STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345397	A. BUILDING _____ B. WING _____	C 05/29/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472

(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 157 SS=D	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 by: Based on physician interview, staff interview and record review the facility failed to notify the primary physician of changes in resident	F 157	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	6/16/14

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

Electronically Signed | 06/16/2014

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F 157	Continued From page 1 behavior/altered mental status/disorientation/restlessness and agitation and failed to notify family with accurate lab result information for 1 of 1 sampled residents (Resident #1) who experienced UTIs. Findings included: Resident #1 was admitted to the facility on 11/02/06 and was readmitted on 05/13/14. The resident's documented diagnoses included recurrent UTIs, chronic kidney disease-stage III, chronic congestive heart failure, and pulmonary fibrosis/end-stage chronic obstructive pulmonary disease. Resident #1's 03/28/14 quarterly minimum data set (MDS) documented her cognition was severely impaired, and she did not exhibit mood problems/behaviors/psychosis/resistance to care. A 04/15/14 physician order documented a UA, C & S (culture and sensitivity) was to be drawn for Resident #1 due to increased confusion. A 04/16/14 care plan for Resident #1 documented, "I have confusional episodes at times. I have hx (history) of episodes of confusion, hallucinations...." Monitor/record/report to MD (physician) new onset s/sx (signs/symptoms) of delirium, changes in behavior, altered mental status, wide variation in cognitive function through the day, communication decline, disorientation, lethargy, restlessness and agitation, altered sleep cycle, dehydration, infection, delusions, hallucinations." Clean catch urine laboratory results, available to the facility on 04/19/14, documented that greater than 100,000 CFU of klebsiella pneumoniae and	F 157	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F157 Corrective Action for Resident Affected Resident # 858 Physician and Responsible Party were notified of the change in condition on 05/09/14 by the hall nurse upon discharge to the hospital where resident received treatment for a urinary tract infection (UTI). Corrective Action for Resident Potentially Affected All residents have a potential to be affected by the alleged deficient practice. Beginning _6_/_9_/2014_ the Nurse Management Team audited all current resident lab results from 04/01/14 to present for any abnormal labs without MD and responsible party notification of the results. In addition to this, all current residents were assessed for signs and symptoms of a potential UTI by the hall nurses under the direction of the nurse management team. Signs and symptoms of UTI assessed were: painful urination; new or worsening urgency, frequency or incontinence; lower abdominal pain or	

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F 157	Continued From page 2 proteus mirabilis were found in the resident's urine sample. Review of physician orders revealed no orders to treat the resident with an antibiotic. A 05/03/14 10:54 PM resident progress note documented, "Rsdt (resident) propelling self up and down hallway hollering out loudly demanding to be taken home; Stating she was not supposed to be left here; Rsdt apporaching other rsdts in hallway stating he has to go home, waving hand at resdts and becoming angry when they spoke to her...: The note documented the staff was unable to console or redirect Resident #1, and her family had to be called to come calm the resident down. A 05/06/14 10:12 PM hospice note documented, "Pt. (patient) sitting in wheelchair. Alert and disoriented. She wanted to go home and was distressed." A 05/09/15 1:48 AM resident progress note documented, "Rsdt very confused with increased agitation and combativeness....Rsdt kept saying she wanted to go to bed because she did not feel good. On several attempts rsdt guided back to her room and attempted to put back into bed but rsdt would yell and scream 'this in not my house. This is not my room.' Rsdt was taking alarm and string off and wrapping it around her hands tightly. Rsdt was yelling and trying to fight staff when they approched to help....911 called for services to transport to ER (emergency room) for evaluation. Out of facility at 2:15 AM...." A 05/09/14 6:29 AM resident progress note documented, "Received report from ____ (name of hospital nurse)/ Rsdt as 'Bad' UTI. IV	F 157	pain in the flank area; urine that is cloudy, red or foul smelling urine; fever (100 degrees F or greater) or chills; and new or worsening confusion. This was completed on 6/16/14_. Number of residents noted with current signs and symptoms of UTI were 5_.The number of residents with unreported abnormal lab values were 0. Affected residents had their physician and responsible party notified of the UTI signs and symptoms or abnormal labs on _6/16/14 by Rebecca Lamm. Systemic Changes In-services were completed on 6/16/2014 by the Staff Development Coordinator. Those who attended were all RNs, and LPNs FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work 6/16/2014_ until training has been completed. The in-service topic for the The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topic for the RN□s and LPN□s included education on the following policies and procedures: ICP 137, NUP 215 and NUP 611. In addition to the policy	

