shift. Staff L said if somebody reported the issue it wouldn't been her. Staff L reported it as questionable too, how long it had been like that. She said she believed that at one of his Urology appointments, they couldn't pull the foreskin back over. When told the documentation showed they did reduce the paraphimosis at all 3 of his appointments, she responded after he came back from one of his appointments, she didn't know if it was that same day or the next morning when she did the treatment, she looked at it and they didn't get the foreskin back over. When read the 11/20/24 progress note to Staff L, she replied she may have said that wrong. Staff L stated she saw issues with not being able to pull his foreskin over the glans prior to 11/20/24. Staff L stated she worked on 11/22/24 and described his penis as edematous, during care, treatment, and retracting of the			

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	foreskin back over the head of his penis. Staff L stated she didn't believe she knew the bacitracin order directed to pull the foreskin back over the glans penis. Staff L explained ideally, they would perform the necessary cares and treatment. In Resident #2's case, he had a very painful and edematous penis. Staff L stated she didn't remember Urology telling them know how to decrease the edema. Staff L stated in Resident #2's case, they thought they would do more damage to him to try and force the foreskin back over the head of the penis then to leave it. He didn't really complain much but they could tell that it was tender, and when they tried to pull the foreskin back over the penile head, it caused him pain. Staff L reported she would probably described it as tender because of the edema with the foreskin pulled back. He didn't complain of it bothering him on a day to day basis when they had issues. Staff L wondered if the facility could do something. Staff L said that after his last Urology appointment, the DON told them Urology called. She explained they were really mad and wanted to know if staff didn't clean him well, or what the problem was because they had to pull his foreskin back again over the head of his penis. The DON wanted 2 nurses to do Resident #2's peri-care to ensure the foreskin got put back into place. Staff L described it as very frustrating.			

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	On 12/4/24 at 2:13 PM, Staff M, LPN, stated she didn't remember for sure the first time she got report of Resident #2's retracted foreskin. The facility ARNP told Staff M to ice and elevate the penis, then try to retract. Staff M stated the Facility ARNP said if Staff M could get the swelling down then to use ointment to try and pull the foreskin back over. Staff M stated they couldn't get the swelling down. Staff M stated the ice and elevation didn't work. Staff M stated she told the Facility ARNP, who made a Urology appointment. Staff M stated Resident #2 never really complained of pain. She said that Urology told them to use bacitracin and that didn't really work to get the foreskin back over. Staff M said she knew Resident #2 had a history of paraphimosis and swelling. Staff M wondered if the catheter was a contributing factor to the swelling and paraphimosis. Staff M stated she made sure the staff did proper catheter care. Staff M didn't see any concerns with the CNAs providing care. Staff M didn't recall talking to the Urology Clinic Provider or anyone about anything other than to schedule the appointment. Staff M stated they couldn't return the foreskin back over the head of the penis at the facility. When the documentation was read to Staff M that the Urology Clinic Provider wrote they talked to Staff M, she responded she didn't remember talking to anyone on the phone. She explained she didn't say it didn't happen, she just didn't remember it. Staff			

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	M stated she remembered an order basically saying the same thing read to her. Staff M stated they looked into his visits, they didn't remember the date, but they wrote a note to not fully retract the foreskin. Staff M stated she applied bacitracin to his urethra several different times. Staff M acknowledged she knew the order directed to pull the foreskin back over the head of the penis after applying the bacitracin. Staff M stated she honestly didn't know if she called a physician/provider to let them know the nurses couldn't get the foreskin back over the penile head. Staff M stated she knew she talked to the Facility ARNP about it at different times. Basically, we had the bacitracin order and he went to urology. Staff M stated they could try ice too. When asked if she should have called a provider she said "yes." She stated at the time, because it wasn't new, she just ... She added again it wasn't new. On 12/4/24 at 3:36 PM, the Facility ARNP stated she knew she saw Resident #2 in October. They had difficulty getting his foreskin back over the penile head. The Facility ARNP believed she ordered a consult to Urology at that time. The Facility ARNP stated she didn't know that the paraphimosis was persistent and stated she didn't receive any calls from the facility regarding his ongoing paraphimosis. She stated she is available all the time and the facility's nurses didn't call her			

