STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345129	A. BUILDING _____ B. WING _____	C 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MOCKSVILLE	1007 HOWARD STREET MOCKSVILLE, NC 27028

(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 1. 483.10 (F 157) at J Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition and the physician was not contacted. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. 2. 483.13 (F 224) at J Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. 3. 483.25 (F 315) at J Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/11/2016

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F 000	Continued From page 1 complete employee and resident education and ensure monitoring systems in place are effective.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		4/1/16

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F 157	Continued From page 2 by: Based on staff and physician interviews and record review the facility failed to notify the physician when a resident ' s condition changed. The resident had decreased urine output, increase in pain and complained of being sick for 1 of 3 sampled residents (Resident #28). Resident #28 was diagnosed with septic shock from a urinary tract infection and in acute renal failure and admitted to intensive care (ICU). Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition and the physician was not contacted. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #28 was admitted to the facility on 09/20/15 with diagnoses that included Alzheimer's disease, history of urinary tract infections, flaccid neuropathic bladder, urine retention, anorexia and others. The most recent Minimum Data Set (MDS) dated 01/12/16 specified the resident had moderately impaired cognition but had clear speech and able to make herself understood; she required extensive assistance with activities of daily living and had an indwelling urinary catheter. A review of Resident #28's total daily fluid intake	F 157	This plan of correction constitutes my written allegation of compliance for deficiencies cited. However, submission of the plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. It is the policy of this facility to notify the resident□s physician immediately upon change in resident□s status. 1. Resident #28 no longer resides in the facility. 2. For other resident□s with the potential to be affected by this cited deficiency the following has been accomplished. On 3/22 and3/23, 2016 all residents were observed by the Licensed Nursing staff to determine if they had a significant change in their physical or mental status. Residents with catheters were further assessed with the Nursing Change in Status Assessment and any identified status change was followed up on by notification of Physician. 3. The Licensed Nursing staff were in-serviced by the Director of Nursing/Designee on March 22 thru April 1, 2016 on use of the Nursing Change of Status Assessment, the policy for Notification of the Physician for a status change and use of the 24 Hour report to identify changes in status from shift to shift. New hired licensed nurses will complete inservice during orientation.	

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F 157	Continued From page 3 with meals and total urine output (measured in milliliters and documented by the nurse aides) revealed: Date Fluid in Urine out 1/31/16 720ml 0ml 2/01/16 440ml 50ml 2/02/16 0ml 0ml On 01/31/16 review of Resident #28's urine output revealed the Resident went 24 hours with no urine output. No documentation was made in the medical record on 01/31/16 that an assessment had been completed for no urine output or that the physician had been contacted. On 02/01/16 review of Resident #28's urine output revealed the Resident #28 went 24 hours and only had 50ml of urine. There was no documentation that an assessment had been completed for the decreased urine output or that the physician had been contacted. Further review of the medical record revealed: - On 02/02/16 at 1:25 AM the resident complained of pain and was given Oxycodone by Nurse #2. - On 02/02/16 at 3:15 AM the resident complained of pain and was given Tylenol by Nurse #2. - On 02/02/16 at 6:37 AM the resident continued to complain of pain and was given Oxycodone again by Nurse #2. There was no documentation in the medical record that Nurse #2 had assessed Resident #28 and had not contacted the physician regarding the Resident's continued complaints of pain.	F 157	The Director of Nursing/Designee will review the twenty-four hour report to identify any changes in status and will validate Notification to MD has been made by review of the residents Medical Record. 4. The Director of Nursing/Designee will complete an audit 2X a week for 2 weeks and then weekly x 4 weeks of the Twenty-Four Hour Report to validate Physician has been Notified of Resident Change in Condition. Results of audits will be submitted to Quality Assurance Committee x 2 months for trending and tracking and on-going monitoring.	

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On 02/02/16 at 5:00 PM a nurse's entry made by the nurse supervisor specified the family of Resident #28 was visiting and reported that the resident was not acting right and demanded the resident be sent to the Emergency Department. Resident #28's blood pressure was 95/54 and temperature was 99.4 degrees Fahrenheit, heart rate was 115 beats per minute and resting respirations were 34. The resident was noted to have 0 ml in urinary catheter bag.

The Emergency Medical Services (EMS) "run report" dated 02/02/16 at 6:15 PM specified Resident #28 was somnolent and had a fever of 100.3 degrees Fahrenheit. The Resident was given 200ml of normal saline intravenously. EMS documented the resident had "thick discolored" urine in catheter bag but did not specify how much.

On 02/02/16 Resident #28 was transported to the Emergency Department (ED). Review of the ED notes dated 02/02/16 specified the resident presented with severe sepsis and in septic shock due to urinary tract infection (UTI). In the ED they attempted to get a urine specimen but documented that there was not enough urine. Resident #28 was also diagnosed with acute renal failure from the sepsis and dehydration. In the ED, Resident #28's urinary catheter was changed and the hospital was able to obtain "reddish pussy urine." Resident #28 was admitted to the Intensive Care Unit (ICU). Resident #28 was discharged from the hospital on 02/11/16 to another facility with a "fair" potential for rehab.

On 02/05/16 Nurse #2 documented a late entry for 02/02/16 that Resident #28 was able to make

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her needs known, the nurse aide (NA) reported resident complained of pain all over and was medicated with Oxycodone. The entry specified the Resident was alert and verbal and noted to be heavily covered up. "Urinary catheter noted with cloudy urine approximately 100cc (cubic centimeters) output." At 3:15 AM resident continued to complain of pain. Resident was noted to be slightly diaphoretic (sweating) and temperature in room was elevated. "Resident appears in no distress."

On 03/21/16 at 4:00 PM Nurse #2 was interviewed on the telephone and stated that she was assigned to work 02/01/16 at 11 PM to 02/02/16 until 7 AM which was a double shift (16 hours) for her. The nurse explained that she did not routinely work the hall with Resident #28 and was not overly familiar with the resident. The nurse recalled the night she was assigned to Resident #28 and her numerous complaints of pain. The nurse stated that she asked the nurse aides about the resident's complaints of pain and they reported to her that the resident "always" complained of pain and that it was normal for her. The nurse explained that when a resident complained of pain she would administer pain medication if ordered, wait 30-60 minutes to assess effectiveness of the pain medication. She added that if the pain was not resolved she would contact the physician. She stated that in the case of Resident #28 she did not call the physician because she did not feel anything was wrong with the resident and at the end of her shift (7 AM) the 2 doses of Oxycodone and 1 dose of Tylenol (650milligrams) appeared to be effective because the resident was no longer complaining of pain. The nurse added that Resident #28's urine output had been poor during the same shift and the

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nurse aides reported that the resident's intake had been poor. The nurse explained that she wasn't concerned with the low urine output since the resident's intake was poor and that during night residents urinated less.

Review of Resident #28's Medication Administration (MAR) record for January 2016 and February 2016 revealed the resident received "as needed" pain medication less than daily expect on 02/02/16 she received 3 doses of "as needed" pain medication.

On 3/22/16 at 10:15 AM Nurse #4 was interviewed and stated she was the nurse assigned to Resident #28 on 02/02/16 from 7 AM to 3 PM. The Nurse explained the resident slept the majority of the shift and was refusing all intake and this was unusual for the resident. Nurse #4 explained that at the end of the shift nurse aide #2 reported to her that Resident #28's catheter bag was empty. The nurse stated that this was concerning to her because the Resident had been drinking fluids and the physician would need to be called. The nurse stated that it was the end of her shift when she became aware of the no urine output and she passed the concern along in report and expected that Nurse #3 follow-up by assessing the resident and contacting the physician. Nurse #4 stated that she did not call the physician earlier in the shift because there was "nothing to call about." Nurse #4 stated that if the nurse aide had reported sooner the resident had no urine output then she would have checked on the resident and contacted the physician.

