STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345343	A. BUILDING _____ B. WING _____	C 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	1700 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		2/9/18

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

Electronically Signed | 02/05/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the Physician of the absence of urine and the presence of blood in a newly inserted indwelling urinary catheter for approximately 6 hours and failed to notify the Physician of a Registered Dietician recommendation for an increase in the tube feeding which resulted in a delay of treatment for 1 of 1 residents (Resident #303). Findings included: 1a Record review revealed Resident #303 was admitted to the facility on 8/15/2017 with diagnoses which included Benign Prostatic Hyperplasia (enlargement of the prostate gland, which is a gland located below the bladder) and a history of Cerebral Vascular Accident (stroke). Review of the Admission Minimum Data Set (MDS) dated 8/22/2017 indicated the resident was moderately cognitively impaired and required the assistance of 2 persons with activities of daily living. The MDS indicated the resident was always incontinent of bowel and bladder. Record review revealed a Physicians Progress	F 580	Resident #303 was discharged on 8/31/2017 and has not returned to the facility. 1a. The Director of Nursing or designee will complete an audit of physician orders and the facility's twenty four hour reports for the past thirty days to ensure physician and/or resident representative notification for residents with significant change in condition , to include absence of urine in a catheter bag . 1b. The Director of Nursing or designee will complete an audit of the previous months Registered Dietitian recommendations to ensure that the attending physician was notified timely and appropriate changes made to the resident's diet were completed. 1b. The Director of Nursing or designee will re-educate all licensed nurses on the facility process for pending /confirming physician orders. Any licensed nurse that does not receive the education will receive prior to working their next scheduled shift. Newly hired licensed nurses will receive the education during new hire the orientation.	

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F 580	Continued From page 2 note and orders dated 8/29/2017. The progress note indicated the resident was seen by the physician. The progress note detailed the resident had a low-grade fever, oxygen saturation was 87% on room air, blood pressure was 106/64, lungs were clear, heart rate was regular, abdomen was soft, no edema (swelling) was present and the resident responded to verbal stimuli. The Physician's orders included to obtain laboratory specimens for a CBC, CMP and Urinary Analysis (UA-analysis of urine) with Culture and Sensitivity (C&S-a test which may grow and identify bacteria in urine). Record review of the nursing notes revealed documentation by Nurse #1 on 8/29/2017 at 9:18 PM which indicated Resident #303 was catheterized for a Urinary Analysis (UA-analysis of urine) and Culture and Sensitivity (C&S-a test which may grow and identify bacteria in urine) per the physician orders. The nursing note reported the resident was catheterized at 6:00PM and the vital signs at that time were: blood pressure 93/56, pulse 104, respirations 20, temperature 98.6 and oxygen saturation was 84% to 89% with oxygen in place. The note revealed there was blood returned upon catheterization, there was no urine upon catheterization and the catheter was left in place. The note indicated the resident did not appear in distress and family was at the bedside. Further review of the nursing notes revealed a note documented by Nurse #2. The note indicated Nurse #2 was called to Resident #303's room and upon entry noted the resident was pale and cool to touch. The note further indicated there was a large amount of blood in the catheter and the catheter tubing. The resident's vital signs	F 580	1b. The facility clinical managers to include Director of Nursing, Staff Development Coordinator and Unit Managers will be provided re- education regarding registered dietitian recommendation to include review, physician notification and processing of the recommendation by the facilitiy's district clinical director. 1a. The Director of Nursing or designee will re-educate facility licensed nursing staff regarding physician notification of significant change in resident condition. Any licensed nurse that does not receive the education will receive prior to working their next scheduled shift. Newly hired licensed nurses will receive the education during new hire orientation. 1a. The Director of Nursing or designee will review the twenty four hour report and physician orders from previous day to ensure that the physician was notified of significant changes in the residents condition timely, daily for thirty days , weekly times four then monthly times three. 1b. The Facility's district clinical director or designee will review the Registered Dietitian's monthly recommendations times 3 months to ensure all recommendations were followed up on timely by the facility. The physician notification/24 hour report/physician order audit/Registered Dietitian Recommendation audit results will be reviewed by the facility's QAPI team weekly times 4 weeks then monthly times 3 months and all negative findings will be addressed and further education	

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were documented in the note as: blood pressure 93/56, pulse 104, temperature 98.6, respirations 20 and his oxygen saturation was 88% to 89%. The note revealed the resident's family was at the bedside and requested the resident to be sent to the emergency department for evaluation. The documentation revealed the physician was notified and the resident left the facility by ambulance at 12:10 AM on 8/30/2017.

