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	345009	A. BUILDING ______ B. WING ______	C 03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The surveyor entered the facility on 3/11/18 to conduct a complaint survey and exited on 3/12/18. Additional information was obtained on 3/13/18, 3/15/18, and 3/16/18. Therefore, the exit date was changed to 3/16/18.	F 000		
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 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	F 690		4/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/02/2018

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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F 690 Continued From page 1

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, staff interviews, physician interviews, nurse practitioner interview, and family interview for one (Resident # 1) out of three sampled residents with an indwelling catheter, the facility failed to monitor the resident's intake and output when it was clinically indicated and there was not communication among nursing staff and the physician when the resident began experiencing catheter complications. The findings included:

Record review revealed Resident # 1 was last admitted to the facility on 2/7/18. The resident had multiple diagnoses. Three of these included a neurological disease, Atrial Fibrillation, and a neurogenic bladder which required the resident to have an indwelling urinary catheter.

Review of the resident's last minimum data set assessment, dated 2/14/18, revealed the resident had a brief interview for mental status assessment score of 13, which indicated he was cognitively intact. The resident was assessed to have a urinary catheter.

Review of the resident's care plan, dated 2/20/18, revealed the staff identified the resident had a catheter related to his neurogenic bladder. Interventions were as follows: "Provide perineal care every day and PRN (as needed); Report redness, swelling, discharge or urinary related odor to supervisor; Follow aseptic technique with

F 690

This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

Process that lead to the deficiency

The Nurses did not consistently monitor the residents output when it was clinically indicated due to inconsistent communication between the certified nursing assistants, licensed nurses and physician/extenders. The inconsistent communication led to Resident #1 being transported to the Emergency Room on 3/5/2018.

Process for implementing a plan of correction for specific deficiency

On 3/26/18 the Clinical Competency

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F 690	Continued From page 2 cath insertion and irrigation; observe and report change in color, odor, presence of cloudiness or sediment in urine to charge nurse; report complaints of pain/discomfort from cath (catheter) to charge nurse; record intake and output as ordered; check cath every shift for patency, proper position of tubing and bag; Report cath leakage to charge nurse." Review of physician orders revealed there were no orders on the March 2018 cumulative order sheet or any time after 3/1/18 for the resident's catheter to be changed or irrigated. This was confirmed with the Director of Nursing (DON) on 3/12/18 at 10:30 AM. According to the DON, the current policy was not to change catheters routinely. Review of physician orders also revealed the following. The resident routinely received Xarelto and Aspirin, which was used for anticoagulation secondary to his Atrial Fibrillation, on a daily basis. There were no orders that addressed the resident's urinary catheter on the dates of 3/3/18 or 3/4/18. On 3/4/18 there was a verbal ordered obtained for Tramadol 50 milligrams every six hours as needed for pain along with an order for Lactulose (used for constipation) 20 grams for one dose. On 3/5/18 there was an untimed order for a urine analysis and culture to be obtained. Following this order there was an untimed 3/5/18 order for the resident to have a complete blood count and basic metabolic panel drawn, and to schedule the resident with outpatient urology for the next available appointment. Following this order there	F 690	Coordinator (CCC) / Nurse Manager (NM) began re-educating the Licensed Nurses on the appropriate documentation related to Foley Cather output that should be entered on the 24 Hour Report. The CCC/NM have also re-educated our Certified Nursing Assistants on the appropriate documentation of reduced urine output in the electronic kiosk, or paper documentation, as well as appropriate notification of decrease output to their charge nurse. Any licensed nurse or Certified Nursing Assistant who is unable to attend the re-education by April 1, 2018, will be required to attend the training prior to working their next scheduled shift. This education has been added to the general orientation training for newly hired and rehired Certified Nursing Assistants and Licensed Nurses. On 3/26/18 the Clinical Competency Coordinator / Nurse Manager began the re-education of our Licensed Nurses on utilization of the SBAR form with notification to the physician upon identifying when a resident experiences catheter complications. This education has been added to the general orientation for newly hired and rehired Licensed Nurses. The Director of Health Services and/or Nurse Managers are conducting reviews of the 24-Hour Report for documentation of any Foley catheter complications. This review of the 24-Hour Report is being completed five times a week for the next four weeks, then three times a week for two weeks, then weekly for two weeks, then monthly thereafter.	