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F 157	Continued From page 3 (intravenous) Levaquin (antibiotic) 750 mg (milligrams) administered at ER...new order for ABT (antibiotic)/UTI." This new order was for Cipro antibiotic by mouth 500 mg BID (twice daily) x 3 days. At 9:47 AM on 05/29/14, during a telephone interview, Resident #1's primary physician stated he almost always treated UTIs when the lab results documented greater than 100,000 CFUs of bacteria. The physician reported Resident #1's family was very involved in the resident's care, and requested to be kept informed of changes in the resident's condition/health so they could participate in making care decisions. He commented, after reviewing his own medical records, he had no documentation of a UA, lab results, or C & S for Resident #1 in April 2014. According to the physician, even if he decided not to treat a UTI with an antibiotic, with a bacterial count as high as greater than 100,000 CFUs, he would expect the facility to notify him if the resident began exhibiting physical or behavioral symptoms indicative of a possible infection. He explained there was nothing in his own notes about being notified of Resident #1 experiencing agitated behaviors until 05/09/14 when she was sent out to the hospital for altered mental status. At 10:22 AM on 05/29/14, during a telephone interview, a family member of Resident #1 stated the resident's behavior had been stabilized until around the middle of April 2014 when she began to exhibit anxiousness, aggression, and hallucinations. According to the family, in the past such behaviors were an indicator of a UTI. The family member reported the physician was asked for help in obtaining a UA for the resident because the facility did not seem to be paying	F 157	215, the nurses were in-serviced on recognizing signs and symptoms of a UTI and how to notify the Physician. The Physician should be called when a change in condition occurs or when abnormal lab values are received 24 hours a day 7 days a week. This process does not change due to time of day or week. The nurses were also in-serviced on the revised lab protocol. See attachments. The in-service topic for the CNA□s included education on the following: Reporting changes noted in a resident□s condition to the nurse when they are seen is very important. Changes to report includes but is not limited to the following; the resident: Seems different than usual; Talks or communicates less; Overall needs more help; Pain-new or worsening, participates less in activities; Ate less; No BM in 3 days or diarrhea; Drank less; Weight change; Agitated or nervous more than usual, Tired, weak, confused or drowsy; Change in skin color or condition (new wound); Help with walking, transferring, toileting more than usual. These changes can be reported to the nurse by using the INTERACT Tool STOP and WATCH tool. Once completed and reported to the Nurse, place the completed form in the file folder on the 100 hall documentation room door. Tools will be available at each nurse□s station in a file folder labeled STOP AND WATCH Tool. Signs and symptoms of a UTI to report to the nurse include: complaints of pain on urination; new or worsening need	

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F 157	Continued From page 4 much attention to the change in the resident's behavior. At 12:42 PM on 05/29/14 the director of nursing (DON) stated Resident #1's behaviors documented in the 05/03/14 progress note were severe enough to warrant notifying the resident's primary physician, especially with lab results in the chart documenting the resident recently had 100,000 CFUs of bacteria in her urine. At 4:08 PM on 05/29/14, during a telephone conversation, a family member of Resident #1 stated on 04/19/14 someone from the facility called to tell the family that the UA showed the resident was "clear". The family explained they thought this meant there was no bacterial contamination of the urine. According to the family member, between 04/15/19 and 05/09/14 family was asked to come sit with the resident three or four times because the facility could not redirect or console Resident #1. The family reported they were puzzled about what was causing such extreme behaviors if a UTI was not present.	F 157	to go to the bathroom or incontinence; lower abdominal pain or pain in the lower back area; urine that is cloudy, red or foul smelling urine; fever (100 degrees F or greater) or resident complaints of chills; and new or worsening confusion. See attachment. In addition to this, this information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the "Survey QA Tool for Monitoring Change in Condition Notification". The monitoring will include sampling 5 residents to verify that residents noted with an abnormal lab or change in condition had there Physician and Responsible Party notified timely. This tool will be completed daily times two weeks then monthly times three months or until resolved by QOL/QA committee. See attachment . Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Social Service, and Dietary Manager.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		6/16/14

