

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/23/2016
NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive plan of care within seven days after the completion of the comprehensive assessment for 1 of 4 residents (Resident #2) reviewed for Urinary Tract Infections (UTIs) and failed to revise a plan of care to include an indwelling catheter for 1 of 3 residents (Resident #3) reviewed with a urinary catheter. The findings included:</p> <p>1. Resident #2 was admitted to the facility on 9/30/16 with multiple diagnoses that included Urinary Tract Infection (UTI).</p>	F 280	<p>F280</p> <p>1. Resident #2 comprehensive plan of care was completed on 11/7/16 to reflect the resident's current status. Resident #3 current comprehensive care plan was revised to include indwelling catheter on 11/22/16 by Minimum Data Set Nurse.</p> <p>2. All admission, re-admission charts, and new orders are brought to Clinical team (consisting of Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Nurse, Treatment Nurse and</p>	12/15/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/15/2016

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 280	<p>Continued From page 1</p> <p>A review of Resident #2's medical record revealed an admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/7/16. Section V, the Care Area Assessment (CAA) Summary Section, revealed the following 9 areas were triggered and the facility indicated the decision to proceed with plans of care: Activities of Daily Living (ADLs), Activities, Dehydration/Fluid Maintenance, Falls, Nutritional Status, Pressure Ulcer, Psychosocial Well-Being, Psychotropic Medications, and Urinary Incontinence.</p> <p>A review of Resident #2's comprehensive plan of care indicated it was initiated on 11/7/16 for ADLs, Dehydration Risk, Fall Risk, Nutritional Status, Urinary Incontinence (addressed skin integrity), Psychosocial Well-Being, and Psychotropic Medications. On 11/16/16 a plan of care was initiated for Activities. The comprehensive plan of care for Resident #2 was signed by MDS Nurse #1. There was no comprehensive plan of care for Resident #2 prior to 11/16/16. This was 41 days after Resident #2's admission MDS dated 10/7/16.</p> <p>An interview was conducted with MDS Nurse #1 on 11/22/16 at 4:24 PM. She stated she was responsible for completion of plans of care. She indicated she was unsure of the required timeframe for completion of the comprehensive plan of care. The admission MDS dated 10/7/16 for Resident #2 was reviewed with MDS Nurse #1. The comprehensive plan of care for Resident #2 was reviewed with MDS Nurse #1. MDS Nurse #1 reported she began working at the facility as an MDS Nurse a few weeks ago. She indicated when she began her employment at the</p>	F 280	<p>Administrator) meetings daily(Monday through Friday) to ensure the plan of care is updated as needed to reflect the resident's current status.</p> <p>3. A 100% audit of residents was conducted to identify all residents who have a catheter by Staff Development Coordinator on 11/25/2016. 10 were identified and their care plan reflects the resident's current status.</p> <p>4. Care plans were reviewed for all residents with catheters and revised as necessary on 11/25/2016 by MDS Coordinator. Only resident #3 was affected. No other revisions were necessary.</p> <p>5. Minimum Data Set department was educated on the required timeframe for completion of the comprehensive plan of care on 11/25/2016 by Administrator and or Director of Nursing.</p> <p>6. Staff Development Coordinator will audit catheter care plans for accuracy one time per week for one month and monthly for eleven months.</p> <p>7. The Minimum Data Set nurse will complete comprehensive care plans as scheduled and as changes occur.</p> <p>8. The Director of Nursing will monitor care plan completion weekly times four weeks and monthly for eleven months.</p> <p>9. Results of these audits will be presented by the Director of Nursing in Quality Assurance Performance Improvement meeting monthly for 6 months and then quarterly with approval of QAPI committee.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 280	<p>Continued From page 2</p> <p>facility she had been given a printed out list of MDS assessments and plans of care that needed to be completed. She stated there were quite a few people on the list. MDS Nurse #1 explained that there were several staff who had helped out with the MDS assessments and plans of care prior to her working at the facility. She reported these people included the current Director of Nursing (DON).</p> <p>An interview was conducted with the DON on 11/22/16 at 5:20 PM. The DON reported she began working at the facility on September 12, 2016 as the Assistant Director of Nursing (ADON). She indicated she trained under MDS Nurse #2 for about a week and then she began assisting with the completion of care plans and assessments. She reported there were multiple care plans and assessments that were due at the time she began in her position. The DON stated at the time that Resident #2's comprehensive care plan was due for completion she and MDS Nurse #2 were both responsible for the completion of care plans. The DON explained that during her second week as the ADON she also became responsible for some of the responsibilities of the previous DON as there were multiple changes in administrative staffing. She continued to explain that during that time she was attempting to complete assessments and care plans without getting behind, but that had not occurred. She revealed the facility had gotten behind with some of their care plans. The DON reported she was not surprised Resident #2's comprehensive care plan wasn't completed within the required timeframe. She indicated MDS Nurse #1 was hired in an effort to help with assessments and care plans.</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>An interview was conducted with the Administrator on 11/23/16 at 12:27 PM. She indicated her expectation was for the comprehensive plan of care to be completed within the required timeframe.</p> <p>2. Resident #3 was admitted 4/28/16 and readmitted 11/11/16 with cumulative diagnoses of Sepsis, Urinary Tract Infection (UTI) and urinary retention. His admission Minimum Data Set (MDS) dated 10/10/16 indicated moderate cognitive impairment, total assistance with toileting and hygiene. He was coded for a urinary catheter. A review of the comprehensive care plan dated 9/21/16 indicated Resident #3 had a urinary catheter. The care plan was reviewed on 10/26/16 and read the urinary catheter was discontinued.</p> <p>A review of the medical record indicated Resident #3 had removed his indwelling catheter himself on 10/26/16 and orders were given to leave the indwelling catheter out and to In and Out catheterize him every 12 hours.</p> <p>A nursing note dated 11/6/16 indicated Resident #3 was discovered unresponsive and was sent to the hospital. Resident #3 returned to the facility on 11/11/16 with diagnoses of UTI with evidence of Sepsis. Resident #3 was readmitted with an indwelling urinary catheter. A review of the care plan revised 11/14/16 did not include a care plan for the indwelling urinary catheter.</p> <p>In an interview on 11/23/16 at 11:25 AM, the treatment nurse stated Resident #3 was readmitted with orders for an indwelling urinary catheter with new orders.</p> <p>In interview on 11/23/16 at 11:25 AM, the MDS</p>	F 280			

