STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345489	A. BUILDING _____ B. WING _____	C 04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SATURN NURSING AND REHABILITATION CENTER	1930 WEST SUGAR CREEK ROAD CHARLOTTE, NC 28262

(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 An onsite complaint investigation survey was conducted on 04/26/2021 and 04/27/2021. Immediate Jeopardy was identified on 04/27/2021. The survey team returned to the facility on 04/30/2021 to validate the credible allegation. Therefore, the exit date was changed to 04/30/2021. Event ID#4B6A11. One of the 2 complaint allegations was substantiated resulting in deficiency. Immediate Jeopardy was identified at CFR 483.25 at tag F690 at a scope and severity of J. F690 constitued substandard quality of care. Immediate Jeopardy began on 04/17/2021 and was removed on 04/28/2021. A partial extended survey was conducted on 04/30/2021.	F 000		
F 690 SS=J	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	F 690		5/24/21

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

Electronically Signed | 05/22/2021

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F 690	Continued From page 1 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 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 staff, nurse practitioner and physician interviews, and record review, the facility failed to identify hematuria (blood in the urine) as a symptom of an indwelling urinary catheter complication and failed to respond and monitor symptoms of urinary retention for 1 of 3 sampled residents who used an indwelling urinary catheter (Resident #1). This failure resulted in an emergency transfer for Resident #1 for treatment of acute kidney injury, urinary retention and severe sepsis secondary to a urinary tract infection. Immediate Jeopardy began on 04/17/2021 when facility staff did not identify Resident #1's hematuria as a symptom of an indwelling urinary catheter complication and did not respond or monitor symptoms of urinary retention. Staff	F 690	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1.Address how corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 690	Continued From page 2	F 690		

assigned to Resident #1 did not identify hematuria as an acute condition and immediately contact the physician for further guidance. Resident #1 required an emergency transfer to the hospital for gross bleeding from the indwelling urinary catheter site. The Immediate Jeopardy was removed on 04/28/2021 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems are in place and the completion of employee education.

The findings included:

Resident #1 was admitted to the facility on 01/22/2021 with diagnoses which included middle cerebral artery infarct, neurogenic bladder and history of deep vein thrombosis.
Admission medication orders dated 01/22/2021 directed Resident #1 to receive Eliquis 5 milligrams twice daily. (According to the pharmaceutical manufacturer, Eliquis is an anticoagulant medication to prevent blood clots.)

Resident #1's admission Minimum Data Set (MDS) dated 02/01/2021 documented an assessment of severely impaired cognition. The MDS indicated Resident #1 used an indwelling urinary catheter and daily administration of an anticoagulant.

The care plan dated 02/09/2021 for Resident #1 included interventions to be free of infection and discomfort related to catheter placement. Interventions included assessment of the color, clarity and character of urine and assessment of

practice:

Charge Nurse noted Resident #1 on 4/17/2021 urine contained dark red blood. Charge nurse failed to immediately notify MD of Hematuria as she felt it was non-urgent, related to Resident #1 history of hematuria. Subsequently, Resident #1 hematuria was communicated via MD communication book. Nurse that worked 7pm to 11pm documented that Resident #1 received 8pm dose of Eliquis (Anticoagulation) as Nurse reported that she was unaware of the hematuria. Night shift nurse on 4/17/2021 documented in nursing note that Resident #1 hematuria continued, MD was not notified. During interview Night shift nurse stated that she did not recall any mention of small amount of urine. On 4/18/2021 Charge nurse documented that Resident#1 did not have urine in the catheter bag when she fed him that morning, MD was not immediately contacted. Charge nurse checked back an hour later to find no urine output and abdomen distended and hard. Charge nurse documented in nursing note that hematuria continued with blood coming out of the foley insertion site. Blood covered Resident #1 groin, inner thighs, and pubic area. Resident was sent out to ER for evaluation. Resident #1’s emergency room evaluation dated 04/18/2021 documented Resident #1’s urinary catheter was replaced which resulted in immediate 2700 cubic centimeters of bloody output and subsequently 1 Liter of dark yellow colored urine. The physician

