STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105967	A. Building B. Wing	05/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Bennet Center for Rehabilitation & Healing	1091 Kelton Ave Ocoee, FL 34761

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** 46665 Based on interview, and record review, the facility neglected to ensure nurses implemented physician's orders for diagnostic testing, failed to notify the physician of any changes of status including refusal of care, and neglected to ensure the resident received the provision of necessary care and services; additionally, the facility failed to complete a thorough investigation for possible neglect for 1 of 6 residents reviewed for neglect, of a total sample of 6 residents, (#1). On [DATE], resident #1 was admitted to the facility from the hospital. On [DATE], the resident was re-hospitalized and required mechanical ventilation (life support to breathe) in the Intensive Care Unit (ICU) due to critically low blood pressure and septic shock from a Urinary Tract Infection (UTI). Sepsis is when your body's immune system has a dangerous response to an infection. It is a medical emergency that can be caused by many different kinds of infections. The quicker you receive treatment, the better your outcome will be. Septic shock can occur when an infection in your body causes extremely low blood pressure and organ failure due to sepsis. Septic shock is life-threatening and requires immediate medical treatment. It's the most severe stage of sepsis, (retrieved on [DATE] from www.clevelandclinic.org). Resident #1 was hospitalized for more than two weeks and was discharged from the hospital to another long term care facility on [DATE] for continued recovery and therapy. On [DATE], facility licensed nurses did not implement the physician's orders for urine diagnostic testing that could have detected infection, prevented complications/ worsening of the condition, and mitigated the risk of serious injury/impairment/death. Nurses never notified the resident's physicians/providers the test was not performed as ordered. The resident's primary care providers did not recognize test results were missing; and did not request results or re-order testing. Six days later, on Wednesday, [DATE] at approximately 3:45 PM, the resident was found by his family cold, clammy, and unresponsive. Nurses assessed the resident with significantly lower blood pressure than his normal readings and contacted the Physician's Assistant (PA) who ordered STAT (without delay) laboratory testing, and Intravenous (IV) fluids. At the resident's family's insistence for emergency treatment, nurses again contacted the PA and obtained orders to transport the resident to the hospital via 911 Emergency Medical Services (EMS). (continued on next page)

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.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to implement physician's orders for diagnostic testing, notify the physician, recognize diagnostic testing results were missing, and to provide necessary care and services contributed to the destabilization of resident #1's medical conditions and placed all residents at risk for neglect and serious injury/impairment/death. For two weeks, the facility was unaware resident #1's test results had not been completed until [DATE], when the resident's wife called to request them, after he was re-hospitalized . This failure resulted in Immediate Jeopardy which began on [DATE]. Findings: Cross reference F684 Review of the medical records revealed resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on [DATE] with diagnoses that included hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke), type 2 diabetes mellitus with polyneuropathy (weakness/numbness/burning), hypertension (high blood pressure), right bundle branch (heart signal) block, dysphagia (difficulty swallowing), cognitive communication deficit, hearing loss, dysarthria and anarthria (slow/slurred speech). The Minimum Data Set (MDS) Comprehensive Admission Assessment with an Assessment Reference Date (ARD) of [DATE] noted during the look-back period, resident #1 scored 12 out of 15 on the Brief Interview for Mental Status that indicated he was moderately cognitively impaired. The assessment showed the resident did not have any behavioral symptoms or rejections of evaluations or care necessary for goals to achieve health and well-being, he had upper and lower extremity (arms/legs) functional Range of Motion limitations, used a wheelchair, was dependent on staff for assistance to complete Activities of Daily Living and mobility, was always incontinent of bladder and bowel functioning, and difficulty swallowing. The MDS Unplanned Discharge Assessment with an ARD of [DATE] noted during the look-back period, resident #1 did not have any behavioral symptoms or rejections of evaluations or care necessary for goals to achieve health and well-being. Resident #1 had care plans related to impaired functional abilities ([DATE], revised [DATE]); altered metabolism related to type 2 diabetes mellitus and medication use ([DATE]); risk for falls/requires staff assistance for transfers ([DATE], revised [DATE]); potential nutritional problems ([DATE]); and potential skin integrity alteration ([DATE], revised [DATE]). On [DATE], a care plan for alteration of urinary elimination as evidenced by incontinence was initiated. Interventions included for nurses to monitor and document signs and symptoms of UTI. The Comprehensive Care Plan did not detail behaviors including refusals of care/treatments, or non-compliance. A nurse's Progress Note dated [DATE] at 2:33 PM, revealed resident #1 had red-tinged urine during the previous night. A note dated [DATE] at 8:23 AM, indicated the resident rolled out of bed onto the floor and required two staff to be assisted off the floor and back to bed. The Order Summary Report for [DATE] included a physician's order dated [DATE] for Urinalysis/Urine Culture (UA/CS). The order was marked as completed on [DATE]. On [DATE] the physician ordered Tylenol 650 milligrams (MG) every six hours as needed for pain, and on [DATE] Tramadol 50 MG, an opiate pain medication, was added for pain every eight hours. On [DATE] Tylenol 650 MG was added for fever over 100. 