STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345266	A. BUILDING B. WING APR 08 2011	C 03/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLUMBLEE NURSING CENTER	1084 US 64 EAST PLYMOUTH, NC 27962

(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 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews with staff and families and review of medical records, the facility failed to provide an on-going assessment for resident's changes in condition and/or act upon those changes for 1 of 8 sampled residents (Residents # 1) that experienced a change in their condition. Findings include: A. Resident # 1 was admitted on 12/16/10 with cumulative diagnoses of sinus bradycardia, syncope, hypertension, diabetes, and urinary tract infection. The Hospital Discharge summary, dated 12/07/10, indicated the resident's Metformin and Glyburide (oral hypoglycemic medication used to control blood sugar) had been discontinued. There was no information included in the discharge summary to explain the discontinuation of the oral hypoglycemics. Discharge medications included Lovastatin (a medication used to lower cholesterol. The medication has a side effect of increasing blood sugar). The discharge summary described Resident # 1 as alert and oriented times three (alert and oriented to person, place and time). The physician documented during	F 309	Roanoke Landing Nursing and Rehab acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Roanoke Landing Nursing and Rehab. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings. Residents #1 is no longer in the facility. A 100 percent audit of current residents medical records has been completed to identify acute changes in condition and follow up as necessary.	4-6-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE NHA (X6) DATE 4-6-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 rounds on the discharge day the resident stated she felt good.	F 309		
	Facility admission orders, dated 12/16/10, indicated the resident would have fingerstick blood sugars (FSBS) tested twice daily at 6:30 AM and 4:30 PM. Coverage using regular insulin on a sliding scale (the amount of insulin given was based on the result of the FSBS) was ordered. Coverage with regular insulin would begin when the results of the FSBS was 201. The orders also indicated the physician would be notified when the blood sugar exceeded 450.		A 100 percent inservice of Licensed Nurses has been completed regarding the recognition, reporting, follow up and documentation of acute changes in resident condition.	4-7-11
	The facility assessment of Resident # 1, dated 12/16/10, indicated she was alert, verbal with confusion. There were no behaviors included.		The lisenced nurse responsible for assisting the attending physician during rounds will make notes in the resident's medical record the date, time and purpose of the physician visit in the nurse's notes.	4-14-11
	The facility physician assessed the resident on 12/17/10. He assessed Resident # 1 as alert, demented and confused. The physician documented the resident probably had Alzheimer's dementia. There was no documentation of Resident # 1 exhibiting behaviors. The facility physician also completed the hospital discharge summary that described the resident as alert and oriented times three.		The Director of Nursing and the Administrative nurses will audit 100 percent of resident medical records weekly x 4 weeks, every 2 weeks x 4 weeks, monthly x 3 months and as deemed necessary by the QI committee.	4-14-11
	Nurse ' s notes from 12/16/10 through 12/25/10 were reviewed. There was documentation the resident was alert and confused at times. Documentation did not indicate Resident # 1 had exhibited behaviors from 12/16/10 to 12/25/10.		The QI findings will be reviewed by the executive QI committee monthly for trends.	4-14-11
	The resident ' s admission Minimum Data Set (MDS), dated 12/23/10, indicated the resident was moderately cognitively impaired. There were no signs of delirium or behaviors coded.			

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F 309	Continued From page 2 Nurse's notes, dated 12/25/10 at 1:30 PM,, indicated the Responsible Party (RP) requested the results of the FSBS that had been completed on Resident # 1. The nurse documented the information was reviewed and questions answered. A nurse's note, dated 12/27/10 at 1:00 PM, indicated the resident asked for a bed for her baby to sleep. The nurse documented the resident thought the stuffed animal in bed was a baby. There was no indication the change in cognition were reported to the physician. There was no indication in the note that an assessment had been completed to determine the cause of the cognitive change. Review of the December 2010 Medication Administration Record (MAR), indicated Resident # 1's blood sugar range for 6:30 AM was 96 to 221 (a normal blood sugar range is considered 65 to 100). The 4:30 PM blood sugars averaged 189 to 349. Documentation did not indicate the physician had been made aware the resident ' s blood sugar had exceeded 201 and had required coverage with regular insulin on 15 out of the 16 days she was in the facility. On 01/3/11 at 10:00 PM and 01/04/11 at 11:00 PM, the nurse documented Resident # 1 talked about a child in her bed. There was no indication an assessment was completed or the change in cognition reported. The resident ' s blood sugar on that day was 227 requiring coverage with regular insulin. On 01/06/11, a verbal order was obtained for a mental health center consult.	F 309		