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F 690	Continued From page 3 symptoms of urinary tract infection. A nurse practitioner (NP) note dated 02/03/2021 documented Resident #1 experienced acute urinary retention. Resident #1's abdomen was distended with no urinary output. The NP obtained 1500 cubic centimeters (cc) of bloody urine when the indwelling catheter was replaced. The NP ordered scheduled irrigation of the indwelling urinary catheter to prevent clot formation. On 02/08/2021, the NP documented Resident #1's urine culture and sensitivity result indicated a urinary tract infection (UTI) which required antibiotic therapy. On 02/10/2021, the NP documented Resident #1's previous hematuria with clots and catheter leakage was resolved. Resident #1 was hospitalized from 03/10/2021 to 03/26/2021 and the discharge summary dated 03/26/2021 indicated Resident #1's indwelling urinary catheter was replaced due to bilateral hydronephrosis which caused urinary retention secondary to a urinary tract infection. (Hydronephrosis occurs when a kidney has an excess of fluid due to a backup of urine.) The discharge summary did not contain orders for scheduled irrigation of the indwelling urinary catheter. Readmission orders included continued administration of twice daily Eliquis. The NP assessed Resident #1 on 03/29/2021 and documented Resident #1's indwelling urinary catheter contained clear, yellow urine. Resident #1 had no bladder distention upon palpation. The NP documented nursing staff were to monitor bladder distention and episodes of hematuria.	F 690	ordered Resident #1's Eliquis to be held. The hospital physician documented post renal acute kidney injury with obstructive uropathy, suspected secondary clot with catheter and hyponatremia secondary to fluid overload from urinary obstruction. Resident #1 was admitted to the hospital for treatment of acute kidney injury, severe sepsis secondary to a urinary tract infection which required Gentamycin. Resident #1 has not returned to the facility. Facility did not identify hematuria as a symptom of an indwelling urinary catheter complication and did not respond nor monitor symptoms of urinary retention. Additionally, Resident #1 was receiving anticoagulation therapy which placed him at a higher risk of bleeding. Staff assigned to Resident #1 did not identify hematuria as an acute condition and immediately contact MD for further guidance. All residents with Indwelling Catheters have the potential to be affected by the deficient practice. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of the past 14 days of nursing notes completed 4/27/2021 was reviewed by the Executive Director, Director of Nursing, Assistant Director of Nursing, and Unit Coordinators to identify any residents with documented signs and	

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F 690	Continued From page 4 On 04/02/2021 and 04/05/2021, the NP documented Resident #1's indwelling urinary catheter contained clear, yellow urine. Resident #1 had no bladder distention upon palpation. A physician's note dated 04/08/2021 documented Resident #1's indwelling urinary catheter contained clear, yellow urine. Resident #1 had no bladder distention upon palpation. The NP documented on 04/09/2021 and 04/12/2021 that Resident #1's indwelling urinary catheter contained clear, yellow urine. Resident #1 had no bladder distention upon palpation. A nursing note, written by Nurse #1, dated Saturday 04/17/2021 at 6:55 PM documented Resident #1's urine contained dark red blood. The nurse wrote Resident #1 was "verbal with increased sleepiness" and placed Resident #1's name in the medical doctor book to be seen Monday, 04/19/2021. There was no description of the amount of urine or vital sign measurement. Interview with NA #1 on 04/26/2021 at 10:50 AM revealed Resident #1 did not want to get out of bed on 04/17/2021 and slept most of the day. NA #1 explained Resident #1 usually got out of bed and liked to talk. NA #1 reported Resident #1's indwelling urinary catheter bag contained approximately 800 cc. of blood tinged urine when it was emptied at the end of the shift at 3:00 PM. NA #1 reported the amount of urine was Resident #1's usual amount. NA #1 reported the color of urine to Nurse #1 who was aware of the discolored urine. A telephone interview was conducted on 04/26/2021 at 12:48 PM with Nurse #1. Nurse #1 reported she worked from 7:00 AM to 7:00 PM	F 690	symptoms of urinary retention or urinary tract infection. No issues identified. Additionally, an assessment of all Residents with Indwelling Catheters was completed on 4/27/2021 by the Director of Nursing to assess for any signs and symptoms of urinary retention, catheter complications, or urinary tract infection. Assessment included observation of catheter, urine color, clarity and output, abdominal inspection/palpation. No issues identified. Director of Nursing reviewed residents with Indwelling catheters on 4/26/2021 to ensure that each had an appropriate care plan to assess for color, clarity, character of urine and to assess for urinary tract infection and blockages. Care guides reviewed to ensure accuracy. No concerns noted. 3. Address how the facility will be put into place or systemic changes made to ensure that the deficient practice will not recur: Beginning 4/27/2021, All nursing staff to include Licensed Nurses, Certified Nurse Aides, and Nurse Aids in Training were re-educated by the Assistant Director of Nursing on the monitoring and reporting of residents with signs and symptoms of urinary retention and urinary tract infections. To include immediate notification of hematuria, decrease in urine output, pain, abdominal distention, pain with abdominal palpation, odor,	