On 03/22/16 at 10:30 AM Nurse #3 was interviewed on the telephone and reported that

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F 157	Continued From page 7	F 157		

she was assigned to care for Resident #28 on 02/02/16 from 3 PM to 11 PM. The nurse explained that the shift was very hectic because when she arrived for her shift she was notified that a pharmacy consultant would be following her on her medication pass. The nurse stated that she was not given any concerns in report about her residents or Resident #28. The nurse stated she did not assess Resident #28 or contact the physician because she was not aware the resident had gone 8 hours with no urine output and/or was complaining of being sick.

On 03/22/16 at 4:10 PM the Director of Nursing (DON) was interviewed and reported that she would expect nurse aides to report concerns of no urine output to the nurse and for the nurse to follow-up with that concern by assessing the resident to determine if the physician needed to be contacted. The DON explained that an assessment would include checking the catheter to make sure it was patent (able to flow) and look for signs of a change such as distended abdomen newness of pain. She added that if concerns were identified the nurse would be expected to call the physician.

On 03/23/16 at 8:48 AM the physician was interviewed on the telephone and explained that if a resident was having no urine output the nurse would be expected to assess the catheter and if unable to provide explanation for the no urine output then contact the physician. The physician stated that the need to contact the physician would rely on nursing judgement and a clinical assessment with data to support a change in the resident's condition.

On 03/22/16 at 4:30 PM the Administrator was

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notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 03/24/16. The following interventions were put into place to remove the immediate jeopardy.

F-157 Failure to notify MD of status change
1. Resident #28 no longer resides in the facility. Resident was transferred to hospital 2/2/16 and did not return to this facility upon discharge from hospital. The alleged deficient practice included a change in condition/overall status of the resident related to decrease output and mental changes which were not immediately assessed and identified and reported to the MD.

2. All residents have the potential to be affected by the alleged deficient practice. On 3/22/16 and 3/23/16 all residents were observed by licensed nursing staff to determine if they had a significant change in their physical or mental status. Any resident observed with a significant change in their physical or mental status was further assessed utilizing the Change Status Assessment. This assessment is a comprehensive assessment including all body systems, vital signs, medications and labs and functional status as well as documentation of the resident's Physician (MD) and Responsible Party (RP) notification. All residents with a catheter have been assessed by licensed nurses March 22 thru March 23, 2016 using the Nursing Change in Status Assessment tool 3/22 & 23, 2016 to identify any changes in status utilizing the Nursing change in status form. The Care plans for patients with catheters have been revised by the licensed nurse on March 23rd, 2016 to include notification of MD for decreased output or any identified status changes including pain, chill,

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change in color, consistency of urine or mental status changes.

3. Licensed Nurses will be in-serviced March 22, 2016 thru March 23rd prior to their next scheduled shift to work by the Director of Nursing/Designee on notifying the resident ' s MD and RP when a resident experiences a significant change in status including assessment of residents with catheters utilizing the Change of status assessment which includes assessment of output each shift and notification of MD and RP when decreased output or other identified status changes occur including pain, chills change in color consistency of urine or mental status changes. Licensed nursing staff also in-serviced on the use of the Change in status assessment form and the utilization of the 24 hour shift report as communication tools to report and document resident status changes on March 22-23 by the Director of Nursing. The Nursing assistants (NA) were in-serviced by Director of Nursing March 22, 2016 thru March 23rd on what constitutes and how to identify a significant change in resident condition including, but not limited to the following: no urinary output, change in color or consistency of the urine, mental status changes, nausea, vomiting, and pain and the need for immediate notification of the Licensed Nurse when they identify a change in the resident ' s status. Licensed nurses or NAs not yet in-serviced will be required to complete the in-service prior to working their next scheduled shift. They will not be allowed to work until they have completed the in-services.

4. Individual nurses identified in the alleged deficient practice were in-serviced by the Director of Nursing on March 22 on completion of the

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F 157	Continued From page 10 change of status assessment which becomes a part of the electronic medical record and includes notification of the MD and RP when a change is identified. The identified NA has been in-serviced the Director of Nursing March 23 on what constitutes a significant change in resident status and on immediate notification of the Licensed Nurse for any identified change in the resident occurs including no urinary output, change in color, consistency, or odor of urine, mental status changes, nausea, vomiting, vital signs or anything they see as a change in the patient. The facility will utilize the 24 Hour shift to shift report as a communication tool to document status changes. The nurse will document any changes that occur during their shift and verbally communicate changes in status of residents from this tool during shift to shift report at shift change. For verification both nurses will be required to record their initials beside each residents name and information on the report as proof of receiving and giving report of status changes. Director of Nursing/Designee will monitor compliance by review of the 24 Hour report. Immediate Jeopardy was removed on 03/24/16 at 2:30 PM when the facility provided evidence of additional training provided to the nursing staff that proved they were aware of the new system for notifying the physician of a resident's change in condition.	F 157		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 224		4/1/16

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F 224	Continued From page 11 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff, physician and family interviews and record review the facility neglected to seek medical intervention when it was reported that a resident had been drinking fluids but had no urine output for 8 hours and complained of not feeling well. The resident ' s family requested Emergency Medical Services (EMS) and the resident was admitted to Intensive Care Unit (ICU) diagnosed with septic shock and acute renal failure for 1 of 1 sampled resident (Resident #28). Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #28 was admitted to the facility on 09/20/15 with diagnoses that included Alzheimer's disease, history of urinary tract infections, flaccid neuropathic bladder, urine retention, anorexia,	F 224	It is the policy of this facility that all residents are provided with the goods and services necessary to avoid physical harm, mental anguish or mental illness. 1. Resident #28 no longer resides in the facility. 2. For other resident□s with the potential to be affected by this cited deficiency the following has been accomplished. On 3/22 &3/23 all residents were observed by Licensed Nursing staff to determine if they experienced a significant change in their physical or mental status. Residents with catheters were assessed utilizing the Nursing Change in Condition Assessment to identify any changes in their physical or mental status. Residents with an identified significant change in physical or mental status had a nursing assessment completed by a licensed nurse utilizing the Nursing Change in Condition Assessment on March 22&23, 2016. Physician was notified for any identified Change in Condition on March 22 & 23, 2016. 3. Licensed Nurses were in-serviced by the Director of Nursing/Designee on March 22 thru April 1, 2016 regarding neglect related to failure to complete a nursing assessment and provide care	