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F 309	Continued From page 3 The nurse's note for 01/07/11 at 10:35 AM indicated the 7 to 3 shift nurse documented Resident # 1 yelled out for most of the shift. The resident ' s blood sugar had exceeded 201 on the first 6 days of January during the 4:30 PM FSBS check. There was no indication the physician was notified. The resident received coverage with regular insulin on each of the days her blood sugar exceeded 200. On 01/09/11 at 5:10 PM, the nurse documented Resident # 1 thought her bed was moving. From 01/07/11 through 01/09/11, Resident # 1 ' s 4:30 PM blood sugars were documented on the MAR as 276, 293, and 250. These results were not reported to the physician. On each of those days, Resident # 1 received regular insulin to cover her blood sugar that exceeded 200. A nurse's note, dated 01/12/11 at 6:00 PM, indicated the resident was confused and had been yelling out most of the evening. The nurse also documented she medicated Resident # 1 for generalized pain. The results of the FSBS at 4:30 PM for 01/10/11 through 01/12/11 were 310, 282 and 344. The MAR indicated regular insulin was given each of the days the resident ' s blood sugar exceeded 200. The family requested the physician review Resident # 1 ' s blood sugars. A NURSES REQUEST FOR PROVIDER EVALUATION was completed by Nurse # 4 on 01/12/11. The request indicated the family felt Resident # 1's blood sugar was not being controlled. The nurse added the family felt this was the reason for Resident # 1's confusion. The nurse did note the blood sugars were higher in the evening. Nurse # 3 added blood sugars were checked twice daily with coverage available. She	F 309		

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F 309	Continued From page 4 also added the resident yelled most of the time and was confused. The physician initialed the form indicating he had read what the nurse reported. On 01/12/11, the facility physician assessed the resident. The progress note indicated the resident had been assessed at the local mental health center and a psychiatric consultation was pending. The physician added that no acute problem had been reported regarding Resident # 1. The progress note did not indicate Resident # 1's blood sugars had been reviewed or addressed. The physician indicated the plan was to continue the same management for Resident # 1. On 01/13/11 the 30 day Medicare assessment indicated the resident exhibited delusions and other behaviors daily. On 01/13/11, Nurse # 3 wrote in the Interdisciplinary Care Plan Notes, the family was concerned about the resident's blood sugars being high. She documented the physician was notified. She also documented there were no new orders after review. The nurse documented the physician wanted a family meeting scheduled to review the labs and discuss the risks of hypoglycemia versus hyperglycemia. Nurse # 3 stated she notified the Social Worker. Nurse # 4 wrote a nurse's note on 01/16/11 at 6:00 PM, that indicated the family thought Resident # 1's confusion was related to her continued high blood sugars. The family told the nurse Resident # 1 normally became confused when her blood sugar was elevated. The nurse explained to the family the resident "yells day &	F 309		

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F 309	Continued From page 5 (and) night, " Even when FSBS (fingerstick blood sugar) is normal." The nurse documented she explained to the family member that Resident # 1 had a diagnosis of dementia. Review of the MAR for 01/13/11 through 01/16/11 indicated the resident ' s blood sugar at 4:30 PM was 223, 231, 260, and 236. Resident # 1 had received coverage with regular insulin all 4 days. A psychiatric consult, dated 01/17/11, indicated the resident had a history of dementia. The psychiatrist wrote on his report that "some nurses wanted to try to control psychosis." The psychiatrist added Risperdal (an antipsychotic medication) 0.25 milligrams twice daily. The psychiatrist documented the attending physician would keep track of the resident's blood sugars as per clinical need. A care plan was added on 01/18/11 that identified Resident # 1 as having a potential for complications secondary to her diagnosis of diabetes. One of the goals was that Resident # 1 would be free of signs and symptoms of hyperglycemia or hypoglycemia. Approaches to attain this goal included monitoring for signs and symptoms of hyperglycemia or hypoglycemia and family education. On 01/24/11, Resident # 1 was seen by her family physician at the request of her family. The physician documented the resident was complaining of dizziness and tremors. The physician also noted the resident's blood sugars were elevated as noted on the nursing home's records. Under diagnosis, the physician documented "DM (diabetes mellitus) - not controlled", vertigo and dementia. Under Recommendations, the physician documented	F 309		