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F 312	Continued From page 5 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide perineal care based upon the facility's perineal care and infection control guidelines for one of three sampled residents, Resident # 1. Findings included: Resident #1 was admitted to the facility from the hospital on 05/02/2014 with diagnoses which included, but were not limited to, dementia, hypertension, and hyperlipidemia. A review of the Minimum Data Set Admission Assessment (MDS) dated 05/09/2014 revealed Resident #1 was severely cognitively impaired and required extensive assistance with dressing, personal hygiene, and bathing, and that she was continent of bowel and bladder. Also, a Significant Change MDS Assessment was in progress which was set to close on 05/30/2014. A review of the telephone orders in the electronic chart revealed that on 05/20/2014, an order was made by the physician to send Resident #1 to the local hospital emergency room for further evaluation of confusion, spiking temperature, and thrush.	F 312	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 312 Corrective Action for Resident Affected Resident # 858 NA #1 and #2 received education on perineal care from the Staff Development Coordinator on 05/28/14. Corrective Action for Resident Potentially Affected All residents have a potential to be affected by the alleged deficient practice. On 6/17-6/18/2014 the Nurse Management Team held a skills fair for all FT and PT CNA□s. During the skills fair, CNA□s were checked off on providing	

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F 312	Continued From page 6 A review of the Hospital Discharge Summary revealed that Resident #1 had an admitting diagnosis of a urinary tract infection and a fall with concussion. The same summary indicated that she was treated with Ancef (antibiotic) and was discharged to the facility on Keflex (antibitotic), 500 milligrams by mouth 4 times per day for 7 days. In an observation of incontinent care provided for Resident #1 on 05/28/2014 at 4:22 PM, two nursing assistants (NA), NA #1 and NA #2, washed their hands and then donned clean disposable gloves. NA #1 explained to the resident that she was providing incontinent care to her. Then NA #1, assisted by NA #2, turned the resident to her right side to inspect the back of the disposable brief. A small to moderate amount of soft stool was noted on the resident's buttocks and in the gluteal fold. NA #1 then used three disposable moistened wipes in her gloved hand to wipe the stool from front (area closest to the perineum) to back (area at the top of the gluteal fold.) NA #1 rearranged the same three wipes in her hand and re-used the group of wipes to again wipe the stool away from front to back. Stool was visible on the wipes as NA #1 rearranged the disposable wipes a third time to wipe the area from front to back. NA #1 then discarded the soiled wipes in the plastic lined trash bin and used two more wipes to finish wiping away the stool. The disposable brief was folded over to be removed, and both NA #1 and NA #2 assisted Resident #1 to lie on her back. Wearing the same pair of gloves, NA #1 used a washcloth moistened with warm water to clean the frontal pelvic region and labia majora from front to back. Neither NA #1 nor NA #2 separated the labia majora to inspect the labia minora for	F 312	perineal care according to policy NUP 611. See attached skills check off. See attachment . Systemic Changes An in-service was conducted on 6/16/2014 by the Staff Development Coordinator. Those who attended were all CNA□s FT, PT, and PRN. The facility specific inservice was sent to Hospice Providers whose CNA□s give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topic included education on policies and procedures: NUP 611. See attachment . In addition to this, this information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Staff Development Coordinator will monitor this issue using the "ADL Care Monitor". The monitoring will include sampling 4 residents to verify that perineal care is provided according to Policy and Procedure NUP 611. This tool will be completed daily times two weeks then monthly times three months or until resolved by QOL/QA committee. See attachment . Reports will be given to the	