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F 224	Continued From page 12 constipation, hypothyroidism, hypertension, pernicious anemia and a sacral ulcer. The most recent Minimum Data Set (MDS) dated 01/12/16 specified the resident had moderately impaired cognition but had clear speech and able to make herself understood; she required extensive assistance with activities of daily living but was able to feed herself with setup from staff; and had an indwelling urinary catheter. The MDS also specified the resident received as needed pain medication and was not on Hospice. Resident #28 had a care plan for her urinary catheter updated on 01/26/16 that specified the bag was to be emptied every shift and to provide catheter care as ordered. The care plan goal was that the resident would not experience catheter relates issues such as failure to drain. Resident #28 received a therapeutic, mechanically altered diet with regular liquids. On 01/31/16 review of Resident #28's urine output revealed the Resident went 24 hours with no urine output. No documentation was made in the medical record on 01/31/16 that an assessment had been completed for no urine output or that the physician had been contacted. On 02/01/16 review of Resident #28's urine output revealed the Resident #28 went 24 hours and only had 50ml of urine. No documentation that an assessment had been completed for the decreased urine output or that the physician had been contacted. On 02/02/16 at 5:00 PM a nurse's entry made by the nurse supervisor specified the family of Resident #28 was visiting and reported that the	F 224	when a resident has a change in status/condition including when a C.N.A. reports a change in resident□s condition. In-service including use of the Nursing Change in Condition Assessment and the use of the Twenty-four Hour report to identify changes in status from shift to shift was completed by Director of Nursing on March 22 thru April 1, 2016. New hired licensed nurses will complete inservice during orientation. Any licensed nurse who has not completed in-service will complete prior to next scheduled shift. The C.N.A. staff were in-serviced by the Director of Nursing/Designee on March 22 thru April 1, 2016 on how to identify a significant change in resident□s status/condition and what constitutes a significant change in condition including but not limited to the following: no urinary output, changes in color, consistency or odor of urine, mental status changes, nausea, vomiting, and pain and to notify the Licensed Nurse immediately of any change they identify. New hired CNAs will be inserviced during orientation. The Nursing staff will utilize the Twenty-four Hour Report as a communication tool to document changes in status/condition from shift to shift and will initial each resident on the Twenty-four hour report to verify Changes in Resident□s status/condition are communicated and followed up on shift to shift. The Director of Nursing/Designee will review the Twenty-four hour Report to identify Resident changes in status/condition and validate assessment	

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F 224	Continued From page 13 resident was not acting right and demanded the resident be sent to the Emergency Department. Resident #28's blood pressure was 95/54 and temperature was 99.4 degrees Fahrenheit, heart rate was 115 beats per minute and resting respirations were 34. The resident was noted to have 0 ml in Foley catheter bag. The Emergency Medical Services (EMS) "run report" dated 02/02/16 at 6:15 PM specified Resident #28 was somnolent and had a fever of 100.3 degrees Fahrenheit. The Resident was given 200ml of normal saline intravenously. EMS documented the resident had "thick discolored" urine in catheter bag but did not specify how much. On 02/02/16 Resident #28 was transported to the Emergency Department (ED). Review of the ED notes dated 02/02/16 specified the resident presented with severe sepsis and in septic shock due to urinary tract infection (UTI). In the ED they attempted to get a urine specimen but documented that there was not enough urine. Resident #28 was also diagnosed with acute renal failure from the sepsis and dehydration. In the ED, Resident #28's urinary catheter was changed and the hospital was able to obtain "reddish pussy urine." Resident #28 was admitted to the Intensive Care Unit (ICU). Resident #28 was discharged from the hospital on 02/11/16 to another facility with a "fair" potential for rehab. On 3/21/16 at 1:10 PM a family member of Resident #28 was interviewed on the telephone and reported that the family visited twice daily. The family member explained that on 02/02/16 around 4:30 PM she visited the resident and the	F 224	and follow up including Physician notification. 4. The Director of Nursing/Designee will complete audits 2x a week x 2 weeks and then weekly x 1 month utilizing the Twenty- four hour Report to validate identified changes in Residents status/condition are identified and follow-up including assessment and Physician notification is completed for those residents with an identified change in status/ condition. Results of audits will be reviewed by the QA committee x 2 months for trending and tracking and on-going monitoring.	

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resident was not her usual self. She explained that the resident was very lethargic and did not engage in conversation with the family as she usually did. The family member added that she attempted to get a nurse and the nurse told her that she was on a medication pass. The family member located a nurse supervisor and asked that the resident be transported to the ED. The family stated that since the hospitalization and time in ICU the resident's cognition was not the same.

On 3/22/16 at 10:15 AM Nurse #4 was interviewed and stated she was the nurse assigned to Resident #28 on 02/02/16 from 7 AM to 3 PM. The Nurse explained the resident slept the majority of the shift and was refusing all intake and this was unusual for the resident because would usually at least accept bites of food. Nurse #4 reported that she did not complete an assessment on Resident #28 that included checking her catheter or assessing her abdomen because the shift had been very busy and the resident did not appear to be in distress. Nurse #4 stated that by the end of the shift she estimated the resident drank a combined total of 60 - 120ml of water during the shift. Nurse #4 explained that at the end of the shift nurse aide #2 reported to her that Resident #28's catheter bag was empty. The nurse stated that this was concerning to her because the Resident had been drinking fluids and the physician would need to be called. During the shift the nurse aide had obtained vitals on the resident and according to Nurse #4 the vitals were "okay." The nurse stated that it was the end of her shift when she became aware of the no urine output and she passed the concern along in report and expected that Nurse #3 follow-up by assessing the resident

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and contacting the physician. Nurse #4 stated that she did not call the physician earlier in the shift because there was "nothing to call about." Nurse #4 added that she wished the nurse aide had reported earlier in the shift the poor urine output. The nurse also stated that she had been in the resident's room a "few times" during the shift but had not visualized the catheter bag because it was on the other side of the bed and she had not assessed Resident #28's catheter or abdomen.

On 03/22/16 at 10:30 AM Nurse #3 was interviewed on the telephone and reported that she was assigned to care for Resident #28 on 02/02/16 from 3 PM to 11 PM. The nurse explained that the shift was very hectic because when she arrived for her shift she was notified that a pharmacy consultant would be following her on her medication pass. The nurse stated that she was not given any concerns in report about her residents and therefore did not conduct an initial round on her residents to check them. Nurse #3 reported that it was her usual practice to make a brief round to "spot check" her residents. Nurse #3 stated that she was not told in report that Resident #28 had gone 8 hours with no urine output. Nurse #3 proceeded to explain that she was completing her medication pass when family of Resident #28 arrived. She added that moments later the nurse supervisor asked the nurse to assess Resident #28 because she was not acting right. Nurse #3 stated she had to finish administering the medications already prepared before she could attend to Resident #28. Nurse #3 estimates she waited 5 to 10 minutes before responding to concern about the resident. Nurse #3 stated that this was around 4:30 - 5 PM and that when she went into Resident

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#28's room it was the first time since her shift had started that she had visualized the resident. Nurse #3 reported that when she went into the room the resident was not her usual self, less alert and her response was very slow. Nurse #3 did not know how long the resident had been in that condition. The nurse also was not aware of how much urine was in the catheter bag and did not have time to fully assess because the family was insistent n calling 911.

The nurse aide assigned to Resident #28 on 02/02/16 from 3 PM to 11 PM was no longer employed at the facility unable to be interviewed.

On 03/22/16 at 1:00 PM the nurse supervisor was interviewed and reported that she was working on 02/02/16 and did not recall any concerns being reported that day about Resident #28. The nurse supervisor explained that around 5 PM the resident's family came and expressed concern that the resident was not acting right and wanted the resident sent to the ED. She added that she reported the concern to Nurse #3 who was busy completing a medication pass. And added that since Nurse #3 was busy she went to the room to check on Resident #28. The nurse supervisor reported that the family was concerned that the resident wouldn't speak but when the nurse supervisor called the resident's name, the resident was able to turn her head and respond. She stated that she glanced at the catheter bag and noted that it was empty. The nurse supervisor added that after the incident she became aware that the resident had gone a few days without having much urine output. She explained that no urine output in 8 hours would be a "flag" and the physician would need to be called. The nurse stated that prior to the incident

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the resident had not been declining in health. The nurse supervisor explained the process for documenting and monitoring fluid intake and urine output for residents with urinary catheters. She stated that the nurse aides were responsible for measuring and documenting the total amount of urine in the catheter bag into the computer. She went on to add that if a concern was noted with the urinary output such as being less than usual or change in appearance or not urine output the nurse aide would report the concern to the nurse. The nurse supervisor stated that the nurse aides were aware and educated to be accurate with their documentation.