0 degrees Fahrenheit (F). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A urine sample should be provided for both a urinalysis and culture test (UA/CS). Your physician might order the urinalysis initially to look for blood cells and bacteria in the urine that can indicate an infection. If it's positive your provider would order a urine culture to grow microorganisms and identify the specific bacteria or fungus causing the infection, (retrieved on [DATE] from www.clevelandclinic.org. Further review of the medical record revealed a physician's order on [DATE] to send resident #1 to the emergency room (ER) for evaluation and treatment for blood pressure of ,d+[DATE], diaphoresis (excessive sweating), and slow to respond to verbal commands per family request. On [DATE] at 10:23 AM, in a telephone interview, Licensed Practical Nurse (LPN) C explained a Certified Nursing Assistant (CNA) informed her blood tinged urine was observed in resident #1's incontinence brief, so she obtained physician orders for the UA/CS. LPN C said she entered the UA/CS orders in to the computer system on [DATE] during the 11:00 PM to 7:00 AM shift and later passed on the information to LPN D for the oncoming 7:00 AM to 3:00 PM shift. She said the normal process was that after orders were processed, a printed copy of the order was placed in a binder at the nurses' station for the specimen bag but could not recall if she had done that. Review of the Medication Administration Record (MAR) for [DATE] revealed a physician's order dated [DATE] for Urinalysis/Urine Culture was signed as completed by LPN A on [DATE] at 5:20 AM. A week later on [DATE] at 10:11 AM, LPN D documentation revealed resident #1 was administered Tylenol for a temperature of 100.2 F and at 1:43 PM, he was administered Tramadol for pain. On [DATE] at 3:11 PM, in a telephone interview, LPN A recalled on [DATE] during the 11:00 PM to 7:00 AM shift, resident #1 had an order pending completion for a UA/CS. The nurse remembered she attempted to collect a specimen in the early morning hours of [DATE] and was unable, so she re-attempted unsuccessfully later in the shift. She said she marked, refused on the MAR but did not complete a progress note nor contact the physician. She could not recall if she passed on the information to the oncoming 7:00 AM to 3:00 PM nurse. She explained in early April, she was informed by the Director of Nursing (DON) that the resident's wife had called for the UA/CS results and the facility found the test was marked in the MAR as completed but it was never done. The LPN said the facility's normal practice was for night shift to obtain labs, but it was difficult to get urine specimens overnight or in the early morning when residents were sleeping. She acknowledged she should have written a progress note to document the refusal and contacted the physician. LPN A confirmed when a resident refused a procedure she should promptly notify the DON and the physician. Review of resident #1's medical record revealed there were no nursing progress notes documented on [DATE] by LPN A regarding the physician's order for the UA/CS not being performed, nor that the physician or anyone else was notified the test was not done. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:31 AM, LPN D recalled she cared for resident #1 many times during his stay including on the 7:00 AM to 3:00 PM shift on [DATE]. The nurse explained earlier in the shift on [DATE], the resident had a fever, so she called the PA who gave her orders for routine labs and Tylenol. She said at approximately 2:00 PM, the resident complained of pain and was administered Tramadol, and approximately a half hour later when the family arrived to visit, she re-checked the resident, and he was, lethargic (fatigue/sluggishness). LPN D stated she called the PA again who gave orders for STAT labs and IV fluids, but the family did not want to wait and were adamant about the resident going to the hospital immediately. The PA was called again, and orders were given to send the resident out to the ER via 911/EMS. Review of nurse's Progress Notes completed by LPN D documented on [DATE] at 10:11 AM, resident #1 had a temperature of 100.2 F. The attending physician was notified, and orders were obtained for Tylenol 650 MG and routine orders were obtained from the PA for laboratory testing. Later at 1:45 PM, the resident complained of left hip pain and was administered the pain medication Tramadol 50 MG. A nurse's Progress Note documented by LPN D on [DATE] at 3:45 PM, noted resident #1's wife and daughter were at the facility visiting and the resident was observed as slow to respond to verbal and touch stimulation, had dilated pupils, and sweaty/clammy skin. The resident's vital signs were assessed and measured with a blood pressure of 85 systolic and 50 diastolic millimeters of mercury (mmHg), and heart rate of 90 beats per minute. The Unit Manager contacted the PA who ordered STAT laboratory tests and IV fluids. The resident's daughter requested the resident be sent to the emergency room and the PA was contacted for orders. LPN D's note dated [DATE] at 4:24 PM, documented resident #1 left the facility by stretcher at 4:25 PM, with EMS to go to the hospital. On [DATE] at 10:16 AM, the North Unit Manager (UM) recalled in [DATE], she was working when resident #1 received Tramadol in the afternoon and a short time later; LPN D informed her the resident seemed more lethargic and wasn't responding to his family who were very concerned with his change in condition. The nurse explained the PA was called and provided orders for STAT labs and IV fluids, but the family was not satisfied