An interview was conducted with Nurse #1 on 1/12/2017 at 8:58AM. The Nurse #1 reported she remembered Resident #303. The nurse stated when a resident is incontinent and a UA is ordered, she used an in and out catheter to obtain urine for the specimen. Nurse #1 recalled there was blood return in the tubing and collection bag. Nurse #1 indicated there was no urine in the collection bag or tubing. Nurse #1 further indicated although she monitored the resident for the rest of the evening shift, she did not reevaluate the catheter for placement. Nurse #1 stated she probably did not call the physician and inform him of the lack of urine and the presence of blood in the urinary collection bag because she recalled there was a lot going on that evening and she just forgot to call him.

An interview was conducted with the Physician on 1/12/2018 at 9:40AM. The Physician stated he did not recall Resident #303. The Physician indicated he certainly expected to be notified of the absence of urine and the presence of blood in an indwelling catheter. The Physician stated he would expect to be notified immediately after insertion if there was only blood observed in the collection bag.

An interview was conducted with the Director of

provided as needed.

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Nursing (DON) on 1/12/2018 at 10:30AM. The DON stated the expectation was for the Physician to be notified with the presence of blood and the absence of urine when an indwelling urinary catheter is placed.

1b
Record review revealed Resident #303 was admitted to the facility on 8/15/2017 with diagnoses which included Dysphagia (difficulty in swallowing) with Gastrostomy Status (feeding tube through the abdominal wall) and a history of Cerebral Vascular Accident (stroke).

Record review of Resident's Admission Physician orders dated 8/15/2017 revealed tube feeding formula orders for continual feedings of 50 milliliters (mls) per hour, water flushes at 125 mls per hour and before and after medications as ordered.

Record review of Resident #303's initial Care Plan dated 8/15/2017 included a goal of adequate nutrition and hydration as evidenced by stable weights through the next review.

Record review of Resident #303's weights revealed a weight on 8/16/2017 of 134 pounds and a weight on 8/21/2017 of 130.4 pounds. Documentation revealed both weights were obtained by the bed scale.
Review of the 7-day Admission Minimum Data Set (MDS) dated 8/22/2017 indicated the resident was moderately cognitively impaired and required the assistance of 2 persons with activities of daily living. The MDS indicated the resident received tube feeds for all his nutritional needs. The Care Area Assessment (CAA) dated 8/22/2017 indicated the resident received nothing by mouth

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and was totally dependent on staff for his nutritional needs and administration of tube feeds.

Review of the clinical progress notes revealed documentation from the Registered Dietician (RD) dated 8/27/2017. The note indicated Resident #303 was at a nutritional risk due to his underweight status. The note indicated the resident required increased nutrient needs and recommended to increase the formula feeds to 55mls an hour.

Review of the electronic record revealed a physician's order dated 8/27/2017 (entered into the electronic record by the RD) to increase Resident #303's formula tube feeds to 55 mls an hour. The order was noted as pending confirmation. A review of the Medication Administration Record and the Treatment Administration Record revealed the formula tube feeds were not increased per the RD recommendation.

An interview was conducted with the RD on 1/11/2018 at 10:09AM. The RD indicated she did not recall Resident #303. The RD reviewed the resident's notes and indicated although the tube feeding rate from the hospital upon admission was adequate, she felt the resident needed more calories and protein based on what his weight should be. The RD indicated she sent the recommendations to the nursing department via email, and put the recommendation in the computer so the nurses would see it was flagged and follow up with the physician. The RD indicated that was the system the facility used for communication.

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An interview was conducted with the Director of Nursing (DON) on 1/11/2018 at 11:15AM. The DON indicated the recommendations from the RD had to be confirmed and usually she received an email from the RD with the recommendations. The DON stated she looked in her email and did not see an email for the recommendations.