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F 690	Continued From page 5 every weekend and cared for Resident #1 on 04/17/2021. Nurse #1 reported she fed Resident #1 the breakfast meal on 04/17/2021 and several hours later observed dark red urine in the catheter bag. Nurse #1 estimated the amount was 500 cc. Nurse #1 explained Resident #1 slept more than usual but did not complain of pain. Resident #1's abdomen was not distended. Nurse #1 explained she placed Resident #1's name and concern of hematuria on the list to be seen on Monday (04/19/2021) by the NP. Nurse #1 did not consider the hematuria urgent since Resident #1 experienced hematuria in the past. Nurse #1 reported the hematuria to Nurse #2 who came on duty at 7:00 PM. Telephone interview with Nurse #2 on 04/26/2021 at 12:20 PM revealed she was not aware of and did not observe Resident #1's hematuria on 04/17/2021 between 7:00 PM and 11:00 PM. Nurse #2 documented administration of Eliquis 5 mg. at 8:00 PM. During an interview with NA #2 on 04/26/2021 at 3:25 PM, NA #2 reported she cared for Resident #1 from 3:00 PM to 11:00 PM on 04/17/2021. NA #2 reported she did not recall the character, color or amount of Resident #1's urine when she emptied the bag at the end of the shift at 11:00 PM. A nursing note, written by Nurse #3, dated 04/18/2021 at 6:29 AM documented Resident #1 continued with hematuria with no complaints of discomfort during the 11:00 PM to 7:00 AM shift. Telephone interview with NA #3 on 04/26/2021 at 2:45 PM revealed she cared for Resident #1 from 11:00 PM on 04/17/2021 to 7:00 AM on	F 690	urgency, frequency, catheter dislodgment, and or blockage. These changes are not to be communicated via communication book. The education will be communicated verbally and telephonically by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed. Beginning 4/27/2021, All Licensed Nurses were educated on Change in Condition Notifications, Signs and Symptoms and when to report to MD. Documentation for residents with indwelling foley catheters to include color, clarity, output, consistency of urine and documentation of site for redness, swelling, bleeding, warmth, discharge, or pain by the Assistant Director of Nursing. As well, all Licensed Nurses were re-educated on their responsibility regarding shift-to-shift reporting utilizing 24-hour report sheets and giving accurate, clear, timely report to on coming shifts by the Assistant Director of Nursing. Additionally, all Licensed Nurses were re-educated on adverse side effects to Anticoagulants which include hematuria, monitoring/assessing for adverse reaction and the immediate notification to MD. The education was communicated verbally and telephonically	