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	reporting persistent paraphimosis. She acknowledged the bacitracin order was to ensure they could move the foreskin back into place twice a day and acknowledged no one notified her that they couldn't get it back. The Facility ARNP stated Resident #2 had a urinary catheter that drained correctly. On 12/4/24 at 4:35 PM, the Administrator and the DON, stated periodically the nurses couldn't pull Resident #2's foreskin back into place, but not always. When informed about the concern of nurses documenting twice a day they pulled the foreskin back over the head of the penis after retracting it to apply ointment, and the facility ARNP stated no one contacted her regarding not being able to pull the foreskin back over the head of the penis, nor did she know he had this as a persistent problem, the DON and the Administrator acknowledged the concern. The DON and Administrator couldn't provide any further information regarding documentation of the penile/scrotal swelling . The DON didn't provide the documentation from the conversation she had with the Urology Clinic. The facility couldn't provide any additional documentation from the skilled daily nursing notes. The facility stated they follow the standard of practice for assessment, intervention, following			

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	doctor's orders, and peri care on un-circumcised males. **FACILITY RESPONSE**			

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58.19(1)j(4)	**481—58.19(135C) Required nursing services for residents.** The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules: **58.19(1)** *Activities of daily living.* *j.* Elimination. (4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III) **DESCRIPTION** ☒F 690 Bowel/Bladder Incontinence, Catheter, UTI SS=G Based on observations, interviews and record review, the facility failed to follow standards for bladder care and services for 2 out of 3 residents reviewed (Residents #1 and #2). Resident #2 had a voiding trial (trial to see if resident could go without a catheter to drain the urine from his bladder) without measuring output or documenting his output for 1 shift. Resident #2 couldn't urinate on a separate shift and had over 1 liter of urine drained from his bladder. Resident #2 had urethral erosion	**Class I**	**$5500.00** **Held in Suspension**	**Upon Receipt**

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	(tissue breakdown around the urinary meatus, opening at the end of the penis) from a Urinary catheter (tube placed in the urethra to drain urine out of the bladder). The facility failed to ensure Resident #2 wore a secure device to hold the catheter in place and to prevent pulling on the catheter. The facility failed to provide timely incontinence care to Resident #1. The facility reported a census of 52 residents. Findings include: 1. Resident #2's Minimum Data Set assessment dated 10/1/24, listed an admission from an acute hospital stay on 9/24/24. The MDS identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. Resident #2 required substantial assistance with rolling left and right, toileting hygiene, and dressing. The MDS listed Resident #2 had a catheter. The MDS included diagnoses of congestive heart failure (CHF), renal (kidney) insufficiency, chronic obstructive pulmonary disease (COPD), and paraphimosis. Resident #2's Hospital Records dated 9/24/24 listed the following physician orders: a. Admit to skilled level of care. b. Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat upon arrival.			

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	c. Urology placed a urinary catheter, recommend leaving the catheter in place until the patient is more mobile and penoscrotal (penis/scrotum) edema (swelling) has improved. d. Recommend voiding trial at nursing facility in 3 to 4 days. The orders repeated to please do a voiding trial at nursing facility in 3 to 4 days to remove the urinary catheter. The Care Plan Focus initiated 10/8/24 indicated Resident #2 required the use of an indwelling catheter related to obstructive uropathy (blocked urinary passage). The Interventions directed staff to use a catheter securement device. The Structured Progress Note dated 9/24/24 at 1:29 PM reflected the note as the Admission Nursing Assessment. The note indicated Resident #2 had abnormalities, edema, with his genitalia. The note lacked documentation of a catheter. The Structured progress notes on 9/26/24 at 4:16 PM, 9/27/24 at 7:46 PM, 9/28/24 at 8:06 PM, 9/29/24 at 10:16 PM, and 9/30/24 at 8:58 PM indicated Resident #2 had an indwelling catheter. The Skilled Note on 10/1/24 at 9:57 PM reflected Resident #2's urinary catheter remained.			