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F 280	Continued From page 4 Nurse #1 stated the presence of urinary catheter should have been care planned on his readmission 11/11/16. In an interview on 11/23/16 at 11:40 AM, the Administrator stated it was her expectation the care plan reflect the current needs of Resident #3 and it did not with the absence of the care plan for his indwelling urinary catheter.	F 280			
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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 observations, staff, resident and physician interviews and record review, the facility failed to obtain Urinalysis (UA) with Culture and Sensitivity (C&S) as ordered by the physician for 2 (Resident #3 and Resident #1) 4 residents reviewed for Urinary Tract Infection (UTI 's) resulting in Sepsis (harmful bacteria and their toxins in the blood) for Resident #3. The facility also failed to initiate treatment for a symptomatic UTI resulting in voiced discomfort for 1 (Resident #2) of 4 residents reviewed for UTI 's. Findings included:	F 315	F315 1. A new Urine analysis and Culture and Sensitivity was obtained for resident #1 on 11/28/2016. The results of the sensitivity were received and reported to the physician on 11/30/2016. A new physician order was obtained. A new Urinary analysis and Culture and Sensitivity was unable to be obtained for resident #3 due to resident no longer in the building. Resident #2 currently has no signs of a urinary tract infection.	12/23/16	

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F 315	<p>Continued From page 5</p> <p>1. Resident #3 was admitted 4/28/16 and readmitted 11/11/16 with cumulative diagnoses of Sepsis, UTI and urinary retention. His admission Minimum Data Set (MDS) dated 10/10/16 indicated moderate cognitive impairment, total assistance with toileting and hygiene. He was coded for a urinary catheter. A review of the comprehensive care plan dated 9/21/16 indicated Resident #3 had a urinary catheter and at an increased risk for UTIs. The staff were to monitor the urine for odor, color, sediments and amount and report abnormal evidence to the physician.</p> <p>A physician order written 10/26/16 read as follows: Send UA C&S tomorrow. A UA is a test to detect microorganism in the urine. The UA results dated 10/27/16 indicated Resident #3 ' s urine was cloudy, positive for White Blood cells, Red blood cells, and blood, protein and trace bacteria. There was no evidence the facility obtained the C&S results (test used to determine what antibiotic would be effective against the identified microorganism) or followed up on the results of the UA. A nursing note dated 11/6/16 indicated Resident #3 was sent to the hospital on 11/6/16 for increased lethargy. The hospital discharge summary dated 11/11/16 indicated Resident #3 was diagnosed with of UTI with evidence of sepsis and acute exacerbation of Chronic Obstruction Pulmonary Disease (COPD). In an observation on 11/23/16 at 11:25 AM, Resident #3 was asleep in bed. The urinary drainage bag was attached to bed frame lower than the bladder. A privacy bag was in place. Urine in the tubing appeared cloudy and pale in color. The treatment nurse stated Resident #3 was readmitted with orders Hospice.</p> <p>In an interview on 11/23/16 at 11:40 AM, the</p>	F 315	<p>2. An 100% audit of physician orders for labs was completed on December 15, 2016 by Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator for past 90 days to ensure all labs were in compliance. 47% compliance was identified. As a result all routine labs will be redrawn by 12/23/2016 to establish a new base line for identified resident.</p> <p>3. Nurses have been in-serviced on the proper way to complete a lab requisition form including Urine analysis and Culture and Sensitivity and on the importance of calling the physician upon receipt of an abnormal lab result so treatment can start as quickly as possible by Staff Development Coordinator by 11/25/2016 and or prior to next shift worked to include weekend and as needed staff.