STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105363	A. Building B. Wing	03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Bay Rehab and Care Center	4033 Beaver Lane Port Charlotte, FL 33952

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on family and staff interviews and record review, the facility failed to protect residents' rights to be free from neglect. The facility failed to appropriately monitor the urinary output after insertion of an indwelling urinary catheter and failed to monitor the resident's change of condition for 1 (Resident #1) of 5 residents with urinary catheter reviewed. Resident #1 was admitted to the facility on [DATE] with diagnoses including prostatic hyperplasia (enlarged prostate). Resident #1 had an indwelling urinary catheter (catheter inserted in the bladder to drain urine). On 1/28/25 at approximately 5:30 a.m., Resident #1's urinary catheter was changed. There was no documentation Resident #1 was monitored to ensure the catheter was properly inserted and draining urine. On 1/28/25 at approximately 4:30 p.m., Resident #1 had no urinary output. The urinary catheter was removed. Resident #1 experienced copious amount of bleeding and clots. There was no documentation the facility monitored Resident #1's status, including obtaining vital signs (temperature, pulse, respiration and blood pressure) with the acute change in condition. On 1/28/25 at approximately 10:00 p.m., Resident #1 was emergently transferred to an acute care hospital. The resident was unresponsive, had no urinary output and was bleeding. The facility's failure to provide the necessary care and services to prevent neglect created a likelihood of serious harm, injury, or death of Resident #1 and other residents with an indwelling urinary catheter from catheter associated complications, including trauma from catheter insertion, urinary tract infections, and blood infections. This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of Isolated (J) starting on 1/28/25. On 3/20/25 at 4:45 p.m., the Administrator was informed of the determination of Immediate Jeopardy. The findings included: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy and procedures titled, Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, Injury of unknown source and Investigations with an effective date of 04/01/2022 revealed, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . The facility shall conduct their own internal investigation including but not limited to staff . resident, and family/resident representative interview, medical record reviews, 24 hours reports reviews, full body skin exam, etc. The resident's representative and physician should be notified that there is an on-going investigation regarding the alleged incident . The facility shall take all necessary corrective action(s) depending on the results of their investigation and must notify the proper agencies as well as licensing authorities of any incidents that would indicate an employee is unfit for service. The facility shall analyze the occurrences to determine what changes are needed, if any, to the residents' care plan or policies and procedures to prevent further occurrences. Review of the facility's policy and procedures titled, Nursing-Catheter Care-Urinary with an effective date of 04/01/22 and a revision date of 02/21/23 revealed, Observe the resident for complications associated with urinary catheters . Check the urine for unusual appearance (i.e., color, blood, etc.) . Notify the physician or supervisor in the event of bleeding, or if the catheter is accidentally removed . Observe for signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately . Review of the clinical record revealed Resident #1 was admitted to the facility on [DATE] from an acute care hospital. Diagnoses included prostatic hyperplasia (enlarged prostate) with urinary symptoms. Resident #1 was admitted with an indwelling urinary catheter (catheter inserted in the bladder to drain urine). Review of the Treatment Administration Record (TAR) for January 2025 revealed on 1/28/25 Licensed Practical Nurse (LPN) staff B changed Resident #1's urinary catheter. The clinical record lacked documentation LPN Staff B verified the catheter was properly inserted and draining urine. On 1/28/25 at 10:59 p.m., LPN Staff A documented in a progress note for an effective date of 1/28/25 at 5:00 p.m., Resident #1's indwelling catheter was removed per the Advanced Practice Registered Nurse (APRN) order due to blood and clots, no urine output. The nurse documented, order given to monitor urine output for a couple of hours if no void and clots continue send resident to ER (emergency room) for further evaluation. The clinical record lacked documentation Resident #1's condition was monitored, including an evaluation of the resident, amount of bleeding, vital signs or urine output. LPN Staff A did not transcribe the APRN's order until 1/28/25 at 10:02 p.m., five hours after receiving the order. The order read, Send out to ER (emergency room) if resident does not void within a couple hours. The transcribed order did not include to monitor for bleeding and clots. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/28/25 at 11:36 p.m., LPN Staff B documented in a progress note with an effective date of 1/28/25 at 10:00 p.m., she received shift report from the dayshift nurse to send Resident #1 to the hospital per the APRN order if Resident #1 was not able to void and clots continue. Staff B documented clots continued, no voiding pt (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified. Review of the documentation in the clinical record, including licensed nurses and Certified Nursing Assistant (CNA) notes and entries revealed the last urinary output was documented on 1/27/25 at 10:00 p.m. There was no documentation of urine output for the night shift (of 1/27/25, the day shift of 1/28/25 and the evening shift of 1/28/25. Review of the Emergency Medical Services (EMS) Prehospital Care Report revealed the unit was notified by dispatch on 1/28/25 at 9:51 p.m. The narrative noted Resident #1 was found lying supine (face up) in bed with a facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a Foley catheter (urinary catheter) removed and since has been having penile bleeding with blood clots and was recommended by the facility provider to call EMS if the bleeding does not improve. The nurse also stated that she's been unable to wake the patient up, patient is normally awake and verbal. He was last seen normal three hours ago. EMS documented that the resident was unresponsive, breathing fast with a radial pulse, skin hot and clammy, bruising noted on abdomen. The report noted under patient condition the primary complaint type was unresponsive, and other, bleeding from penis with large blood clots. The date and time of symptom onset was 1/28/25 at 6:07 p.m. Review of the local hospital record revealed Resident #1 was initially seen in theER on [DATE] at 10:22 p.m. The ER progress note documented Resident #1 arrived at the Emergency Department from the facility for complaint of blood clots after foley removal. Upon EMS arrival, Resident #1 was unresponsive to painful stimuli, and had a temperature of 100.2. The hospital History and Physical noted, The nursing staff at the facility stated that due to decreased urinary output they switched the catheter out and received large amounts of blood and clots shortly after that the patient became unresponsive . The patient was found immediately hypotensive and hypoxic requiring airway oxygen support with intubation . Resident #1 was admitted to the Intensive Care Unit with respiratory support on ventilator. The assessment and plan was: Septic shock (life threatening infection), Metabolic encephalopathy (impaired brain function due to imbalance in metabolism), Hematuria (blood in urine), Urinary retention. Review of the facility's incident investigations revealed on 2/4/25 at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a urinary tract infection and pneumonia that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation of neglect and started an investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The investigation noted that on the morning of 1/28/25 Resident #1's catheter was changed per the physician order. The resident was later noted to have no urine output, and his catheter was irrigated with blood clots observed. New orders were obtained from the APRN to remove the catheter at