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F 309	Continued From page 6 Lantus (a long acting insulin) and/or Actos (an oral hypoglycemic medication). This recommendation was relayed to the facility physician who agreed. The resident started receiving Lantus 10 units every morning. The MAR indicated blood sugar results for Resident # 1 from 01/17/11 through 01/24/11 at 4:30 PM were 240, 238, 292, 298, 364, 331, 260, and 285. Each day Resident # 1 required coverage with regular insulin. Social Work Progress Notes indicated a family meeting was held on 01/26/11. The physician was not in attendance. One family member expressed concern over the resident ' s blood sugar. The Social Worker documented that nurses spoke with the family member and told the family member Resident # 1 ' s sugars were elevated during the evening hours. Review of nurse's notes for January 2011 indicated the resident exhibited behaviors of yelling out and hallucinations on an almost daily basis. On 01/30/11 at 6:00 PM, the nurse documented Resident # 1 hallucinated frequently. There was no indication the staff had reported the blood sugars exceeding 201 to the physician. Review of the January 2011 MAR indicated the resident's blood sugar range at 4:30 PM for the period from 01/25/11 through 01/31/11 were 295, 206, 288, 283, 205, 186 and 234. Resident # 1 received coverage with regular insulin every day except for 01/30/11. There was no documentation to indicate the physician was aware the resident had received regular insulin coverage for 30 out of 31 calendar days.	F 309		

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F 309	Continued From page 7 The Physician's Progress Note, dated 02/09/11, indicated Resident # 1 had been reviewed by the psychiatrist for dementia with psychosis and medication adjustments made. The physician documented the family had taken to the resident to her family physician. On 02/14/11, a physician ' s order was received to add the diagnosis of dementia with psychosis behaviors to Resident # 1 ' s diagnosis list. A Report of Consultation, dated 02/28/11, indicated Resident # 1 returned to the psychiatrist. He indicated on the report the resident continued to have periodic visual hallucinations and the same psychiatric medications would be continued. Review of the February 2011 MAR indicated the range for Resident # 1's blood sugar at 6:30 AM was 99 to 168. The resident did not receive any coverage. At 4:30 PM, the blood sugar range was 154 to 355. The resident received regular insulin coverage for 18 out of 28 days on which her blood sugar exceeded 200. The nurse ' s notes did not indicate blood sugars that continued to exceed 201 were reported to the attending physician. Review of the March 2011 MAR indicated Resident # 1 received regular insulin at 4:30 PM for blood sugars of 245 and 213. Resident # 1 received coverage of regular insulin for the elevated blood sugars. On 03/03/11 at 3:00 PM, the nurse's notes indicated Resident # 1 was discharged to the care of her family.	F 309		

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An interview was held with a family member on 03/16/11 at 11:30 AM. The family member stated Resident # 1 had diabetes for years. When her sugar goes up, the family member stated the resident talked out of her head. She stated when the resident was discharged from the nursing home, the family took her to a local hospital. During admission, the resident's blood sugar was stabilized and the confusion cleared. According to the family member, Resident # 1's blood sugars in the hospital ranged from 90 to 143.

An interview was held with Nurse # 3 on 03/17/11 at 10:14 AM. She stated the expectation was to report any blood sugars that required insulin coverage for several days in a row. Any change in cognition or any new behaviors should be reported to the physician. Nurse # 3 stated she was responsible for making rounds with the facility physician. Normally, FSBS's were done four times a day. For Resident # 1, the order for twice daily blood sugar checks were taken from the FL-2 (a form that indicated diagnosis, mental status, medications and ability to perform personal care). Nurse # 3 stated a normal blood sugar range would be from 80 to 120. Signs and symptoms of hyperglycemia would be increased thirst, change in mental status, confusion and possible lethargy. Nurse # 3 stated standing orders were available to be used by nurses as they saw the need. The nurse reviewed the nurse's notes for Resident # 1 and stated it would have been appropriate for the nurses to report Resident # 1 ' s blood sugars over 201 since the resident had received regular insulin coverage for a long period of time.