On 03/22/16 at 4:10 PM the Director of Nursing (DON) was interviewed and reported that she would expect nurse aides to report concerns of no urine output to the nurse and for the nurse to follow-up with that concern by assessing the resident to determine if the physician needed to be contacted. The DON explained that an assessment would include checking the catheter to make sure it was patent (able to flow) and look for signs of a change such as distended abdomen newness of pain. She added that if concerns were identified the nurse would be expected to call the physician.

On 03/23/16 at 8:48 AM the physician was interviewed on the telephone and explained that if a resident was having no urine output the nurse would be expected to assess the catheter and if unable to provide explanation for the no urine output then contact the physician. The physician stated that the need to contact the physician would rely on nursing judgement and a clinical assessment with data to support a change in the resident's condition.

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F 224	Continued From page 18 On 03/23/16 at 3:45 PM NA #4 was interviewed and reported that on 02/02/16 she reported for her 3 PM to 11 PM shift and was told by NA #2 that Resident #28 was not acting right and was sick and the nurses were aware. The NA went on to explain that she checked on the resident frequently that shift and the resident only wanted to sleep which was not usual for her and that she obtained vitals on the resident and the resident slept through getting her vitals taken. The NA recalled that the resident's vitals were "okay." NA #4 stated that during the shift she asked the nurse supervisor if she knew what was wrong with Resident #28 and the nurse supervisor stated she was not aware anything was wrong with the resident. The NA added that around 5 PM she left the hall to help with the evening meal in the dining room and when she came back the resident had been transported to the ED. On 03/22/16 at 4:30 PM the Administrator was notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 03/24/16. The following interventions were put into place to remove the immediate jeopardy. F-224 Neglect/Failure to assess resident to identify status change 1. Resident #28 no longer resides in the facility. Resident was transferred to hospital 2/2/16 and did not return to this facility upon discharge from hospital. The alleged deficient practice included a change in condition/overall status of the resident related to decrease output and mental changes which were not immediately assessed and identified and reported to the MD.	F 224		

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2. All residents have the potential to be affected by this alleged deficient practice. On 3/22 and 3/23 all residents were observed by Licensed nursing staff to determine if they experienced a significant change in status in their physical or mental status. Any resident observed with a significant change in status was further assessed utilizing the Change in status assessment tool which is a comprehensive assessment of body systems, medications, vital signs, labs and functional status as well as documentation of the resident's Physician (MD) and Responsible Party (RP) notification. Licensed nursing staff also in-serviced on the use of the Change in status assessment form and the utilization of the 24 hour shift report as communication tools to report and document resident status changes on March 22 thru March 23 by the Director of Nursing. All residents with catheters were assessed by licensed nurses on March 22, 2016 to identify any change in status utilizing the Change in Status Assessment which includes a complete assessment of the resident including pain, lab, and system review as well as documentation of MD/RP notification. Care plans were updated for the patients with catheters to include notification of the MD when decreased output or any other status changes occur including chills, pain, change in color consistency, and odor of urine, mental status change.

3. Licensed Nurses were in-serviced March 22, 2016 thru March 23rd prior to their next scheduled shift to work by the Director of Nursing/designee regarding neglect related to failure to complete an assessment and provide care when a resident has a change in status including follow up when Nursing Assistant (NA)

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F 224	Continued From page 20 staff report a change in resident condition. The Nursing assistants (NA) were in-serviced by Director of Nursing March 22, 2016 thru March 23rd on what constitutes and how to identify a significant change in resident condition including, but not limited to the following: no urinary output, change in color or consistency of the urine, mental status changes, nausea, vomiting, and pain and the need for immediate notification of the Licensed Nurse when they identify a change in the resident's status. Licensed nurses and NAs who have not completed in-service will be required to complete in-service prior to their next scheduled shift to work. They will not be allowed to work until they have completed the in-services. 4. The facility will utilize the 24 Hour shift to shift report as a communication tool to document status changes. The nurse will document any changes that occur during their shift and verbally communicate changes in status of residents from this tool during shift to shift report at shift change. For verification both nurses will be required to record their initials beside each residents name and information on the report as proof of receiving and giving report of status changes. Director of Nursing/Designee will monitor compliance by review of the 24 Hour report. Immediate Jeopardy was removed on 03/24/16 at 2:30 PM when the facility provided evidence of additional training provided to the nursing staff that proved they were aware of the new system for monitoring, assessing and reporting changes in a resident's condition.	F 224		
F 315 SS=J	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		4/1/16

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F 315	Continued From page 21 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff, physician and family interviews and record review the facility failed to assess a resident when her condition changed. The Resident went 72 hours with little to no urine output, complained of pain, refused to eat before being sent to the Emergency Department where she was admitted to Intensive Care Unit (ICU) for septic shock and acute renal failure for 1 of 3 sampled residents (Resident #28). Immediate jeopardy began on 01/31/16 when Resident #28 had no urine output and was not assessed for a change in condition. Immediate jeopardy was removed on 03/24/16 when the facility implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity level D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee and resident education and ensure monitoring systems in place are effective. The findings included: Resident #28 was admitted to the facility on	F 315	It is the policy of this facility that based on the resident's assessment, the facility must assure care and services are provided to prevent urinary tract infections for residents with catheters. 1. Resident #28 no longer resides in the facility. 2. For other resident□s with the potential to be affected by this cited deficiency the following has been accomplished. On 3/22 &3/23 all residents were observed by Licensed Nursing staff to determine if they experienced a significant change in their physical or mental status. Residents with catheters were assessed utilizing the Nursing Change in Condition Assessment to identify any changes in their physical or mental status. Residents with an identified significant change in physical or mental status had a nursing assessment completed by a licensed nurse utilizing the Nursing Change in Condition Assessment on March 22&23, 2016. Physician was	

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09/20/15 with diagnoses that included Alzheimer's disease, history of urinary tract infections, flaccid neuropathic bladder, urine retention, anorexia, constipation, hypothyroidism, hypertension, pernicious anemia and a sacral ulcer. The most recent Minimum Data Set (MDS) dated 01/12/16 specified the resident had moderately impaired cognition but had clear speech and able to make herself understood; she required extensive assistance with activities of daily living but was able to feed herself with setup from staff; and had an indwelling urinary catheter. The MDS also specified the resident received as needed pain medication and was not on Hospice.

Resident #28 had a care plan for her urinary catheter updated on 01/26/16 that specified the bag was to be emptied every shift and to provide catheter care as ordered. The care plan goal was that the resident would not experience catheter relates issues such as failure to drain.

Resident #28 received a therapeutic, mechanically altered diet with regular liquids.