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F 690	Continued From page 6 04/18/2021. NA #3 reported Resident #1's catheter bag contained a small amount of dark red urine when she emptied it at the end of her shift. NA #3 reported the discolored urine and small amount to Nurse #3. A telephone interview was conducted with Nurse #3 on 04/26/2021 at 6:10 PM. Nurse #3 explained she was not aware of Resident #1's hematuria until informed by NA #3 between 6:30 AM and 7:00 AM on 04/18/2021. Nurse #3 looked at Resident #1's clinical record and noted Nurse #1 documented hematuria on 04/17/2021. Nurse #3 did not recall NA #3 report of the small amount of urine. Nurse #3 informed the oncoming nurse, Nurse #1, of the continued hematuria. A nursing note, written by Nurse #1, dated 04/18/2021 at 10:44 AM documented Resident #1's hematuria continued with blood coming out of the catheter insertion site. Blood covered Resident #1's groin, inner thighs and pubic area. Resident #1's blood pressure measured 137/93 mm/Hg., heart rate of 103, respiratory rate of 18 and temperature measurement of 97.7 degrees Fahrenheit. Resident #1 received an emergency transfer to the hospital. During a telephone interview on 04/26/2021 at 12:48 PM with Nurse #1, Nurse #1 reported she attempted to feed Resident #1 the breakfast meal on 04/18/2021 but he accepted only a few bites of food and sips of a carbonated beverage. Nurse #1 held Resident #1's medications due to lethargy. Nurse #1 reported there was no urine in Resident #1's urinary catheter bag when she fed him breakfast at approximately 8:30 AM. When she returned approximately one hour later to check on Resident #1, his top sheet contained	F 690	by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Written education was available for review prior to the staff member working their assigned shift. Assistant Director of Nursing utilized a master employee list to track completion of education. All Education was completed on 4/30/2021. Effective 4/27/2021 education for management of residents with urinary catheters, including monitoring for complication and how to respond will be included in general orientation by the Staff Development Coordinator for newly hired Licensed Nurses and Certified Nursing Assistants. 4. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 4/27/2021 Nursing Management to include Charge Nurse, Unit Coordinators, Director and Assistant Director of Nursing will review 24-hour report sheets and previous day nurses notes to identify any change in condition for appropriate follow up and notification to MD review will be completed daily. Administrator educated the Nursing Management team to include Charge Nurse, Unit Coordinators, Director and Assistant Director of Nursing on the new process of monitoring and responsibilities of this plan on 4/27/2021.Monday-Sundary for 12 weeks or until a pattern of compliance is maintained.	

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F 690	Continued From page 7 blood. Upon further examination, Nurse #1 observed blood covered Resident #1's groin and thighs with blood coming out of the penis. Nurse #1 reported Resident #1's abdomen was distended and hard with no urinary output. Nurse #1 stated she immediately transferred Resident #1 to the hospital at approximately 10:30 AM on 04/18/2021. Resident #1's emergency room evaluation dated 04/18/2021 documented Resident #1's indwelling urinary catheter was replaced which resulted in immediate 2700 cc of bloody output and subsequently 1 liter of dark yellow colored urine. The hospital physician documented post renal acute kidney injury with obstructive uropathy, suspected secondary clot with catheter and hyponatremia secondary to fluid overload from urinary obstruction. Resident #1 was admitted to the hospital for treatment of acute kidney injury, and severe sepsis secondary to UTI which required intravenous Gentamycin (an antibiotic). Interview with the NP on 04/26/2021 at 11:14 AM revealed staff should have notified the on-call physician when Resident #1's hematuria occurred to obtain orders for irrigation and probable replacement of the urinary catheter. The NP explained Resident #1 required monitoring for symptoms of infection, recurrence of blood clots and complications of urinary catheter use. Telephone interview with Resident #1's physician on 04/26/2021 at 4:46 PM revealed Resident #1 would have received catheter irrigation and immediate discontinuance of the anti-coagulant had staff contacted the on-call physician service when the hematuria occurred. The physician explained the onset of hematuria was a serious	F 690	The Director of Nursing will be report and discussed in monthly Quality Assurance and Performance Improvement a review of the audit's meetings monthly for 3 months and/or until substantial compliance is maintained. QAPI committee can modify this plan in order to assure substantial compliance. Effective 04/27/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.	

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concern and required response.

Interview with the Director of Nursing (DON) on 04/26/2021 at 4:55 PM revealed staff should have contacted Resident #1's physician on-call when the hematuria first occurred. The DON reported staff should recognize hematuria as a symptom of a urinary catheter complication and monitor symptoms of urinary retention. The DON explained Resident #1 was at risk for bleeding due to anti-coagulant use.

The Administrator was notified of Immediate Jeopardy on 04/27/2021 at 1:55 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Nurse #1 noted Resident #1 on 4/17/2021 urine contained dark red blood. Nurse #1 failed to immediately notify MD of hematuria as she felt it was non-urgent, related to Resident #1 history of hematuria. Subsequently, Resident #1 hematuria was communicated via MD communication book. Nurse that worked 7pm to 11pm documented that Resident #1 received 8pm dose of Eliquis (Anticoagulation) as Nurse reported that she was unaware of the hematuria. Night shift nurse on 4/17/2021 documented in nursing note that Resident #1 hematuria continued, MD was not notified. During interview Night shift nurse stated that she did not recall any mention of small amount of urine. On 4/18/2021, Nurse #1 documented that Resident#1 did not have urine in the catheter bag when she fed him that morning,