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F 690	Continued From page 3 was an order on 3/5/18 at 1:55 PM to send the resident to the emergency room for evaluation of hematuria and altered mental status. Review of input and output sheets for the dates of 3/2/18, 3/3/18, 3/4/18, and 3/5/18 revealed the following information. There were four columns for intake documentation. These were for morning meal fluid intake, mid-day meal fluid intake, evening meal fluid intake, and between meals intake. On 3/2/18 the form was totally blank for fluid intake. On 3/3/18 three of the four intake columns were blank. The one documented entry was for the evening meal intake which was 560 CC. On 3/4/18 the form was totally blank for fluid intake. On 3/5/18 the resident was documented as having 240 cc morning meal fluids; no fluids at midday. For the outputs there were five entries between 3/2/18 and 3/5/18. These were 3/2/18 at 11:11 PM-1100 cc 3/3/18 at 10:55 PM-2200 cc 3/4/18 at 4:43 AM -450 CC 3/5/18 at 3:37 AM-500 cc 3/5/18 at 12:21 PM-200 CC The following information was located in the resident's nursing notes and MAR (medication administration record). On 3/2/18, which corresponded to a Friday, the resident's temperature was documented as 99.0 on dayshift. The dayshift nurse documented the resident was alert and oriented times three and was stable. On 3/3/18, which corresponded to a Saturday, a	F 690	The Director of Health Services and/or Nurse Managers are correlating the 24 Hour Report with the SBAR�s completed and physician notification as appropriate for catheter complications. This is being completed five times a week for the next four weeks, then three times a week for two weeks, then weekly for two weeks, then monthly thereafter. Monitoring to ensure effectiveness of POC The Director of Health Services / Assistant Director of Health Services will present the analysis of the tracking and trending of the 24-Hour Reports to the Quality Assurance and Performance Improvement Committee Meeting on a monthly basis until three months of substantial compliance is maintained, then it will be reviewed quarterly thereafter. The Director of Health Services / Assistant Director of Health Services will present the analysis of the tracking and trending of the 24- hour reports with the SBAR forma and physician notification to the Quality Assurance and Performance Improvement Committee monthly until three months of substantial compliance is maintained, then it will be reviewed quarterly thereafter. Title of person responsible for implementing the POC The Administrator and Director of Nursing is responsible for implementation of the	

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dayshift nurse documented at 11:00 AM that the resident's indwelling catheter was draining yellow urine, the resident was alert and oriented times three, able to voice his needs, and had been up in the wheelchair.

On 3/3/18 an evening shift nurse entered at an undocumented time the following information in a nursing note. The resident's output was observed to "be bloody." at 3:40 PM. The catheter was flushed and the NP (nurse practitioner) was notified. The nurses were advised to keep monitoring the resident, who denied pain or discomfort. At 5 PM the urine appeared more clear, and the total output was 1900 cc (cubic centimeters).

On 3/4/18 at 6:30 AM, a night shift nurse noted the following. The resident had no signs of distress or discomfort. The resident's indwelling catheter was draining tea colored urine, the NP was aware, and the resident would continue to be monitored. The resident's temperature was 97.4.

On 3/4/18 there was one nursing narrative entry by the dayshift nurse which was made at 12 noon. The nurse noted, "A & O (alert and oriented) times three, able to voice needs, feeds self, still has blood in urine, will make MD aware, no SOB (shortness of breath) noted."

According to the March, 2018 MAR, the resident's catheter was changed on 3/4/18 by the dayshift nurse. There were no notations regarding the time the catheter was changed and if the resident experienced any complications or difficulty with the exchange of the catheter. There was no notation regarding the urine flow directly following the exchange of the catheter.

Provider's plan of correction (F 690): plan of correction.

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On 3/4/18 at 4:05 PM, Nurse # 1 documented on the MAR she administered Tramadol 50 mg for pain. The nurse did not note where the resident's pain was.

On 3/4/18 the evening shift nurse documented the following information in an untimed entry. The resident was alert and oriented times three. He complained of pain and was medicated with Ultram with positive effect. The resident's urine had blood in it. The catheter was flushed and patent. The NP was notified and orders were received for Ultram (a pain medication) every six hours as needed and Lactulose to be given "now." The nurse noted the NP would see the resident the next day. At the end of the narrative note, the nurse noted at 10:30 PM the resident had a fever of 99.8 for which he received Tylenol. The nurse concluded the note by documenting that the 11 PM to 7 AM staff would monitor the resident and note any changes.

There was no nursing note narrative for the shift which began on 3/4/18 at 11 PM and continued to 7 AM. The resident's temperature was recorded to be 98.2 on night shift.