A review of Resident #28's total daily fluid intake with meals and total urine output (measured in milliliters and documented by the nurse aides) revealed:

Date	Fluid in	Urine out
1/21/16	360ml	600ml
1/22/16	600ml	400ml
1/23/16	360ml	325ml
1/24/16	600ml	200ml
1/25/16	720ml	450ml
1/26/16	180ml	900ml
1/27/16	300ml	300ml
1/28/16	480ml	700ml
1/29/16	560ml	1750ml

notified for any identified Change in Condition on March 22 & 23, 2016.

3. Licensed Nurses were inserviced by the Director of Nursing/Designee on March 22 thru April 1, 2016 regarding failure to complete a nursing assessment and provide care when a resident has a change in status/condition including when a CNA reports a change in resident's condition. The inservice included no urinary output, changes in color, consistency or odor of urine, mental status changes, nausea, vomiting, and pain. In-service of licensed nurses including use of the Nursing Change in Condition Assessment and the use of the Twenty-four Hour report to identify changes in status from shift to shift was completed by Director of Nursing on March 22 thru April 1, 2016. New hired licensed nurses will be inserviced during orientation. Any licensed nurse who has not completed in-service will complete prior to next scheduled shift.

The C.N.A. staff were inserviced by the Director of Nursing/Designee on March 22 thru April 1, 2016 on how to identify a significant change in resident□s status/condition and what constitutes a significant change in condition including but not limited to the following: no urinary output, changes in color, consistency or odor of urine, mental status changes, nausea, vomiting, and pain and to notify the Licensed Nurse immediately of any change they identify. New hired CNAs will

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F 315	Continued From page 23 1/30/16 840ml 400ml 1/31/16 720ml 0ml 2/01/16 440ml 50ml 2/02/16 0ml 0ml The fluid intake documented was from meals only documented by the nurse aides and did not include water with medication pass. On 01/21/16 the nurse practitioner (NP) saw Resident #28 for a routine visit. The NP noted that the resident had a chronic urinary catheter, made no changes to the resident's medications and ordered routine laboratory work. On 01/25/16 the NP was asked to review Resident #28 for decreased solid oral intake. The NP assessed that the resident's abdomen was soft, non-tender and without mass. The NP increased the resident's medication for Alzheimer's, discontinued a salt restriction, added a fortified nutritional supplement and recommended monitoring for weight loss, signs of increased agitation and decreased oral intake. On 01/26/16 the nurse documented in the medical record that Resident #28's urinary catheter was patent and draining yellow urine. On 01/31/16 at 5 PM a nurse's entry made by the Nurse Supervisor specified Resident #28's urinary catheter was intact and that, "The resident had not complained of leaking, dysuria, distention or bladder pain; that there had been no report of a change in the resident's condition and the catheter bag was emptied every shift by the nurse aides." On 01/31/16 review of Resident #28's urine	F 315	be inserviced during orientation. The Nursing staff will utilize the Twenty-four Hour Report as a communication tool to document changes in status/condition from shift to shift and will initial each resident on the Twenty-four hour report to verify Changes in Resident□s status/condition are communicated and followed up on shift to shift. The Director of Nursing/Designee will review the Twenty-four hour Report to identify Resident changes in status/condition and validate assessment and follow up including Physician notification. 4. The Director of Nursing/Designee will complete audits 2x a week x 2 weeks and then weekly x 1 month utilizing the Twenty- four hour Report to validate identified changes in Residents status/condition are identified and follow-up including assessment and Physician notification is completed for those residents with an identified change in status/ condition. Results of audits will be reviewed by the QA committee x 2 months for trending and tracking and on-going monitoring.	

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output revealed the Resident went 24 hours with no urine output. No documentation was made in the medical record on 01/31/16 that an assessment had been completed for no urine output or that the physician had been contacted.

On 02/01/16 at 4 PM a nurse's entry made by the nurse supervisor specified Resident #28's, "urinary catheter was intact and that the resident had not complained of leaking, dysuria, distention or bladder pain and the bag was emptied by the nurse aides."

On 02/01/16 review of Resident #28's urine output revealed the Resident #28 went 24 hours and only had 50ml of urine. No documentation that an assessment had been completed for the decreased urine output or that the physician had been contacted.

Further review of the medical record revealed she received as needed pain medication ordered by the physician:
- On 02/02/16 at 1:25 AM the resident complained of generalized pain (not specified) and was given Oxycodone by Nurse #2.
- On 02/02/16 at 3:15 AM the resident complained of generalized pain (not specified) and was given Tylenol by Nurse #2.
- On 02/02/16 at 6:37 AM the resident continued to complain of generalized pain (not specified) and was given Oxycodone again by Nurse #2.

Review of the nurses' entries made by Nurse #2 revealed there was no documentation of a pain assessment.

On 02/02/16 at 2:04 PM a nurse's entry made by

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the Director of Nursing (DON) specified Resident #28's urinary catheter "was in place."

On 02/02/16 at 5:00 PM a nurse's entry made by the nurse supervisor specified the family of Resident #28 was visiting and reported that the resident was not acting right and demanded the resident be sent to the Emergency Department. Resident #28's blood pressure was 95/54 and temperature was 99.4 degrees Fahrenheit, heart rate was 115 beats per minute and resting respirations were 34. The resident was noted to have 0 ml in Foley catheter bag.

The Emergency Medical Services (EMS) "run report" dated 02/02/16 at 6:15 PM specified Resident #28 was somnolent and had a fever of 100.3 degrees Fahrenheit. The Resident was given 200ml of normal saline intravenously. EMS documented the resident had "thick discolored" urine in catheter bag but did not specify how much.

On 02/02/16 Resident #28 was transported to the Emergency Department (ED). Review of the ED notes dated 02/02/16 specified the resident presented with severe sepsis and in septic shock due to urinary tract infection (UTI). In the ED they attempted to get a urine specimen but documented that there was not enough urine. Resident #28 was also diagnosed with acute renal failure from the sepsis and dehydration. In the ED, Resident #28's urinary catheter was changed and the hospital was able to obtain "reddish pussy urine." Resident #28 was admitted to the Intensive Care Unit (ICU). Resident #28 was discharged from the hospital on 02/11/16 to another facility with a "fair" potential for rehab.

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On 02/05/16 Nurse #2 documented a late entry for 02/02/16 that Resident #28 was able to make her needs known, the nurse aide (NA) reported resident complained of pain all over and was medicated with Oxycodone. The entry specified the Resident was alert and verbal and noted to be heavily covered up. "Urinary catheter noted with cloudy urine approximately 100cc (cubic centimeters) output." At 3:15 AM resident continued to complain of pain. Resident was noted to be slightly diaphoretic (sweating) and temperature in room was elevated. "Resident appears in no distress."

On 3/21/16 at 1:10 PM a family member of Resident #28 was interviewed on the telephone and reported that the family visited twice daily. The family member explained that on 02/02/16 around 4:30 PM she visited the resident and the resident was not her usual self. She explained that the resident was very lethargic and did not engage in conversation with the family as she usually did. The family member added that she attempted to get a nurse and the nurse told her that she was on a medication pass. The family member located a nurse supervisor and asked that the resident be transported to the ED. The family stated that since the hospitalization and time in ICU the resident's cognition was not the same.