An interview was conducted with the Cooperate Clinical Director on 1/11/2018 at 11:30AM. The Cooperate Clinical Director indicated the facility had 48 or 72 hours to get the recommendations to the Physician for review and completion. The Clinical Cooperate Director stated the recommendation was put in the computer on 8/27/2017 at 8:30PM and the resident was discharged to the hospital on 8/30/2017 at 12:10AM.

An interview was conducted with the Administrator (ADM) on 1/11/2018 at 3:30PM. The ADM indicated the order for the tube feeding formula increase for Resident #303 should have been reviewed in the daily clinical meeting the day after it was entered in the computer. The ADM stated there was no way to know why the order was not reviewed and confirmed.

An interview was conducted with the Physician on 1/11/2018 at 7:14PM. The Physician reported he did not recall Resident #303. The Physician indicated when the RD made recommendations, he expected the recommendations to be placed in his box located at the nursing station so he could address them as soon as possible. The Physician stated if the RD made a recommendation to increase a tube feeding rate due to weight loss and caloric needs he would want to address it on his next facility visit. The

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F 580	Continued From page 7 Physician reported he was usually in the facility every day. The Physician indicated he did not think the increase in the tube feeds for the resident would have made any difference in the resident's weight in such a short time. The Physician indicated he relied on the facility staff to inform him of RD recommendations as the computer system does not alert him. The Physician stated the system needed to be changed to prevent delays in residents' needs.	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to obtain a physician's order for the use of an indwelling urinary catheter for 1 of 1 sampled residents reviewed for urinary catheter use (Resident #303). Findings included: Record review revealed Resident #303 was admitted to the facility on 8/15/2017 with diagnoses which included Benign Prostatic Hyperplasia (enlargement of the prostate gland, which is a gland located below the bladder) and a history of Cerebral Vascular Accident (stroke). Review of the Admission Minimum Data Set (MDS) dated 8/22/2017 indicated the resident was moderately cognitively impaired and required	F 658	Resident #303 was discharged on 8/31/2017 and has not returned to the facility. The Director of Nursing or designee will review the facility's current Residents identified with indwelling catheters to ensure physician orders are in place. The Director of Nursing or designee will re-educate all licensed nursing staff on the facilities policy requiring a physician's order prior to inserting an indwelling catheter. The Director of nursing or designee will audit 2 patients who have an indwelling catheter to ensure the appropriate physicians order weekly times 4 weeks then monthly times 3 months. The indwelling catheter audit results will be reviewed by the facility's QAPI team	2/9/18

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F 658	Continued From page 8 the assistance of 2 persons with activities of daily living. The MDS indicated the resident was always incontinent of bowel and bladder. Record review of the nursing notes revealed documentation by Nurse #1 on 8/29/2017 at 9:18 PM which indicated Resident #303's vital signs at the beginning of the 3:00PM to 11:00PM shift were: blood pressure 113/74, pulse 116, respirations 20, temperature 100.3 degrees Fahrenheit and his oxygen saturation ranged between 80% and 84% on room air. The note indicated the Physician was notified and orders were obtained for laboratory tests including a urine specimen for Urinary Analysis (UA-analysis of urine) and Culture and Sensitivity (C&S-a test which may grow and identify bacteria in urine). The note indicated the resident was straight catheterized for the urine sample. The nursing note reported the resident was catheterized at 6:00PM and the vital signs at that time were: blood pressure 93/56, pulse 104, respirations 20, temperature 98.6 and oxygen saturation was 84% to 89% with oxygen in place. The note revealed there was blood returned upon catheterization, there was no urine upon catheterization and the catheter was left in place. The note indicated the resident did not appear in distress and family was at the bedside. Record review revealed a Physicians Progress note and orders dated 8/29/2017. The progress note indicated the resident was seen by the physician. The progress note detailed the resident had a low-grade fever, oxygen saturation was 87% on room air, blood pressure was 106/64, lungs were clear, heart rate was regular, abdomen was soft, no edema (swelling) was present and the resident responded to verbal	F 658	weekly times 4 weeks then monthly times 3 months and all negative findings will be addressed and further education provided as needed.	

