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BIRKWOOD VILLAGE OF FORT MADISON	1702 41ST STREET FORT MADISON, IA 52627

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F 000	INITIAL COMMENTS	F 000		
✓	Correction date: 11/12/24			
JFS	The following deficiency resulted from the investigation of complaint #124344-C, conducted October 28, 2024 to October 30, 2024. Complaint #124344-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.			
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sara Popp | TITLE: Administrator | (X6) DATE: 11/22/24

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.

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prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to evaluate the placement of the urinary catheter after a routine catheter change with little to no urine output along with bloody urine for 2 days and then continued to have bloody urine for an additional 2 days before sending the resident to the hospital 4 days where it was found the balloon inserted in the urethra causing trauma and the resident diagnosed with a UTI (Urinary Tract Infection) for 1 of 3 residents reviewed for urinary catheters (Resident #1). The facility reported a census of 59 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 10/3/24 revealed Resident #1 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed the resident had impairment in both lower extremities and used a wheelchair. The MDS revealed the resident was dependent on staff with toileting hygiene, and transferring to the toilet was not applicable due to not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. The MDS revealed resident used an indwelling

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catheter. The MDS revealed medical diagnoses of heart failure, benign prostatic hyperplasia (BPH), and diabetes mellitus (DM).

The Care Plan revealed a focus area dated 10/2/23 for an indwelling catheter related to urinary retention. The interventions dated 10/2/23 revealed monitored and documented intake and output as per facility policy; monitored/documented for pain/discomfort due to the catheter; monitored/recorded/reported to the MD (Medical Director) for s/sx (signs/symptoms) of UTI (Urinary Tract Infection) such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns; and catheter size and type per order. Position catheter bag and tubing below the level of the bladder and in dignity bag.

The Electronic Medical Record (EMR) revealed the following diagnosis:
a. Benign prostatic hyperplasia (BPH) with lower urinary tract symptoms

The EMR revealed the following Physician Orders:
a. Lasix oral tablet 20 mg- give 1 tablet by mouth one time a day
b. sodium chloride irrigation solution- use 60 cc (milliliters) via irrigation two times a day for maintain patent Foley catheter flush
c. 18 fr (french) 10 cc Foley change monthly and PRN (as needed)- every shift starting on the 19th and ending on the 19th every month for failing voiding trial, follow up with urology and as needed
d. hydrocodone-acetaminophen oral tablet 5-325

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F 690	Continued From page 3 mg (milligrams)- give one tablet three times a day The Indwelling Catheter Reassessment for Resident #1 signed by the provider on 7/3/24 revealed: a. diagnosis: BPH b. attempts at removal in the past resulted in: failed voiding trial, to follow up with urology c. This resident is not a candidate for surgical correction at this time. I feel that it is in the resident's interest to continue the catheter. I will reassess the need in 3 months and if any medical changes haven't taken place which would allow us to make any changes, I will consider discontinuing the catheter at that time. The Health Status Note dated 9/19/24 at 9:45 PM, revealed routine Foley catheter change. Removed 18 FR/10 mL catheter. Inserted new 18 FR/10 mL Foley catheter per sterile technique with immediate return of light amber urine. Res (resident) tolerated procedure well. The Nutrition/Dietary Note dated 10/19/24 at 6:46 PM, revealed Meal/Fluid Intake Fair or Poor or Refused for 2 or more meals in the day-Staff continue to encourage and assist as needed at meals. Snacks in room at times. Provide set-up assist with meals. The Health Status Note dated 10/19/24 at 10:00 PM, revealed Routine catheter change due. Removed 18 FR 10 mL catheter with large amount of sediment around catheter when removed. Inserted new 18 FR 10 mL catheter with immediate return of bloody urine. Res tolerated procedure well. The Health Status Note dated 10/20/24 at 5:10	F 690		

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AM, revealed continued to have hematuria. No c/o (complaints) pain or discomfort. Fluids offered and encouraged throughout night.

The Nutrition/Dietary Note dated 10/20/24 at 6:34 PM, revealed Meal/Fluid Intake Fair or Poor or Refused for 2 or more meals in the day-Staff continue to encourage and assist as needed at meals. Snacks in room at times. Provide set-up assist with meals.

The Health Status Note dated 10/20/24 at 7:35 PM, revealed T (temperature) 99.9, P (pulse) 100, R (respirations) 18, SPO2 (oxygen saturation) 95% room air, BP 121/75. Continues to have hematuria. Fluids offered and encouraged. No c/o pain or discomfort. Catheter flushes freely with Sodium chloride as ordered.

The Encounter Note dated 10/21/24 at 00:00 revealed visit type: acute/follow-up
Chief Complaint / Nature of Presenting Problem:
Gross hematuria
History Of Present Illness:
73 year old Caucasian male seen this day at [facility name redacted]. Patient awaiting shower at time of assessment. Staff report to this provider that catheter change was performed. Noted sediment around catheter removed. Inserted 18 Fr 10 mL with ease that patient tolerated well per [name redacted] electronic medical record. Noted gross hematuria on 10/20. Patient afebrile, asymptomatic. Denies pain or discomfort. Staff report catheter flushes with ease and patency. On call notified over the weekend of gross hematuria. Ordered UA with reflex to C&S. Staff utilized infectious disease processes protocol and did not obtain related to afebrile status and history of catheter change at time of