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	The New Order Note dated 10/2/24 at 4:18 PM indicated the facility received new orders to remove Resident #2's urinary catheter from the physician. The orders directed if once removed Resident #2 can't void within 8 hours, replace the urinary catheter and notify the provider then refer to urology. The Skilled Note dated 10/2/24 at 10:24 PM reflected they took out the catheter as ordered and gave Resident #2 a urinal. The Skill Note dated 10/2/24 at 11:44 PM, indicated the staff provided 100% assistance with urinary catheter management. The Health Status Note dated 10/6/24 at 6:16 AM written by Staff L, Registered Nurse (RN), reflected the certified nurse aides (CNAs) reported to the nurse Resident #2 went to the bathroom multiple times throughout the night. The nurse catheterized Resident #2 to see if he had residual (urine remaining after voiding), he had 1,025 milliliters (ml) of urine out. The nurse left the urinary catheter in place. The day nurse would notify the family and provider. The General Progress Note dated 10/6/24 at 9:27 PM identified Resident #2's urinary catheter as intact and patent (in place and working). The			

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	urinary output appeared clear and yellow with adequate output noted. Resident #2 denied pain/discomfort with the re-insertion of his catheter. The Health Status Note 10/7/24 at 10:27 PM, identified Resident #2 had a large amount of urine in his bag (3/4 full at 8:00 PM) that night. The nurse asked the staff to empty the catheter bag. The Skilled Note dated 10/7/24 at 11:14 PM indicated Resident #2's urinary catheter remained in place. The New Order Follow-up Note dated 10/8/24 at 9:43 AM identified Resident #2 had a catheter in place, patent, and draining clear yellow urine. The Skilled Note dated 10/8/24 at 7:51 PM indicated Resident #2's urinary catheter remained in place. The New Order Follow-up Note dated 10/9/24 at 12:10 PM reflected Resident #2 had a patent catheter draining clear yellow urine. Resident #2 reported he didn't feel the urge to go constantly, like he did before. He explained he actually could get some sleep. No tearfulness observed on assessment.			

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	The Skilled Note dated 10/9/24 at 6:57 PM indicated Resident #2's urinary catheter remained in place. The Health Status Note dated 10/9/24 at 9:08 PM identified Resident #2 had a patent catheter draining clear yellow urine. He denied urinary discomfort. The New Order Follow-up Note dated 10/10/24 at 7:10 AM, reflected Resident #2 reported he had relief when they placed the catheter as he didn't have the constant urge to urinate. The Skilled Note dated 10/10/24 at 10:45 PM, identified Resident #2's scrotum had 2+ edema and his urinary catheter remained in place. The Health Status Note dated 10/11/24 at 12:38 PM reflected the facility's Advanced Registered Nurse Practitioner (ARNP) saw Resident #2 on 10/10/24 at the facility. The ARNP wrote orders to use a secure lock for his urinary catheter to prevent pulling. In addition, related to his paraphimosis put an icepack to his groin area for 20 minutes, then try manual manipulation with KY gel. The ARNP planned to see him the next week.			

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	The Skilled Note dated 10/11/24 at 11:31 PM indicated Resident #2's urinary catheter remained in place. The Skilled Note dated 10/12/24 at 7:32 PM indicated Resident #2's urinary catheter remained in place. The Skilled Note dated 10/13/24 at 11:53 PM, indicated Resident #2's urinary catheter remained in place. The Communication – with Outside Vendor dated 10/18/24 at 2:06 PM reflected the facility received a fax from the Urology Clinic Provider. The fax identified the Urology clinic would do the next couple catheter changes. Resident #2 would follow up in the office on 10/20/24 at 3:00 PM. The provider gave a new order to apply bacitracin to tip of penis/urethra twice a day (BID) and ensure the foreskin is not behind the head of penis. The note instructed to pull the foreskin back and clean it daily then pull it back over the penile head to prevent edema paraphimosis. Resident #2's October 2024 Documentation Survey Report related to bladder elimination report lacked documentation on the night shift of 10/4/24. The report didn't document the amount of urine output for each shift. It documented Resident #2 had a			