</p> <p>4. The lab tracking form (consisting of date of order, lab ordered, lab transcribed correctly to lab requisition form, when lab drawn, when lab results received, when reported to physician and treatment as indicated by physician) will be brought to clinical meetings daily (Monday through Friday) to ensure physician orders are carried out for labs.</p> <p>5. An audit of lab process completion rate will be conducted by the Assistant Director of Nursing and presented to the Director of Nursing weekly for three months and then monthly for eleven months to ensure compliance. Results will be presented to Quality Assurance Performance Improvement by Assistant Director of Nursing monthly for 6 months and then quarterly with approval of QAPI</p>		

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F 315	<p>Continued From page 6</p> <p>Administrator and the Director of Nursing stated it was their expectation Resident #3 's ordered 10/26/16 UA with C&S would have been completed as ordered.</p> <p>In an interview on 11/23/16 at 11:50 AM, the Staff Development Coordinator (SDC) provided the facility copy of the completed lab requisition form dated 10/27/16. The requisition was coded as requesting a urinalysis with microscopic testing. Urine C&S was not circled as ordered on the sample. The SDC stated normally Nurse #1 took off the physician orders and completed any order lab requisition sheets and added the lab test ordered to the Lab Tracking Sheet. He stated it appeared the lab requisition form was completed by Nurse #4 and it was not completed properly to include the C&S and it was not added to the Lab Tracking Sheet for follow up. He stated he contacted the lab today and there was no record that a C&S was ordered for completed on the urine sample tested on 10/27/16.</p> <p>In an interview on 11/23/16 at 12:05 PM, Nurse #4 stated she was not aware that the UA with a microscopic test was not the same as a C&S. Nurse #4 stated normally Nurse #1 completed all the lab requisition forms but on 10/26/16, she completed her own to help out or because Nurse #1 was not working.</p> <p>In an interview on 11/23/16 at 12:10 PM, Nurse #1 stated she had recently been out of work and usually in her absence, the SDC or the floor nurses took off their own orders. Nurse #1 stated if she was not working the nurses knew to complete their own lab requisition forms and review their own returned lab work and contact the physician with the lab results.</p> <p>In an interview on 11/23/16 at 12:30 PM, Physician #3 stated when he ordered the UA C&S</p>	F 315	<p>committee.</p> <p>6. A list of residents with routine labs, Urine analysis and urine analysis and culture and sensitivity , those with a diagnosis of urinary tract infection or who have had a recent catheter removed in last 30 days, will be updated daily (Monday through Friday) at clinical meeting by Assistant Director of Nursing or his/her designee by 12/23/2016. This list will be put in front of lab book prior to first day of the month. List will be updated and maintained by Assistant Director of Nursing or his /her designee with new admissions, readmissions, room changes, new or changed orders. List will be audited weekly x4, then monthly x3 or until compliance is met.</p> <p>7. Assistant Director of Nursing will audit all residents by 12/23/2016 for any residents who has had urinary catheter removed in last 30 days. Those residents who have had a catheter removed in last 30 days will be assessed for urinary incontinence. Residents who demonstrate urinary incontinence will be placed on a bladder retraining program. They will continue on program for 30 days. Then be re-assessed for further need. Restorative nurse will follow and monitor resident progress on retraining program as per restorative policy for bowel and bladder retraining. Restorative nurse will compile results of bladder training program and report to QAPI monthly x 4 until goal is met, then will report quarterly.</p> <p>8. A new lab process has been developed to include ordering, monitoring, tracking and follow up of all lab</p>		