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F 690	Continued From page 5 onset. Poor appetite noted with refusal of more than one meal in one day and rejection of alternatives. GU: 18 French 10 cc Foley catheter present with gross hematuria ~50 cc. Plan: Gross hematuria: Initial evaluation. Large amount of bright red blood noted to cath bag. No clots noted. Suspected urethral trauma related to routine catheter changes. Continue to monitor. Benign prostatic hyperplasia with lower urinary tract symptoms, symptom details unspecified: Contributing to the above. Continue tamsulosin 0.4 mg daily. Continue finasteride 5 mg daily. Poor appetite: Encouraged oral intake as tolerated. Monitor hydration status. Continue weekly weights and report any changes as indicated. Offer alternatives as indicated at meals based on availability. Adult failure to thrive: Contributing to the above. May hinder infectious disease processes. Weight stable at this time. Continue current dietary recommendations. The Health Status Note dated 10/21/24 at 8:00 PM, revealed T 99.0, P 80, R 16, SPO2 96% room air, BP 110/64. Continues to have hematuria. Fluids offered and encouraged. No c/o pain or discomfort. Catheter flushes freely with Sodium chloride as ordered. The Nutrition/Dietary Note dated 10/22/24 at 6:30 PM, revealed Meal/Fluid Intake Fair or Poor or Refused for 2 or more meals in the day-Staff continue to encourage and assist as needed at meals. Snacks in room at times. Provide set-up assist with meals.	F 690		

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The Health Status Note dated 10/22/24 at 8:30 PM, revealed T 98.6, P 110, R 18, BP 146/65, SPO2 95% on room air. Offered and encouraged fluids. Resident resting with no c/o pain or discomfort. Continues to have hematuria.

The Encounter Note dated 10/23/24 at 00:00 PM, revealed visit type: acute/follow up
Chief Complaint / Nature of Presenting Problem:
Arterial wounds, gross hematuria
History Of Present Illness:
73-year-old Caucasian male seen this day at [name of facility redacted]. Patient awaiting breakfast at time of assessment. Staff report to this provider that hematuria continues. At time of assessment bright red blood present to catheter bag with no improvement compared to Monday. Arterial wounds to third and fourth right toes have been stable for some time with Betadine to affected areas. Affected areas fluctuate from week to week. No gauze treatment noted at time of assessment. Patient denies pain or discomfort. Patient denies chest pain dizziness shortness of breath. Patient denies GI upset such as nausea or vomiting. Appetite per patient baseline per [name redacted] documentation.
GU: 18 French 10 cc Foley catheter present with gross hematuria ~100 cc.
Plan: Gross hematuria:
Gross hematuria continues with no improvement compared to Monday. Large amount of bright red blood noted to catheter bag. No clots noted. Suspected urethral trauma related to routine catheter changes. CBC and CMP at next routine lab day.
Benign prostatic hyperplasia with lower urinary tract symptoms, symptom details unspecified:
Contributing to the above. Continue tamsulosin

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0.4 mg daily. Continue finasteride 5 mg daily.
Long-term use of aspirin therapy:
Contributing to the above. Neuro improvement in hematuria. Discontinue aspirin 81 mg.
Adult failure to thrive:
Contribute to the above. Hinders infectious disease processes. Weight stable at time of assessment. Continue current dietary recommendations. Contributing to the above. May hinder infectious disease processes. Weight stable at this time. Continue current dietary recommendations.

The Health Status Note dated 10/23/24 at 10:26 AM, revealed [name redacted] medical provider in for rounds with new orders for CBC (complete blood count) and CMP (comprehensive metabolic panel) r/t (related to) hematuria and to D/C Aspirin r/t hematuria. Resident aware of orders.

The Health Status Note dated 10/23/24 at 3:24 PM, revealed CBC and CMP results sent to [name redacted]. Infection screen assessment completed and triggered for suspected UTI. BP 135/77, HR 118. Resident reports suprapubic pain/tenderness. [name redacted] Medical provider notified of lab results and infection screen assessment. Pending response for any new orders.

The Health Status Note dated 10/23/24 at 3:24 PM, revealed new orders from [name redacted] (medical provider) for a UA (urinalysis) reflex to culture. Resident aware of orders.

The Health Status Note dated 10/23/24 at 5:27 PM, revealed decrease in appetite and fluid intake, gross hematuria with decreased output, pale in color, elevated pulse rate [name redacted]

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medical provider 10/23/2024 3:00 PM [name redacted] emergency contact 10/23/2024 6:35 PM

The Health Status Note dated 10/23/24 at 5:42 PM, revealed catheter clamped to obtain urine specimen. Resident pale and drowsy.

The Health Status Note dated 10/23/24 at 6:15 PM, revealed unclamped catheter to obtain urine sample. Scant amount of bright red blood noted when sample obtained. Resident states he would like to go to the hospital and doesn't feel well. [name redacted], DON notified and began process to send resident to ER (emergency room).

The Health Status Note dated 10/23/24 at 6:30 PM, Resident requesting to go to ER, urine bright red blood with minimal output, tachycardia noted, poor appetite and fluid intake.

The Health Status Note dated 10/23/24 at 6:45 PM, EMS (Emergency Medical Services) called for transport, report called to [name redacted] nurse at [name redacted] (local hospital) ER, [name redacted] (emergency contact) notified and [name redacted] provider called.

The POC (Plan of Care) Response History for Catheter Output revealed the following urinary outputs:
a. 10/18/24: 5:55 AM- 400 ml (milliliters); 11:44 AM- 500 ml; 9:59 PM- 350 ml
b. 10/19/24: 5:59 AM- 325 ml; 12:58 PM; 650 ml; 8:56 PM- 850 ml
c. 10/20/24: 5:45 AM- 150 ml; 9:59 PM- 100 ml
d. 10/21/24: 5:28 AM- 50 ml; 1:36 PM- 300 ml; 9:27 PM- not applicable