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	catheter in on 10/2/24 and 10/6/24 on the first shift. The documentation between the two shifts reflected Resident #2 as continent or incontinent, with the exception of the 10/4/24 night shift due to no documentation. The Clinical Physician's Order printed 12/3/24 included an order by the Facility Advanced Registered Nurse Practitioner (ARNP) dated 10/11/24 entered in the electronic health record by the Director of Nursing (DON), to place a urinary catheter secure lock to prevent pulling of the catheter two times a day (BID) for catheter safety. Resident #2's October 2024 and November 2024 Treatment Administration Records (TARs) reflected the nurses started signing on 10/11/24 at bedtime (HS) twice a day that he had a secure lock in place. In addition, the TARs reflected the nurses started signing on 10/18/24 at HS that they applied bacitracin to the tip of his penis twice a day. The documentation reflected the nurses signed they ensured the foreskin wasn't behind the head of the penis, it should be pulled back, and cleaned daily then pulled forward over the penile head. The Clinical Physician Orders dated 10/18/24, directed to apply bacitracin (antibiotic ointment) to the tip of the penis twice a day. The order directed the nurses to ensure the foreskin is not behind the			

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	head of the penis. The note instructed to pull the foreskin back and clean it daily then pull it over the penile head, twice a day for paraphimosis. The Urology Progress Notes dated 10/16/24, identified Resident #2 had a recent hospitalization and had urinary retention. They placed a urinary catheter and started tamsulosin. The facility reported conducting 2 separate voiding trials without success. After further discussion with him and his daughter, they attempted a voiding trial, however, he couldn't urinate. They discussed starting a catheter and adjusting his medications. They planned to do a follow-up voiding trial in one month. If unsuccessful at that time, they would start a permanent catheter that the nursing home (NH) could change monthly. He is not a surgical candidate and not interested in surgery. He didn't have hematuria or urinary tract infection issues. He did have urethral (urinary tract opening at end of penis) erosion (breakdown of tissue surrounding the urethra) and paraphimosis (foreskin pulled back but unable to return to its original position over the head, or glans, of the penis). The Urology staff reduced the paraphimosis in the clinic. The Urology team would provide education to the nursing staff at his care facility. The Impression/Plan listed they reduced the paraphimosis at the bedside. They provided education to the nursing home (NH) staff to ensure they retract the foreskin back over the			

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	head of the penis after catheter care. The Urology Clinic would do the next couple of catheter changes. In a Urology Clinic Conversation between a Urology Clinic Nurse and the Urology Clinic Provider dated 10/18/24, indicated the facility needed urinary catheter instructions sent to them. In addition, the provider instructed the Clinic Nurse to make sure the NH staff knew they needed to alternate the catheter so it didn't cause tension. The NH needs an order to apply bacitracin to the end of the penis/urethra twice daily on the sore area. In addition, make sure they know when they do catheter care they must make sure the foreskin is not left behind the head of the penis. Resident #2 had significant swelling/paraphimosis when they saw him from this. They should pull the foreskin back daily and clean with catheter care but the foreskin needed returned over the penile head. A Clinical Physician's Order dated 10/18/24, directed to apply bacitracin (antibiotic ointment) to the tip of the penis twice a day. The order directed the nurses to ensure the foreskin is not behind the head of the penis. The note instructed to pull the foreskin back and clean it daily then pull it over the penile head, twice a day for paraphimosis.			

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	The Urology Progress Note dated 11/20/24, reflected the staff provided urethral erosion education to the NH staff, apply bacitracin BID, and adjust the urinary catheter to avoid tension on the catheter. On 11/26/24 at 7:15 AM, observed Staff H, Certified Medication Aide (CMA)/CNA, and Staff I, CNA, in Resident #2's room to provide his morning care. When they rolled Resident #2 to his left side, he had his catheter bag attached to the right side of the bed with the tubing taunt (pulled tight). The Director of Nursing (DON) entered the room to apply bacitracin to the glans penis, and noted the tight tubing. She grabbed the tubing and pulled on the bag side to provide slack to the catheter insertion site of Resident #2's urethra, then they placed the catheter bag on the bed. The DON applied the bacitracin to the penis after retracting the foreskin and then she pulled the foreskin back over the glans (head of the penis) after applying the bacitracin. The DON stated something about a secure lock for him when they took the slack out of the tubing. She left and retrieved a secure lock then applied it to his right leg, removed the catheter from the catheter strap on the left leg and placed the tubing in the secure lock. She then moved the leg strap over to the right leg as well, right below the secure lock and put the tubing through the catheter strap as well. When asked who can apply			