with that intervention and wanted him to go to the hospital immediately, so the PA was called back and approved the orders for transport to the hospital. She explained that sometime later, in early [DATE] she was informed by the DON that the resident's lab could not be found and had been signed off as completed by a nurse. She said resident #1 had at least one family member visit every day and nurses could have asked the family to assist in obtaining the urine if the resident was refusing. She said the Unit Managers were responsible for checking a binder kept at the nurse's station for collection tracking and the APRNs (Advanced Practice Registered Nurses) assisted to check for results. The Unit Manager did not explain how or why resident #1's lab result was not done. Review of a Situation Background Assessment Recommendations-SBAR progress note completed by the North UM on [DATE] at 4:53 PM, revealed, at 2 PM, nurse on unit administered Tramadol 50 MG po (by mouth) for pain x 1 dose. Resident eyes were dilated, slow to respond to verbal commands and diaphoretic at 1550 (3:50 PM). Temperature 100.2 this AM with complaints of sore throat. Throat was pink, and moist with no patchy areas noted. The North UM documented the resident 's vital signs were blood pressure of , d+[DATE], heart rate of 90, respirations of 19, blood sugar of 159, and temporal temperature of 97.5 F. She noted resident #1 had excessive sweating on the trunk of his body. She said the PA ordered IV fluids, Normal Saline, get STAT labs for UA, C/S, a complete blood count with differential and a basic metabolic panel. The UM documented that the wife and daughter adamantly requested for him to go to hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 10:37 AM, the PA explained she regularly came to the facility to see residents and as part of her assessments, she reviewed orders, labs, medications, vital signs, imaging, etc. The PA said lab orders and results were reviewed with the UM and stated, if I couldn't find results, I will go back and look to see when it was ordered to be collected, and if more than a day or two after it was to be collected, I notify nursing to see if it was even collected. She recalled on [DATE], she received a call from the North UM that resident #1 wasn't looking good and thought he either had a UTI or sepsis, so she gave orders for STAT labs and more frequent vital sign monitoring, but a short time later was called again because the family wanted to send him to the ER, so she gave those orders. She said she expected UA/CS orders to be processed the same day and sent to the lab, and for nurses to notify the provider when a test wasn't completed. She could not recall the facility informing her resident #1's order for UA/CS from [DATE] was not ever done. The PA stated, they [residents] can become septic, and we don't know the source of the infection; we have to treat them emergently. Review of Progress Notes completed by the PA dated [DATE] and [DATE], after the physician's diagnostic testing was ordered included documentation the resident was seen at the request of staff for a follow-up visit. Both notes indicated, Patient's labs/diagnostics and care provider notes reviewed . In a telephone interview on [DATE] at 11:59 AM, resident #1's wife recalled on [DATE], the family received a voicemail from the resident who stated he wasn't feeling well. She explained she and her daughter came to the facility, they observed him and described his condition as, cold, sweaty, clammy, and non-responsive. She said her daughter was a paramedic and believed he was in distress, possibly septic shock. She said nurses called the physician who ordered labs, but the family was very concerned he needed emergent care and insisted he be sent to the ER immediately, so 911 was initiated. She said she believed her husband would have died had they not been there and insisted he go immediately. She said she later requested the UA results from the facility and learned they were never done. She recalled the experience was very stressful, her family was distraught during the crisis and thought they may lose their loved one. She said her husband required a breathing machine and ICU care at the hospital for over two weeks. Resident #1's wife said he had to go to another facility to recover with continued therapy and nursing care. The resident's wife stated, looking back, he had no energy and would fall back like a ragdoll; no wonder he had no energy; he wasn't like that before; even now, he has gone down a lot. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a joint interview with the DON and Nursing Home Administrator (NHA) on [DATE] at 1:05 PM, the DON recalled on [DATE], the facility received a call from resident #1's wife who requested the UA/CS results from during his stay at the facility. The DON said after checking the medical records, she found the test was never done and LPN A had documented on the MAR that it was completed on [DATE]. She explained the facility initiated a grievance and found through interview with LPN A she attempted to obtain a specimen twice on [DATE], and the resident refused but she did not inform the physician, nursing management, nor complete a progress note. The DON said resident #1 did not return to the facility after he was sent to the hospital on [DATE], so the facility did not further investigate the reason for re-hospitalization . On [DATE] at 11:15 AM, the DON explained she believed resident #1 was hospitalized for something infection based and stated, I do believe it was UTI for his admitting diagnosis into the hospital. The DON recalled she spoke with resident #1's daughter on approximately [DATE] and was informed the resident was not returning to the facility. The DON said the facility did not consider requesting the hospital records to see if the adverse incident may have contributed to resident #1's re-hospitalization . She explained the facility's investigation revealed