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F 690	Continued From page 9 e. 10/22/24: 5:37 AM- 250 ml; 1:43 PM- 575 ml; 9:41 PM- 650 ml f. 10/23/24: 5:18 AM- 800 ml; 1:33 PM- 700 ml The Change of Condition Evaluation V4.2 dated 10/23/24 at 5:27 PM revealed the following: a. situation: change in condition, symptoms or signs I am calling about are 1. abnormal vital signs (low/high BP (blood pressure), heart rate, respiratory rate, weight change) 2. bleeding (other than GI (gastrointestinal)) 3. food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts) 4. functional decline (worsening function and/or mobility 5. started on 10/20/24 at night b. background general information: 1. resident long term in the facility 2. additional pertinent diagnoses: chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), diabetes 3. additional information as required: recent catheter change 10/19/24 4. specify other directives: indwelling catheter c. background (evaluation) 1. most recent vitals: BP (blood pressure) 135/77 on 10/23/24 at 3:20 PM lying left arm; pulse 118 beats per minute (BPM) on 10/23/24 at 3:20 PM; apical heart rate: 123 bpm; respirations 16 breaths/minute on 10/23/24 at 5:29 PM; temperature 97.9 Fahrenheit on 10/23/24 at 3:20 PM; most recent O2 (oxygen) saturation 98% on 10/3/24 at 5:43 PM 2. functional status change: general weakness 3. describe the change in weakness: general weakness without fever, change in level of consciousness, or other acute symptoms	F 690		

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F 690	Continued From page 10 4. describe the functional status signs or symptoms: non appetite, sleeping more 5. describe cardiovascular changes: resting pulse >100 or <50; tachycardia 6. describe abdominal/GI changes: decreased appetite/fluid intake 7. describe decreased appetite: significant decline in food and fluid intake in resident with marginal hydration and nutritional status 8. describe genitourinary changes: decreased urine output blood in urine 9. describe decreased output: decreased urinary output over 1-2 days, or new onset of post-void residual > 400 cc 10. describe hematuria: gross hematuria with pain, fever or other signs of bleeding at other sites 11. Laboratory tests/diagnostic procedures: abnormal results: chemistry 12. other chemistry values: creatinine, BUN (blood urea nitrogen), and GFR (glomerular filtration rate) dated 10/23/24 13. since the change of condition occurred have the symptoms or signs gotten: worse summarize observations and evaluation: decreased in appetite and fluid intake, gross hematuria with decreased output, pale in color, elevated pulse rate d. review and notify 1. reviewed and acknowledged the notifications: yes 2. reported to primary care clinician [name redacted] 3. date and time of clinician notification: 10/23/24 at 3:00 PM 4. recommendation of primary condition: UA with reflux 5. testing: urinalysis or culture	F 690		

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F 690	Continued From page 11 The eInteract Transfer Form V4.1 dated 10/23/24 at 6:36 PM revealed the following: a. transfer/discharge details 1. sent to [name redacted] local hospital on 9/29/23 at 9:34 PM for abnormal kidney function for unplanned transfer b. conditions of return: nursing home would be able to accept resident back under the following conditions: 2. ED (emergency department) determines diagnoses, treatment can be done in nursing home c. devices and treatments: bladder (Foley) catheter- chronic d. additional relevant information: routine catheter change on 10/19/24, has had bloody urine since 10/20/24 that has progressively gotten worse. Increased heart rate, not eating or drinking, change in pallor, decline in kidney labs. The ED (Emergency Department) Physician Note dated 10/23/24 at 7:32 PM from [name redacted] local hospital revealed the following: a. Chief Complaint: 1. Patient arrives via EMS from [name redacted], complaints of bloody urine draining from Foley, complains of abdominal pain, EMS gave 50 mcg (micrograms) of Fentanyl in route and 4 mg of Zofran, Hx (history) of stroke b. history of present illness: 1. 73-year-old male brought from the nursing home with increasing abdominal pain over the past 4 days. Today he is having dark red bloody urine in his catheter. Patient is paraplegic due to stroke. c. Review of symptoms: 1. constitutional: denies fever, chills, or recent illness 2. Respiratory: Increased shortness of breath	F 690		

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today no cough.
3. Cardiovascular: No chest pain, no palpitations.
4. Abdominal: Abdominal pain without nausea or vomiting.
d. Physical exam:
1. vitals and measurements: T: 36.4 °C (Temporal Artery) HR: 79 (Monitored) RR: 10 BP: 94/59 SpO2: 100% HT (height): 170 cm WT (weight): 56.30 kg (Dosing) BMI (body mass index): 19.00 kg/m2 BSA (body surface area): 1.650 m2
e. General: Alert, no acute distress.
f. ENT (ear, nose, throat): Oral mucosa moist, no LAD
g. Cardiovascular: Regular rate and rhythm, Normal peripheral perfusion.
h. Respiratory: Lungs are clear to auscultation, respirations are non-labored.
i. Gastrointestinal: Abdomen distended, mildly firm, bowel sounds normal.
j. Extremities: Contractions of bilateral lower extremities. No evidence of trauma
k. Neurological: Soft but normal speech. Upper extremities show no motor or sensory
l. deficits. Lower extremities are contracted but sensory is intact.
m. Medical Decision Making
1. 73-year-old male presents with abdominal pain and frankly bloody urine. Differential diagnosis includes but is not limited to renal carcinoma, bladder carcinoma, intestinal-Bladder fistula, kidney stones, bladder stones, UTI, etc.
2. Review of laboratory work CBC (complete blood count) shows normal white count 9.4 H&H (hematocrit & hemoglobin) 10.5 and 31 platelets normal at 1.3. There is left shift of 84% neutrophils. Metabolic panel shows a slightly low sodium of 134 normal potassium at 4.1 CO2 is

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decreased at 17.5. There is an anion gap of 17.6 glucose of 223 BUN and creatinine elevated at 90 and 3.24, Most recent comparison 2 months ago shows BUN of 46 and creatinine of 1.95. Calcium slightly low at 8.2, albumin low at 2.3. Lipase normal at 48, lactic acid normal at 1.1. Urinalysis is red and cloudy with 250 glucose large amount of bilirubin 1+ ketones 3+ blood positive nitrites and large amount of leukocyte esterase, microscopic shows greater than 50 white blood cells greater than 50 red blood cells and 3+ bacteria.