On 03/21/16 at 4:00 PM Nurse #2 was interviewed on the telephone and stated that she was assigned to work 02/01/16 at 11 PM to 02/02/16 until 7 AM which was a double shift (16 hours) for her. The nurse explained that she did not routinely work the hall with Resident #28 and was not overly familiar with the resident. The

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nurse recalled the night she was assigned to Resident #28 and her numerous complaints of pain. The nurse stated that she asked the nurse aides about the resident's complaints of pain and they reported to her that the resident "always" complained of pain and that it was normal for her. The nurse explained that when a resident complained of pain she would administer pain medication if ordered, wait 30-60 minutes to assess effectiveness of the pain medication. She added that if the pain was not resolved she would contact the physician. She stated that in the case of Resident #28 she did not call the physician because she did not feel anything was wrong with the resident and at the end of her shift (7 AM) the 2 doses of Oxycodone and 1 dose of Tylenol (650milligrams) appeared to be effective because the resident was no longer complaining of pain. The nurse added that Resident #28's urine output had been poor during the same shift and the nurse aides reported that the resident's intake had been poor. The nurse explained that she wasn't concerned with the low urine output since the resident's intake was poor and that during night residents urinated less. She stated that she visualized the catheter bag but could not recall what the bag had in it or what the resident's urine looked like. The nurse stated that she recalled a nurse aide reporting something to her about the resident's catheter but couldn't remember the details. The nurse stated that low urine output was considered less than 30cc (cubic centimeters) urine in 8 hours or no urine output in 8 hours. The nurse could not recall if she assessed the resident's abdomen or catheter by checking placement and did not obtain vitals on the resident or call the physician because the resident did not appear in distress.

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Review of Resident #28's Medication Administration (MAR) record for January 2016 and February 2016 revealed the resident received "as needed" pain medication less than daily expect on 02/02/16 she received 3 doses of "as needed" pain medication.

On 3/22/16 at 10:15 AM Nurse #4 was interviewed and stated she was the nurse assigned to Resident #28 on 02/02/16 from 7 AM to 3 PM. The Nurse explained the resident slept the majority of the shift and was refusing all intake and this was unusual for the resident. She added that Resident #28 had poor intake but usually accepted some of her meals. Nurse #4 reported that she did not complete an assessment on Resident #28 that included checking her catheter or assessing her abdomen because the shift had been very busy and the resident did not appear to be in distress. Nurse #4 stated that by the end of the shift she estimated the resident drank a combined total of 60 - 120ml of water during the shift. Nurse #4 explained that at the end of the shift nurse aide #2 reported to her that Resident #28's catheter bag was empty. The nurse stated that this was concerning to her because the Resident had been drinking fluids and the physician would need to be called. During the shift the nurse aide had obtained vitals on the resident and according to Nurse #4 the vitals were "okay." The nurse stated that it was the end of her shift when she became aware of the no urine output and she passed the concern along in report and expected that Nurse #3 follow-up by assessing the resident and contacting the physician. Nurse #4 stated that she did not call the physician earlier in the shift because there was "nothing to call about." Nurse #4 added that she wished the nurse aide

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had reported earlier in the shift the poor urine output. The nurse also stated that she had been in the resident's room a "few times" during the shift but had not visualized the catheter bag because it was on the other side of the bed and she had not assessed Resident #28's catheter or abdomen.

On 03/22/16 at 10:30 AM Nurse #3 was interviewed on the telephone and reported that she was assigned to care for Resident #28 on 02/02/16 from 3 PM to 11 PM. The nurse explained that the shift was very hectic because when she arrived for her shift she was notified that a pharmacy consultant would be following her on her medication pass. The nurse stated that she was not given any concerns in report about her residents and therefore did not conduct an initial round on her residents to check them. Nurse #3 reported that it was her usual practice to make a brief round to "spot check" her residents. Nurse #3 stated that she was not told in report that Resident #28 had gone 8 hours with no urine output. Nurse #3 proceeded to explain that she was completing her medication pass when family of Resident #28 arrived. She added that moments later the nurse supervisor asked the nurse to assess Resident #28 because she was not acting right. Nurse #3 stated she had to finish administering the medications already prepared before she could attend to Resident #28. Nurse #3 estimates she waited 5 to 10 minutes before responding to concern about the resident. Nurse #3 stated that this was around 4:30 - 5 PM and that when she went into Resident #28's room it was the first time since her shift had started that she had visualized the resident. Nurse #3 reported that when she went into the room the resident was not her usual self, less

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alert and her response was very slow. Nurse #3 did not know how long the resident had been in that condition. The nurse also was not aware of how much urine was in the catheter bag and did not have time to fully assess because the family was insistent n calling 911.

The nurse aide assigned to Resident #28 on 02/02/16 from 3 PM to 11 PM was no longer employed at the facility unable to be interviewed.

On 03/22/16 at 1:00 PM the nurse supervisor was interviewed and reported that she was working on 02/02/16 and did not recall any concerns being reported that day about Resident #28. The nurse supervisor explained that around 5 PM the resident ' s family came and expressed concern that the resident was not acting right and wanted the resident sent to the ED. She added that she reported the concern to Nurse #3 who was busy completing a medication pass. And added that since Nurse #3 was busy she went to the room to check on Resident #28. The nurse supervisor reported that the family was concerned that the resident wouldn't speak but when the nurse supervisor called the resident's name, the resident was able to turn her head and respond. She stated that she glanced at the catheter bag and noted that it was empty. The nurse supervisor added that after the incident she became aware that the resident had gone a few days without having much urine output. She explained that no urine output in 8 hours would be a "flag" and the physician would need to be called. The nurse stated that prior to the incident the resident had not been declining in health. The nurse supervisor explained the process for documenting and monitoring fluid intake and urine output for residents with urinary catheters.

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She stated that the nurse aides were responsible for measuring and documenting the total amount of urine in the catheter bag into the computer. She went on to add that if a concern was noted with the urinary output such as being less than usual or change in appearance or not urine output the nurse aide would report the concern to the nurse. The nurse supervisor stated that the nurse aides were aware and educated to be accurate with their documentation.

On 03/22/16 at 1:38 PM nurse aide (NA) #3 was interviewed and stated she was assigned to Resident #28 on 01/31/16 from 11 PM to 7 AM. The NA reported that during the shift Resident #28 did not have any urine output and reported the resident's catheter and tubing was "bone dry;" and that she was "certain" she reported the concern to the nurse (she couldn't recall who the nurse was). The NA added that she did not know if the nurse assessed the resident after reporting the concern.

On 03/22/16 at 4:10 PM the Director of Nursing (DON) was interviewed and reported that she would expect nurse aides to report concerns of no urine output to the nurse and for the nurse to follow-up with that concern by assessing the resident to determine if the physician needed to be contacted. The DON explained that an assessment would include checking the catheter to make sure it was patent (able to flow) and look for signs of a change such as distended abdomen newness of pain. She added that if concerns were identified the nurse would be expected to call the physician. The DON reported that she had visualized Resident #28 on 02/02/16 between 8 - 9 AM during wound care. She added that the resident's abdomen did not

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look distended and the resident was able to carry on conversation during the treatment.

On 03/23/16 at 8:48 AM the physician was interviewed on the telephone and explained that if a resident was having no urine output the nurse would be expected to assess the catheter and if unable to provide explanation for the no urine output then contact the physician. The physician stated that the need to contact the physician would rely on nursing judgement and a clinical assessment with data to support a change in the resident's condition.

On 3/23/16 at 2:13 PM the nurse practitioner (NP) was interviewed on the telephone and reported that she had reviewed Resident #28 on 01/21/16 and 01/25/16 for routine visits and to liberalize the resident's diet to encourage better intake of food. The NP reported that there was no acute illness or change in the resident's condition during the visits.