which time further blood clots were noted by nursing staff. Additional orders were then obtained to hold aspirin and Plavix (prevents clots from forming) and to transfer resident out if no urine output was observed and clots continued. Nursing continued to evaluate the resident with no urine output identified with continued blood clots and Resident #1 was subsequently transferred to the hospital. Review of the nursing staff statements obtained as part of the investigation revealed: LPN Staff B documented in an undated statement she worked on 1/27/25 from 7:00 p.m. to 7:00 a.m. She used sterile technique to replace Resident #1's urinary catheter. LPN Staff B wrote at 5:50 a.m., she informed Resident #1 she was going to change the catheter. She documented, Sterile technique used to remove Foley (urinary) catheter. No retention or bleeding. Resident #1 denied pain or discomfort. Pericare was provided and sterile technique used to insert catheter, no resistance noted. No complaints of discomfort from resident . LPN Staff B wrote, I will come back to check on you, resident was alert and thankful. Writer followed up with the resident at approximately 0630 (6:30 a.m.), no urine output. Writer palpated abdomen, no distention, resident denied discomfort or pain. 0700 (7:00 a.m.) report given to day shift. LPN Staff B told the on coming nurse at the time of insertion, no resistance was noted, and the resident was denying discomfort, no urine output noted yet. LPN Staff A's statement dated 2/5/25 noted on 1/28/25 at approximately 3:00 p.m., Resident #1's spouse called her to the room and voiced concerns about no urine in the catheter drainage bag. LPN Staff A said Resident #1 was alert, oriented, very pleasant and cooperative. His abdomen was not distended, was not tender to touch. Resident #1 had no complaints or discomfort. LPN Staff A flushed the catheter with saline with return of small clots passing in drainage tubing. Staff A said she called the APRN while at the bedside. The APRN gave an order to hold the aspirin and Plavix for three days and keep the catheter out. The APRN said not to send the resident to the hospital, to just monitor him for urine output without the catheter. If Resident #1 did not void and continued to clot send him out for further evaluation. On 2/7/25 at 2:18 p.m., in an email addressed to the Director of Nursing, LPN Staff C documented on 1/28/25 at 3:26 p.m., he took over Resident #1's care and received report from LPN Staff A. LPN Staff A was irrigating Resident #1's catheter. The resident's spouse told him he still has no pee. LPN Staff C documented he contacted the APRN about the resident not passing urine and passing one blood clot from irrigating the catheter. The APRN gave an order to remove and reinsert the catheter. LPN Staff C said he removed the catheter, and copious amount of blood came from penis. He immediately applied pressure to the penis region. LPN Staff C documented, Writer asked spouse to put on gloves, apply pressure to the area, and asked the patient does he have any pain? Patient denied pain or discomfort to lower abdominal region still nondistended. Staff C documented he had to call the doctor. While spouse was applying pressure to penis region writer rushed to nurse's station to get LPN Staff A for assistance. The writer sanitized his hands and applied gloves. Resident #1's Spouse removed her hands and writer continued to apply pressure. Writer waited approximately 5 minutes and stopped applying pressure . Patient released a quarter size blood clot after writer stopped applying pressure. He applied pressure to the penis region and ask LPN Staff A to call the APRN. The APRN gave a verbal order to not reinsert the catheter, hold blood thinners, monitor urine output. If the resident has not voided, and clots continue to pass then send the resident to the ER. LPN Staff C documented he stopped applying pressure, the bleeding and clot passing stopped. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LPN Staff B documented in the witness statement on 1/28/25 at 7:00 p.m., she received a report from the previous nurse that Resident #1 had no urine output during the day. The catheter was irrigated, and the resident had passed a blood clot during removal of the catheter. Staff B documented she checked on the resident at the beginning of the shift and asked the Certified Nursing Assistant (CNA) to keep an eye on resident's output. At 8:50 p.m., she documented the resident's vital signs and blood sugar were within normal limits. The resident had no blood or urine in his brief. At approximately 9:45 p.m., she checked on Resident #1. She called the resident by name. Resident #1 was alert. Resident #1 appeared lethargic. LPN Staff B documented again she took the resident's vital signs, and they were within normal limits. LPN Staff B and the CNA checked the resident's brief and observed a medium size blood clot. The CNA remained in the room with another CNA to change the resident's brief while LPN Staff B called 911. The facility's investigation noted, Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted . Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on foley catheter care upon receiving this allegation . On 3/18/25 the Administrator provided In-service Attendance Record Signature sheets dated 2/4/25, 2/7/25, and 2/9/25, for inservice education for neglect provided to the nursing staff. The content of the education was, Neglect is the failure to provide goods and services to maintain the residents' physical mental and psychological wellbeing. This includes but is not limited to providing showers, turning and positioning, ADL (Activities of Daily Living) care and peri care. Catheter care is also on this list. Catheter care is to be provided a minimum of once a shift by the CNA. For residents' incontinence of stool after the stool is cleaned then catheter care needs to be provided again. Also making sure the tubing and bag are positioned properly and not touching the floor. The education did not include failing to appropriately monitor the resident's urinary output and failure to monitor the resident's condition, amount of bleeding, obtaining vital signs with the acute onset of bleeding constituted neglect. 14 of 33 nurses employed by the facility signed that they attended the in-service. On 3/18/25 at 8:30 a.m., in a telephone interview Resident #1's daughter said on 1/28/25 her mother was at the facility. She complained to facility staff several times that he was not passing urine after the catheter was changed that morning. On 1/28/25 at 10:00 p.m., a nurse called and told her mother that he was unresponsive and had been transferred to the hospital. Her father (Resident #1) was placed on a ventilator and admitted . Her mother complained to the Administrator about the care he received. On 3/18/25 at 10:00 a.m., in a telephone interview LPN Staff B said she had a physician's order to change the catheter. On 1/28/25 at approximately 5:30 a.m., there was no urine in the catheter drainage bag when she changed the catheter. She said she got a small amount of urine return when she changed the catheter and there was no blood. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/18/25 at 12:21 p.m., in a telephone interview, the Consulting Physician said he was not aware of the incident involving Resident #1. He said Staff should have obtained Resident #1's vital signs at least every shift and with any change in condition. He said Resident #1 should have been sent to the hospital within eight hours of no urine output. He said staff should have notified the physician if Resident #1 was not having a minimum of 30 milliliters of urine output hourly. On 3/18/25 at 1:00 p.m., in a telephone interview the APRN said staff never told her Resident #1 had no urine output for more than eight hours. She would have sent the resident to the hospital immediately. She said on 1/28/25 at 4:15 p.m., LPN Staff C sent her a text message to let her know Resident #1 had no urine output. She told the nurse to irrigate the catheter and call her back. They told her Resident #1 passed blood clots when they tried to irrigate the catheter. She gave an order to remove and reinsert the catheter. When they removed the catheter, copious amounts of blood came out. She told them to hold the anticoagulants (medication to prevent blood clots). She gave the order to wait an hour, call her or send the resident to the emergency room if he did not urinate or