n. Review of radiology dated 10/23/2024 8:40 PM CT (Computed Tomography) Abdomen Pelvis WO (without) Contrast) with the following impression:

1. massively distended urinary bladder with air within the bladder lumen and extensive emphysematous changes to the wall of the bladder highly suspicious for emphysematous cystitis. Urology consultation is recommended.
2. Foley catheter has its balloon inflated in the urethra. recommend immediate removal and urology consultation.
3. right lower lobe pneumonia
4. other findings discussed

o. The previous urinary catheter was removed and we were able to get a 16 French coudé in and patient did quickly empty 1500 mL of dark bloody.

p. We do not have urology on-call in our system and for the next 4 days. I (Provider) called (tertiary hospital, name redacted) and they do not have any bed availability.

q. After the bladder was completely drained patient's blood pressure did drop down to a MAP (mean arterial pressure) between 60 and 65. Patient was given 2 L (liters) normal saline IV (intravenous) and his MAP

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F 690	Continued From page 14 stayed above 70. r. We contacted [hospital name redacted] and I (provider) spoke with [doctor's name redacted] in urology. He felt that the patient would simply need to be treated as a severe UTI and did not need any specialty care. I (provider) spoke with [doctor's name redacted] Super (supervisor) triage and they do not have any beds available. With [doctor's name redacted] stating that the patient does not need specialty care, I (provider) talked with our Hospitalist here tonight [name redacted] and she agrees to accept the patient for admission at this facility. There was a slight delay in the patient getting over to the MedSurg unit as a nurse needed to be called in. Patient remained stable with heart rate of 75 blood pressure of 99/58 with a MAP of 72, O2 sats (saturation) of 100% on room air with a respiratory rate of 13-15. s. Assessment/Plan: 1. Emphysematous cystitis 2. AKI (acute kidney injury) 3. Right lower lobe pneumonia The Chemistry Report from the [name redacted] local hospital revealed the following lab results collected on 10/23/24 at 7:40 PM and resulted on 10/23/24 at 8:12 PM: a. BUN- 90 mg/dl (milligrams per deciliter) with reference range of (7-18) b. Creatinine Level- 3.24 mg/dl with reference range of (0.70-1.30) c. BUN/Creatinine ratio- 27.8 with a reference range of (9.0-21.6) The Urinalysis Report from the [name redacted] local hospital revealed the following results collected on 10/23/24 at 8:16 PM and resulted on 10/23/24 at 8:51 PM a. UA color: red with reference range of (yellow)	F 690		

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F 690	Continued From page 15 b. urine clarity: cloudy with a reference range of (clear) c. urine pH: 8.0 with reference range of (5.0-8.0) d. specific gravity: 1.010 with reference range (1.001-1.030) e. glucose: 250 mg/dl with reference range (negative) f. bilirubin: large with reference range (negative) g. ketones: 1+ with a reference range (negative) h. urine HGB (hemoglobin): 3+ with a reference range (negative) i. urine protein >=300 mg/dl with a reference range (negative) j. nitrite: positive with a reference range (negative) k. leuk esterase: large with a reference range of (negative) l. Urine WBC (white blood cells) >50 with reference range (0-2) m. bacteria: 3+ with a reference range of (none) n. urine culture indicated? yes The CT Report from [name redacted] local hospital dated 10/23/24 at 8:40 PM revealed a. reason for exam: (CT Abdomen without contrast) abdominal pain, hematuria, abdominal distention b. Report: history: abdominal pain, hematuria, abdominal distention c. Findings: There is consolidation in the right lung base with air bronchograms compatible with right lower lobe pneumonia. There are intrarenal calcifications both kidneys compatible with kidney stones. This includes staghorn calculus on the right. There is mild bilateral hydronephrosis and hydroureter. There is air within the bladder wall with massively distended urinary bladder. This is highly concerning for emphysematous cystitis. Urology consultation is recommended. There is	F 690		

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air within the urinary bladder consistent with infection. There is a Foley catheter with the catheter balloon inflated within the urethra. There is artifact in the pelvis associated with right hip prosthesis. There is mild stool in the colon with moderate stool within the rectum. There are degenerative changes lumbar spine there are changes of ankylosis.
d. Impression:
1. massively distended urinary bladder with air within the bladder lumen and extensive emphysematous changes to the wall of the bladder highly suspicious for emphysematous cystitis. Urology consultation is recommended.
2. Foley catheter has its balloon inflated in the urethra. recommend immediate removal and urology consultation.
3. right lower lobe pneumonia
4. other findings discussed

The Chemistry Report from the [name redacted] local hospital revealed the following lab results collected on 10/24/24 at 5:20 AM and resulted on 10/24/24 at 6:33 AM:
a. BUN- 89 mg/dl with a reference range of (7-18)
b. Creatinine Level- 2.99 mg/dl with a reference range of (0.70-1.30)
c. BUN/Creatinine ratio- 29.8 with a reference range of (9.0-21.6)

The Bacteriology Report from the [name redacted] local hospital revealed the final report dated 10/26/24 at 7:46 AM:
a. Staphylococcus aureus isolated from both bottles
b. Enterococcus faecalis isolated from 1 bottle Beta Lactamase test is negative

The Gram Stain Report from the [name redacted]