On 03/23/16 at 3:45 PM NA #4 was interviewed and reported that on 02/02/16 she reported for her 3 PM to 11 PM shift and was told by NA #2 that Resident #28 was not acting right and was sick and the nurses were aware. The NA went on to explain that she checked on the resident frequently that shift and the resident only wanted to sleep which was not usual for her and that she obtained vitals on the resident and the resident slept through getting her vitals taken. The NA recalled that the resident's vitals were "okay." NA #4 stated that during the shift she asked the nurse supervisor if she knew what was wrong with Resident #28 and the nurse supervisor stated she was not aware anything was wrong with the resident. The NA added that around 5

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PM she left the hall to help with the evening meal in the dining room and when she came back the resident had been transported to the ED.

Attempts were made to contact the Emergency Department physician but he was unable to be reached.

On 03/22/16 at 4:30 PM the Administrator was notified of immediate jeopardy. The facility provided an acceptable credible allegation of compliance on 03/2416 at 2:30 PM. The following interventions were put into place to remove the immediate jeopardy.
F-315 Maintaining Urinary Catheter
1. Resident #28 no longer resides in the facility. Resident was transferred to hospital 2/2/16 and did not return to this facility upon discharge from hospital. The alleged deficient practice included a change in condition/overall status of the resident related to decrease output and mental changes which were not immediately assessed and identified and reported to the MD.

2. All residents have the potential to be affected by the alleged deficient practice. On March 22 &23, 2016 all residents were observed by licensed staff to determine if they had experienced a significant change in physical or mental status. Any resident observed with a significant change in status was further assessed by licensed nursing staff using the Change in status assessment which is a comprehensive assessment of body systems, medication, labs, vital sign and functional status as well as documentation of Physician (MD) and Responsible Party (RP) notification. All residents with a catheter have been assessed by licensed nurses on March 22, 2016 to identify any changes

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in status utilizing the Nursing change of status assessment which includes a complete assessment of the resident including pain, labs and body system assessment and documentation of MD/RP notification. The care plans for patients with catheters have been revised by the Licensed Nurse on March 23, 2016 to include notification of MD for decreased output, change in temperature, abnormal vital signs, chills, pain, any change in color, consistency or odor of urine, or mental status changes. The Nursing change of status assessment is completed and included in the electronic Medical Record and includes documentation of MD and RP notification.

3. Licensed Nurses were in-serviced March 22, 2016 thru March 23th prior to their next scheduled shift to work by the Director of Nursing/Designee on assessment and provision of care to residents who experience a significant change of status including notification of the resident ' s MD and RP when a resident experiences a significant change in status. Licensed Nurses were also in-serviced by the Director of Nursing on assessment of residents with catheters including assessment of output each shift and notification of MD and RP when decreased output or other identified status changes occur including mental status changes, chills, change in consistency, color or odor of urine, pain. They were also in-serviced on neglect related to failure to complete assessment when a patient has a change in status. Licensed nursing staff also in-serviced on the use of the Change in status assessment form and the utilization of the 24 hour shift report as communication tools to report and document resident status changes on March 22-23 by the Director of Nursing. The Nursing assistants (NA) were in-serviced by the

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Director of Nursing March 22, 2016 thru March 23rd on what constitutes and how to identify a significant change in resident condition including, but not limited to the following: no urinary output, change in color or consistency of the urine, mental status changes, nausea, vomiting, and pain and the need for immediate notification of the Licensed Nurse when they identify a change in the resident ' s status. Staff who have not been in-serviced will be required to complete the in-service prior to the beginning of their next shift. They will not be allowed to work until in-services are completed.

4. Individual nurses identified in the alleged deficient practice were in-serviced by the Director of Nursing on March 22 on completion of the change of status assessment which becomes a part of the electronic medical record and includes notification of the MD and RP when a change is identified. The identified NA has been in-serviced by the Director of Nursing on March 23 on what constitutes a significant change in resident status and on immediate notification to the Licensed Nurse for any identified changes in the resident including no urinary output, change in color, consistency, or odor of urine, mental status changes, nausea, vomiting, vital signs or anything they see as a change in the patient.

The facility will utilize the 24 Hour shift to shift report as a communication tool to document status changes. The nurse will document any changes that occur during their shift and verbally communicate changes in status of residents from this tool during shift to shift report at shift change. For verification both nurses will be required to record their initials beside each residents name and information on the report as proof of

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F 315	Continued From page 36 receiving and giving report of status changes. Director of Nursing/Designee will monitor compliance by review of the 24 Hour report. Immediate Jeopardy was removed on 03/24/16 at 2:30 PM when the facility provided evidence of additional training provided to the nursing staff that proved they were aware of the new system for monitoring, assessing and reporting changes in a resident's condition.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to ensure that the medication error rate was 5% or below as evidence by 2 errors out of 27 opportunities resulting in a medication error rate of 7.4% for 1 of 7 residents observed during medication pass (Resident # 105). The findings included: 1a. Resident #105 was admitted to the facility on 03/11/16 with diagnoses that included neuropathy and gastroesophageal reflux disease (GERD). Minimum data set (MDS) information was not available for Resident #105. Review of medical record and staff interviews indicated that Resident #105 was cognitively intact.	F 332	It is the policy of this facility that residents will be free of any significant medication errors. 1. Resident #105 immediately received the correct dose of the two medications during the medication pass when the dosage error was identified. She originally received 20 mg of Prilosec and 400 mg of gabapentin. The order was 1200 mg of gabapentin and 40 mg of Prilosec. She was given an additional 800 mg of gabapentin and 20 mg of Prilosec to equal correct dose. 2. Any Resident receiving medication in the facility has the potential to be effected by this alleged deficient practice. The Licensed nurse who made the medication	4/1/16

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F 332	Continued From page 37 Review of Resident #105's medical record revealed a physician order dated 03/18/16 that read gabapentin capsule 400 milligram (mg) give 1200 mg by mouth 3 times a day for neuropathy. Observation of medication pass on 03/23/16 at 8:18 AM revealed Nurse #1 prepared Resident #105's medications which included gabapentin 400 mg one capsule. The medication was placed in a medication cup and administered to Resident #105. Interview with Nurse #1 on 03/23/16 at 9:38 AM confirmed that he had administered the incorrect dose of gabapentin to Resident #105. Nurse #1 stated that this was the first time he had worked with Resident #105 and he was aware that was no excuse but that was the truth. Nurse #1 further stated he did not notice the directions on the card of medication and that is why he administered the incorrect dose of medication. Interview with the Director of Nursing (DON) on 03/24/16 at 9:52 AM revealed that Nurse #1 was fairly new to the facility. The DON further stated that on February 2, 2016 Nurse #1 was observed by a nurse with the consultant pharmacy on medication pass and no concerns were noted. After the initial medication pass done by the pharmacy, the licensed nursing staff received a yearly medication pass observation and additional training was provided as needed. The DON stated that her expectation is that Nurse #1 would give the correct medication, correct dose, via the correct route to the correct patient at all times. The DON also stated that she expected all administration directions to be followed to ensure the medication was administered correctly.	F 332	error will complete a medication in-service for Policies and Procedures for medication pass by the Director of Nursing /Designee and will have a Medication Pass observation completed by the Pharmacy consultant by 4/1/2016. 3. The Licensed Nursing staff have been in-serviced on March 23 - April 1, 2016 on the Policies and Procedures for Medication Pass by the Director of Nursing/Designee. Licensed Nurses have also had a Medication Pass Observation completed by the Pharmacy Consultant/Director of Nursing/Regional QA nurse by 4/1/2016. New hired licensed nurses will complete inservice and Medication Pass Observation during orientation. 4. The Pharmacy consultant will complete at random a Medication Pass Observations monthly x 2 months. Results of Medication Pass Observations will be submitted to Quality Assurance Committee Monthly x 2 months for ongoing trending/tracking and monitoring.	