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	the secure lock the DON replied it wasn't licensed. Both the CNA and the CMA stated they never put a secure lock on a resident before. Unable to visualize Resident #2's full urethra as they didn't fully pull down the foreskin over the glans penis. On 11/26/24 at 8:00 AM, Staff H and Staff I both stated they didn't like working with the catheter lock device the DON placed on Resident #2. On 11/26/24 at 8:25 AM, Staff J, CNA, stated when Resident #2 first came into the facility, they couldn't tell if Resident #2 was circumcised or not due to the swelling in his penis and she couldn't tell if he had foreskin. The CNA stated Resident #2 retained a lot of water. She stated she gave him a bath the previous Sunday (11/24/24) and his penis looked swollen but he had his foreskin pulled over the head of the penis. When asked about the secure locks, she said she hated those things. She said the facility normally didn't put the secure locks on but residents who come from the hospital wore them. Staff J stated that, in fact, Resident #2 had one on the day she gave him a bath, but she took it off and put a catheter strap on him instead because they are more comfortable for the resident and they didn't have the risk of spinning the tubing. She said the secure lock on Resident #2 caused the tubing to be too tight on his leg. When asked how they knew what each resident needed and what			

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	they are Care Planned for, she said it's in the tablets, such as if they had a catheter or how they transfer. She added at the beginning of each shift the nurse would let them know if about any changes to the residents' plan of care. On 11/26/24 at 11:46 AM, the DON reported she didn't document the conversation she had with the Urology Clinic on 11/20/24 and 11/21/24 as it just happened. She stated she would document the conversation. When asked about removal of the catheter on 10/2/24 and then Resident #2's clinical record didn't have anything documented about outputs or tolerance until 10/6/24 when the nurse did a residual and he voided over 1 liter of urine, she replied she would look into it. She stated since changing corporations, they updated the systems and they are looking into getting information that the survey team requested. She reported she understood the concern with the lack of documentation of assessments and interventions. On 12/3/24 at 3:55 PM, Staff L, RN, reported she had her first encounter with Resident #2 when she catheterized him. Staff L reported she worked as the overnight nurse in the back area of the facility until November 1st. It happened very early in the morning when the CNAs came to her and told her Resident #2 wasn't urinating. Staff L said Resident #2 kept saying to the CNAs that he had to go to the			

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	bathroom and he kept trickling urine. That's when Staff L looked into it more and discovered Resident #2 was on a voiding trial. Staff L went ahead and catheterized Resident #2. She got over 1,000 milliliters (ml) out. Staff L left the catheter in and the dayshift nurse Staff M, LPN, was to call the physician. It was around 6:00 AM when they asked if Resident #2's clinical record had documentation for the voiding trial. Staff L stated she didn't know what they were doing as far as monitoring because she was the night shift nurse for the back. Staff L stated that usually, for a trial, the nurses ask the staff or resident, if they could tell them, if they are voiding. Staff L stated she read the order that night, and that's how she knew. Staff L stated she knew that they told her in report they removed his catheter. Staff L saw the order that directed if he didn't void in 8 hours or something like that to place a catheter. That's when Staff L inserted a catheter for Resident #2 and he had residual urine. On 12/4/24 at 2:13 PM, Staff M stated she knew Resident #2 had a sticky strap (catheter tubing holder) when he first came in and they switched it to a catheter strap. On 12/4/24 at 4:35 PM, the Administrator and the DON, stated they didn't have further information on Resident #2's voiding trial as they sent what they had which was mostly the CNAs documentation on			