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stimuli. The Physician's orders included to obtain laboratory specimens for a CBC, CMP and UA with C&S.

Further review of the nursing notes revealed a note documented by Nurse #2 on 8/30/2017 at 8:07AM. The note indicated Nurse #2 was called to Resident #303's room and upon entry noted the resident was pale and cool to touch. The note further indicated there was a large amount of blood in the catheter and the catheter tubing. The resident's vital signs were documented in the note as: blood pressure 93/56, pulse 104, temperature 98.6, respirations 20 and his oxygen saturation was 88% to 89%. The note revealed the resident's family was at the bedside and requested the resident to be sent to the emergency department for evaluation. The documentation revealed the physician was notified and the resident left the facility by ambulance at 12:10 AM on 8/30/2017.

Nurse #2 was unavailable for interview during the investigation.

Review of the hospital records dated 8/30/2017 revealed Resident #303 was evaluated in the emergency department on 8/30/2017 at approximately 12:30 AM. The documentation indicated the resident arrived to the emergency department with an indwelling urinary catheter in place and blood noted in the drainage bag.

An interview was conducted with Nurse #1 on 1/12/2017 at 8:58AM. Nurse #1 reported she remembered Resident #303 and cared for him on 08/29/17. The nurse stated when a resident is incontinent and a UA is ordered, she used an in and out catheter to obtain urine for the specimen.

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Nurse #1 indicated she did not remember why she placed an indwelling catheter for Resident #303 on 08/29/17. Nurse #1 further indicated she did not recall calling the physician to get an order for the indwelling catheter, and if she called the physician she would have documented it.

An interview was conducted with the Physician on 1/12/2018 at 9:40AM. The Physician stated he did not recall Resident #303. The Physician indicated if he ordered a UA and C&S for an incontinent resident, he would expect the nursing staff to use an in and out catheter to obtain the specimen. The Physician stated if the in and out catheter procedure did not produce urine, an indwelling catheter could be used and if the urine return is greater than 400 milliliters to leave the catheter in. The Physician indicated he would certainly expect the catheter placement to be reevaluated if there was no urine in the collection bag within 2 hours post insertion and with the presence of only blood in the collection bag.

Another interview was conducted with Nurse #1 on 1/12/2018 at 10:10AM. Nurse #1 called this surveyor and stated she had been thinking about the evening since the previous interview and remembered the physician was in the facility and assessed the resident on the evening of 8/29/2017. Nurse #1 reported the physician told her to catheterize the resident for the urine sample and she forgot to write the order. Nurse #1 indicated she still did not recall why she used an indwelling urinary catheter instead of an in and out catheter for the collection of urine. Nurse #1 also indicated she did not recall if the physician told her to use an indwelling urinary catheter, but the physician trusted her judgment.

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F 658	Continued From page 11 An interview was conducted with the Director of Nursing (DON) on 1/12/2018 at 10:30AM. The DON stated the expectation was a Physician's order be obtained and written along with the justification for an indwelling urinary catheter.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to maintain a hazard free environment when 1 of 112 resident call bell cords were observed to have exposed wires (Resident #75). Findings included: A review of medical records revealed Resident #75 was admitted 10/7/2016 with diagnoses of Chronic Obstructive Pulmonary Disease, Bi polar disorder, chronic pain syndrome, anxiety, tobacco use and epilepsy. The 5 day Minimum Data Set (MDS) dated 12/1/2017 noted Resident #75 to be cognitively intact and needed extensive to total assistance for all Activities of Daily Living, with the physical help of one person. On 1/9/2018 at 10:34 AM, during an interview	F 689	Resident #75's call bell was replaced by the Maintenance Director on 1/11/2018. The Administrator or designee will audit all of the facility's call bell cords to ensure they do not exhibit exposed wires. The Administrator or designee will re-educate all facility staff on the facilities expectation of observing patient equipment while in a patient's room and the appropriate reporting method to inform Administration of an item needing repair. The Administrator or designee will audit 10-15 rooms per week then 10-15 per month times 3 months, to ensure call bell cords do not have any exposed wires. The call bell cord audit results will be reviewed by the facility's QAPI team weekly x 4 weeks then monthly times 3 months and all negative findings will be addressed and further education provided	2/9/18