On 03/17/11 at 10:54 AM an interview was held with Nursing Assistant (NA) # 1. She worked with

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F 309	Continued From page 9 Resident # 1 on the 7 to 3 shift. The NA stated on admission, Resident # 1 was alert and oriented but forgetful. About a month into her stay at the facility, Resident # 1 started to see things and would think the bed was moving. Nurse # 4 was interviewed on 03/17/11 at 11:14 AM. Nurse # 4 worked with the resident on the 7 to 3 and the 3 to 11 shift. Nurse # 4 authored the 01/16/11 at 6:00 PM nurse's note. The nurse stated she had been taught the normal range for blood sugar was 80 to 120, but she knew the range had been modified to 60 to 100. Nurse # 4 stated signs and symptoms of elevated blood sugars included confusion, increased thirst, increased urination and weakness. She stated if a resident were on a sliding scale insulin regime, she would only notify the physician if the blood sugar exceeded 400. If the blood sugar was consistently elevated, requiring coverage on an almost daily basis, she would leave a message on the physician's book (a book used by the facility to notify the physician of non-emergency resident issues). Nurse # 4 agreed the family was the best source of information about a resident's usual and normal behavior during certain circumstances. Information given by the family should always be heeded. Nurse # 4 reviewed Resident # 1's MAR She acknowledged Resident # 1 had no normal blood sugars at 4:30 PM for the months of January and February 2011. The nurse stated she say a resident that received insulin coverage every day did not have their diabetes controlled. Nurse # 4 stated a high blood sugar could affect a resident's mind. Nurse # 4 stated she did write in the physician's book one time when the family asked her to ask the physician to review the blood sugars. She acknowledged she did not follow up	F 309		

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to see if the physician addressed the family's concerns. Nurse # 4 added the resident had been confused for as long as she had known her. The nurse added she thought the hallucinations were part of the dementia and it never occurred to her the hallucinations could have an underlying cause such as hyperglycemia.

An interview was held with the Director of Nursing (DON) on 03/17/11 at 1:56 PM. The DON stated if the resident consistently exhibited high blood sugars that exceeded 201 over a 2 week period, she would expect the nurses to notify the physician. The expectation was for the physician to respond either that day or the next. If no response, the nurses were expected to keep trying to notify the physician. The DON added that any blood sugar less than 200 would be considered normal for the geriatric population. The DON reviewed the blood sugars for Resident # 1 and stated she saw the 4:30 PM blood sugars that consistently were above 201 as an issue that should have been reported.

A telephone interview was held with Resident # 1 ' s facility physician on 03/29/11 at 8:39 AM. The physician stated he vaguely remembered Resident # 1. He stated signs of hyperglycemia depended on how much out of a normal range the blood sugar ran. The physician added at times, a person could have hyperglycemia that was only confirmed by routine testing such as a FSBS. Blood sugars that run greater than 200 can carry dangers. The physician did not elaborate on the dangers, but added the threat of danger was related to the resident ' s baseline condition. He added a resident that was already compromised was at a higher risk. The physician stated if he had a patient that consistently ran a

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blood sugar higher than 200, he would start a sliding scale regular insulin and add an oral hypoglycemic. The physician added if the nurses documented they had told him about Resident # 1 ' s family wanting him to review her blood sugars, he was sure they had told him. He did add if he did not address the blood sugars in a progress note, then he did not review the blood sugars, calling the absence an oversight. The physician stated even with the order to notify him with a blood sugar over 450, his expectation was to be notified if a resident, such as Resident # 1, received regular insulin almost daily per sliding scale since this indicated a blood sugar over 201 for a 1 to 2 week period. The physician stated had he known the results of the 4:30 PM blood sugars, he would have added an oral hypoglycemic to try to gain control of Resident # 1 ' s diabetes. The physician added had the staff listened to the family, had the resident ' s diabetes been controlled and if infection had been ruled out, Resident # 1 hallucinations may have resolved and she could have avoided the use of an antipsychotic medication.

B. Resident # 1 was admitted on 12/16/10 with cumulative diagnoses of sinus bradycardia, syncope, hypertension, diabetes, and urinary tract infection.

Hospital laboratory results, dated 12/05/10, indicated Resident # 1 had a urinary tract infection caused by Escherichia coli (a bacteria normally found in the digestive tract).