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F 315	<p>Continued From page 7</p> <p>on Resident #3, he expected the facility to have obtained the ordered test and to have followed up on the results and contacted him in order to initiate needed treatment if indicated.</p> <p>2. Resident #2 was admitted 9/30/16 with cumulative diagnoses of UTI and Chronic Obstructive Pulmonary Disease. The admission Minimum Data Set (MDS) dated 10/7/16 indicated Resident #2 was cognitively intact with no behaviors. She was coded as requiring total assistance with assistance with transfers, limited assistance with hygiene and always incontinent of bladder and bowel. She was not coded as being on a toileting program. Resident #2 was coded as having a UTI in the last 30 days. She was care planned on 11/7/16 for UTI risk with an intervention to monitor for signs or symptoms of a UTI and report to the physician.</p> <p>On review of Resident #2 ' s medical record, it was noted Physician #1 ordered a Urinalysis with a Culture and Sensitivity (UA C&S) on 10/3/16. A review of the Lab Tracking Sheet dated 10/4/16 indicated Resident #2 had a UA C&S completed as ordered.</p> <p>A review of Resident #2 nursing note dated 10/5/16 dated she was experiencing nausea. Physician #1 was notified and orders were given for an antiemetic (medication to reduce nausea) and increase oral fluids.</p> <p>A nursing note dated 10/8/16 read there was a " strong odor of urine " around Resident #2. She was encouraged to increase her fluids and Resident #2 denied any symptoms of a UTI. The note was written by the previous Director of Nursing who was no longer employed at the facility.</p> <p>A nursing note 10/9/16 read " noted aroma of strong urine in room " around Resident #2. Education was provided on increasing fluids to</p>	F 315	<p>procedures. New process will be audited by ADON or his/her designee weekly x4, monthly x3 or until 100% compliance is obtained.</p> <p>9. Staff Development or his/her designee will in-service on new lab procedure, ordering and tracking lab, notifying physician regarding labs for follow up, signs and symptoms of urinary tract infection, urinary retention and bladder distention. 100% of nursing staff will be in-serviced by 12/23/2016 or prior to next shift worked.</p>		

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F 315	<p>Continued From page 8</p> <p>manage concentrated urine. Resident #2 denied symptoms of a UTI. The note was written by the previous Director of Nursing who was no longer employed at the facility.</p> <p>A review of the UA C&S lab results print date at the laboratory 10/12/16 indicated greater than 100,000 colonies of Enterococcus faecalis (a bacteria known to cause abdominal pain, urgency, nausea and vomiting). The C&S was not called and faxed to Physician #1 until 10/13/16 and orders were given to start an antibiotic on 10/14/16.</p> <p>During an interview and observation on 11/22/16 at 10:40 AM, Resident #2 stated early in her admission to the facility, she recalled having pain in her lower abdomen and being nauseous. She stated once she got started on an antibiotic, the pain started to subside. She stated the staff commented on how strong her urine smelled during that time too. Incontinence care observed at this time with Nursing Assistant (NA) #1 stated she was taught to clean a female resident from front to back and use a clean part of a cloth for each wash. There was no observed concerns.</p> <p>In an interview on 11/22/16 at 4:34 PM, the Staff Development Coordinator (SDC) stated he or Nurse #1 reviewed the lab work daily. Nurse #1 stated she recently been out of work recently and if she was not working the SDC would have sent the UA C&S results to the physician. Nurse #1 stated it took 72 hours to get a final C&S result to be sure the proper antibiotic was used to treat the UTI. Nurse #1 confirmed Resident #2 's C&S would have been available no later than 10/7/16 for Physician #1 to have initiated the proper treatment. The SDC stated nobody was assigned to follow up on outstanding lab work to ensure all lab results were obtained timely.</p> <p>In an interview on 11/22/16 at 4:40 PM, Nurse #2</p>	F 315			