continued to pass clots. The APRN said she never told the nurse to wait two hours. On 3/18/25 at 1:30 p.m., in a telephone interview LPN Staff C said on 1/28/25 at approximately 3:30 p.m., he observed Staff A attempting to irrigate Resident #1's urinary catheter. The APRN was giving orders. He said there was no urine in the urinary drainage bag. He removed Resident #1's catheter, and a copious amount of blood and clots came out. The APRN gave an order to LPN Staff A to stop all anticoagulants and send the resident to the ER if he kept bleeding or had no urinary output. LPN Staff C said he did not know Resident #1 had no urine output since the previous night. On 3/18/25 at 2:00 p.m., in an interview Unit Manager LPN Staff D said on 1/28/25 she was assigned to Resident #1 from 7:00 a.m., to 2:00 p.m. She said LPN Staff B who worked the night shift did not tell her the resident had no urine output. She said the CNAs empty the urinary drainage bag at the end of each shift. The CNA who worked the day shift on 1/28/25 did not tell her Resident #1 had no urine output. Staff D said she could not remember if she checked the resident's catheter or drainage bag. On 3/18/25 at 3:00 p.m., in an interview LPN Staff A verified on 1/28/25 Resident #1's spouse told her there was no urine in the drainage bag. When she checked on the resident on 1/28/25 at approximately 4:00 p.m., the drainage bag was empty. She said no one told her the resident had no urine output all day. On 3/19/25 at 8:30 a.m., in an interview LPN Staff B said there was no urine in Resident #1's urinary catheter bag before she changed the catheter on 1/28/25 at 5:30 a.m. She said when she left work on 1/28/25 at 7:00 a.m., there was no urine in the drainage bag. When she returned to work on 1/28/25 at 7:00 p.m., LPN Staff A told her Resident #1 had no urine output since the previous evening. He only passed blood and clots when they tried to irrigate the catheter. LPN Staff B verified the APRN's orders to monitor the resident and send him out if he did not stop bleeding were not transcribed until 1/28/25 at 10:00 p.m. She said she took Resident #1's vital signs twice during her shift but did not document them. She said Resident #1 was alert but lethargic when EMS arrived. She could not remember when Resident #1 became lethargic. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/19/25 at 3:05 p.m., in a telephone interview Resident #1's spouse said on 1/28/25 she spent the whole day at her husband's bedside. At 9:00 a.m., she noticed there was no urine in the urinary drainage bag. At approximately 11:00 a.m., 12:00 p.m., she told LPN Staff D the catheter was not draining urine. LPN Staff D told her she was busy and would come later. She never came to the room and left at 2:00 p.m. On 1/28/25 at approximately 4:00 p.m., LPN Staff A tried to flush the catheter and said, it was traumatized. LPN Staff C came in the room and removed the catheter. A large blood clot came out. On 3/19/25 at 4:10 p.m., a joint interview was conducted with the Administrator, the Director of Nursing (DON) and the Regional Nurse Consultant to discuss the facility's neglect investigation related to Resident #1's care and emergency transfer to the hospital. The Regional Nurse Consultant said she could not argue with the fact that there were no vital signs taken and no assessment documented for Resident #1. The DON said she interviewed the nurses as part of the investigation but did not interview the CNAs. She verified that no corrective actions were implemented related to the lack of assessment, and timely transfer of Resident #1 when he had not passed urine for more than eight hours. On 3/19/25 at 5:05 p.m., in an interview Registered Nurse Staff F said she has been the Staff Educator at the facility for [AGE] years and was responsible for competencies of the nursing staff. She said the facility had not been doing urinary catheter care competencies, including ensuring the nurses were knowledgeable to insert catheters and monitor residents with urinary catheters. She said, We will now. 41905 On 3/22/25 after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 3/22/25. The Immediate actions implemented by the facility and verified by the survey team included: On 3/22/25 at 2:04 p.m. during an interview with the Director of Nursing (DON) she said she has completed education for almost all of the nursing staff. The remaining staff will be educated before the start of their next scheduled shift. She said there have been several in-person live events and there have been over the phone education for (2 nurses) and they will complete their competencies before their next working shift. She said there were no new hires for nursing staff. They are re-educating the Certified Nursing Assistants (CNAs), Registered Nurses (RNs) and Licensed Practical Nurses (LPNs). On 3/19/25 the facility Administrator and Director of Nursing were re-educated by the Regional Nurse Consultant on: The components of the regulation F600 Free from Abuse and Neglect, Exploitation, Misappropriation, Mistreatment and Injury of Unknown Origin with indicators of Neglect including screening, training, prevention, identification, investigation, protection, and reporting. On 3/19/25 the facility began staff education on Abuse and Neglect with the emphasis on failure to protect resident rights to be free of neglect by failing to monitor urinary output and to monitor the resident when the catheter was discontinued. 141/171 staff members have received this education by 3/21/25. All remaining staff will receive this education prior to returning to work. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility neglected to monitor the residents' status, including vital signs with a significant change in condition. On 3/18/25 the facility completed a facility wide audit of 155 residents to ensure that all residents have physician's orders to take vital signs was in place and transcribed to the medication administration record (MAR). Long term care resident vital signs are obtained on a weekly basis and short-term rehab residents vital signs are obtained daily. On 3/18/25 the facility reviewed all foley catheter orders. Urinary output was added to the medication administration record (MAR) on 3/19/25 to ensure nursing documentation. On 3/18/25 CNA education was initiated to ensure any changes in urinary output for residents with foley catheters, and any residents experiencing a change in condition must be reported immediately to the nurse. 77 of 82 CNAs were educated by 3/21/25. All remaining CNAs will be educated prior to working their next scheduled shift. On 3/21/25 the facility initiated vital sign assessment competencies including temperature, pulse, respirations, and blood pressure on staff members. On 3/22/25 the surveyor verified through a record review of 3 randomly selected residents that the facility was monitoring the vital signs for the selected short and long term residents. On 3/22/25 interviews with 3 Certified Nursing Assistants (CNA), and 3 nurses verified they had been re-educated on catheter care including measuring, reporting, and documenting the amount on the MAR. On 3/22/25 the surveyor verified through record review of 3 randomly selected residents with urinary catheters the facility was monitoring and documenting vital signs every shift. The nursing staff was measuring and recording the amount of urine for residents with urinary catheters. On 3/22/25 the surveyor confirmed through interview with 3 random CNAs they were educated to report to the nurse any changes in urinary output for residents with catheters, and to report changes in resident condition immediately to the nurse. On 3/22/25 the surveyor verified through record reviews of 3 random residents that the facility was documenting the vital signs on the MAR twice a day. On 3/18/25 the facility educated their licensed nurses on completing a Change in Condition Assessment on residents. The education included identifying conditions that required an assessment including: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Accidents resulting in injury; significant change in the resident's physical or mental condition, deterioration in health, mental or psychosocial status; life threatening conditions or clinical complications including changes in urinary output including color, consistency and output; circumstances that require an alteration in treatment including acute and chronic conditions. A complete