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	output. The DON stated that a secure lock meant a leg strap. When asked if she had a policy on that, she stated no, it's a standard of practice. When asked if leg straps are Care Planned on residents with catheters, she stated no. When asked if an order is needed for a leg strap she said no. When asked why she wrote an order then for a Secure Lock, this DON stated she didn't remember writing an order for a Secure Lock. She checked another resident's (who also had a catheter) doctor's orders to see if he had a secure lock order, and he didn't. Information was then requested from the Administrator and the DON, to be sent that would show a secure lock was the same as a catheter leg strap. When shared the concern regarding a delay in the start of a voiding trial, a shift going without documentation of whether or not he voided, and Resident #2 ending up retaining over 1 liter of urine, they acknowledged the concern. When shared the concern regarding the observation of the pulling of Resident #2's catheter during care and no secure lock in place at the time, the DON and Administrator acknowledged the concern. The DON acknowledged walking in during the care, noticing the tension on the catheter tubing and relieving the tension on the tubing. The DON acknowledged she then left the room and grabbed a Stat Lock (secure lock), then placed it on his leg and also applied the catheter leg strap on his leg attaching the catheter tubing to both of the			

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	devices. This DON acknowledged Resident #2 had urethral erosion. As of 12/5/24 at 4:30 PM, the facility provided no regarding a secure lock. On 12/5/24 at 3:12 PM, the Facility's ARNP responded the secure lock she ordered was for a stat lock device, as they are the same thing. The facility stated they follow the standard of practice for following doctor's orders. 2. Resident #1's Minimum Data Set (MDS) assessment dated 10/3/24 identified a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. Resident #1 required supervision/touching assistance with toileting transfers and partial/moderate assistance with toileting hygiene. The MDS listed Resident #1 as frequently incontinent of bowel and bladder. The MDS included diagnoses of hypertension (high blood pressure), renal disease (kidney), cerebrovascular accident (CVA), non-Alzheimer's dementia, Parkinson's disease, and neurocognitive disorder with Lewy bodies (a type of dementia). The Care Plan Focus with a target date of 12/24/24 reflected Resident #1 required assistance with activities of daily living (ADL's) related to			

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	neurocognitive disorder with Lewy bodies, possible stroke, confusion and weakness. The Care Plan Interventions directed the staff the following: a. Provide extensive assistance from 1 staff member for toileting needs. b. See if Resident #1 was incontinent, aid with incontinence cares, and changing incontinence products. The Care Plan lacked direction on how often to check Resident #1 for incontinence. On 11/25/24 at 8:22 AM, Resident #1's daughter reported she came to the facility on 9/21/24 in the afternoon. She stated the staff told her that her dad was sleeping and they couldn't get him up. She stated she returned to the facility later that evening and found her dad in a urine-soaked bed. She stated the aide (Staff B) cried because of it. On 11/25/24 at 4:35 PM, Staff B, CMA, described Resident #1 as combative and resistant to care at times. Staff B stated the Assistant Director of Nursing (ADON) called her into Resident #1's room to help with incontinent cares. She stated Resident #1's daughter was present. Staff B reported Resident #1 stayed in bed all day. Staff B reported Resident #1 looked like nobody touched him all day. She described Resident #1's clothes and bedding as soaked with urine. She stated Resident #1 had urine			

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	from the back of his knees to his hair line. Staff B reported she broke down and started crying. She stated she cleansed Resident #1's back side and changed his bedding. She stated she had to wipe down the bed with a sanitizing wipe. She reported confusion on why the other aides didn't tell her no one changed Resident #1 or did his care. She stated she didn't understand why the other aides didn't take care of Resident #1 themselves or tell her so she could. She stated reported there was a big difference between being in bed all day and not receiving care. On 11/26/24 at 8:12 AM, the ADON reported she expected the staff to complete incontinence care and check on the residents every 2 hours and as needed (PRN). The ADON reported they had a time when they didn't perform incontinence cares for Resident #1 and the facility took disciplinary actions. She explained the 2-10 shift was involved and the first shift may have been a contributing factor. The ADON reported she came in to work at 6 PM and around 6:30 PM, she observed Resident #1 laying in a wet bed full of urine. She described Resident #1 as very sleepy (lethargic) and he didn't get up that day. She couldn't recall if Resident #1 ate or not that day. She stated it was common for Resident #1 to have days where he was sleepier than others. She identified herself as the one to			