when the nurse signed the order as completed it fell off the record and stated, It's the Unit Manager or designee's responsibility to follow up on ordered lab results. On [DATE] at 12:14 PM, the facility's Grievance Officer checked her records and recalled on [DATE], the NHA received a call from resident #1's wife and daughter concerning lab collection for a UA and customer service. She said an investigation was completed and the facility found LPN A documented the test was completed on [DATE] when in fact it was never done. She said the facility made the family aware of the investigation results and interventions. In a joint interview with the NHA, DON and Risk Manager, on [DATE] at 1:52 PM, the Risk Manager recalled the facility conducted an investigation that started [DATE], after resident #1's wife called for test results. She said the investigation revealed nurses had not implemented the physician's order nor notified the physician. When asked what the facility considered resident neglect to be, the Risk Manager stated, Neglect is not providing goods and services; goods and services did not occur because they did not provide the UA. The NHA, DON, and Risk Manager did not explain why the facility had not reported possible neglect to the State Agency (SA) when they realized the ordered lab was not done. On [DATE] at approximately 2:00 PM, the NHA said the facility had submitted a Facility Reported Incident regarding neglect to the SA after it was brought to their attention during the survey. On [DATE] at 10:11 AM, in a telephone interview, resident #1's attending physician recalled resident #1 after reviewing his notes. He remembered a UA/CS was ordered on [DATE] for blood in the urine. The physician said he expected his orders to be completed by nurses or to notify him if they were unable to fulfill the order so he could decide what should be done as a next step. He confirmed he was told recently as to what happened regarding resident #1 not getting the ordered urine testing and stated, undetected UTI can lead to sepsis; in this case that is what happened. In a telephone interview on [DATE] at 10:53 AM, the facility's Medical Director said he was aware of the incident concerning resident #1's hospitalization and he knew the provider was not notified the lab tests were not performed hence the missing test results. The physician explained that he expected nurses to notify providers when they were unable to collect specimens and stated, unidentified UTI can lead to sepsis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of resident #1's hospital records from [DATE] showed during transport to the hospital EMS personnel used a Bag-Valve Mask to manually maintain resident #1's breathing until they arrived at the ER at approximately 4:30 PM. After resident #1 arrived at the ER, life sustaining measures were immediately implemented including insertion of an endotracheal airway (breathing tube), respiratory ventilation (breathing by machine), insertion of vena cava (heart) infusion IV device, and irrigation (flushing) of the genitourinary tract (genital tract in/out of bladder) due to severe sepsis. The resident required IV medications to stabilize his blood pressure and IV antibiotics for UTI and septicemia (blood infection) and was transferred to the ICU. The ICU physician's note read, Upon my evaluation, this patient has high probability of imminent, life-threatening, or organ-threatening deterioration and I provided life/organ saving interventions as noted above. Resident #1 required continued acute care hospitalization for more than two weeks until he was discharged to another long term care facility on [DATE] for continued recovery. The resident's hospital diagnoses included: critical hypotension (low blood pressure), acute (sudden onset) toxic encephalopathy (brain dysfunction), acute hypoxemia (low blood oxygen) respiratory failure, acute tubular necrosis (severe kidney cell damage from oxygen loss), and septic shock from UTI. Bag-Valve-Mask (BVM) ventilation is a critical life-saving technique used to provide oxygen and ventilation to patients who are apneic (temporary breathing cessation) or experiencing severe ventilatory (provision of air to the lungs) failure, (retrieved on [DATE] from www.medscape.com). The facility's undated standards and guidelines titled Abuse, Neglect, Exploitation & Misappropriation noted the Risk Manager/designee conducted a thorough investigation and reported possible neglect to the State Agency as per regulatory guidelines. The document included the following definition of neglect, Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. Neglect occurs when the facility is aware of or should be aware of goods and services that a resident requires, but the facility fails to provide them to the resident resulting in or may result in physical harm. The facility's undated standards and guidelines titled Nursing-Change in Resident's Condition or Status noted the physician and representative were to be promptly notified of any changes in condition or status. The procedure included nurse notifications to the attending or on-call physician when there was a refusal of treatment. The Facility assessment dated [DATE] noted the facility provided care and services for management of medical conditions including, Early Identification of Problems, and provided Person-Centered Care that included, Abuse/Neglect Prevention, and disorders of the genitourinary system.