nursing evaluation must be conducted and documented in the medical record of systems. The nurses were educated to obtain a new set of vital signs and document them in the electronic record in that the Change in Condition Assessment would contain the most recent and relevant vital signs. The provider shall be notified of pertinent evaluation findings. Nurses must visualize catheters for urine amount of output, color and clarity during each shift. On 3/19/25 the facility daily clinical meeting agenda was edited to include the review of all residents with changes in condition to ensure vital signs and a timely transfer was completed; review of all new and existing residents with urinary catheters had monitoring and documentation of urine output amount in place. On 3/19/25 the facility conducted RN assessments of every current resident including vital signs and foley catheter observations for output and patency. Any changes were reported to the family and the provider. On 3/20/25 the facility initiated audits of residents in the facility to ensure the nursing staff completed proper documentation of those vital signs. On 3/20/25 the facility completed a 7-day audit for residents with urinary catheters to ensure measuring and documenting of the urine output was completed on each shift. On 3/20/25 an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI meeting included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Therapy Director, Minimum Data Set nurse, Nurse, CNA. On 3/21/25 48 of 50 nurses were re-educated. The remaining nurses will be educated prior to working their next shift. On 3/22/25 a review of three random resident records was completed to ensure accurate assessment and interventions were in place to prevent neglect related to the care of residents with foley catheters and for those who experience a change in condition.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charlotte Bay Rehab and Care Center	4033 Beaver Lane Port Charlotte, FL 33952

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review, review of facility's policies and procedures, and staff interviews the facility failed to ensure Licensed Nurses had the skills set to safely care for residents with indwelling urinary catheters, including inserting the catheters, monitor residents, recognize significant changes in condition and complications from urinary catheters requiring immediate physician notification and interventions to prevent further deterioration. On 1/28/25 at approximately 5:30 a.m., Licensed Practical Nurse (LPN) Staff B changed Resident #1's urinary catheter and did not ensure free flow of urine to verify the tip of the catheter was in the appropriate location in the bladder. On 1/28/25, Unit Manager LPN Staff D did not monitor Resident #1 from 7:00 a.m., to 2:00 p.m. to ensure the urinary catheter was functioning and draining urine. On 1/28/25 at approximately 5:00 p.m., LPN Staff A received a practitioner's order to monitor Resident #1 and send him to the hospital when the urinary catheter was removed and the resident had significant bleeding and was passing blood clots from his penis. She did not monitor Resident #1 and did not transcribe the order until 1/28/25 at 10:00 p.m., five hours after receiving the order. On 1/28/25 at 10:00 p.m., Resident #1 was unresponsive and bleeding through his penis and was emergently transferred to an acute care hospital via Emergency Medical Services (EMS). Resident #1 was intubated in the emergency room and admitted to the Intensive Care Unit. The facility failure to ensure Licensed Nurses had the skill sets and were competent to provide safe care to residents with indwelling urinary catheters placed Resident #1 and other residents with urinary catheters at a likelihood of significant harm, injury or death from catheter associated complications such as trauma from improper catheter insertion, urinary tract infections, and blood infection. This failure resulted in the determination of Immediate Jeopardy. On 3/20/25 at 4:45 p.m., the Administrator was notified in the determination of Immediate Jeopardy. The findings included: Cross reference to F600, F690 and F835 Review of the Facility Assessment Tool revealed the purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility, at least annually per requirement. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Assessment Tool noted the facility accepts residents with genitourinary system diagnoses such as neurogenic bladder (lack of bladder control due to a brain or spinal cord condition), benign prostatic hyperplasia (enlarged prostate), obstructive uropathy (blockage of urinary tract), urinary incontinence. The assessment noted services and care offered based on resident needs included intermittent or indwelling or other urinary catheter. 1. Review of the facility's incident investigations revealed on 2/4/25 at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a urinary tract infection and pneumonia that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation of neglect and started an investigation. The investigation noted that on the morning of 1/28/25 Resident #1's catheter was changed per the physician order. The resident was later noted to have no urine output, and his catheter was irrigated with blood clots observed. New orders were obtained from the Advanced Practice Registered Nurse to remove the catheter at which time further blood clots were noted by nursing staff. Additional orders were then obtained to hold aspiring and Plavix and to transfer resident out if no urine output was observed and clots continued. Nursing continued to evaluate resident with no urine output identified with continued blood clots and resident was subsequently transferred to the hospital. The facility's investigation noted, Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted . Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on foley catheter care upon receiving this allegation . Review of the clinical record revealed Resident #1 was admitted to the facility on [DATE] from an acute care hospital. Diagnoses included prostatic hyperplasia (enlarged prostate) with urinary symptoms. Resident #1 was admitted with an indwelling urinary catheter (catheter inserted in the bladder to drain urine). Review of the Treatment Administration Record (TAR) for January 2025 revealed on 1/28/25 Licensed Practical Nurse (LPN) staff B changed Resident #1's urinary catheter. The clinical record lacked documentation LPN Staff B verified the catheter was properly inserted and draining urine. On 3/18/25 at 10:00 a.m., in a telephone interview LPN Staff B said she followed the physician's order to change Resident #1's catheter. On 1/28/25 at approximately 5:30 a.m., when she changed the catheter, there was no urine in the drainage bag. She said she got a small amount of urine return when she inserted the catheter and had no blood. She verified she left work on 1/28/25 at 7:00 a.m., Resident #1 had no urine in the drainage bag. She did not write a progress note for the catheter change, including the small amount of urine return. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/28/25 at 11:36 p.m., LPN Staff B documented in a progress note for an effective date of 1/28/25 at 10:00 p.m., she received [shift] report from the dayshift nurse to send Resident #1 to the hospital per the APRN order if Resident #1 was not able to void and clots continues. Staff B documented, clots continued, no voiding pt (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified. On 3/19/25 at 8:30 a.m., in an interview LPN Staff B verified on 1/28/25 at 5:30 a.m., there was no urine in Resident #1's urinary catheter bag before she changed the catheter and when she left work on 1/28/25 at 7:00 a.m. When she returned to work on 1/28/25 at 7:00 p.m., LPN Staff A told her Resident #1 had no urine output since the previous evening. He only passed blood and clots when they tried to irrigate the catheter. She said Resident #1 was alert but lethargic when EMS (Emergency Medical Services) arrived. She could not remember when Resident #1 became lethargic. She verified there was no documentation she monitored Resident #1's for changes in condition, including continuous or increase bleeding, vital signs, and physician's notification Resident #1 had no urine output for more than eight hours. Review of the facility's employee list revealed LPN Staff B's date of hire was 4/9/24. The orientation for LPN Staff B did not include care