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F 689	Continued From page 12 with Resident #75, the Resident was asked to turn on her call bell. When Resident #75 picked up the call bell it was observed to have 1 ½ inches of the wiring inside the cord cover exposed. This was just below the handle where a resident would hold to turn the call bell on. The wires were insulated, but at the point where the wires went into the handle the wires could be seen. The call bell was observed on 1/10/2018 at 11:00 AM, to be in the same condition with the insulated wires exposed. An observation was made on 1/11/2018 of the call bell for Resident #75. The call bell was repaired with no exposed wiring. In an interview at 10:00 AM on 1/11/2018, the Maintenance Director stated he had repaired the call bell cord the night before (1/10/2018). The Maintenance Director stated these particular types of cords have this problem when they are wrapped around the bed rail and get pulled and expose the wires. The Maintenance Director stated he had repaired the call bell cords in the past. The Maintenance Director indicated he did not audit call bell cords routinely throughout the facility because he worked alone and did not have time. The Maintenance Director stated there is a logbook at each nursing station where problems were signed in, and he reviewed them throughout the day, made repairs and dated and signed the book when the repairs were finished. On 1/11/2018 at 3:20 PM in an interview, the facility Administrator stated his expectation was the call bell cords would be reported and repaired.	F 689	as needed.	

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician	F 690	Resident #303 was discharged from the	2/9/18

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F 690	Continued From page 14 interviews, the facility failed to evaluate an indwelling urinary catheter for proper placement after observations of blood in the drainage bag and no urine output which resulted in a hospitalization for hematuria (blood in urine) for 1 of 1 resident reviewed for urinary catheter (Resident #303). Findings included: Record review revealed Resident #303 was admitted to the facility on 8/15/2017 with diagnoses which included Benign Prostatic Hyperplasia (enlargement of the prostate gland, which is a gland located below the bladder) and a history of Cerebral Vascular Accident (stroke). Review of the Admission Minimum Data Set (MDS) dated 8/22/2017 indicated the Resident #303 was moderately cognitively impaired and required the assistance of 2 persons with activities of daily living. The MDS indicated the resident was always incontinent of bowel and bladder. Record review of the nursing notes revealed documentation by Nurse #1 on 8/29/2017 at 9:18 PM which indicated Resident #303's vital signs at the beginning of the 3:00 PM to 11:00 PM shift were: blood pressure 113/74, pulse 116, respirations 20, temperature 100.3 degrees Fahrenheit and his oxygen saturation ranged between 80% and 84% on room air. The note indicated the Physician was notified and ordered some laboratory tests including a urine specimen for Urinary Analysis (UA-analysis of urine) and Culture and Sensitivity (C&S-a test which may grow and identify bacteria in urine). The note indicated the resident was straight catheterized	F 690	facility on 8/30/2017 and has not returned. The Director of Nursing or designee will audit all Residents who have had an indwelling catheter placed within the last 30 days to ensure proper placement and appropriate drainage. The Director of Nursing or designee will re-educate all licensed staff on the facility's indwelling catheter insertion policy. The Director of Nursing or designee will audit 3-4 patients who have indwelling catheters to ensure proper placement and drainage weekly times 4 weeks then monthly times 3 months. The indwelling catheter audit results will be reviewed by the facility's QAPI team weekly times 4 weeks then monthly times 3 months and all negative findings will be addressed and further education provided as needed.	

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F 690	Continued From page 15	F 690		

for a urine sample at 6:00 PM. The nursing note reported the resident was catheterized at 6:00PM and there was blood returned upon catheterization, there was no urine upon catheterization and the catheter was left in place. The note indicated the resident did not appear in distress and family was at the bedside.