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	issue the disciplinary actions with the staff members who were involved. On 11/26/24 at 8:16 AM, Staff C, CNA, reported Resident #1's daughter came to the facility and told the staff to leave Resident #1 be as he slept. Staff C described Resident #1 as very noncompliant with his care. She stated she worked 6 AM to 6 PM that day. Staff C reported she went in Resident #1's room approximately every 2 hours to check on him. Staff C stated she asked Resident #1 if she could change him and he told her no, he wanted to be left alone. She stated it was uncommon for him to be in bed and not get up. She stated he didn't eat either. She stated Resident #1's daughter instructed her to let him sleep. Staff C reported she received a write up for not completing incontinence care. She stated she wrote a statement on the write up that the daughter wanted him to be left alone. A facility form titled Employee Counseling form dated 9/21/24 for Staff B, Staff C, and Staff D listed the problem as providing and assisting Resident #1 with incontinence cares approximately every 2 hours or as needed. The form described Resident #1 as laying in urine-soaked bedding from head to toe at 6 PM. The counseling forms documented the following employee statements: a. Staff B documented she received report at 2 PM that Resident #1's daughter stated he was			

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	comfortable sleeping, leave him because he had an eventful night before. b. Staff C documented Resident #1's daughter told them not to mess with Resident #1. c. Staff D documented multiple people, multiple times tried to get Resident #1 changed, but he refused. Resident #1's daughter came and she told them to leave him and let him sleep. Staff D documented the daughter commented she couldn't get him to wake up or do anything. A facility form titled Employee Counseling form dated 9/21/24 for Staff A, CMA, listed the problem as a failure to report to the charge nurse due to lack of care for Resident #1. The form indicted they found Resident #1 lying in a urine-soaked bedding from head to toe at 6 PM. Staff A documented on the counseling form that Resident #1's daughter said to leave him around noon when they tried to re-approach him to check and change him, so they left him be. On 11/26/24 at 11:42 AM, the Administrator reported the facility didn't have a policy related to urinary incontinence and the facility followed the standard of care. On 11/26/24 at 11:45 AM, the DON reported she expected the staff to check for incontinence after each meal, at HS, and on rounds during the night,			

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	approximately every 2 hrs. The DON reported Resident #1's daughter dictated his care and would help develop interventions. She stated if a resident refused to get out of bed or have cares completed, she expected the staff to check on the resident, reproach, and offer care again. An Appropriate Use of an Indwelling Catheter Policy, revised on 12/10/05, directed to not use an indwelling catheter unless there is valid medical justification. It will be discontinued as soon as clinically warranted and services will be provided to restore or improve normal bladder function after the removal of the catheter. A resident will receive appropriate care and services to prevent urinary tract infections while utilizing an indwelling catheter. The assessment for indwelling catheter use should include consideration of the risks and benefits (supra-pubic or urethral); the potential for removal of the catheter; and consideration of complications resulting from the use of an indwelling catheter, such as, but not limited to: a. Symptoms of blockage of the catheter with associated bypassing of urine. b. Expulsion of the catheter. c. Pain d. Discomfort and bleeding. A Care Plan will be implemented to detail the treatment regime with the following information:			

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	a. Measurable objectives with time frames to be able to assess whether the objectives have been met. b. Interventions specific enough to outline treatment required including approaches to minimize risk of infection. Interventions may include, but not be limited to the following: i. Type of drainage device. ii. Tubing and bag care. iii. Catheter care. iv. Time frames for changing the catheter, tubing and bag. v. Type of anchoring device to prevent excessive tension on the catheter during transfers and care delivery. vi. Assessing and managing catheter related pain. An indwelling catheter for which continuing use is not medically justified will be discontinued as soon as clinically warranted.			

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	FACILITY RESPONSE			

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