The Hospital Discharge summary, dated 12/07/10, described Resident # 1 as alert and oriented times three (alert and oriented to person, place and time). Final discharge diagnoses

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F 309	Continued From page 12 urinary tract infection. The discharge summary did not include a diagnosis of dementia Resident # 1 had standing orders signed that allowed nurses to perform an urinalysis if symptoms indicated. The facility assessment of Resident # 1, dated 12/16/10, indicated she was alert, verbal with confusion. There were no behaviors included. The facility physician assessed the resident on 12/17/10. He assessed Resident # 1 as alert, demented and confused. The physician documented the resident probably had Alzheimer's dementia. There was no documentation of Resident # 1 exhibiting behaviors. The facility physician also had completed the hospital discharge summary indicating the resident was alert and oriented times three. Nurse ' s notes from 12/16/10 through 12/25/10 were reviewed. There was documentation the resident was alert and confused at times. Documentation did not indicate Resident # 1 had exhibited behaviors. A nurse's note, dated 12/27/10 at 1:00 PM, indicated the resident asked for a bed for her baby to sleep. The nurse documented the resident thought the stuffed animal in bed was a baby. There was no indication the change in cognition had been reported to the physician. There was no indication in the note that an assessment had been completed to determine the cause of the cognitive change. The resident's care plan, dated 12/28/10,	F 309		

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	345266	A. BUILDING ____ B. WING ____	C 03/17/2011

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F 309	Continued From page 13	F 309		

indicated she was at risk for urinary tract infections. Approaches to ensure Resident # 1 would be free of urinary tract infections included monitoring for signs and symptoms of an infection.

On 01/3/11 at 10:00 PM and 01/04/11 at 11:00 PM, the nurse documented Resident # 1 talked about a child in her bed. There was no indication an assessment was completed or the change in cognition reported.

The nurse's note for 01/07/11 at 3:15 AM indicated the resident was complaining of pain in the bottom of her stomach (pain in the abdominal area can be a sign of an urinary tract infection) and her legs. An assessment indicated Resident # 1's abdomen was soft and non-tender . The nurse wrote an order for Tylenol 500 milligrams, 2 tablets every 4 hours as needed for complaints of pain per standing order. The order also indicated the physician should be notified if the pain persisted. The nurse gave the Tylenol and documented there were good results. There was no indication the abdominal pain was reported.

On 01/09/11 at 5:10 PM, the nurse documented Resident # 1 thought her bed was moving.

A nurse's note, dated 01/12/11 at 6:00 PM, indicated the resident was confused and had been yelling out most of the evening. The nurse also documented she medicated Resident # 1 with Tylenol for generalized pain with relief obtained. There was no documentation the nurse reported the resident ' s pain to the physician.

On 01/12/11, the physician assessed the resident. The physician added that no acute

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F 309	Continued From page 14 problem had been reported regarding Resident # 1. The physician indicated the plan was to continue the same management for Resident # 1. A psychiatric consult, dated 01/17/11, indicated the resident had a history of dementia. The psychiatrist wrote on his report that "some nurses wanted to try to control psychosis." The psychiatrist added Risperdal (an antipsychotic medication) 0.25 milligrams twice daily for Resident # 1. On 01/17/11 at 5:55 PM, the resident was medication for pain. There was no documentation that indicated where the pain was located. The nurse added the medication was effective. There was no indication the pain was reported to the physician. A nurse ' s note, dated 01/20/11 at 12:45 AM, the nurse documented the resident was complaining of pain in the top of her head. The resident ' s temperature was listed as 99.2 degrees Fahrenheit. Tylenol was given. There was no effectiveness for the Tylenol listed, no indication the physician was notified of the low grade temperature or pain. Nurse ' s notes, dated 01/20/11 at 6:35 PM, indicated visual hallucinations and confusion continued for Resident # 1. On 01/23/11 at 10:20 AM, Resident # 1 was medicated once for complaints of pain. Location of the pain and effectiveness of the medication was not documented in the nurse ' s notes. There was no documentation the pain was reported to the physician.	F 309		