Record review revealed a Physician's Progress note and orders dated 8/29/2017. The progress note indicated the resident was seen by the physician. The progress note detailed the resident had a low-grade fever, oxygen saturation was 87% on room air, blood pressure was 106/64, lungs were clear, heart rate was regular, abdomen was soft, no edema (swelling) was present and the resident responded to verbal stimuli. The Physician's orders included to obtain a laboratory specimen for a UA with C&S

Further review of the nursing notes revealed a note documented by Nurse #2 on 8/30/2017 at 8:07 AM. The note indicated Nurse #2 was called to Resident #303's room and upon entry noted the resident was pale and cool to touch. The note further indicated there was a large amount of blood in the catheter drainage bag and the catheter tubing. The resident's vital signs were documented in the note as: blood pressure 93/56, pulse 104, temperature 98.6, respirations 20 and his oxygen saturation was 88% to 89%. The note revealed the resident's family was at the bedside and requested the resident to be sent to the emergency department for evaluation. The documentation revealed the physician was notified and the resident left the facility by ambulance at 12:10 AM on 8/30/2017.

Review of the hospital records revealed Resident

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F 690	Continued From page 16	F 690		

#303 was evaluated in the emergency department (ED) on 8/30/3017 at approximately 12:30 AM and was admitted to the hospital with diagnoses including hematuria. The hospital records indicated the resident arrived to the ED with an indwelling urinary catheter with blood observed in the drainage bag. The hospital records did not indicate anything about the removal of the indwelling catheter. The hospital records revealed an order for a STAT (immediate) urinalysis to be obtained. The records indicated the urinalysis was obtained from a clean catch specimen (non-invasive and obtained from catching urine in a container as opposed to a catheter) and the results were documented at 2:15 AM on 8/30/2017.

An interview was conducted with Nurse #1 on 1/12/2017 at 8:58 AM. Nurse #1 reported she remembered Resident #303 and confirmed she cared for him on 8/29/17 from 3:00 PM to 11:00 PM. The nurse stated when a resident was incontinent and a UA was ordered, she used an in and out catheter to obtain urine for the specimen. Nurse #1 indicated she did not remember why she placed an indwelling catheter in Resident #303 on 8/29/17. Nurse #1 recalled inserting the catheter and stated there was not any unusual resistance when the catheter was inserted. Nurse #1 recalled there was blood return in the tubing and collection bag and no urine in the collection bag or tubing. Nurse #1 further indicated although she monitored the resident for the rest of the evening shift, she did not reevaluate the catheter for placement. Nurse #1 indicated there was no urine in the collection bag from 6:00 PM until the end of her shift at 11:00 PM. Nurse #1 stated she probably did not call the physician and inform him of the lack of urine and the presence of blood in

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F 690	Continued From page 17	F 690		

the urinary collection bag because she recalled there was a lot going on that evening and she just forgot to call him. Nurse #1 stated she recalled the resident's condition was essentially the same all evening, so the lack of urine in the urinary collection bag did not seem to affect him. Nurse #1 indicated she did not recall the information she shared during the shift report with the oncoming nurse on 8/29/2017.

Nurse #2 was unavailable for interview during the investigation.

An interview was conducted with the Physician on 1/12/2018 at 9:40 AM. The Physician stated he did not recall Resident #303. The Physician indicated if he ordered a UA and C&S for an incontinent resident, he would expect the nursing staff to use an in and out catheter to obtain the specimen. The Physician stated if the in and out catheter procedure did not produce urine, an indwelling catheter could be used and if the urine return is greater than 400 milliliters to leave the catheter in. The Physician indicated he would certainly expect the catheter placement to be reevaluated if there was no urine in the collection bag within 2 hours post insertion and with the presence of only blood in the collection bag. The Physician also indicated he expected to be notified of the absence of urine and the presence of blood in an indwelling catheter, but could not speculate as to what his course of action would have been.