On 3/5/18 a SBAR (situation, background, assessment, and recommendation) communication form was completed by a dayshift nurse. The nurse noted the following information. "Resident at first check was verbal and stated no complaints of pain, noted with bloody urine, elevated temp and Tylenol given NP alerted upon arrival and second check resident temperature was down 99.2. When MD arrived notified her of changes with resident Continue to monitor temperature remains down and resident alert and

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communicated at 12:00 Pm meds. (RP) arrived and informed staff of verbal change. Both UA and C & S (urine culture and sensitivity) and CBC/BMP complete blood count/basic metabolic panel stat done. Then resident sent to ER. Resident was confused and unable to communicate at time of discharge." According to the form the nurse spoke to the physician at 10 AM and the NP at 1 PM. The form did not indicate what time the temperature readings were taken, but noted the readings to be 102.2 and 99.2 after Tylenol. Under "urine evaluation" the nurse noted blood in the urine, but she did not check that the resident had decreased output, which was an option to check on the form.

The resident's RP was interviewed on 3/12/18 at 9:50 AM. The RP reported that prior to 3/4/18 the resident had his catheter for several months, and she had not been aware of problems with bloody urine in his drainage bag. She visited on Sunday, 3/5/18, from around 12:30 PM to around 4:00 PM. She saw there was blood in the catheter, and thought it was routinely changed once a month. Therefore, she asked the staff to change it. A nurse changed the catheter and the RP perceived the nurse to have trouble with the insertion. Following the procedure, the RP reported she saw there was blood coming around the catheter to the extent that the nurse used about 3 guaze pads to wipe the blood away. A second nurse came in before the RP left that day and told the RP the resident had trauma. The second nurse irrigated the catheter, but the RP did not see any urine come out of the catheter before she left for the day. She asked the staff to have the NP see the resident in the morning. The next day she arrived on 3/5/18 around 12:30 PM and found the resident in his room. He was delirious and did not

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know who she was, and was warm to the touch. She went to the desk to find the NP, who had the resident sent to the hospital after the RP talked to her.

On 3/11/18 at 5:20 PM the DON (Director of Nursing) provided a list of the resident's care staff for 3/3/18 to 3/5/18. Interviews were conducted as follows.

NA (Nurse Aide) # 1 had been assigned to care for Resident # 1 on 3/3/18 (Saturday) during the dayshift. NA # 1 was interviewed on 3/12/18 at 4:08 PM. The NA reported the following information. She recalled the resident had blood in his urine, and the blood was "obvious" in the tubing as well as the drainage bag, She knew the nurse had been in the room and thought the nurse knew about the bloody urine. She could not definitely recall if she had reported the blood to the nurse on that particular day. When she washed around the resident's catheter, there was blood on the washcloth.

Nurses # 3 had been assigned to care for Resident # 1 on 3/3/18 (Saturday) on the evening shift. Nurse # 3 was interviewed on 3/12/18 at 10:45 AM. The nurse reported the following. She was told the resident's urine was bloody around 4 PM. She took the catheter apart and flushed the drainage bag tubing. She did not flush the catheter which led to his bladder. Following this, the urine appeared to be clearer. The drainage bag was emptied twice. She recalled that at approximately 6 PM the resident had around 1800 cc out of the catheter, and at around 10:30 PM the resident had about 600 to 800 cc more of urine output.

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Nurse # 2 had been assigned to care for Resident # 1 on the night shift which began on 3/3/18 (Saturday) at 11 PM and continued till 7 AM. This same nurse cared for the resident on the night shift which began on 3/4/18 (Sunday) at 11 PM and continued till 7 AM on 3/5/18. Nurse # 2 was interviewed on 3/12/18 at 9:05 AM. The nurse recalled the resident had blood in his urine, and otherwise was normal.

NA # 2 had cared for the resident on the night shift which began on 3/3/18 (Saturday) at 11 PM and continued until 7 AM. This same NA also cared for the resident on the nightshift which began on 3/4/18 (Sunday) at 11 PM. NA # 2 was interviewed on 3/12/18 at 3:55 PM and reported the following. She recalled that sometime during her week-end shifts, the resident had blood in his urine, and when she would clean the resident there was a "little bit" of blood coming from around the catheter also. She had told Nurse # 2.

Nurse # 1 had been assigned to care for Resident # 1 on the dayshift of 3/4/18 (Sunday). Nurse # 1 was interviewed on 3/12/18 at 3:10 PM and reported the following. The catheter was changed by her because of the RP's request to do so, and because it had been leaking and needed to be changed. Nurse # 1 recalled she experienced no problems with the insertion. Prior to the insertion, the resident had hematuria (bloody urine), but following the insertion the resident's urine was clear yellow. The nurse recalled the resident had some trauma area around the penis area.

