STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0018831	A. BUILDING: _____ B. WING _____	C 11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE POINTE ASSISTED LIVING AND MEMORY CA	286 N WILLSON DR ALTOONA, WI 54720

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 11/02/2023, Surveyor conducted a complaint investigation at Prairie Pointe Assisted Living and Memory Care. Data collection continued through 11/30/2023. The complaint was substantiated. One deficiency was identified. Census: 36	N 000		
N 439	83.39(1) Infection control program. The licensee shall establish and follow an infection control program based on current standards of practice to prevent the development and transmission of communicable disease and infection. This Rule is not met as evidenced by: Based on observation, record review and interview, the provider did not follow an infection control program based on current standards of practice to prevent the development of urinary tract infections (UTI) associated with catheter use for Resident 1 who received daily urinary catheter assistance. Findings include: The provider is licensed to care for 50 adults from the client groups terminally ill, irreversible dementia/Alzheimer's disease and advanced aged. The facility is licensed as a class CNA (non-ambulatory). On 09/07/2023, the department received a	N 439		

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

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N 439	Continued From page 1	N 439		

complaint alleging resident's urinary catheter bags were not being cleaned and managed appropriately.

"Proper Techniques for Urinary Catheter Insertion Perform hand hygiene immediately before and after insertion or any manipulation of the catheter device or site. Ensure that only properly trained persons (e.g. hospital personnel, family members, or patients themselves) who know the correct technique of aseptic catheter insertion and maintenance are given the responsibility ..." (Source: The Centers for Disease Control and Prevention Website, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, Healthcare Infection Control Practices Advisory Committee, Updated June 6, 2019, https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines-H.pdf (retrieval date 11/08/2021).)

On 11/02/2023 at 9:47 AM, Surveyor interviewed Resident 3. Resident 3 stated staff change out his/her urinary catheter bags every morning and before bed. Surveyor observed in Resident 3's bathroom, an overnight catheter bag hanging from the shower grab bar with approximately 35 ml of yellow liquid inside. Surveyor also observed a catheter leg bag on the shower chair with what appeared to be dried urine inside it. Surveyor asked Resident 3 when his/her urinary catheter bag was changed this morning and s/he stated at 7:20 AM.

At approximately 10:15 AM, Surveyor interviewed Resident 1. Resident 1 stated staff do not know how to clean his/her catheter bags. Resident 1 stated s/he previously had to do it him/herself. S/he had quit requesting staff change his/her urinary catheter bag due to staff not knowing how

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to clean them properly. Resident 1 stated s/he wore overnight urinary catheter bags all of the time and the catheter was changed monthly at the clinic. Resident 1 stated s/he had a urinary tract infection (UTI) last weekend.

At 10:39 AM, Surveyor interviewed Caregiver F. Caregiver F stated there were 4 residents with urinary catheters. Caregiver F stated urinary catheter care training consisted of a checklist and another staff demonstrating how to do cares. Caregiver F stated some staff would leave the catheter bags to soak with the vinegar solution and others did not. Caregiver F stated the checklist did not specify which to do.

At 12:22 PM, Surveyor interviewed Resident 4. Resident 4 stated s/he had a UTI over a week ago. Resident 4 stated his/her urinary catheter was plugged for a few hours today and Registered Nurse (RN) A replaced his/her urinary catheter this morning.

At 12:37 PM, Surveyor observed in Resident 3's bathroom that the two urinary catheter bags had been removed.

At approximately 1:10 PM, Surveyor interviewed Caregiver E. Caregiver E stated s/he had observed Resident 1's urinary catheter bags to be dirty in the past. S/he stated second shift staff were not routinely cleaning urinary catheter bags. Caregiver E stated s/he would let the vinegar solution soak in the urinary catheter bags for 1 hour before rinsing them out.

At approximately 3:10 PM, Surveyor reviewed Resident 1's records. Resident 1 was admitted to the facility on 12/03/2022 with diagnoses of neuromuscular dysfunction of the bladder, long

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term (current) use of anticoagulants and quadriplegia.