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F 332	Continued From page 38	F 332		

1b. Resident #105 was admitted to the facility on 03/11/16 with diagnoses that included neuropathy and gastroesophageal reflux disease (GERD). Minimum data set (MDS) information was not available. Review of the medical record and staff interviews indicated that Resident #105 was cognitively intact.

Review of Resident #105's medical record revealed a physician order dated 03/18/16 that read omeprazole capsule delayed release 40 mg one time a day for GERD.

Observation of medication pass on 03/23/16 at 8:18 AM revealed Nurse #1 prepared Resident #105 medications which included omeprazole capsule delayed release 20 mg one capsule. The medication was placed in a medication cup and administered to Resident #105.

Interview with Nurse #1 on 03/23/16 at 9:38 AM confirmed that he had administered the incorrect dose of omeprazole to Resident #105. Nurse #1 stated that this was the first time he had worked with Resident #105 and he was aware that was no excuse but that was the truth. Nurse #1 stated that he read the dosage on the package incorrectly.

Interview with Director of Nursing (DON) on 03/24/16 at 9:52 AM revealed that Nurse #1 was fairly new to the facility. The DON further stated that on February 2, 2016 Nurse #1 was observed by a nurse with the consultant pharmacy on medication pass and no concerns were noted. After the initial medication pass done by the pharmacy the licensed nursing staff received a yearly medication pass observation and additional training was provided as needed. The DON

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F 332	Continued From page 39 stated that her expectation is that Nurse #1 would give the correct medication, correct dose, via the correct route to the correct patient at all times. The DON also stated that she expected all administration directions to be followed to ensure the medication is administered correctly.	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to air dry 8 of 8 soup bowls before storing them, and to discard 1 apple and 3 heads of lettuce, all of which were visibly brown and spoiled. The findings included: 1. On 3/21/16 at 9:35 AM eight small bowls were observed stored on a flat tray, which was placed on a wire storage rack. All eight bowls were stored face down. Moisture was observed along the interior of each bowl. The Dietary Manager was interviewed at this time and stated the bowls should be allowed to air dry before they were stored. She removed the bowls and stated they	F 371	It is the facility policy to (1) procure food from the sources approved or considered satisfactory by the federal, state and local authorities and (2) store, prepare, distribute and serve food under sanitary conditions. 1. Dinex bowels with water droplets that were identified were not utilized for food service on March 21, 2016 They were immediately returned to the commercial dishwasher by the Dietary manager and re-cleaned and properly stored for air drying on 3/21/16. The lettuce and apples that were identified were discarded on March 21, 2016 by the	4/1/16

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F 371	Continued From page 40 would be rewashed and allowed to dry before storing them. On 3/21/16 at 12:00 PM during interview the Dietary Manager stated that all dishes should remain in the dish room to dry. Dishes should not be put away until totally dry. 2. On 3/21/16 at 9:38 AM a small stainless steel holding pan filled with yellow apples was observed in the walk-in cooler. The apple at the top of the pan was observed to be brown and appeared to be rotten on one side. The Dietary Manager removed the pan and stated the apples would be discarded. On 3/21/16 at 9:40 AM a clear plastic bag of what appeared to be wilted lettuce was observed on the bottom shelf of the walk-in cooler. The bag contained what appeared to be three heads of lettuce that were turning brown and appeared slimy. The bag was placed on the wire rack in front of a box of fresh heads of lettuce. The Dietary Manager stated the lettuce should have been discarded, but she did not think staff would have used it. On 3/21/16 at 12:05 PM during interview the Dietary Manger stated that she expects staff to discard old or spoiled produce right away, and that all staff are responsible for this.	F 371	Dietary Manager. 2. No resident experienced negative outcomes as a result of this cited deficiency. Any resident has the potential to be affected by this alleged deficient practice. No patients were affected as the bowls and the lettuce and apples were not utilized for food service on March 21, 2016. 3. In-service training was conducted for all Dietary Staff by the Dietary Manager and Regional Dietitian on March 21, 2016 regarding storage of dishes and storage of fresh produce. This training will be completed for any newly hired dietary employees as part of orientation. 4. The Dietary Manager or designee will complete a QA tracking tool 3x per week x 1 month and then randomly to assure compliance. Audit tracking tools were implemented on March 24, 2016. Results of these audits will be reported to the QA Committee monthly by the Dietary Manager with follow-up corrective action taken as needed to assure compliance.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		4/1/16

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F 520	Continued From page 41 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place in April 2015. This was for one recited deficiency which was originally cited in April 2015 on the recertification/complaint survey and on the current recertification/complaint survey. The deficiency was in the area of nutritional/therapeutic diet. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assessment and Assurance Program.	F 520	It is the policy to maintain a quality assessment and assurance committee consisting of the director of nursing, a physician designated by the facility and at least three other members of the facility□s staff. One way this facility achieves compliance is by conducting quarterly quality assurance committee meetings containing the administrator, all dept. managers, consultant pharmacist, medical director and any other identified staff. The committee is guided by the administrator and audits are identified through review of facility practices, quality measure indicators, facility identified	

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F 520	Continued From page 42 The findings included: This tag is cross referred to F325 Nutritional/Therapeutic diet: Based on observation and interview, the facility failed to air dry 8 of 8 soup bowls before storing them, and to discard 1 apple and 3 heads of lettuce, all of which were visibly brown and spoiled. During an interview on 02/12/16 at 4:55 PM the Administrator stated the Quality Assessment and Assurance Committee currently met on a quarterly basis with their meetings focusing on clinical indicators not being met. He stated they continued to discuss previously cited issues but had not monitored as closely as they had for the plan of correction. He stated they focused on specific issues at each meeting and would be taking all problems related to citations found during the current recertification survey to monthly Quality Assessment and Assurance Committee meetings.	F 520	continuous audits and newly identified areas of concern. 1. Dinex bowels with water droplets that were identified were not utilized for food service on March 21, 2016 They were immediately returned to the commercial dishwasher by the Dietary manager and re-cleaned and properly stored for air drying on 3/21/16. The lettuce and apple that were identified were discarded on March 21, 2016 by the Dietary Manager. 2. Any resident has the potential to be affected by this alleged deficient practice. No patients were affected as the bowls and the lettuce and apple were not utilized for food service on March 21, 2016. 3. In-service training was conducted for all Dietary Staff by the Dietary Manager and Regional Dietitian on March 21, 2016 regarding storage of dishes and storage of fresh produce. This training will be completed for any newly hired dietary employees. Department Managers and Medical Director were inserviced by the Administrator related to the QA process on 3/30/2016. 4. The Dietary Manager or designee will complete a QA tracking tool 3x per week x 1 month and then randomly to assure compliance. Audit tracking tools were implemented on March 24, 2016. Results of these audits will be reported to the QA Committee monthly by the Dietary Manager with follow-up corrective action taken as needed to assure compliance. To ensure compliance with cited deficiency. The QA committee will meet monthly through next quarter to review all	

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F 520	Continued From page 43	F 520	findings from audits put in place related to annual survey and any other areas of concern identified. QA committee will review findings for any need of further corrective action and Administrator will monitor to ensure compliance.	