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F 312	Continued From page 7 any stool residue. The nursing assistants then applied a clean disposable adult brief on Resident #1. Still wearing the same pair of gloves, NA #1 readjusted the resident's bed level and head of bed using the electric control on the bed. Then NA #1 removed her gloves, placed them in the trash bin, and tied the trash bag. She then carried the trash bag out into the hall, disposed of it in the hallway trash bin, and came back into the resident's room to wash her hands. In an interview with NA #1 on 05/28/2014 at 4:50 PM immediately following the observation, NA #1 stated that Resident #1 had needed more assistance with incontinent care ever since she returned to the facility after her hospitalization on 05/23/2014. She also stated that she had been trained to start with cleaning the back of the resident (rectal area) and then turn the resident to clean the front perineal area. She explained that she should separate the labia to clean the perineal area and also to inspect whether all of the stool had been removed. A review of the facility's Perineal Care Policy, #NUP-611, issued 10/01/2014, indicated that if a resident was soiled with feces, the resident should be turned on her side and that the perineum and rectal area should be cleaned. The policy stated that the resident should then be turned on her back and that the labia should be separated to be cleaned. An interview was conducted with the facility ' s Infection Control Nurse on 05/29/2014 at 2:40 PM. During the interview, she stated that the nursing assistant should start first with the female resident's perineum to clean, and then clean the bowel area of an incontinent resident. She	F 312	weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Social Service, and Dietary Manager.	

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F 312	Continued From page 8 further stated that if the nursing assistant cleaned the stool from the buttocks prior to cleaning the perineum, she should definitely wash her hands and don clean gloves before providing perineal care. In addition, she stated that the procedure for providing perineal care is the same for all female residents, whether they have a history of urinary tract infections or not. In an interview with the director of Nursing (DON) on 05/29/2014 at 4:25 PM, she stated gloves should be changed in between stool cleaning and perineal cleaning, and that one disposable wipe should be used per "swipe" rather than re-using or rearranging one to use again. She also stated she would expect the nursing assistants to open the labia to check for any stool that might still be in the perinal area and to clean it. In addition, she acknowledged that the facility's Perineal Care Policy should be changed to address the use of disposable wipes, the use of gloves, when to dispose of them, and when to wash hands.	F 312		
F 315 SS=D	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	F 315		6/16/14

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F 315	Continued From page 9 by: Based on physician interview, staff interview, and record review the facility failed to provide treatment for a urinary tract infection (UTI) presenting with greater than 100,000 colony-forming units (CFU) of bacteria and the emergence of behaviors for 1 of 3 sampled residents (Resident #1) who experienced UTIs. The facility also failed to allow family members to participate in formulating a plan of care to address the UTI by providing the family with inaccurate information regarding lab results. Findings included: Resident #1 was admitted to the facility on 11/02/06 and was readmitted on 05/13/14. The resident's documented diagnoses included recurrent UTIs, chronic kidney disease-stage III, chronic congestive heart failure, and pulmonary fibrosis/end-stage chronic obstructive pulmonary disease. Resident #1's 03/28/14 quarterly minimum data set (MDS) documented her cognition was severely impaired, she was occasionally incontinent of bowel and bladder, she required minimal assist from a staff member with toileting, and she did not exhibit mood problems/behaviors/psychosis/resistance to care. A 04/15/14 resident progress note documented Resident #1's primary physician office called on behalf of the resident's family to request that a urinalysis (UA) be completed. A 04/15/14 physician order documented a UA, C & S (culture and sensitivity) was to be drawn for Resident #1 due to increased confusion.	F 315	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 315 Corrective Action for Resident Affected Resident # 858 received treatment for a urinary tract infection (UTI) on 05/09/14. The Physician and Family were notified of the change in condition upon sending the resident to the emergency room on 05/09/14. Corrective Action for Resident Potentially Affected All residents have a potential to be affected by the alleged deficient practice. Beginning 6/9/2014 the Nurse Management Team audited all current resident lab results from 04/01/14 to present for any abnormal labs without MD and responsible party notification of the results. In addition to this, all current residents were assessed for signs and symptoms of a potential UTI by the hall nurses under the direction of the nurse management team. Signs and symptoms	