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MD was not immediately contacted. Nurse #1 checked back an hour later to find no urine output and abdomen distended and hard. Nurse #1 documented in nursing note that hematuria continued with blood coming out of the urinary catheter insertion site. Blood covered Resident #1 groin, inner thighs, and pubic area. Resident was sent out to ER for evaluation. Resident #1's emergency room evaluation dated 04/18/2021 documented Resident #1's urinary catheter was replaced which resulted in immediate 2700 cubic centimeters of bloody output and subsequently 1 Liter of dark yellow colored urine. The physician ordered Resident #1's Eliquis to be held. The hospital physician documented post renal acute kidney injury with obstructive uropathy, suspected secondary clot with catheter and hyponatremia secondary to fluid overload from urinary obstruction. Resident #1 was admitted to the hospital for treatment of acute kidney injury, severe sepsis secondary to a urinary tract infection which required Gentamycin. Resident #1 has not returned to the facility.

Facility did not identify hematuria as a symptom of an indwelling urinary catheter complication and did not respond nor monitor symptoms of urinary retention. Additionally, Resident #1 was receiving anticoagulation therapy which placed him at a higher risk of bleeding. Staff assigned to Resident #1 did not identify hematuria as an acute condition and immediately contact MD for further guidance.

All residents with Indwelling Catheters have the potential to be affected by the deficient practice.

2) Specify the action the entity will take to alter

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the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

An audit of the past 14 days of nursing notes completed 4/27/2021 was reviewed by the Executive Director, Director of Nursing, Assistant Director of Nursing, and Unit Coordinators to identify any residents with documented signs and symptoms of urinary retention or urinary tract infection. No issues identified. Additionally, an assessment of all Residents with Indwelling Catheters was completed on 4/27/2021 by the Director of Nursing to assess for any signs and symptoms of urinary retention, catheter complications, or urinary tract infection. Assessment included observation of catheter, urine color, clarity and output, abdominal inspection/palpation. No issues identified.

Director of Nursing reviewed residents with Indwelling catheters on 4/26/2021 to ensure that each had an appropriate care plan to assess for color, clarity, character of urine and to assess for urinary tract infection and blockages. Care guides reviewed to ensure accuracy. No concerns noted.

Beginning 4/27/2021, All nursing staff to include Licensed Nurses, Certified Nurse Aides, and Nurse Aids in Training will be re-educated by the Assistant Director of Nursing on the monitoring and reporting of residents with signs and symptoms of urinary retention and urinary tract infections. To include immediate notification of hematuria, decrease in urine output, pain, abdominal distention, pain with abdominal palpation, odor, urgency, frequency, catheter dislodgment, and or blockage. These changes

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are not to be communicated via communication book. The education will be communicated verbally and telephonically by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until education is completed.

Beginning 4/27/2021, All Licensed Nurses to be educated on Change In Condition Notifications, Signs and Symptoms and when to report to MD. Documentation for residents with indwelling urinary catheters to include color, clarity, output, consistency of urine and documentation of site for redness, swelling, bleeding, warmth, discharge, or pain by the Assistant Director of Nursing. As well, all Licensed Nurses to be re-educated on their responsibility regarding shift-to-shift reporting utilizing 24-hour report sheets and giving accurate, clear, timely report to on coming shifts by the Assistant Director of Nursing. Additionally, all Licensed Nurses to be re-educated on adverse side effects to Anticoagulants which include hematuria, monitoring/assessing for adverse reaction and the immediate notification to MD. The education will be communicated verbally and telephonically by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Written education will be available for review prior to the staff member working their assigned shift. Assistant Director of Nursing will utilize a master employee list to track completion of education. No staff will be allowed to work until

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education is completed.

Effective 4/27/2021 education for management of residents with urinary catheters, including monitoring for complication and how to respond will be included in general orientation by the Staff Development Coordinator for newly hired Licensed Nurses and Certified Nursing Assistants.

Effective 4/27/2021 Nursing Management to include Charge Nurse, Unit Coordinators, Director and Assistant Director of Nursing will review 24-hour report sheets and previous day nurses notes to identify any change in condition for appropriate follow up and notification to MD review will be completed daily. Administrator educated the Nursing Management team to include Charge Nurse, Unit Coordinators, Director and Assistant Director of Nursing on the new process of monitoring and responsibilities of this plan on 4/27/2021.