NA # 3 was assigned to care for Resident # 1 on the dayshift of 3/4/18. NA # 3 was interviewed on 3/12/18 at 4 PM. NA # 3 reported the following. She recalled at the beginning of her dayshift, the

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F 690	Continued From page 9 night shift nurse had spoken to her and informed her to be prepared to see blood in the resident's catheter. It was NA # 3's understanding that the catheter had been changed on night shift before the dayshift began. The NA recalled the resident having blood in his urine, and there was blood on the washcloth when she cared for him and wiped around the catheter. The NA reported that the blood was upsetting to the resident, and he wanted her to tell the nurse, which she did. Nurse # 4 had been assigned to Resident # 1 on the evening shift of 3/4/18 (Sunday). On 3/13/18 at 9 AM Nurse # 4 was interviewed and conveyed the following information. At the beginning of her shift she was informed by the dayshift nurse that the resident had blood in his urine, and his catheter had been changed earlier at some point. The nurse did know who had changed the catheter or when it had been changed. Nurse # 4 went to look at the catheter with the dayshift nurse. When she pulled back the covers to expose the catheter she found that the lock, used to secure the catheter, was not in place to the resident's thigh. It was dangling on the catheter itself. There was blood in the urine, and there was "a little bit" of blood coming from around the catheter. The resident was having some pain around the penis area, and she saw him tug at the catheter. The dayshift nurse went to call the physician while she irrigated the catheter. During the shift the resident continued to have urine mixed with blood, and he had 200 cc output on her shift. The pain medication helped his pain. NA # 4 was assigned to care for Resident # 1 on 3/3/18 (Saturday) and 3/4/18 (Sunday) evening shifts. NA # 4 was interviewed on 3/12/18 at 11:25 AM. NA # 4 reported the following. His urine	F 690		

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output was very dark on Saturday, and she recalled he had 2200 cc out on Saturday. On Sunday evening, she noticed that his urine was still very dark and he only had 200 cc out of the drainage bag. She thought this was odd, and she mentioned it to Nurse # 4 several times during the shift when she saw there was very little urine in the bag.

NA # 5 had been assigned to care for Resident # 1 on the dayshift (Monday) of 3/5/18. NA # 5 was interviewed on 3/12/18 at 11:30 AM, and the NA reported the following. The resident appeared tired, chilly, and had a fever when she first took his temperature on dayshift. She told the nurse. There was blood in his urine. His eyes were open, but she did not recall the resident talking to her during care, and he did not help with any part of his care.

Nurse # 5 had been assigned to care for the resident on the dayshift of 3/5/18 (Monday). Nurse # 5 was interviewed on 3/12/18 at 8:45 AM and again on 3/15/18 at 2:53 PM. Interview with Nurse # 5 revealed the following. The only information she had received in verbal report regarding the resident's problem was that there was blood in his urine and the catheter had been changed. In report she had not been told when the catheter had been changed, that the catheter had been irrigated, that the resident had a decreased output of 200cc on the Sunday evening shift following irrigation and exchange of the catheter, that he had been experiencing bleeding from around the catheter on both days of the week-end, or that he had a temperature reading of 99.8 the previous evening. Therefore, she did not relay any of this information to the NP and the physician when they arrived on Monday

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(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) COMPLETION DATE
F 690	Continued From page 11 (3/5/18). At the beginning of the shift the resident was talking but did not feel well. The urine in his catheter bag had blood in it and it was "very red," and she did assess the insertions site and saw nothing about the catheter or insertion site which seemed abnormal. The NP arrived around 10 AM and she asked the NP to see the resident while she was there. The resident's temperature reading registered 102.3 in the AM when it was taken, and he did respond to the Tylenol she administered. She paged the NP, but did not know if the NP heard the page because the NP was with another resident. The subsequent reading came down. The physician also came in around 10:30 AM, and she asked the MD to also see the resident. The MD mentioned she had a couple other things to get done, but would see the resident. She was not sure of the time the MD saw the resident. She saw the NP had written an order for a urine culture, and she obtained the specimen. At 12:00 PM the resident answered appropriately when she gave him a routine medication. The RP came in around 1 PM and found the resident to be non coherent. The RP went to find the NP, and the resident was sent to the ER for evaluation. Review of hospital records revealed in the Emergency Department (ED) the resident was found to have crusted blood around his catheter. The ED physician noted on his abdominal exam that the resident's "pelvis upwards and suggestion that bladder is full." The resident was admitted to the intensive care unit, and it was determined he was in septic shock likely secondary to a urinary tract infection. The resident was found to have bilateral hydronephrosis (swelling of the kidneys due to back up of urine) secondary to bladder outlet	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING ______ B. WING ______	C 03/16/2018

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F 690		F 690		

Continued From page 12
obstruction due to inadequate Foley catheter placement.