The Individual Service Plan (ISP), dated 11/01/2023, included an area of assessment titled "Nursing Procedures." In the "Interventions and Strategies" section of the nursing procedures, dated 11/1/2023, the record stated Resident 1 had a suprapubic catheter that was changed by urology at a monthly frequency. In the "Interventions and Strategies" section of the nursing procedures, dated 11/1/2023, the record stated Resident 1 received assistance with catheter care 3 times daily and as needed by staff. The "Measurable Goal" included, "Resident 1's needs will be met within CBRF (community based residential facility) regulations. This is an ongoing goal that will be reviewed annually and PRN (as needed)." The ISP did not identify interventions to prevent infection or manage Resident 1's catheter care. The ISP did not include reference to or details of a catheter care protocol.

Resident 1's ISP read, in part: "Toileting A1 [Assist of 1 staff]. Resident's desired outcome: Resident 1 would like hygiene needs to be met at all times. Staff will provide verbal cues and assistance to complete ADL (activities of daily living) tasks as needed while encouraging Resident 1 to be as independent as possible." The ISP did not contain information on or reference catheter care in this area. The ISP did not identify interventions to prevent infection or manage Resident 1's catheter bag. The ISP did not include reference to or details of a catheter care protocol.

Surveyor reviewed staff progress notes on Resident 1 from 06/01/2023 - 11/02/2023 and

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N 439	Continued From page 4 found the following: 07/26/2023 - "Renacidin Solution. Use 30 ml via irritation one time a day for Suprapubic catheter related to NEUROMUSCULAR DYSFUNCTION OF BLADDER, UNSPECIFIED (N31.9) Clamp Catheter for 30-60 min then Drain." 09/23/2023 - "Fax is received from (doctor's name) from Urology with orders received for Renacidin to be used nightly to irrigate catheter." 10/30/2023 - "Call is received from staff that resident is voicing c/o (complaints of) back pain, and [s/he] is noted to have an increased temp of 100.9. [S/he] had made a request that staff update MD day prior as [s/he] feels [s/he] may getting a UTI ...[s/he] is requesting to go out and be seen EMS to be called." 10/31/2023 - "Writer does pull lab results and it is noted that [s/he] does have e-coli present to [his/her] blood cultures. [S/he] is currently receiving Cefdinir for UTI with same noted bacteria ...Resident returns from ER with diagnosis of UTI." At 2:31 PM, Surveyor interviewed RN A. RN A stated staff were to change Resident 1's urinary catheter bag every morning and before bed. RN A stated that due to Resident 1's motorized wheelchair being broken, Resident 1 decided not to only use the overnight urinary catheter bag and not change to a leg bag during the day. RN A stated staff were to rinse the urinary catheter bags with the vinegar solution and let soak for a couple minutes before rinsing. Surveyor asked about staff training with urinary catheter cares. RN A stated staff were trained by another staff and did quarterly online trainings. Surveyor asked	N 439		

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N 439	Continued From page 5 what if the staff training new staff on urinary catheter cares was not teaching the appropriate protocol. RN A stated s/he would intervene in that situation. On 11/09/2023 at 1:15 PM, Surveyor obtained additional documentation from Chief Operating Officer (COO) B via email. When asked how daily catheter care was charted, COO B stated, "This was done as part of [his/her] routine personal cares. This is not something that is charted on an ongoing basis." Surveyor reviewed a document titled "Catheter Training" that demonstrated steps to complete cleaning drainage bags and leg bags. Under section titled, "Cleaning drainage bags and leg bags," the document stated that after staff had injected the cleaning solution into the bag, staff were to return in approximately 20 minutes. Under section titled, "Monitoring," the document stated, "Discard and replace bags earlier if they become discolored, brittle, or if they smell even after cleaning." The provider did not establish and follow an infection control program based on current standards of practice to prevent the development of UTIs associated with catheter use. Resident 1 stated staff did not know how to clean his/her catheter bags and had recently developed a UTI. The Catheter Training checklist stated staff were to return approximately 20 minutes after the cleaning solution was injected into the catheter bag to soak. Caregiver E stated second shift staff were not routinely cleaning catheter bags and s/he would let the solution sit for approximately 1 hour. Caregiver F stated some staff would leave the catheter bags to soak with the vinegar solution and others did not. Caregiver F stated the checklist did not specify which to do.	N 439		