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F 315	Continued From page 10 A 04/16/14 hospice clinical update/progress note documented, "UA obtained for increased confusion per ___'s (family member designation's) request." A 04/16/14 care plan for Resident #1 documented, "I have confusional episodes at times. I have hx (history) of episodes of confusion, hallucinations. No routine antipsychotic medication per request of family. History 'seeing ants on food', none were present. See nurse's notes. Wants to go home to see my little 4 year old son." Interventions to this problem included, "Check urine per order/protocol and as needed for volume, color, and odor. Monitor/record/report to MD (physician) new onset s/sx (signs/symptoms) of delirium, changes in behavior, altered mental status, wide variation in cognitive function through the day, communication decline, disorientation, lethargy, restlessness and agitation, altered sleep cycle, dehydration, infection, delusions, hallucinations." Clean catch urine laboratory results, available to the facility on 04/19/14, documented that greater than 100,000 CFU of klebsiella pneumoniae and proteus mirabilis were found in the resident's urine sample. Documentation on the lab results indicated that they were faxed to the primary physician's office on 04/21/14. However, there was no returned fax in the resident's medical record indicating acknowledged receipt from the physician office, and there was no notation that a response to abnormal lab results had been obtained (see interview with unit supervisor). A physician signature, minus a date, was observed on these lab results.	F 315	of UTI assessed were: painful urination; new or worsening urgency, frequency or incontinence; lower abdominal pain or pain in the flank area; urine that is cloudy, red or foul smelling urine; fever (100 degrees F or greater) or chills; and new or worsening confusion. This was completed on 6/16/2014. Number of residents noted with current signs and symptoms of UTI were 5_. The number of current residents with unreported abnormal lab values were 0_. Affected residents had their physician and responsible party notified of the UTI signs and symptoms or abnormal labs on __6/16/2014_ by Rebecca Lamm _. Systemic Changes in-services were completed on 6/16/2014 by the Staff Development Coordinator. Those who attended were all RNs, and LPNs FT, PT, and PRN. Any in-house staff member who did not receive in-service training will not be allowed to work 6/16/2014 until training has been completed. The facility specific in-service was sent to Hospice Providers whose employees give residents care in the facility to provide training for staff prior to returning to the facility to provide care. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topic for the RN□s and LPN□s included education on the following policies and procedures: ICP 137, NUP 215 and NUP 611. In addition to the policy 215, the nurses were in-serviced on recognizing signs and	

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F 315	Continued From page 11 Review of physician orders revealed no orders to treat the resident with an antibiotic. A 04/26/14 physician progress note documented Resident #1 was assessed in the facility, but no information was included about a recent UA or the lab result/C & S. The note documented the resident did have chronic UTIs and chronic kidney disease. The physician did note, "Repeat labs are pending." (However, no orders were found to draw any repeat labs). A 04/30/14 hospice clinical update/progress note documented, "UA negative." A 05/03/14 10:54 PM resident progress note documented, "Rsdt (resident) propelling self up and down hallway hollering out loudly demanding to be taken home; Stating she was not supposed to be left here; Rsdt approaching other rsdts in hallway stating he has to go home, waving hand at resdts and becoming angry when they spoke to her...: The note documented the staff was unable to console or redirect Resident #1, and her family had to be called to come calm the resident down. A 05/06/14 10:12 PM hospice note documented, "Pt. (patient) sitting in wheelchair. Alert and disoriented. She wanted to go home and was distressed." A 05/09/15 1:48 AM resident progress note documented, "Rsdt very confused with increased agitation and combativeness....Rsdt kept saying she wanted to go to bed because she did not feel good. On several attempts rsdt guided back to her room and attempted to put back into bed but	F 315	symptoms of a UTI and how to notify the Physician. The Physician should be called when a change in condition occurs or when abnormal lab values are received 24 hours a day 7 days a week. This process does not change due to time of day or week. The nurses were also in-serviced on the revised lab protocol. See attachments. Quality Assurance The Director of Nursing will monitor this issue using the "Survey QA Tool for Monitoring Change in Condition/Lab Notification". The monitoring will include sampling 5 residents to verify that residents noted with an abnormal lab or change in condition had there Physician and Responsible Party notified timely. This tool will be completed daily times two weeks then monthly times three months or until resolved by QOL/QA committee. See attachment . Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The QOL/QA Meeting is attended by Administrator, Director of Nursing, Unit Manager, other nurse managers, Social Service, and Dietary Manager.	

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rsdt would yell and scream 'this in not my house. This is not my room.' Rsdt was taking alarm and string off and wrapping it around her hands tightly. Rsdt was yelling and trying to fight staff when they approached to help....911 called for services to transport to ER (emergency room) for evaluation. Out of facility at 2:15 AM...."