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview and record review, the facility failed to develop an individualized Comprehensive Care Plan to include an indwelling urinary catheter for 1 of 3 residents reviewed for urinary catheters, of a total sample of 6 residents, (#3). Findings: Review of the medical record revealed resident #3, an [AGE] year old female was admitted to the facility from an acute care hospital on 12/11/24. She had diagnoses that included wedge compression fracture of thoracic (mid-spine) and lumbar (lower spine) vertebrae, and Urinary Tract Infection (UTI). The Minimum Data Set (MDS) Comprehensive Admission 5-day Assessment with an Assessment Reference Date (ARD) of 12/13/24 noted during the look back periods, resident #3 scored 10 out of 15 on the Brief Interview for Mental Status that indicated she was moderately cognitively impaired. The resident required staff assistance to complete Activities of Daily Living (ADLs) and the use of an indwelling urinary catheter appliance. During the 7-day look back period, the resident required high-risk antibiotic medications. The Care Area Assessment (CAA) Triggers dated 12/24/24 and the Comprehensive Care Plan Decisions dated 12/25/24 included an indwelling urinary catheter. The Order Summary Report noted resident #3 had physician's medication orders for antibiotics to treat a UTI that included: From 12/30/24 to 12/31/24, Macrobid 100 milligrams (mg) every 12 hours, and from 12/31/24 to 1/08/25, Cipro 500 mg every 12 hours. Review of the Nurses Progress Notes showed on 12/12/24, resident #1 was unable to urinate and required insertion of an indwelling urinary catheter. Review of the Care Plan Report with care plans completed 12/25/24, and revised 1/03/25 did not include a Focus, Goal, or Interventions for an indwelling urinary catheter. In an interview on 5/15/25 at 11:37 AM, the MDS Coordinator explained Comprehensive Care Plans were completed with input from the Interdisciplinary Team, and the MDS department was responsible for coordination to ensure all individualized elements were included. She checked resident #1's medical record and said the MDS CAA was triggered for inclusion of an indwelling urinary catheter in the Comprehensive Care Plan and acknowledged it was omitted. The MDS Coordinator stated, it was overlooked and not placed in the care plan. Review of the facility's standards and guidelines dated September 2024 and titled, Resident Assessment Instrument Comprehensive Care Plan Policy noted the facility used the CAA to ensure all possible resident care needs and risks identified during the MDS process were considered.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on interview, and record review, the facility failed to attain or maintain the resident's highest practicable physical well-being by failing to ensure nurses implemented physician's orders for diagnostic testing, notified the physician, and ensured provision of necessary care and services for 1 of 6 residents reviewed for Quality of Care, of a total sample of 6 residents, (#1). The facility failed to implement a physician's order for Urinalysis with Culture and Sensitivity (UA/CS) for resident #1, failed to notify the physician that the ordered diagnostic test was not completed, and failed to follow up on the missing laboratory result. Additionally, the physician/provider did not recognize or act upon the absence of the test result. Due to these combined failures in care coordination, resident #1's Urinary Tract Infection (UTI) went undiagnosed and untreated, leading to the development of septic shock, a life-threatening condition. This failure to provide necessary care and services placed the resident and other residents in Immediate Jeopardy that began on [DATE], when the facility failed to ensure timely diagnostic testing and appropriate medical intervention. On [DATE], resident #1 was admitted to the facility from the hospital. Thirteen days later on [DATE], the facility sent the resident back to the hospital where he required mechanical ventilation (life support for breathing) in the Intensive Care Unit (ICU) for septic shock from the UTI. Sepsis is when your body's immune system has a dangerous response to an infection. It is a medical emergency that can be caused by many different kinds of infections. The quicker you receive treatment, the better your outcome will be. Septic shock can occur when an infection in your body causes extremely low blood pressure and organ failure due to sepsis. Septic shock is life-threatening and requires immediate medical treatment. It's the most severe stage of sepsis, (retrieved on [DATE] from www.clevelandclinic.org). Findings: Cross reference F600 Resident #1, a [AGE] year old male was admitted to the facility from an acute care hospital on [DATE] with diagnoses that included hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke), type 2 diabetes mellitus with polyneuropathy (weakness/numbness/burning), hypertension (high blood pressure), right bundle branch (heart signal) block, dysphagia (difficulty swallowing), cognitive communication deficit, hearing loss, dysarthria and anarthria (slow/slurred speech). The Minimum Data Set (MDS) Comprehensive Admission Assessment with an Assessment Reference Date (ARD) of [DATE] noted during the look-back period, resident #1 scored 12 out of 15 on the Brief Interview for Mental Status that indicated he was moderately cognitively impaired. The assessment showed the resident did not have any behavioral symptoms or rejections of evaluations or care necessary for goals to achieve health and well-being, he had upper and lower extremity (arms/legs) functional Range of Motion limitations, used a wheelchair, was dependent on staff for assistance to complete Activities of Daily Living and mobility, was always incontinent of bladder and bowel functioning, and difficulty swallowing. The MDS Unplanned Discharge Assessment with an ARD of [DATE] noted during the look-back period, resident #1 did not have any behavioral symptoms or rejections of evaluations or care necessary for goals to achieve health and well-being. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 had care plans related to impaired functional abilities ([DATE], revised [DATE]); altered metabolism related to type 2 diabetes mellitus and medication use ([DATE]); risk for falls/requires staff assistance for transfers ([DATE], revised [DATE]); potential nutritional problems ([DATE]); and potential skin integrity alteration ([DATE], revised [DATE]). On [DATE], a care plan for alteration of urinary elimination as evidenced by incontinence was initiated. Interventions included for nurses to monitor and document signs and symptoms of UTI. The Comprehensive Care Plan did not detail behaviors including refusals of care/treatments, or non-compliance. There were no care plans for blood in urine or for an actual urinary infection. The Order Summary Report for [DATE] included a physician's order dated [DATE] for Urinalysis/Urine Culture (UA/CS). The order was marked as completed on [DATE]. On [DATE] the physician ordered Tylenol 650 milligrams (MG) every six hours as needed for pain, and on [DATE] Tramadol 50 MG, an opiate pain medication, was added for pain every eight hours. On [DATE] Tylenol 650 MG was added for fever over 100. 0 degrees Fahrenheit (F). A urine sample should be provided for both a urinalysis and culture test (UA/CS). Your physician might order the urinalysis initially to look for blood cells and bacteria in the urine that can indicate an infection. If it's positive your provider would order a urine culture to grow microorganisms and identify the specific bacteria or fungus causing the infection, (retrieved on [DATE] from www.clevelandclinic.org. On [DATE] a physician order indicated staff to send resident #1 to the emergency room (ER) for evaluation and treatment for blood pressure of ,d+[DATE], diaphoresis (excessive sweating), and slow to respond to verbal commands per family request. A nurse's Progress Note dated [DATE] at 2:33 PM, revealed resident #1 had red-tinged urine during the previous night. A note dated [DATE] at 8:23 AM, indicated the resident rolled out of bed onto the floor and required two staff to be assisted off the floor and back to bed. On [DATE] at 10:23 AM, in a telephone interview, Licensed Practical Nurse (LPN) C explained she obtained and entered UA/CS orders into the computer on [DATE] during the 11:00 PM to 7:00 AM shift after a Certified Nursing Assistant (CNA) informed her blood tinged urine was observed in resident #1's incontinence brief. The nurse recalled she later passed on the information to LPN D for the oncoming 7:00 AM to 3:00 PM shift. She said the normal process was that after orders were processed, a printed copy was placed in a binder at the nurses station for the specimen bag, but she could not recall if she had done that, or if the next shift did it. Review of the Medication Administration Record (MAR) showed a physician's order dated [DATE] for Urinalysis/Urine Culture was signed as completed by Licensed Practical Nurse (LPN) A on [DATE] at 5:20 AM. On [DATE] at 10:11 AM, LPN D signed that resident #1 was administered Tylenol 650 MG for a temperature of 100.2 F and at 1:43 PM, the nurse administered Tramadol 50 MG for pain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:11 PM in a telephone interview, LPN A recalled on [DATE] during the 11:00 PM to 7:00 AM shift, resident #1 had an order pending completion for a UA/CS. The nurse recalled she attempted to collect the urine specimen in the early morning hours of [DATE] but was unable, so she tried again, unsuccessfully, later in the shift. She said she thought she marked refused on the MAR, but confirmed she did not complete a progress note nor contact the physician, that the lab was not collected. She did not recall if she passed on the information to the oncoming 7:00 AM to 3:00 PM shift nurse. She explained in early April, she was informed by the Director of Nursing (DON) that the resident's wife had called for the results and the facility found the test was marked in the MAR as completed but it was never done. The LPN said the facility's normal practice was for night shift to obtain labs and it was difficult to get urine specimens overnight or early morning when residents were sleeping. She said she should have written a progress note and contacted the physician and stated, I learned my lesson that when I go do a procedure and they refuse, don't wait until the end of the shift; notify the DON and the doctor. Review of resident #1's medical record revealed there were no nursing Progress Notes on [DATE] completed by LPN A that documented the UA/CS physician's order was not implemented, nor that the physician was notified. On [DATE] at 3:50 PM, Registered Nurse (RN) B explained that nurses entered the order for the lab in the computer by going into the documentation program and selecting the tab for labs. They would select the test that was ordered by the physician and put in the diagnosis for the test. The nurse would notify the resident or the family if a urine sample was needed and would try to obtain the sample. The nurse would print the order, place a copy in the specimen bag and get a cup to collect the urine. This gets completed just prior to collection of the sample. She confirmed another nurse created the order for resident #1's UA/CS, but she was the one to revise it. RN B confirmed the order should not be clicked off until it was actually done and said you would make a note if it was refused or you were unable to collect it. RN B conveyed you would notify the provider so they could reorder it or decide if they wanted to do something else. She explained the Unit Managers (UM's) would check the lab book to check the labs to ensure they were collected by the nurses. RN B said it was important to collect the labs timely before symptoms worsened. On [DATE] at 10:31 AM, LPN D recalled she cared for resident #1 many times during his stay including on the 7:00 AM to 3:00 PM shift on [DATE]. The nurse explained earlier in the shift on [DATE], the resident had a fever, so she called the Physician's Assistant (PA) who gave her orders for routine labs and Tylenol. She said at approximately 2:00 PM, the resident complained of pain and was administered Tramadol, and approximately a half hour later when the family arrived to visit, she re-checked the resident, and he was, lethargic (fatigue/sluggishness). LPN D stated she called the PA again who gave orders for STAT labs and IV fluids, but the family did not want to wait and were adamant about the resident going to the hospital immediately. The PA was called again, and orders were given to send the resident out to the ER via 911/EMS. Review of nurse's Progress Notes completed by LPN D documented on [DATE] at 10:11 AM, resident #1 had a temperature of 100.2 F. The attending physician was notified, and orders were obtained for Tylenol 650 MG and routine orders were obtained from the PA for laboratory testing. Later at 1:45 PM, the resident complained of left hip pain and was administered the pain medication, Tramadol 50 MG. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Progress Note documented by LPN D later on [DATE] at 3:45 PM, noted resident #1's wife and daughter were at the facility visiting and the resident was observed as slow to respond to verbal and touch stimulation, had dilated pupils, and sweaty/clammy skin. LPN D described that the resident's vital signs were assessed as a blood pressure of 85 systolic and 50 diastolic millimeters of mercury (mmHg), and heart rate of 90 beats per minute. She documented that the UM contacted the PA who ordered STAT laboratory tests and IV fluids. LPN D's note continued, the resident's daughter requested the resident be sent to the emergency room and the PA was contacted for orders. LPN D's note dated [DATE] at 4:24 PM, documented resident #1 left the facility by stretcher at 4:25 PM, with EMS to go to the hospital. On [DATE] at 10:16 AM, the North UM recalled in [DATE], she was working when resident #1 received the pain medication, Tramadol in the afternoon and a short time later; LPN D informed her the resident seemed more lethargic and wasn't responding to his family who were very concerned with his change in condition. The nurse explained the PA was called and provided orders for STAT labs and IV fluids, but the family was not satisfied with that intervention and wanted him to go to the hospital immediately, so the PA was called back and approved the orders for transport to the hospital. The UM explained that sometime later, in early [DATE] she was informed by the DON that the resident's lab could not be found and had been signed off as completed by a nurse. She said resident #1 had at least one family member visit every day and nurses could have asked the family to assist in obtaining the urine if the resident was refusing. She said the Unit Managers were responsible for checking a binder kept at the nurse's station for collection tracking and the APRNs (Advanced Practice Registered Nurses) assisted to check for results. The UM did not explain how or why resident #1's lab result was not done. Review of a Situation Background Assessment Recommendations-SBAR progress note completed by the North UM on [DATE] at 4:53 PM, revealed, at 2 PM, nurse on unit administered Tramadol 50 MG po (by mouth) for pain x 1 dose. Resident eyes were dilated, slow to respond to verbal commands and diaphoretic at 1550 (3:50 PM). Temperature 100.2 this AM with complaints of sore throat. Throat was pink, and moist with no patchy areas noted. The North UM documented the resident 's vital signs were blood pressure of , d+[DATE], heart rate of 90, respirations of 19, blood sugar of 159, and temporal temperature of 97.5 F. She noted resident #1 had excessive sweating on the trunk of his body. She said the PA ordered IV fluids, Normal Saline, get STAT labs for UA, C/S, a complete blood count with differential and a basic metabolic panel. The UM documented that the wife and daughter adamantly requested for him to go to hospital. In a telephone interview on [DATE] at 10:37 AM, the PA explained she regularly came to the facility to see residents and as part of her assessments, she reviewed orders, labs, medications, vital signs, imaging, etc. The PA said lab orders and results were reviewed with the UM and stated, if I couldn't find results, I will go back and look to see when it was ordered to be collected, and if more than a day or two after it was to be collected, I notify nursing to see if it was even collected. She recalled on [DATE], she received a call from the North Unit Manager that resident #1 wasn't looking good and thought he either had a UTI or sepsis, so she gave orders for STAT labs, including a UA and more frequent vital sign monitoring. Later they called back because the family wanted to send him to the ER immediately, so she gave those orders. She said she expected any UA/CS orders to be processed the same day and sent to the lab, and for nurses to notify the provider when a test wasn't completed. She could not recall the facility informing her resident #1's UA/CS from [DATE] wasn't done. The PA stated, they can become septic, and we don't know the source of the infection; we have to treat them emergently. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Progress Notes documented by the PA dated [DATE] and [DATE], after the physician's diagnostic testing was ordered included documentation the resident was seen at the request of staff for a follow-up visit. Both notes indicated, Patient's labs/diagnostics and care provider notes reviewed . In a telephone interview on [DATE] at 11:59 AM, resident #1's wife recalled on [DATE], the family received a voicemail from the resident who stated he wasn't feeling well. She explained she and her daughter came to the facility, they observed him and described his condition as, cold, sweaty, clammy, and non-responsive. She said her daughter was a paramedic and believed he was in distress, possibly septic shock. She said nurses called the physician who ordered labs, but the family was very concerned he needed emergent care and insisted he be sent to the ER immediately, so 911 was initiated. She said she believed her husband would have died had they not been there and insisted he go immediately. She said she later