of residents with indwelling urinary catheters, including verification LPN Staff B was able to safely and correctly insert an indwelling catheter in a male or female resident. On 1/28/25 at 10:59 p.m., LPN Staff A documented in a progress note dated 1/28/25 at 5:00 p.m., Resident #1's indwelling catheter was removed per the Advanced Practice Registered Nurse (APRN) order due to blood and clots, no urine output. The nurse documented, order given to monitor urine output for a couple of hours if no void and clots continue send resident to ER (emergency room) for further evaluation. The clinical record lacked documentation Resident #1's condition was monitored, including an evaluation of the resident, amount of bleeding, vital signs or urine output. LPN Staff A did not transcribe the APRN's order until 1/28/25 at 10:02 p.m., five hours after receiving the order. The order read, Send out to ER (emergency room) if resident does not void within a couple hours. The transcribed order did not include to monitor for bleeding and clots. On 3/18/25 at 3:00 p.m., in an interview LPN Staff A verified on 1/28/25 Resident #1's spouse told her there was no urine in the drainage bag. When she checked on the resident on 1/28/25 at approximately 4:00 p.m., the drainage bag was empty. She said no one told her the resident had no urine output all day. Review of the facility's staff roster revealed LPN Staff A's date of hire was 4/19/24. The orientation, competency and skills checklist completed on 4/30/24 did not include indwelling urinary catheters. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/18/25 at 1:00 p.m., in a telephone interview the APRN said on 1/28/25 at 4:15 p.m., LPN Staff C sent her a text message to let her know Resident #1 had no urine output. She told the nurse to irrigate the catheter and call her back. They told her Resident #1 passed blood clots when they tried to irrigate the catheter. She gave an order to remove and reinsert the catheter. When they removed the catheter, copious amounts of blood came out. She told them to hold the anticoagulants. She gave the order to wait an hour, call her or send the resident to the ER if the resident did not urinate or continued to pass clots. She said she never told the nurse to wait for two hours. Staff never told her Resident #1 had no urine output for more than eight hours. She would have sent the resident to the hospital immediately. On 3/18/25 at 1:30 p.m., in a telephone interview LPN Staff C said on 1/28/25 at approximately 3:30 p.m., he observed Staff A attempting to irrigate Resident #1's urinary catheter. The APRN was giving orders. He said there was no urine in the urinary drainage bag. He removed Resident #1's catheter, and a copious amount of blood and clots came out. The APRN gave an order to LPN Staff A to stop all anticoagulants (medications to prevent formation of blood clots) and send the resident to the emergency room if he kept bleeding or had no urinary output. LPN Staff C said he did not know Resident #1 had no urine output since the previous night. There was no documentation LPN Staff C, obtained vital signs, monitored Resident #1 for continuous or increased bleeding. Review of the facility's employee roster revealed LPN Staff C's date of hire was 4/3/24. LPN Staff C's orientation and competency evaluation did not include management of residents with urinary catheters, complications, and significant change in condition from a urinary catheter warranting immediate physician notification. On 3/18/25 at 2:00 p.m. in an interview LPN Staff D (Unit Manager) said she was assigned to Resident #1 on 1/28/25 from 7:00 a.m., until 2:00 p.m. She said LPN Staff B never told her Resident #1 had no urine output. She said she could not remember if she checked the resident's catheter bag for urine output that day. She left work on 1/28/25 at 2:00 p.m., and the CNA who worked with Resident #1 was supposed to empty the drainage bag around 3:00 p.m. She verified the lack of documentation verifying she monitored Resident #1 for adequate urine output, complications and significant change in condition. Review of the facility's employee roster revealed LPN Staff D's date of hire was 5/15/23. LPN Staff D's competency validation dated 5/21/24 did not include management of residents with urinary catheters, complications, and significant change in condition from a urinary catheter warranting immediate physician notification. On 3/19/25 at 5:05 p.m., in an interview RN Staff F said she had been the Staff Educator at the facility for [AGE] years and was responsible to ensure the competency of the nursing staff. She said LPN Staff B has been employed at the facility since 4/9/24 and did not have a skills competency completed to ensure she had the skills to properly insert urinary catheters and monitor the residents for complications. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RN Staff F provided a list titled, Tasks that must be observed/deemed competent in performing and a list titled Daily tasks (This is not a complete list). She said the items on the list are covered on day 2 of orientation for nurses. The list did not include insertion of urinary catheters, monitoring and prompt identification of and change of condition from complications of urinary catheters. She said the facility has not been doing urinary catheter care competencies, and did not ensure the nurses were knowledgeable to insert catheters and monitor residents with urinary catheters. She said, We will now. She provided a skills checklist which she said the facility started to use on 3/18/25 to verify the nurse's competency on urinary catheters. She said the facility uses a mannequin for the competency demonstration. Review of the competency evaluation for LPN Staff B dated 3/18/25 included indwelling catheter insertion for male and female and Straight catheter (In and Out). The Staff Educator checked P for previous experience, D for Demonstrated and/or instructed by the Department head, Supervisor or Mentor/Preceptor, and RD for Return demonstration by the orientee and/or meets Performance Objective. The Staff Educator said she checked the boxes D and RD on the checklist without observing LPN Staff B inserting the urinary catheter to ensure competency. On 3/19/25 at 5:35 p.m., in an interview the Director of Nursing said Resident #1's spouse voiced multiple complaints related to his care, including the urinary catheter. She said she investigated her complaints, but she did not focus on urinary catheter output, the lack of assessment and vital signs when Resident #1 experienced acute bleeding. She said she discussed the concerns this week in an Ad Hoc (Unplanned) Quality Assurance and Performance Improvement Plan on 3/18/25. 41905 On 3/22/25 after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 3/22/25. The Immediate actions implemented by the facility and verified by the survey team included: On 3/18/25 the facility educated their licensed nurses on completing a Change in Condition Assessment on residents. The education included identifying conditions that required an assessment including: Accidents resulting in injury; significant change in the resident's physical or mental condition, deterioration in health, mental or psychosocial status; life threatening conditions or clinical complications including changes in urinary output including color, consistency and output; circumstances that require an alteration in treatment including acute and chronic conditions. A complete nursing evaluation must be conducted and documented in the medical record of systems. The nurses were educated to obtain a new set of vital signs and document in the electronic record in that the Change in Condition Assessment would contain the most recent and relevant vital signs. The provider shall be notified of pertinent evaluation findings. Nurses must visualize catheters for urine amount of output, color and clarity during each shift. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	48 out of 50 licensed nurses were educated by 3/21/25. All remaining licensed nurses will be educated prior to working their next scheduled shift. On 3/21/25 the facility began CNA and licensed nurse competencies on obtaining vital signs. Vital signs obtained for a change in condition are to be documented in the electronic record under the weights and vitals tab, so they populate in the change in condition assessment. As of 3/21/25 40 out of 82 CNAs and 22 out of 50 nurses were educated. On 3/20/25 the facility completed audits including weekends and off hours to ensure the proper documentation of vital signs for all residents. On 3/20/25 the facility initiated the completion of audits 7 days a week and off hours to include urinary output for all residents with urinary catheters. On 3/22/25 the surveyor randomly selected 6 residents in the facility to ensure the facility was obtaining and documenting vital signs and urinary output. On 3/19/25 the daily clinical meeting form was edited to include review of the 24-hour report for change in condition; vital signs and timely transfer to a higher level if necessary; indwelling catheters for new and existing residents to ensure orders to monitor output were in place; review of the nurses' Change in condition Assessment to include current vital signs during the change, and review of the vital signs for all residents per the physician's orders. On 3/19/25 the RN assessed all residents currently at the facility for vital signs and urinary output if indicated. Any changes were communicated to the provider and family. On 3/19/25 the facility began competencies on the proper insertion of indwelling urinary catheters. 42/50 licensed nurses had completed by 3/21/25. The remaining licensed nurses would complete the competency prior to working their next scheduled shift. On 3/20/25 the facility added to the orientation agenda for newly hired licensed nurses. They will complete competency on the proper insertion of indwelling catheters with return demonstration prior to resident care. On 3/20/25 the facility began education with licensed nurses on the requirement of detailed communication during shift-to-shift report to include any changes in condition, new orders, and review any existing devices including foley catheters. 39/50 licensed nurses were educated as of 3/21/25. All remaining nurses to be re-educated prior to their next shift. The education was also added to the orientation for all newly hired nurses. On 3/20/25 the facility began educating nurses on 3/20/25 on ensuring new orders for indwelling catheters will include placement, patency/draining, irrigation, catheter securement, catheter care every shift and recording of output on the MAR. Verified 37 nurses out of 50 were educated by 3/21/25. Verified through observation and interview, nurses were educated prior to working their next shift. On 3/22/25 the surveyor verified through interview with the DON and review of audits completed, interviews with 3 CNAs, 3 nurses and review of 6 random residents records to ensure proper nursing care and services for residents with urinary catheters and those experiencing changes in condition. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/20/25 an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Therapy Director, Minimum Data Set nurse, Nurse, CNA.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on record review and staff interviews, the facility's Administration failed to utilize resources effectively to ensure nursing staff were trained, knowledgeable and competent to prevent the neglect of residents with urinary diagnoses, including insertion of urinary catheters and monitoring for complications from the urinary catheters. Resident #1 was an [AGE] year-old-male admitted to the facility with a diagnosis of prostatic hyperplasia (enlarged prostate). Resident #1 had an indwelling urinary catheter (catheter inserted in the bladder to drain urine). On 1/28/25 at 5:30 a.m., nursing staff changed Resident #1's urinary catheter and failed to ensure the catheter was properly inserted and draining. Nursing staff neglected to notify the physician until 1/28/25 at approximately 4:30 p.m. that Resident #1 had no urinary output since the catheter was inserted. On 1/28/25 at approximately 4:30 p.m., Resident #1 experienced a copious amount of bleeding and blood clots when the catheter was removed. Nursing staff neglected to take vital signs (Temperature, pulse, respiration and blood pressure) and monitor the resident with acute and significant bleeding. On 1/28/25 at 10:00 p.m., Resident #1 was emergently transferred to the hospital via Emergency Medical Services. The resident was unresponsive, and bleeding from his penis. Resident #1 had no documented urine output since 1/27/25 at 10:00 p.m. The failure of the facility Administration to ensure nursing staff had the appropriate knowledge and competencies to safely care for residents with urinary catheters created a likelihood of serious harm, rehospitalization and death of Resident #1 and other residents with urinary catheters from catheter associated urinary tract infection, blood infection, bleeding from trauma from improper catheter insertion and resulted in the determination of Immediate Jeopardy. On 3/20/25 at 4:45 p.m., the Administrator was notified of the determination of Immediate Jeopardy. The findings included: Cross Reference to F600, F690, and F726. Review of the Administrator's job description signed on 1/30/24 revealed, The primary purpose of this position is to direct the day-t0-day functions of the facility in accordance with current federal state and local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to residents at all times. The duties and responsibilities of the Administrator included, Ensure that an adequate number of appropriately trained, competent, licensed professionals and non-licensed personnel are on duty at all times to meet the needs of the residents. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing job description signed on 5/8/23 noted, the primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator, or the Medical Director to ensure that the highest degree of quality care is maintained at all times. The Director of Nursing duties and responsibilities included, Develop, implement, and maintain an ongoing quality assurance program for the nursing service department . Assist the Quality Assessment & Assurance committee in developing and implementing appropriate plans of action to correct identified deficiencies . Assist in developing plans of action to correct potential or identified problem areas . Nursing Care Functions . Ensure that direct nursing care be provided by LPN (Licensed Practical Nurses), CNA's (Certified Nursing Assistants), and/or a nurse aide trainee qualified to perform the procedure . Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to care, and that such care is provided in accordance with the resident's wishes . Develop and participate in the planning, conducting and scheduling of timely in-service training classes that provide instructions on how to do the job and ensure a well-educated nursing service department . develop, implement and maintain an effective orientation program that orients the new employee to the department, its policies and procedures, and to his/her job position and duties. Review of the Facility Assessment Tool revealed the facility accepts residents with genitourinary system diagnoses such as neurogenic bladder (lack of bladder control due to a brain or spinal cord condition), benign prostatic hyperplasia (enlarged prostate), obstructive uropathy (blockage of urinary tract), urinary incontinence. The assessment noted services and care offered based on residents needs included intermittent or indwelling or other urinary catheter. 1. Review of the clinical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included benign prostatic hyperplasia. Resident #1 had an indwelling urinary catheter (catheter inserted in the bladder to drain urine). The physician's orders as of 1/22/25 included to measure and record [Foley] urine output every shift. The CNA's urine output documentation for Resident #1 differed from the urine output documented by the Licensed Nurses on the Treatment Administration Record (TAR), making it difficult to determine Resident #1's urinary output for the following days: On 1/22/25 at 10:56 p.m., the CNA documented the output was 1400 cc. The Licensed Nurse documented on the TAR the output was 250 cc. On 1/23/25 at 8:57 p.m., the CNA documented the output was 700 cc. The Licensed Nurse documented the output was 450 cc. On 1/24/25 the CNA documented at 2:59 p.m., Response not required. The Licensed Nurses documented a total of 750 cc. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/25/25 the CNA documentation showed a total of 1000 cc. The Licensed Nurses documented a total of 650 cc. On 1/26/25 the CNA documentation showed a total of 700 cc. The Licensed Nurses documented a total of 550 cc. On 1/27/25 there was no CNA documentation of urine output. The Licensed Nurses documented a total of 1000 cc. There was no urine output documented for the night shift of 1/27/25, the day shift of 1/28/25, or the evening shift of 1/28/25. On 3/18/25 at 9:20 a.m., in an interview Registered Nurse Staff E said the facility policy was to document intake and output on the Treatment Administration Record (TAR). He said the nurses get the output from the CNAs each shift and document the total output on the TAR. On 3/19/25 at 4:10 p.m., a joint interview was conducted with the Administrator, the Director of Nursing and the Regional Nurse Consultant to discuss Resident #1's care and emergent transfer to the hospital on 1/28/25. The Regional Nurse Consultant verified the documentation of urine output for Resident #1 was not accurate. The Director of Nursing said the best practice would be for the nurses to monitor the urinary catheter and the output and document on the TAR. She verified she did not review Resident #1's clinical record for accuracy of the documentation when he was transferred to the hospital until the concerns voiced this week related to the accuracy and lack of CNA documentation of urine output. Review of the Treatment Administration Record (TAR) for January 2025 revealed on 1/28/25 Licensed Practical Nurse (LPN) Staff B changed Resident #1's urinary catheter. The clinical record lacked documentation LPN Staff B verified the catheter was properly inserted and draining urine. There was no urine output documented for the day shift of 1/28/25, or the evening shift of 1/28/25. On 1/28/25 at 10:59 p.m., LPN Staff A documented in a progress note for an effective date of 1/28/25 at 5:00 p.m., Resident #1's indwelling catheter was removed per the Advanced Practice Registered Nurse (APRN) order due to blood and clots, no urine output. The nurse documented, order given to monitor urine output for a couple of hours if no void and clots continue send resident to ER (emergency room) for further evaluation. LPN Staff A did not transcribe the APRN's order until 1/28/25 at 10:02 p.m., five hours after receiving the order, and after Resident #1 was transferred to the hospital. The order read, Send out to ER (emergency room) if resident does not void within a couple hours. The order did not include to monitor for bleeding and clots. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing progress notes revealed on 1/28/25 a 11:36 p.m., LPN Staff B documented in a progress note for an effective date of 1/28/25 at 10:00 p.m., she received report from the day shift nurse to send Resident #1 to the hospital per the Advanced Practice Registered Nurse (APRN) order if Resident #1 was not able to void and clots continued. LPN Staff B documented, Clots continued, no voiding pt (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified. The clinical record lacked documentation Resident #1 was monitored, vital signs obtained, and amount of bleeding assessed and documented to promptly identify significant changes requiring physician notification. Review of the Emergency Medical Services (EMS) Prehospital Care Report revealed the unit was notified by dispatch on 1/28/25 at 9:51 p.m. The narrative noted Resident #1 was found lying supine (face up) in bed with a facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a Foley catheter (urinary catheter) removed and since has been having penile bleeding with blood clots and was recommended by the facility provider to call EMS if the bleeding does not improve. The nurse also stated that she's been unable to wake patient up, patient is normally awake and verbal. Last seen normal three hours ago. EMS documented that the resident was unresponsive, breathing fast with a radial pulse, skin hot and clammy, bruising noted on abdomen. The report noted under patient condition the primary complaint type was unresponsive, and other. Bleeding from penis with large blood clots. The date and time of symptom onset was 1/28/25 at 6:07 p.m. Review of the local hospital record revealed Resident #1 was initially seen in theER on [DATE] at 10:22 p.m. The ER progress note documented Resident #1 arrived at the Emergency Department from the facility for complaint of blood clots after foley removal. Upon EMS arrival, Resident #1 was unresponsive to painful stimuli, and had a temperature of 100.2. Review of the facility's incident investigations revealed on 2/4/25 at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a urinary tract infection and pneumonia that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation of neglect and started an investigation. The investigation noted that on the morning of 1/28/25 Resident #1's catheter was changed per the physician order. Resident #1 was later noted to have no urine output and his catheter was irrigated (flushed) with blood clots observed. New orders were obtained from the Advanced Practice Registered Nurse to remove the catheter at which time further blood clots were noted by nursing staff. Additional orders were then obtained to hold aspiring and Plavix and to transfer resident out if no urine output was observed and clots continued. Nursing continued to evaluate Resident #1 with no urine output identified with continued blood clots and resident was subsequently transferred to the hospital. As part of their investigation, the facility obtained statements from LPN Staff A, LPN Staff B and LPN Staff C. The facility's investigation did not include statements from the Certified Nursing Assistants who took care of Resident #1 on 1/27/25 and 1/28/25 and did not document urinary output. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's investigation noted, Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted . Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on foley catheter care upon receiving this allegation . The facility's investigation did not include the lack of monitoring of Resident #1's urinary output, LPN Staff B's lack of documentation of urine return verifying correct placement of the catheter, the resident's condition including vital signs (Temperature, pulse, respiration and blood pressure) with the acute onset of copious bleeding, the passing of blood clots, and amount of bleeding, and the change in mental status not addressed by the nursing staff. On 3/19/25 at 8:30 a.m., in an interview LPN Staff B said on 1/28/25 at 5:30 a.m., there was no urine in Resident #1's urinary catheter bag before she changed the catheter. She said when she left work on 1/28/25 at 7:00 a.m., there was no urine in the drainage bag. When she returned to work on 128/25 at 7:00 p.m., LPN Staff A told her Resident #1 had no urine output since the previous evening. He only passed blood and clots when they tried to irrigate the catheter. LPN Staff B verified the Advanced Practice Registered Nurse gave orders to monitor the resident and send him out if he did not stop bleeding on 1/28/25 at approximately 5:00 p.m., but she did not transcribe the orders until 1/28/25 at 10:00 p.m. She said she took Resident #1's vital signs twice during her shift but did not document them. She said Resident #1 was alert but lethargic when Emergency Medical Services (EMS) arrived. She could not remember when Resident #1 became lethargic. On 3/19/25 at 5:05 p.m., in an interview RN Staff F said she had been the Staff Educator at the facility for [AGE] years and was responsible to ensure the competency of the nursing staff. She said LPN Staff B had been employed at the facility since 4/9/24 and did not have a competency to ensure she had the skills to properly insert urinary catheters and monitor the residents for complications. She said the facility had not been doing urinary catheter care competencies, and did not ensure the nurse's were knowledgeable to insert catheters and monitor residents with urinary catheters. She said, We will now. She provided a skills checklist which she said the facility started to use on 3/18/25 to verify the nurses competency on urinary catheters. She said the facility uses a mannequin for the competency demonstration. Review of the competency evaluation for LPN Staff B dated 3/18/25 included indwelling catheter insertion for male and female and Straight catheter (In and Out). The Staff Educator checked P for previous experience, D for Demonstrated and/or instructed by the Department head, Supervisor or Mentor/Preceptor, and RD for Return demonstration by the orientee and/or meets Performance Objective. The Staff Educator said she checked the boxes D and RD on the checklist without observing LPN Staff B inserting the urinary catheter to ensure competency. On 3/19/25 at 5:35 p.m., in an interview the Director of Nursing said Resident #1's spouse voiced multiple complaints. In the investigation she did not focus on urinary catheter output, the lack of assessment and vital signs when Resident #1 experienced acute bleeding. She verified she discussed the concerns identified this week in an Ad Hoc (Unplanned) Quality Assurance and Performance Improvement Plan on 3/18/25. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	41905 On 3/22/25 after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of 3/22/25. The Immediate actions implemented by the facility and verified by the survey team included: On 3/21/25 the [NAME] President of Operations reviewed their job descriptions with the Nursing Home Administrator (NHA) and Director of Nursing (DON). During this review it was discussed in detail that the administrator must ensure that each resident receives necessary care and services to attain and maintain the highest practical physical, mental and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. On 3/21/25 the [NAME] President of Operations and NHA re-reviewed the job description of the DON with the DON. It was discussed in detail that the purpose of her position is to plan, organize, develop, and direct the overall operation of the nursing services department in accordance with regulations and standards, guidelines, and to ensure the highest degree of care is maintained at all times. As of 3/21/25, the DON will be lead investigator on all clinical investigations to ensure resident care met all accepted standards. This investigation will include a 72-hour look back in time to include additional information on the events leading to the event. As of 3/21/25 the investigations on Abuse, Neglect, Exploitation, Misappropriation, and Injury will be reviewed in detail with the medical director to ensure all areas of the investigation were completed and that the facility has identified the root cause analysis of the incident. As of 3/21/25 the NHA and DON will complete a comprehensive investigation to include a 72-hour look back on events to ensure no deprivation of care or services occurred. On 3/20/25 the NHA and DON were educated by the regional nurse consulted on utilizing an investigation checklist to ensure all elements and facts are thoroughly reviewed and completed. On 3/18/25 the facility conducted an unplanned (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Therapy Director, Minimum Data Set nurse, Nurse, CNA. The meeting addressed the adequate monitoring of urine output for residents with foley catheters and the adequate monitoring of vital signs for residents with changes in condition. The DON rereviewed the facility assessment and identified the facility's clinical capabilities included caring for residents with catheters without nurse competency for indwelling catheters completed. On 3/19/25 the facility initiated training to the nurses for foley catheter insertion and return demonstration for 42 of 50 nurses with all nurses to be retrained prior to working their next shift. Verified the retraining and return demonstration for Staff A, LPN, Staff C, LPN, Staff B, LPN, and Staff D. On 3/20/25 the facility added to the orientation plan of all newly hired nurses to include complete competencies on the proper insertion of indwelling catheters with return demonstration prior to providing resident care. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/18/25 CNA education was initiated to ensure the following: any notable changes in urine output for residents with foley catheters and those residents experiencing a change in condition must be reported immediately to the nurse. 77/82 CNAs were educated by 3/21/25. All remaining CNAs are to be educated prior to working their next shift. On 3/18/25 the facility educated their licensed nurses on completing a Change in Condition Assessment on residents. The education included identifying conditions that required an assessment including: Accidents resulting in injury; significant change in the resident's physical or mental condition, deterioration in health, mental or psychosocial status; life threatening conditions or clinical complications including changes in urinary output including color, consistency and output; circumstances that require an alteration in treatment including acute and chronic conditions. A complete nursing evaluation must be conducted and documented in the medical record of systems. The nurses were educated to obtain a new set of vital signs and document in the electronic record in that the Change in Condition Assessment would contain the most recent and relevant vital signs. The provider shall be notified of pertinent evaluation findings. Nurses must visualize catheters for urine amount of output, color and clarity during each shift. On 3/21/25 48/50 nurses were re-educated. The remaining nurses will be educated prior to working their next shift. On 3/20/25 the facility initiated audits of residents in the facility to ensure the nursing staff was recording vital signs and proper documentation of those vital signs. On 3/20/25 the facility initiated audits of residents with urinary catheters 7 days a week to ensure the measuring and documenting of the urine output each shift. On 3/19/25 the facility edited the daily clinical meeting to include the review of all residents with changes in condition to ensure vital signs and a timely transfer was completed; review of all new and existing residents with urinary catheters had monitoring and documenting of urine output amount in place; review of vital signs for all residents per physician order. On 3/19/25 the Nursing Home Administrator (NHA) and Director of Nursing (DON) were re-educated on the policy and procedure for Abuse, Neglect, and Exploitation by the Regional Clinical Nurse. The education included screening, training staff to prevent abuse, neglect and exploitation. All allegations of neglect are to be reported to the NHA or the person in charge immediately. Investigation, protection, and reporting to follow. On 3/19/25 the facility began staff in-service training and education on Abuse and Neglect with the emphasis on failure to protect resident rights to be free of neglect by failing to monitor urinary output and to monitor the resident when the catheter was discontinued. The resident experienced copious amounts of bleeding and blood clots through his penis. The facility failed to monitor vital signs with a significant change in condition. 141 of 171 staff members received this education by 3/21/25. All remaining staff would be educated prior to working their next shift. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/21/25 the DON and nurse management team was re-educated by the regional clinical director on the components of the management of foley catheters with an emphasis on Abuse, Neglect, Exploitation, Misappropriation, and Injury. On 3/20/25 the facility initiated education with licensed nurses to ensure new orders for indwelling catheters included placement, patency/draining, irrigation, catheter securement, catheter care each shift and recording of output on the MAR. 37 nurses out of 50 were educated by 3/21/25. On 3/22/25 the surveyor verified through interviews that the nurses were educated prior to working their next shift. On 3/20/25 for educating nurses on the requirement of detailed communication during shift-to-shift report will include any changes in condition, any new orders, and review any new or existing devices including urinary catheters. Verified the training of 39/50 nurses by 3/21/25. All remaining licensed nurses will be educated prior to working their next shift. This education has also been added to the orientation agenda for all newly hired licensed nurses to be provided prior to resident care. On 3/20/25 an (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Therapy Director, Minimum Data Set nurse, Nurse, CNA. On 3/22/25 the surveyor verified through interviews with the DON and facility staff, review of the audits, and review of 6 random resident records to ensure accurate assessment of resident vital signs, obtaining and documenting catheter urine output and proper documentation for residents experiencing a change in condition.