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F 309	Continued From page 15 Review of nurse's notes for January 2011 indicated the resident exhibited behaviors of yelling out and hallucinations on an almost daily basis. On 01/30/11 at 6:00 PM, the nurse documented Resident # 1 hallucinated frequently. The Physician's Progress Note, dated 02/09/11, indicated Resident # 1 had been reviewed by the psychiatrist for dementia with psychosis and medication adjustments made. The physician documented the family had taken to the resident to her family physician. A Report of Consultation, dated 02/28/11, indicated Resident # 1 returned to the psychiatrist. He indicated on the report the resident continued to have periodic visual hallucinations and the same psychiatric medications would be continued. Review of February 2011 nurse's notes indicated the Resident continued to have hallucinations and intermittent low grade temperatures. On 03/03/11 at 3:00 PM, the nurse's notes indicated Resident # 1 was discharged to the care of her family. An interview was held with a family member on 03/16/11 at 11:30 AM. She stated when the resident was discharged from the nursing home the family took her to a local hospital for evaluation. The resident was admitted to the hospital that day. The family member reported Resident # 1 had been discharged on 03/14/11. An interview was held with Nurse # 3 on 03/17/11 at 10:14 AM. She stated any new symptom, change in cognition or any new behaviors should	F 309		

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F 309	Continued From page 16 be reported to the physician. Nurse # 3 stated she was responsible for making rounds with the facility physician. Nurse # 3 stated standing orders were available for a urinalysis to be used by nurses as they saw the need. The nurse reviewed the nurse's notes for Resident # 1 and stated it would have been appropriate to complete a urinalysis on Resident # 1 given her change in cognition, complaints of pain and low grade temperature. The nurse had no idea why a urinalysis had not been completed. On 03/17/11 at 10:54 AM an interview was held with Nursing Assistant (NA) # 1. She worked with Resident # 1 on the 7 to 3 shift. The NA stated on admission, Resident # 1 was alert and oriented but forgetful. About a month into her stay at the facility, Resident # 1 started to see things and would think the bed was moving. Nurse # 4 was interviewed on 03/17/11 at 11:14 AM. Nurse # 4 worked with the resident on the 7 to 3 and the 3 to 11 shifts. Nurse # 4 authored the 01/16/11 at 6:00 PM nurse's note. Nurse # 4 stated signs and symptoms of a urinary tract infection included pain in the lower abdomen, urgency, burning with voiding and confusion. She stated not all symptoms may be present at one time. The nurse stated she would not necessarily do a urinalysis if the symptoms were present. Nurse # 4 stated if the resident was admitted with a diagnosis of urinary tract infection, then that resident would be at a higher risk of developing another infection. The nurse stated she did not collect urine for an urinalysis, adding the resident had been confused for as long as she had known her. The nurse added she thought the hallucinations were part of the dementia and it never occurred to her the	F 309		

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F 309	Continued From page 17 hallucinations could have an underlying cause such as infection. Nurse # 1 was interviewed on 03/17/11 at 12:16 PM. She cared for Resident # 1 on the 11 to 7 shift. Nurse # 1 stated Resident # 1 would call out for help at night. She described the resident as confused. Nurse # 1 stated she would give the resident Tylenol to help her relax. Nurse # 1 had no reason for a urinalysis not being collected. An interview was held with the Director of Nursing (DON) on 03/17/11 at 1:56 PM. The DON stated the first sign of a urinary tract infection in the geriatric population was a change in cognition. Standing orders for an urinalysis can be used if needed by the nurses. The expectation was for the nurses to notify the physician of changes in condition. The physician usually responded the same day or the next. If no response, the nurses are expected to keep trying to notify the physician. The facility nurse consultant interjected she thought, after review of the nurse's notes, that a urinalysis should have been the first step after the resident exhibited the change in mental status. A telephone interview was held with the resident ' s facility physician on 03/29/11 at 8:39 AM. The physician stated he vaguely remembered Resident # 1. He stated signs and symptoms of an urinary tract infection included a change in mental status and confusion. The physician added if a change in cognition was observed, it could be a result of any infection and the source would need to be determined. The physician stated an order was not needed for completion of an urinalysis, but could be completed by standing orders that he had with the facility. He added if	F 309		

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F 309	Continued From page 18 the facility had listened to the family and completed an urinalysis per standing orders, the use of an antipsychotic medication possibly could have been avoided. The physician was unsure if he had been notified about the resident ' s pain or low grade temperature.	F 309		