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F 690	Continued From page 17 local hospital dated 10/24/24 at 2:06 PM revealed the following: a. gram positive Cocci in clusters Seen On Smear From Both Bottles b. Gram Positive Cocci in chains Seen on smear from anaerobic bottle The Infectious Disease Consultation dated 10/24/24 at 3:18 PM from [name redacted] local hospital revealed a. chief complaint: Pt is from [facility name redacted] and staff noticed the urine in his Foley was red so they called EMS. b. Pt (patient) arrived to the ED where they discovered that the balloon in the Foley was lodged in his urethra c. reason for consultation: bacteremia d. history of present illness: infectious disease consultation was done via telemetry from my remote office location here in [place redacted] using two-way audiovisual technology and assistance from bedside RN (Registered Nurse). Patient is located in [name of hospital and room number redacted] while I am located in my remote office here in [place redacted]. Consultation involved but not limited to chart review, history taking, physical examination, recommendation for workup as well as treatment. Treatment recommendation was communicated to the primary team. I personally examined patient using telemedicine video with assistance from bedside RN. Patient is a 73-year-old gentleman with multiple medical problems including CVA (cerebrovascular accident) with paraplegia, BPH with chronic urinary retention for which patient has chronic indwelling Foley catheter. Patient also has diabetes, osteoarthritis, hypertension	F 690		

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and hyperlipidemia. Patient was brought to the emergency room from the nursing home of his residence because of hematuria. There was blood in his urine bag and by imaging it was discovered that the Foley catheter balloon is in the urethra resulting in the bleeding. It has been replaced but patient did have significant urine retention with
massively distended urinary bladder seen on CT scan with extensive emphysematous changes to the wall of the bladder suspicious for emphysematous cystitis. Patient now has continuous bladder drainage which is quite bloody. Patient is very frail, and unable to give history and very somnolent. His blood culture is growing gram-positive cocci in clusters as well as gram-negative rod in one of the 2 blood culture bottles. Infectious disease service consulted for antimicrobial management. He has been having cough and chest imaging did show right lower lobe pneumonia
e. Assessment
1. bacteremia with gram-positive cocci in clusters indicating staphylococcal bacteremia. There is also gram-negative rod isolated in one of the blood culture bottles. We will await identification of these organisms to opine on the other sources however with patient being admitted with acute urinary retention and hematuria, urinary source is worth considering. Patient also has right lower lobe pneumonia which could be a source of bacteremia depending on which
2. Right lower lobe pneumonia
3. Acute urinary retention with hematuria due to malpositioned Foley catheter. Catheter balloon was in the urethra
f. Plan
1. Repeat blood culture x 2

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F 690	Continued From page 19 2. Obtain transthoracic echocardiogram 3. Start IV vancomycin, target trough between 15 and 20 4. Continue IV Zosyn dosed per creatinine clearance 5. Will follow-up on the ID and sensitivity of the blood culture isolate; Will de-escalate antibiotics based on culture data and clinical course; Obtain sputum culture if patient can expectorate The Discharge Summary dated 10/24/24 at 5:12 PM from [name redacted] local hospital revealed the following information a. admission date: 10/23/24 b. discharge date: 10/24/24 c. reason for hospitalization: blood in catheter d. diagnoses: discharge diagnoses: AKI (acute kidney injury); emphysematous cystitis; right lower lobe pneumonia. e. Summary of Events leading to admission: f. [name redacted] Resident #1 is a 73-year-old gentleman with past medical history of CVA with paraplegia, BPH and urinary retention with chronic indwelling Foley, hypertension, hyperlipidemia, type 2 diabetes mellitus, osteoarthritis, allergic rhinitis who presented to [name redacted] emergency room from [name redacted] nursing home when staff noticed urine in his Foley was red so they called EMS. When the patient arrived in the ED it was noted that the balloon and the Foley was lodged in his urethra and he had abdominal pain for last 4 days. Given that his Foley was noted to be in the urethra it was later removed in the ED. CBI (continuous bladder irrigation) catheter was attempted however could not be passed. Foley was replaced and 1.5 L (liters) of urine was drained with improvement of abdominal pain. Patient does also report a	F 690		

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nonproductive cough and chills but denies any nausea, vomiting, shortness of breath, chest pain, fevers, chills. Patient's wife also present at bedside and patient also reports having abdominal pain and hematuria ongoing for 4 days. However he reports after Foley was replaced in the ED no further episodes of abdominal pain.

g. Lab work on admission noted for WBC 10.3 with neutrophilic shift, hemoglobin 12.5, hematocrit 38, platelets 157, sodium 133, potassium 5.1, chloride 98, bicarb 19.8, anion gap 20.3, glucose 266, BUN 86, creatinine 3.43, calcium 9.1, total protein 6.9, albumin 2.8, total bilirubin 0.6, alkaline phosphatase 78, AST 10, ALT 20, lipase within normal limits at 48, lactic acid 1.1, UA is red and cloudy with 250 glucose large amount of bilirubin 1+ ketones 3+ blood positive nitrites and large amount of leukocyte esterase, microscopic shows greater than 50 white blood cells greater than 50 red blood cells and 3+ bacteria.

h. CT abdomen pelvis without contrast noted for impression :

1. massively distended urinary bladder with air within the bladder lumen and extensive emphysematous changes to the wall of the bladder highly suspicious for emphysematous cystitis. Urology consultation is recommended.
2. Foley catheter has its balloon inflated in the urethra. recommend immediate removal and urology consultation.
3. right lower lobe pneumonia
4. other findings discussed

i. The previous urinary catheter was removed and ED able to get a 16 French coudé in and patient did quickly empty 1500 mL of dark bloody. After the bladder was completely drained blood pressure did drop down to a MAP between 60-65

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and the patient received 2 L of NS with improvement of maps staying above 70. Given lack of urology available in [town redacted] for the next 4 days ED physician reached out to [name of hospital] Hospital in [name of town and state redacted] and they do not have any bed availability. Later ED physician spoke with [hospital and name of doctor redacted] in urology. He felt that the patient would simply need to be treated as a severe UTI and did not need any specialty care. ED physician also spoke with [name of doctor redacted] super (supervisor) triage in [hospital name redacted] and they do not have any beds available. Given urologist at [hospital name redacted] said no need of specialty care patient was admitted to [town name redacted] for further management

j. Plan:

1. Foley replaced in ED on 10/24
2. continue Zosyn inpatient
3. blood Cxes (cultures): Pending identification and sensitivities and will follow till completion
4. Gram Positive Cocci in clusters Seen On Smear From Both Bottles
5. Gram Positive Cocci in chains Seen on smear from anaerobic bottle
6. Gram Negative Bacilli Seen on smear from anaerobic bottle
7. urine cultures pending, follow till completion
8. Echocardiogram ordered for gram-positive cocci bacteremia
9. Consider transfer to facility which has urology inpatient for further evaluation to see if cystoscopy and CBI indicated
10. Also noted to have borderline low blood pressure-treated with 2 L IV fluids on admission to the ED, and also started some IV fluids inpatient and held antihypertensive medication. Will work with case management on transfer to

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F 690	Continued From page 22 tertiary care hospital given drop in hemoglobin and soft blood pressures 11. Infectious disease consult, appreciate recs (recommendations)- 12. Repeat blood culture x 2 k. Obtain transthoracic echocardiogram l. Start IV vancomycin, target trough between 15 and 20 m. Continue IV Zosyn dosed per creatinine clearance n Will follow-up on the ID and sensitivity of the blood culture isolate 1. Will de-escalate antibiotics based on culture data and clinical course 2. Obtain sputum culture if patient can expectorate 3. Hematuria o. Iron deficiency anemia secondary to acute on chronic blood loss 2/2 to above 1. CBI catheter could not be placed 2. ED reviewed case with Urology at [name redacted] prior to admission due to emphysematous cystitis noted on CT, recommend Zosyn and local admission and no need of specialty services p. Hemoglobin trend 12.5-> 10.5-> 9.3-->9.0 q. Trend H&H closely and transfuse if hemoglobin less than 7 r. Monitor hematuria clinically for resolution(unable to do CBI catheter) s. Consider transfer to facility which has urology inpatient for further evaluation to see if cystoscopy and CBI indicated t. Also noted to have borderline low blood pressure-treated with 2 L IV fluids on admission to the ED, and also started some IV fluids inpatient and held antihypertensive medication. Will work with case management on transfer to tertiary care hospital given drop in hemoglobin	F 690		

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F 690	Continued From page 23 and soft blood pressures u. Acute on chronic urinary obstruction; BPH v. on CKD (chronic kidney disease), stage III 1. pt's baseline Cr (creatinine) is around 1.9 2. Creatinine trend 3.43->3.24-> 2.99 3. Foley noted to be in urethra; removed and replaced by ED physician at [name redacted], monitor UOP (urinary output) closely 4. IV fluid hydration 5. continue finasteride and tamsulosin 6. Monitor I's and O's 7. Trend daily BMP w. Disposition: Pending clinical improvement resolution of hematuria, stabilization of hemoglobin, urinary culture and blood culture results, infectious disease evaluation recommendations.-Also noted to have borderline low blood pressure-treated with 2 L IV fluids on admission to the ED, and also started some IV fluids inpatient and held antihypertensive medication. Will work with case management on transfer to tertiary care hospital given drop in hemoglobin and soft blood pressures. Case management working on transferring patient to [name of hospital and city redacted] which has inpatient urology once beds are available. No urologist available in [city redacted] for at least 4 days. x. Discharge Plan: Patient is discharged on stable condition. . I also discussed the care plan with Hospitalist and urologist at [name of hospital, city, and state redacted]. Total time spent at the time of discharge 35 minutes, >50% of time spent in counseling about diagnosis, discussing plan, filling out discharge instruction sheets, doing medication reconciliation and coordination of care. During an interview on 10/28/24 at 1:55 PM, Staff	F 690		

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A, CNA (Certified Nurse Aide) queried if she took care of Resident #1 last week and she stated she told the nurse last Monday (10/21/24) about the blood in the catheter bag. Staff A stated she thought Resident #1 looked like it was starting to swell and she was told it was because he had trauma with the catheter change. Staff A stated the penis started to get better on Tuesday. Staff A stated the nurse did a catheter change on Sunday and when she seen it didn't look good, she asked the nurse about it. Staff A stated Resident #1 seemed irritated and she thought the catheter was hurting him. Staff A stated the nurse flushed his catheter and as the nurses kept flushing the catheter, the blood got better, but the urine didn't completely go clear. Staff A stated she didn't remember the output of his urine and couldn't remember if the output was low.

During an interview on 10/28/24 at 3:07 PM, Staff B, CNA queried if he ever took care of Resident #1 catheter last week and he stated yes. Staff B stated Resident #1 had a catheter change and had a lot of blood coming out of it for a day or two. Staff B stated he did the normal catheter cares and as he went through them, he noticed blood and told the resident he would be right back and told the nurse and the nurse said she already let the NP (Nurse Practitioner) know. Staff B stated this was the only time he noticed blood in his urine bag and the resident's urine in his tubing was orange tinted.

During an interview on 10/28/24 at 3:17 PM, Staff C, CNA stated she took care of Resident #1 last week when she worked the 2-10 shift and she was told he had a catheter change during the day and had blood come out and when she checked on him around 9:00-9:15 PM, she noticed blood

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and let the nurse know the resident had blood coming out. Staff C stated the urine looked like a mixture of red and pink, with more red in it.