An interview was conducted with the Director of Nursing (DON) on 1/12/2018 at 10:30 AM. The DON indicated the expectation was for in and out catheters to be used for obtaining a urine specimen from incontinent residents. The DON

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F 690	Continued From page 18 stated the expectation was for indwelling catheters to be reassessed with the presence of blood and the absence of urine to ensure correct placement. The DON further stated she was unaware of the reason Nurse #1 utilized an indwelling catheter for Resident #303. The DON indicated informing the Physician for guidance with the absence of urine from an indwelling catheter was expected as reevaluation of the catheter placement was warranted.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		2/9/18

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F 761	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to dispose of expired medications or biologicals for one of three medication storage refrigerators reviewed. Findings included: During the medication storage review on 1/12/2018 at 1:45 PM, a bagged, multi-dose vial of Purified Protein Derivative (PPD) which is used for Tuberculosis testing, was noted to be in the refrigerator in the medication storage room on the 100/200 hall. The lot number was 301013 and the expiration date was 02/19. The vial was opened and no date was on the vial, the box or the bag containing the boxed vial. There was a sticker on the bag with a line noted for the open date, but no date was on it. On 1/12/2018 at 2:20 PM, during a review of the 300 hall medication cart, there was a large container of Calcium Carbonate chewable tabs, lot number 31608 and an expiration date of 10/17. On 1/12/2018 at 1:45 PM, the Director of Nursing stated her expectation was the vial would be dated when it was opened and the expired medications were sent back to the pharmacy or disposed of.	F 761	The Purified Protein Derivative (PPD) and the Calcium Carbonate were immediately discarded by the Director of Nursing. The Director of Nursing or designee will audit all nurses carts and medication storage areas to ensure all opened medications are dated and medications have not expired. The Director of Nursing or Designee will re-educate all licensed staff on the facility's policy regarding medication storage to include proper dating and observing expiratory dates. The Director of Nursing or designee will audit 2-3 medication storage areas to ensure all opened medications are dated and all medications have not expired weekly times 4 weeks then monthly times 3 . The medication storage audit results will be reviewed by the facility's QAPI team weekly times 4 weeks then monthly times 3 months and all negative findings will be addressed and further education provided as needed.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		2/9/18

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F 867	Continued From page 20 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures put into place 12/8/2016. These interventions were in 2 areas originally cited in the recertification survey of 11/10/2016 (F281 and F315) and recited in the recertification survey of 1/12/2018. The deficiencies were in the areas of services to meet professional standards and bowel/bladder incontinence/catheter. The continued failure of the facility during two consecutive federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings included: This citation is cross referenced to: 1)F281-Based on record review and staff interview the facility failed to obtain a laboratory blood test for a Basic Metabolic Panel as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications. The facility was cited during the 11/10/2016 recertification survey for failure to obtain a laboratory blood test as ordered by the physician. During the current survey, the facility failed to obtain a physician's order for an indwelling catheter. 2) F315-Based on record review, observation and staff and resident interview the facility failed to provide scheduled or prompted toileting in order	F 867	The facility QAPI team to include the Administrator , Director of Nursing, Unit managers, Social Worker, Rehab Manager and Dietary Manager were provided re- education regarding the Quality Assurance and Performance Improvement process by district clinical Director. Resident #303 was discharged from the facility on 8/30/2017 and has not returned. The Director of Nursing or designee will audit all Residents who have had an indwelling catheter placed within the last 30 days to ensure proper placement and appropriate drainage. The Director of Nursing or designee will re-educate all licensed staff on the facility's indwelling catheter insertion policy. The Director of Nursing or designee will audit 3-4 patients who have indwelling catheters to ensure proper placement and drainage weekly times 4 weeks then monthly times 3 months. The indwelling catheter audit results will be reviewed by the facility's QAPI team weekly times 4 weeks then monthly times 3 months and all negative findings will be addressed and further education provided as needed. The District director of clinical services and/or district director of operation will attend the facility QAPI meeting monthly times 3 months to ensure implemented procedures are appropriately maintained.	

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F 867	Continued From page 21 to maintain or prevent decline of urinary incontinent episodes for 1 of 2 residents. The facility was cited during the 11/10/2016 recertification survey for failing to provide scheduled toileting to prevent decline in urinary incontinence. During the current survey, the facility failed to evaluate an indwelling urinary catheter for proper placement. During an interview with the Administrator on 01/22/2018 at 4:00 PM, the Administrator stated the QAA Committee met monthly and identified, developed and implemented plans of action to correct identified quality deficiencies. The Administrator also stated that after the previous recertification survey, corrective actions were put in place and until this survey, he felt the facility was in substantial compliance with regard to aa former citations.	F 867		