A Urology PA (physician's assistant) was interviewed on 3/15/18 at 2:15 PM. The PA had routinely cared for the resident prior to his 3/5/18 hospitalization and had helped with his care while he was hospitalized. The PA reported the following. In the emergency room, the resident's Foley bulb was found to be in the urethra and not in the resident's bladder. It was totally obstructing the emptying of his bladder. The catheter had either not been inserted correctly, or it could have been displaced by the resident if he had tugged on the catheter. When the catheter was removed, and a new one was inserted, there was a return of 1600 cc of urine. The amount of swelling in the resident's kidneys was "impressive" and was not typically seen with an acute problem of one day. At times an individual could continue to have some urine through the catheter when it was displaced depending on where the balloon was. At the time of the resident's presentation to the ER, the resident was totally obstructed but the PA could not speak regarding to where the placement had been while at the facility. The swelling in the resident's kidneys had resolved with treatment in the hospital, and the resident was not deemed to have any long term negative effects. It was his medical opinion that it would be advisable for a resident to be seen first thing in the morning if the resident had experienced on a week-end evening unresolved hematuria and decreased catheter output following bladder irrigation and catheter replacement; given there were no other symptoms.

The resident's nurse practitioner was interviewed on 3/12/18 at 12:00 PM and again on 3/15/18 at

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F 690	Continued From page 13 5:35 PM. Interview with the NP revealed the following. She recalled a nurse had texted her on Saturday (3/3/18) to let her know his urine was bloody, and the nurse felt he had tugged on it and therefore the nurse had irrigated the catheter. It was the NP's understanding that the nurse had irrigated the resident's bladder, and not that she took the catheter apart and irrigated the drainage tubing. She received another call on the week-end letting her know the staff felt the resident had tugged on the catheter and he had some bleeding, and they were going to irrigate it and change the catheter. Although the staff mentioned he had decreased output, "they never mentioned a number" to her and she informed them they needed to let her or the person on call know if his urine output was less than 300cc in an eight hour period. It was not conveyed to her that his urine output dropped to 200 cc, or made clear to her the extent of the bleeding around the catheter on multiple shifts. She had also not been informed when he started to register a temperature in conjunction with the decreased output of 200 cc of bloody urine on 3/4/18. She did not recall where the staff said the resident was specifically hurting when she ordered the Ultram, but did not recall that it was the penile area. The resident's physician was interviewed on 3/12/18 at 12:50 PM. The physician referenced her progress note of 3/5/18. Her note indicated the resident had a temperature of 98.2, was alert and oriented, and complained of mild abdominal pain with hematuria. The physician did not recall the exact time she saw the resident. According to the physician, the staff had not informed her that the resident had been running a fever and had decreased output before she saw the resident.	F 690		

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F 690	Continued From page 14 She was concerned about the hematuria, and therefore had ordered labs. Her plan was to send him to a urologist that day either in the ER or as an outpatient. According to the physician, when the RP approached the NP about the resident's mental status change, it made it clear the resident needed to go to the ER. The administrator and DON were interviewed on 3/16/18 at 9:30 AM regarding their procedures and expectations of nursing standards of practice. According to the DON, the resident's condition during the week-end of 3/3/18 and 3/4/18 would have been a clinical indication for the nurses to assess his intake and output. Also it was the expectation of the DON that per standards of practice the nurse should have documented the exchange of the catheter per the guidelines on the procedures they follow. According to the DON the staff are to verbally communicate between shifts about symptoms and change in conditions which need to be monitored, and this information is relayed to the physician. A written 24 hour report is also maintained when residents experience problems. The DON stated she had reviewed the facility's written 24 report for the date of 3/5/18. There was documentation on the AM of 3/5/18 that Resident # 1 had a change of his catheter on Sunday, was having hematuria, and a low grade fever. This information was written for the NP to see on Monday morning. There had been no mention on the report of his decreased output. It was also the DON's expectation that nurses document where residents are having pain when they administer pain medication.	F 690		