During an interview on 10/28/24 at 4:26 PM, Staff D, LPN (Licensed Practical Nurse) queried about Resident #1 catheter change and she stated it was a routine catheter change. She stated she used an 18 French and when she pulled out the old one, it had a lot of sediment on it and pulled out with difficulty. Staff D stated he had blood in the urine with urine return and so she pushed fluids on him. Staff D stated the resident had bled before with other catheter changes. Staff D stated once she had urine return, she inflated the balloon. Staff D stated she went up until she got resistance. Staff D asked how far she pushed the catheter tubing in and she stated she didn't go up to the fluid insertion port. Staff D asked if Resident #1 usually bled after the catheter change and she stated no, not typically as long he did but the NP saw him the next day and the bleeding was still there. Staff D stated she didn't know what the NP said because she wasn't there when the NP seen him. Staff D stated he got in report the NP thought everything was fine. Staff D queried if she tried to deflate the balloon or reposition the catheter and she stated no, and she didn't know if anyone else did or not. Staff D stated a day or two after the catheter change Resident #1 had pain, but she thought it was the same time as his COVID vaccine. Staff D asked if she was concerned about his bloody urine and she stated yes, so she pushed extra fluids and the blood was clearing. Staff D asked if she was concerned about the positioning of the catheter and she stated Resident #1 had urine output so she figured it went in far enough and she guessed it was possible she didn't go up far

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enough, but they don't have an x-ray to check and the resident had urine return. Staff D stated she checked his vitals and they were normal. Staff D asked if she ever notified the NP of the blood urine and she stated no, she told the day shift nurse to have the NP see him on rounds. Staff D stated she never contacted the NP because she continued to push fluids and do his vitals and the urine started to clear.

During an interview on 10/28/24 at 4:38 PM, Staff E, LPN queried on how she performed a catheter change on a male and she stated she pushed the catheter in until she got urine return and then pushed the catheter in a little further, inflated the balloon and then pulled back a little to make sure the catheter secure. Staff E asked what she did when she had blood in the urine upon return and she stated she passed it on to the on coming nurse and called the provider. Staff E asked if she would check for placement after seeing blood for a day or two and she stated she thought that would be too long, she would check the placement right away, especially if they were bleeding.

During an interview on 10/29/24 at 8:40 AM, the ADON (Assistant Director of Nursing) stated she got an order from the NP for a UA (urinalysis) because his catheter was pretty bloody with a decent amount of urine. I clamped the tubing for about a half an hour and then went back and Resident #1 only had a small amount maybe 5 ml of urine and it was bloody. The ADON asked him how he felt and he said his belly hurt a little and asked if he wanted to go to the hospital and he said yes, so the DON (Director of Nursing) got him ready to go. The ADON stated she saw documentation from the hospital the catheter

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moved down into the urethra and she wondered what happened. The ADON stated the resident watched adult movies and would pleasure himself regularly. The ADON queried if she reviewed his urine output and she stated she didn't and she didn't know if anyone tried to adjust it because if it was trauma. The ADON stated the NP saw him a few times last week. The ADON stated she didn't notice a lot of difference in the catheter placement and it looked like 4 to 6 inches of the catheter tubing was out of the penis. She stated she didn't know the catheter was misplaced until she read the note. The ADON queried if she ever seen anything like this with Resident #1 and she stated no, she seen blood with him before but nothing like the amount he had this time.

During an interview on 10/29/24 at 9:42 AM, Staff F, LPN queried on Resident #1 catheter last week and she stated he had blood in his catheter and the NP saw him on Monday. Staff F stated he had a catheter change and that was when the bleeding started when another nurse changed it. Staff F stated the more they gave him to drink, the less issues he had and the urine got clearer and it flushed easily. Staff F asked if anyone reported low urinary outputs to her and she stated no. Staff F asked if she ever assessed the catheter and she stated yes and took his temperature and when she flushed it, the resident didn't state any pain. Staff F asked if she checked placement and she stated no, she was afraid to cause more damage so we did not reinsert it. Staff F stated she never had blood when she did a catheter change on Resident #1. Staff F stated she thought maybe she should of checked the placement but didn't want to cause more trauma.

During an interview on 10/29/24 at 10:19 AM, the

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NP queried about Resident #1 catheter and the blood urine and she stated he had gross hematuria and she read the 24 hour report and seen they called the on call and they ordered a UA with c/s (culture and sensitivity) and it didn't get done so they were going to do one and then the resident went tachycardic and they called the on call and sent him out. The NP stated she didn't check placement but saw gross hematuria in the tubing. The NP stated she saw 50 to 100 ml in the catheter bag but she saw resident early in the morning and thought they just changed the catheter bag. The NP stated she didn't look at the outputs for him and no one reported the urinary outputs to her. The NP confirmed low outputs would be concerning.

During an interview on 10/29/24 at 10:48 PM, the MDS Coordinator stated she briefly took care of Resident #1 last week and the resident had a catheter change and bleeding with it. She stated she saw blood in Resident #1 catheter and flushed it without difficulty. The MDS Coordinator stated she informed the nurse and the CNA of the blood and instructed them follow up if the resident didn't continue to have urinary output or other changes. The MDS Coordinator asked about placement and she stated she didn't see anything abnormal and didn't have any indication for it being misplaced because no complaints with the flush and it flushed without difficulty. The MDS Coordinator stated she saw the resident early when she did his flush and he didn't have much in the catheter bag but didn't think it was abnormal because it was early in the morning.

During an interview on 10/29/24 at 11:44, the Infection Preventionist (IP) stated she only knew Resident #1 had blood in his urine. She stated the

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NP came in and gave her orders on Wednesday and all she knew was Resident #1 had a catheter change and hematuria afterwards. The IP stated she flushed the catheter without resistance or difficulty. The IP stated no one reported to her, the resident didn't have a lot of urinary output, because he was having output.

During an interview on 10/29/24 at 2:43 PM, Staff G, CNA stated when she came in last week, the nurses knew Resident #1 had blood in his catheter. Staff G stated she reported off colors of the urine, odors, or anything unusual if it had not already been reported to the nurse. Staff G stated Resident #1 didn't urinate much and she told the CNA. Staff G stated the nurses already knew about it and they changed the catheter that day.