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F 315	<p>Continued From page 9</p> <p>she was working with Resident #2 on 10/5/16 and recalled speaking with Physician #1 about Resident #2 complaints of nausea. Physician #1 ordered something for her nausea and told the staff to encourage fluids. Nurse #2 stated she was not aware Physician #1 had ordered a UA C&S and did not think to check to see if the results were ready for Physician #1 to review. She stated Nurse #1 normally did all the lab review and follow up. Nurse #2 stated Physician #1 was in the facility several times each week and had she been aware of the UA C&S results, she would have treated it timely.</p> <p>In a telephone interview on 11/22/16 at 5:10 PM, Nurse #3 stated she was assigned Resident #2 on 10/13/16. She stated when UA C&S results came in, she called Physician #1 and also sent the results to the Physician #1 ' s office.</p> <p>In a telephone interview on 11/23/16 at 8:55 AM, Physician #1 stated since Resident #2 was exhibiting symptoms associated with an UTI and had a history of recent, UTI, it would have been her expectation that the staff would have followed up on the C&S prior to 10/13/16 and there was a delay in the initiation of treatment since the results were not available.</p> <p>In an interview on 11/23/16 at 11:40 AM, the Administrator and the Director of Nursing stated it was their expectation the nursing staff who cared for Resident #2 would have followed up timely on the obtaining the C&S results and notified Physician #1 prior to 10/13/16 since she was having symptoms of a UTI.</p> <p>3. Resident #1 was admitted 10/1/12 with a diagnoses of Alzheimer ' s disease, urinary retention and Chronic UTIs. The quarterly Minimum Data Set (MDS) dated 10/12/16 indicated severe cognitive impairment with verbal</p>	F 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345509	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/23/2016
NAME OF PROVIDER OR SUPPLIER KINGSWOOD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 915 PEE DEE ROAD ABERDEEN, NC 28315		
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F 315	<p>Continued From page 10</p> <p>and physical behaviors. She was coded as total assistance with hygiene and as having a suprapubic catheter (urinary catheter inserted into the bladder through a hole in the abdomen) and always incontinent of bowel. She was care planned for the suprapubic catheter on 4/14/16 and last revised on 10/8/16. Interventions included monitoring for any changes such as blood in her urine, sediment, fever of foul smelling urine and notifying the physician. A review of Resident #1 Urine testing indicated the following:</p> <ul style="list-style-type: none"> -On 6/27/16 an order for a Urinalysis with Culture and Sensitivity (UA C&S) due to escalated agitation and crying. The Urinalysis (UA) indicated the urine was hazy, positive for White Blood cells, trace protein and moderate bacteria. There was no evidence of a Culture and Sensitivity (C&S) in the medical record. - On 7/13/16 an order for UA C&S for unexplained weight loss. There was no evidence in the medical record that the UA or C&S was ever completed. <p>In an observation on 11/22/16 at 10:10 AM, Resident #1 was lying in bed. Her urinary drainage bag was attached low to the bed frame and covered to ensure privacy. The urine in the catheter tubing appeared clear and pale yellow in color. There was no observed sediment or blood. Resident #1 appeared cooperative but uncertain of circumstances or surrounding.</p> <p>In an interview on 11/23/16 at 10:00 AM, the SDC stated at the time these test were ordered, there was nobody tracking the lab work and the nurses were taking off their own orders and completing the lab requisition forms. The SDC stated he was unable to locate the C&S results or the lab requisition form for 6/27/16. The SDC stated it was likely the UA with C&S ordered 7/13/16 was</p>	F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2016
FORM APPROVED
OMB NO. 0938-0391

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F 315	Continued From page 11 not done at all since the lab had no record of receiving or testing Resident #1 ' s urine in July 2016. In an interview on 11/23/16 at 11:40 AM, the Administrator and the Director of Nursing stated it was their expectation Resident #1 ' s ordered June and July UA with C&S would have been completed as ordered. In a telephone interview on 11/23/16 at 12:20 PM, Physician #2 stated if he ordered the UA C&S on the dates in question, he would have expected the testing to have been completed for Resident #1.	F 315			