Effective 04/27/2021, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

The facility alleged immediate jeopardy removal effective date 04/28/2021.

On 04/30/2021, the facility's credible allegation for Immediate Jeopardy removal on 04/28/2021 was validated by the following: Observations of residents in the facility who used an indwelling urinary catheter revealed no symptoms of indwelling urinary catheter complications. Resident care plans included direction to assess for color, clarity, character of urine and to assess

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F 690	Continued From page 13 for urinary tract infection and blockages. Staff interviews revealed receipt of education regarding identification and response to indwelling urinary catheters. The facility implemented audit tools to monitor residents with indwelling urinary catheters reviewed by nursing management.	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews, and record review, the facility administered an anticoagulation medication after hematuria (blood in the urine) occurred for 1 of 3 sampled residents who received anticoagulant medication	F 757	1. Address how corrective action will be accomplished for those residents found to have be affective by the deficient practice. Resident #1 was administered anticoagulation medication on 4/17/21	5/24/21

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F 757	Continued From page 14 (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/22/2021 with diagnoses which included neurological disorder, chronic osteomyelitis, middle cerebral artery infarct, neurogenic bladder, history of deep vein thrombosis, and seizure disorder. Medications ordered upon admission included Eliquis 5 milligrams (mg.) twice daily. (Eliquis is an anticoagulant medication to prevent blood clots. Since anticoagulants thin blood, the manufacturer recommends observation for signs of bleeding.) Resident #1's admission Minimum Data Set (MDS) dated 02/01/2021 documented an assessment of severely impaired cognition. The MDS indicated Resident #1 received daily anticoagulant medication. Resident #1's care plan dated 02/09/2021 documented Resident #1 received an anticoagulant. Interventions included monitoring of signs and symptoms of bleeding and bruising with report of abnormal findings to the physician. Resident #1 was hospitalized from 03/10/2021 to 03/6/2021. Readmission physician's orders included continuance of Eliquis 5 mg. twice daily. Interview with medication aide #1 on 04/26/2021 at 12:07 PM revealed Resident #1 did not have hematuria when she administered the Eliquis at 8:00 AM on 04/17/2021. A nursing note, written by Nurse #1, dated 04/17/2021 at 6:55 PM documented Resident	F 757	after hematuria (blood in the urine) was noted in catheter bag. Resident was transferred to the hospital on 4/18/2021. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Beginning on May 17th, 2021 Nursing Management, to include Director of Nursing, Assistant Director of Nursing/Staff Development Coordinator, conducted an audit of current residents on anticoagulation therapy documentation for the prior 14 days to ensure no adverse side effects were noted related to of medication use. Additionally, Nurse Management observed residents on anticoagulation therapy for any signs and symptoms of adverse side effects related to medication use. No concerns noted. Audit was completed on 5/17/21. Nursing Management will review current residents on anticoagulation therapy to ensure the care plan includes anticoagulation use and risk, to include for monitoring for signs and symptoms of bleeding, bruising with report of any abnormal findings to the physician. Audit will be completed on 5/21/2021. Any identified issues will be corrected immediately. 3. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur Effective 4/27/2021, All Licensed Nurses	