During an interview on 10/30/24 at 8:41 PM, the NP queried on her thoughts of the urinary output for 10/20 and 10/21 and she stated the outputs were concerning. The NP stated her concerns were they told her they changed the catheter on the 19th and notified the on call and got an order for the UA with c/s and then told me on Monday they didn't do it because he didn't meet the criteria and then they didn't notify me or the on call provider they didn't do it. The NP stated they were supposed to do the UA and note he was in the hospital. The NP stated the outputs were concerning especially with the recent catheter change and hematuria. She stated when she assessed Resident #1 the blood looked bright red, but she wanted to monitor it since it was new. She stated she checked his urine again on Wednesday when she saw him for his wounds and ordered labs for the possibility of kidney stones. The NP stated she didn't realize he didn't have output because she saw her residents early

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in the morning and figured the CNA already did the catheter cares. The NP stated if they would have notified her of the urinary output she would have reviewed the flush, ordered a 24 hour report on the input and output. The NP stated a whole shift with no output was concerning, and she stated she reviewed with a colleague the gross hematuria and then discontinued the aspirin because she just started him on it and thought that might be the cause of it.

During an interview on 10/30/24 at 9:55 AM, Staff F, LPN stated on Monday she did an assessment for whether they needed to do a urinalysis and he didn't meet the criteria. Staff F stated on Tuesday he looked so much better. Staff F stated the resident watched adult movies and would pleasure himself. Staff F stated by Tuesday the urine looked light and flushed easily. Staff F stated no one told her about his output being low and she didn't look in the catheter bag. Staff F stated if it had been her who placed the catheter she might have inserted a new catheter. Staff F stated the outputs of 50 would especially be concerning. Staff F stated the output of 250 for the whole day would be concerning. Staff F stated she was more concerned with the blood in his urine and it lessened with the pushing of fluids. Staff F stated she never had issues with Resident #1 catheter and if she inserted it, she would have went a different route and reached out and asked if she could redo the catheter. Staff F stated she didn't get any reports on low outputs, just the bloody outputs of urine. Staff F asked how she knew the catheter placed correctly and she stated she went to the hub and when urine returns, you know the placement is correct. Staff F stated you go a bit further and set the balloon and pull down a little.

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F 690	Continued From page 31 During an interview on 10/30/24 at 11:42 AM, the DON queried about Resident #1 and she stated she knew he had a catheter change on the 18th or 19th and had blood tinged urine the day they sent him out because the ADON did a sample for a UA and it was bright red and only had maybe 10 ml after she clamped the tubing for 30 minutes. The DON reviewed the outputs and asked if any were concerning and she stated yes. The DON queried what would be the next step and she stated the provider would be notified and she saw him on Monday and Wednesday. The DON asked if any other interventions would be done and she stated notify the provider, check placement, and made sure it flushed okay. The DON stated she wanted to know if it was actually inflated in the urethra or the the balloon displaced when it was pulled on because Resident #1 watched adult movies and pleasured himself. The DON asked if he ever had issues like this before with his catheter and she stated no, not that she knew of. The DON asked if he could have displaced it shortly after the catheter change and she stated she couldn't say because he watched the movies every day. The DON asked her thoughts on the situation and she stated they should have probably checked the placement of the catheter, but it was flushing so you don't usually go to that and in the past he had blood tinged urine with catheter changes. The DON asked if he normally had the blood tinged urine for that long and she stated no, not this bad in the past. During an interview on 10/30/24 at 11:57 AM, the ADON queried if she was ever told of Resident #1 low urinary output and she stated no, she wasn't. The ADON reviewed Resident #1 output and	F 690		

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stated she thought the resident had a PRN (as needed) order for a Foley catheter change. The ADON stated she would have flushed the catheter if she knew the output low and make sure the catheter patent and there was no issues with the catheter, then she would palpate the abdomen to make sure it wasn't distended, changed the catheter, and done an assessment. The ADON asked if any of the outputs looked concerning and she stated the big ones would be between 10/20 and 10/21. The ADON stated when she got report, the MDS Coordinator stated the catheter flushed fine and there was a little bit of blood in it that morning. The ADON stated between her communication and the MDS Coordinator and the IP nurse, the catheter flushed without resistance and the IP didn't seem overly concerned after she checked on Resident #1. The ADON stated when she saw Resident #1 on the 23rd, it was definitely different and that was when she asked the resident if he wanted to go the hospital and he said yes, and said his abdomen felt achy, but he wasn't acting obnoxiously different. The ADON stated she didn't know if anyone tried to adjust his catheter, but it wasn't in the documentation and she didn't know if he adjusted by accident. The ADON asked if the resident ever adjusted his catheter before and she stated not, that she was aware of.

Received email from the DON on 10/30/24 at 12:10 PM, that revealed the facility did not have policies for catheters outputs, insertions, or removals.

During an interview on 10/30/24 at 12:24 PM, Administrator confirmed they did not have any policies for urinary catheters. She stated the DON conducted competencies on catheters with the

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F 690	Continued From page 33 staff. The Administrator asked the kind of competencies for example catheter insertions and outputs and she stated she assumed so, but needed to ask the DON to confirm.	F 690		

Birkwood Village of Fort Madison

1702 41st St.

Fort Madison, Ia. 52627

Date survey completed: 10/30/24

Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

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In response to the findings outlined in the 2567 report, Birkwood Village of Fort Madison is committed to ensuring compliance with all regulatory requirements and providing the highest standard of care for our patients. The following plan of correction has been developed to address the identified deficiency:

Action Taken: All Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) will receive education on proper male catheterization techniques and post-catheterization documentation and monitoring. This education will include the importance of assessing urinary output, identifying any complications (such as blood in the urine), and the appropriate steps for reporting findings to the provider.

Director of Nursing or designated representative will audit monthly catheter changes x3 then quarterly x3.

Identified concerns shall be reviewed by the facility's QAPI team. Recommendations for further corrective action will be discussed and implemented as needed.

Completion Date: Staff education will be completed prior to the start of the next shift, effective November 12, 2024

Staff education was completed November 22, 2024.