requested the UA results from the facility and learned they were never done. She recalled the experience was very stressful, her family was distraught during the crisis and thought they may lose their loved one. She said her husband required a breathing machine and ICU care at the hospital for over two weeks. Resident #1's wife said he had to go to another facility to recover with continued therapy and nursing care. She exclaimed her family suspected her husband had a UTI at that time and would ask facility nurses about their concerns, but they would say he's fine, and tell her he just needed to, sleep it off. His wife said, they never did a urinalysis, they just didn't do it. She continued, we came in and basically had to find him catatonic before they did something. The resident's wife stated, looking back, he had no energy and would fall back like a ragdoll; no wonder he had no energy; he wasn't like that before; even now, he has gone down a lot. In a joint interview with the DON and Nursing Home Administrator (NHA) on [DATE] at 1:05 PM, the DON conveyed if a lab was unable to be collected, nurses were expected to report to the oncoming nurse and notify the physician for further orders. She said the physician may say to recollect or could decide to do something else. She confirmed that the facility had a responsibility to follow up on any orders including the collection of labs such as urine. The DON recalled on [DATE], the facility received a call from resident #1's wife who requested the UA/CS results from during his stay at the facility. She explained after she checked resident #1's medical records, she found the urine test was never done but LPN A had signed the MAR that it was completed on [DATE]. The DON explained when they questioned her, LPN A stated she attempted to obtain a specimen twice on [DATE], but the resident refused. LPN A told them she did not inform the physician, nursing management, nor did she complete a progress note explaining what happened. The DON explained routine labs were collected by the 11:00 PM to 7:00 AM nurses, and any time a test was not done for any reason, nurses were expected to notify the physician. She said when the nurse signed the order as completed it fell off the record and stated, It's the Unit Manager or designee's responsibility to follow up on ordered lab results. On [DATE] at 10:11 AM, in a telephone interview, resident #1's attending physician explained he checked resident #1's medical record and recalled a UA/CS was ordered on [DATE] for blood in the urine. The physician said he expected his lab orders to be carried out and for nurses to let him know if they were unable to obtain them so he could decide what to do next. He stated, undetected UTI can lead to sepsis; in this case that is what happened. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview on [DATE] at 10:53 AM, the facility's Medical Director said he was aware of resident #1's incident. The Medical Director related he knew the provider was not notified the urine sample was not collected and the test was never completed. The physician explained he expected nurses to notify providers when they were unable to collect specimens and stated, unidentified UTI can lead to sepsis. Review of resident #1's hospital records from [DATE] showed during transport to the hospital EMS personnel used a Bag-Valve Mask to manually maintain resident #1's breathing until they arrived at the ER at approximately 4:30 PM. After resident #1 arrived at the ER, life sustaining measures were immediately implemented including insertion of an endotracheal airway (breathing tube), respiratory ventilation (breathing by machine), insertion of vena cava (heart) infusion IV device, and irrigation (flushing) of the genitourinary tract (genital tract in/out of bladder) due to severe sepsis. The resident required IV medications to stabilize his blood pressure and IV antibiotics for UTI and septicemia (blood infection) and was transferred to the ICU. The ICU physician's note read, Upon my evaluation, this patient has high probability of imminent, life-threatening, or organ-threatening deterioration and I provided life/organ saving interventions as noted above. Resident #1 required continued acute care hospitalization for more than two weeks until he was discharged to another long term care facility on [DATE] for continued recovery. The resident's hospital diagnoses included: critical hypotension (low blood pressure), acute (sudden onset) toxic encephalopathy (brain dysfunction), acute hypoxemia (low blood oxygen) respiratory failure, acute tubular necrosis (severe kidney cell damage from oxygen loss), and septic shock from UTI. Bag-Valve-Mask (BVM) ventilation is a critical life-saving technique used to provide oxygen and ventilation to patients who are apneic (temporary breathing cessation) or experiencing severe ventilatory (provision of air to the lungs) failure, (retrieved on [DATE] from www.medscape.com). The facility's undated policy and procedure, Laboratory Tests/Diagnostic Procedures: Communicating the results, revealed the facility would track ordered labs and diagnostic procedures and promptly notify the medical provider, resident and/or the representative. The procedure section described a facility designated nurse would review lab log sheets daily to verify protocol was followed and follow up on any discrepancies noted. The facility's undated standards and guidelines titled Nursing-Change in Resident's Condition or Status noted the physician and representative were to be promptly notified of any changes in condition or status. The procedure included nurse notifications to the attending or on-call physician when there was a refusal of treatment. The Facility assessment dated [DATE] noted the facility provided care and services for management of medical conditions including, Early Identification of Problems, and provided Person-Centered Care that included, disorders of the genitourinary system.