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F 757	Continued From page 15 #1's urine contained dark red blood. Resident #1's electronic medication administration record revealed documentation of Eliquis 5 mg. at 8:00 PM on 04/17/2021 by Nurse #2. A telephone interview was conducted on 04/26/2021 at 12:48 PM with Nurse #1. Nurse #1 reported she worked from 7:00 AM to 7:00 PM every weekend and cared for Resident #1 on 04/17/2021. Nurse #1 observed dark red urine in the catheter bag several hours after she fed Resident #1 the breakfast meal. Nurse #1 explained Resident #1 slept more than usual but did not complain of pain. Resident #1's abdomen was not distended. Nurse #1 explained she placed Resident #1's name and concern of hematuria on the list to be seen on Monday (04/19/2021) by the NP. Nurse #1 did not consider the hematuria urgent or an adverse consequence of Eliquis since Resident #1 experienced hematuria in the past. Nurse #1 reported the hematuria to Nurse #2 who came on duty at 7:00 PM. Telephone interview with Nurse #2 on 04/26/2021 at 12:20 PM revealed she was not aware of and did not observe Resident #1's hematuria. Nurse #2 documented administration of Eliquis 5 mg. at 8:00 PM. A telephone interview was conducted with Nurse #3, who worked from 11:00 PM on 04/17/2021 to 7:00 AM on 04/18/2021, on 04/26/2021 at 6:10 PM. Nurse #3 reported she was not aware of Resident #1's hematuria until informed by NA #3 at approximately 7:00 AM on 04/18/2021. Nurse #3 informed the oncoming nurse, Nurse #1 of the	F 757	were educated on Change in Condition Notifications, Signs and Symptoms and when to report to MD. Additionally, all Licensed Nurses were re-educated on adverse side effects to Anticoagulants which include hematuria, monitoring/assessing for adverse reaction and the immediate notification to MD when there are abnormal findings. The education was communicated verbally and telephonically by the Executive Director, Director of Nursing and Assistant Director of Nursing/Staff Development coordinator. Education was completed on 4/28/2021. Certified nursing assistants were re-educated by the Assistant Director of Nursing on notification to nursing for change in conditions to include bleeding or abnormal bruising. Education was completed on 4/28/2021. All newly hired employees will receive the education in new hire orientation. No employee will be allowed to work without the education. 4.Indicate how the facility plans to monitor their performance to make sure that solutions are sustained and corrective action will be complete. Effective 5/24/2021, Nursing Management to include, Director of Nursing, Assistant Director of Nursing and Unit Mangers will review the 24-hour report sheets and previous days nursing notes to identify any change in condition as it relates to	

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F 757	Continued From page 16 hematuria. Resident #1's medication notes, written by Nurse #1, dated 04/18/2021 documented Resident #1's 8:00 AM medications which included Eliquis 5 mg. were held due to lethargy. Nurse #1 documented Resident #1's hematuria continued with blood coming out of the catheter insertion site. Blood covered Resident #1's groin, inner thighs and pubic area. Resident #1's blood pressure measured 137 mm/Hg. With heart rate of 103, respiratory rate of 18 and temperature measurement of 97.7 degrees Fahrenheit. Resident #1 received an emergency transfer to the hospital. Resident #1's emergency room evaluation dated 04/18/2021 documented Resident #1 received treatment for post renal acute kidney injury with obstructive uropathy, suspected secondary clot with catheter and hyponatremia secondary to fluid overload from urinary obstruction. The hospital physician ordered Resident #1's Eliquis to be held. During a telephone interview with Nurse #1 on 04/26/2021 at 12:48 PM Nurse #1 explained she did not administer Resident #1 the 8:00 AM Eliquis and other morning medications due to lethargy. Telephone interview with Resident #1's physician on 04/26/2021 at 4:46 PM revealed Resident #1 should not have received Eliquis when hematuria occurred. The physician reported he would have discontinued the Eliquis. Interview with the Director of Nursing (DON) on 04/26/2021 at 4:55 PM revealed staff should have	F 757	anticoagulation therapy and monitoring. This Audit will take place Monday-Friday during clinical morning meeting and documented on the daily clinical round checklist. Monday-Friday for 12 weeks or until a pattern of compliance is maintained. Effective 5/24/21, Nursing Management to include, Director of Nursing, Assistant Director of Nursing and Unit Mangers will conduct staff questionnaires to address employee knowledge of adverse effects of anticoagulation therapy. Audit to include 15 staff members per week for 2 weeks, 10 staff members per week for 4 weeks, 5 staff members per week for 6 weeks or until a pattern of compliance is maintained. The Director of Nursing will be report and discussed in monthly Quality Assurance and Performance Improvement a review of the audit□s meetings monthly for 3 months and/or until substantial compliance is maintained. QAPI committee can modify this plan in order to assure substantial compliance. Effective 5/25/2021 the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this plan of correction for this alleged noncompliance to ensure the facility remains in substantial compliance. The facility alleged full compliance with this plan of correction effective date 5/24/2021.	

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F 757	Continued From page 17 contacted Resident #1's physician on-call when the hematuria occurred and not administer the 8:00 PM Eliquis. The DON explained Resident #1 was at risk for bleeding due to anti-coagulant use.	F 757		