A 05/09/14 6:29 AM resident progress note documented, "Received report from ____ (name of hospital nurse)/ Rsdt as 'Bad' UTI. IV (intravenous) Levaquin (antibiotic) 750 mg (milligrams) administered at ER...new order for ABT (antibiotic)/UTI." This new order was for Cipro antibiotic by mouth 500 mg BID (twice daily) x 3 days.

At 9:47 AM on 05/29/14, during a telephone interview, Resident #1's primary physician stated he almost always treated UTIs when the lab results documented greater than 100,000 CFUs of bacteria. The physician reported Resident #1's family was very involved in the resident's care, and requested to be kept informed of changes in the resident's condition/health so they could participate in making care decisions. He commented, after reviewing his own medical records, he had no documentation of a UA, lab results, or C & S for Resident #1 in April 2014. According to the physician, even if he decided not to treat a UTI with an antibiotic, with a bacterial count as high as greater than 100,000 CFUs, he would expect the facility to notify him if the resident began exhibiting physical or behavioral symptoms indicative of a possible infection.

At 10:22 AM on 05/29/14, during a telephone interview, a family member of Resident #1 stated the resident's behavior had been stabilized until

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around the middle of April 2014 when she began to exhibit anxiousness, aggression, and hallucinations. According to the family, in the past such behaviors were an indicator of a UTI. The family member reported the physician was asked for help in obtaining a UA for the resident because the facility did not seem to be paying much attention to the change in the resident's behavior.

At 12:22 PM on 05/29/14 Nurse #1, who cared for Resident #1 on first shift, stated there were times when the resident became agitated, combative, aggressive about wanting to go home, and refused medications and alarms. She reported sometimes such behaviors were symptoms of recurrent UTIs. She explained the facility usually drew UAs when the behaviors emerged to check for the presence of bacteria in the urine. She was unable to recall if Resident #1 exhibited such behaviors prior to the resident's 05/09/14 hospitalization because her assignment varied as help was needed throughout the facility.

At 12:30 PM on 05/29/14 nursing assistant (NA) #4, who regularly cared for Resident #1 on first shift, stated sporadically the resident would yell out, get anxious and combative, and resist care. She reported this frequently meant the resident had a UTI. She commented Resident #1 was experiencing these symptoms at least for a couple weeks before being hospitalized on 05/09/14.

At 12:42 PM on 05/29/14 the director of nursing (DON) stated labs results were always faxed to the physician offices, and if there was no return call or return fax, the lab results were refaxed or called into the physician offices.

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F 315	Continued From page 14 At 12:50 PM on 05/29/14 the unit supervisor stated Resident #1's primary physician always wanted to be called by facility staff, and did not like for lab results or concerns to be faxed to his office. She stated the 04/19/14 lab results for Resident #1 were not initialed and marked "noted". She explained that "noted" indicated response was received from the physician or action was taken by the physician in response to lab results. The supervisor also commented Resident #1's 04/19/14 lab results were signed in pen by the physician which meant he was in the facility when he signed off on them. However, she reported the physician forgot to supply a date with his signature on the 04/19/14 lab results, which was not like him. She pointed out all the other lab results in Resident #1's chart with dated signatures from the resident's physician. At 1:50 PM on 05/29/14, during a telephone interview with Nurse #2, who regularly cared for Resident #1 on first shift, stated sporadically Resident #1 would yell out, demand to be taken home, get combative with staff, and family would have to be called to calm her down. She reported sometimes such behaviors indicated the resident had a UTI. She explained the facility usually drew a UA to see if bacteria was present in the urine when these behaviors emerged. Nurse #2 stated she knew for sure that these types of behaviors were exhibited by Resident #1 for at least two days before going out to the hospital on 05/09/14, maybe even longer. At 4:08 PM on 05/29/14, during a telephone conversation, a family member of Resident #1 stated on 04/19/14 someone from the facility called to tell the family that the UA showed the	F 315		

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F 315	Continued From page 15 resident was "clear". The family explained they thought this meant there was no bacterial contamination of the urine. According to the family member, between 04/15/19 and 05/09/14 family was asked to come sit with the resident three or four times because the facility could not redirect or console Resident #1. The family reported they were puzzled about what was causing such extreme behaviors if a UTI was not present.	F 315		