STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165231	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Park Nursing & Rehab Center of Carroll	500 East Valley Drive Carroll, IA 51401

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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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, hospital record review and policy review the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 4 residents reviewed (Residents #1). The facility failed to obtain a urinalysis (UA) per Physician order in a timely manner which resulted in Resident #1 being transferred to the hospital and dying due to septic shock (bacterial infection that causes low blood pressure and organ failure) and urosepsis (untreated urinary tract infection (UTI) that spreads to the kidneys and causes sepsis). The facility received an order to obtain a UA on 8/12 and did not obtain the UA until 8/16. The facility failed to notify the Physician they were unable to obtain the UA due to Resident #1 being incontinent and did not get an order to obtain the UA via catheter until 8/16. The facility reported a census of 30 residents. Findings include: Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The MDS identified Resident #1 was dependent on staff with bed mobility, transfers including transfers to the toilet and toileting hygiene. The MDS revealed Resident #1 had other behavioral symptoms not directed at others during the 7 day look back period. The MDS indicated Resident #1 was always incontinent of urine and frequently incontinent of bowel. Resident #1's MDS included diagnoses of anemia, hypertension (high blood pressure), coronary artery disease, benign prostatic hyperplasia (BPH) (enlarged prostate), and cerebrovascular accident (CVA)(stroke) with affected left side. The Care Plan with a target date of 10/8/24 revealed Resident #1 was at risk for bladder incontinence and UTI's. The care plan directed staff to monitor for signs and symptoms of a UTI which include: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating habits. A Progress Note dated 8/5/24 documented Resident #1 fell out of bed and showed signs of agitation and wanted to hit someone. The note indicated a fax was sent to Resident #1's Provider and asked for antianxiety medication to be used as needed. A Progress Note dated 8/6/24 documented Resident #1 Provider declined to start an antianxiety medication due to risk for sedation. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	A facility fax form dated 8/9/24 sent to the Provider documented the facility asking if there was anything they could give Resident #1 for anxiety, restlessness and agitation. The fax form documented the staff had tried redirection, reassurance, fluids, snacks, activities. The fax documented when Resident #1 gets started and it seems to just escalate. A Progress Note dated 8/10/24 documented Resident #1 was showing signs of increased anxiousness and agitation. A Progress Note dated 8/11/24 at 4:32 AM documented a return fax received and the Provider would see Resident #1 that week. A Progress Note dated 8/11/24 at 9:21 PM documented Resident #1 had been agitated in the dining room, throwing cups, attempting to get out of the wheelchair, throwing a Kleenex box, taking off the rail on the side of the wheelchair. Resident #1 was laid down in bed at 8:00 PM and was trying to climb out of bed at 8:30 PM. Resident #1 was assisted back to the dining room. A Progress Note dated 8/12/24 at 12:43 AM documented a phone call was placed to on-call Provider due to Resident #1 increase in behaviors. The note revealed Resident #1 was yelling in the dining room after 10:00 PM and demanding 911 to be called. Resident #1 was calling the nurse a bitch, idiot, and had no respect for the nurse. The note indicated interventions of redirection, warm blankets, stress ball, and puzzles were not successful. The note documented a new order was received from on-call Provider to give Lorazepam (antianxiety) 0.25 mg (milligrams) one time only and to repeat in 30 minutes if needed. A Progress Note dated 8/12/24 at 10:46 AM documented a late entry for 8/12/24. The note indicated a UA with culture and sensitivity (C&S) if indicated would be obtained at this time due to increased behaviors. Resident #1 daughter was made aware of the new order. A Physician Order dated 8/12/24 at 1:21 PM directed staff to check UA with C&S if indicated and not to discontinue the order until the UA was obtained. A Progress Note dated on 8/12/24 at 10:18 PM documented Resident #1 was very anxious at times and did not follow simple requests for any period of time. A Progress Note dated on 8/13/24 at 10:28 AM documented the Advanced Registered Nurse Practitioner (ARNP) was at the facility and a new order was received to start gabapentin (medication to treat nerve pain) twice a day for hand pain. The note documented the family was asking for an antidepressant to be started. A Progress Note dated 8/13/24 at 1:32 PM documented the facility spoke with ARNP regarding family requesting something for Resident #1 mood. The ARNP suggested starting sertraline 25 mg at bedtime. Resident #1 family made aware of the new order. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	A Physician Progress Note dated 8/13/24 documented ARNP saw Resident #1 for a 30 day evaluation. The note documented Resident #1 has had shooting pain to his left hand which was his affected side from the stroke. The note documented staff reported Resident #1 has not been drinking a lot of fluids and he had been more anxious over the past week. Staff reported Resident #1 had gotten agitated easily with the staff, which was unusual behavior from when he was first admitted . According to the note, Resident #1 denied feeling anxious. The assessment and plan documented Resident #1 had anxiety and would check a UA to rule out a UTI due to increased agitation and anxiety. Resident #1 denied any symptoms but his behaviors are different from when initially admitted . A Progress Note dated 8/13/24 at 9:40 PM documented Resident #1 had been anxious this evening in the dining room. Resident #1 asked for a pen and paper to write letters which helped him calm down. A Progress Note dated 8/15/24 documented Resident #1 continued to be restless from supper meal and into sleep time. The note documented once Resident #1 got into bed he settled in some but some nights continued to attempt to exit the bed multiple times. A Physician Order dated 8/16/24 at 7:44 AM documented to insert a 16 FR (French)/10 ml(milliliter) catheter with a drainage bag and to remove once a urine specimen was obtained. A Progress Note dated 8/16/24 at 10:43 AM documented a UA obtained and taken to the lab. The note lacked documentation on how the UA was obtained, how Resident #1 tolerated the procedure and what the characteristics of the urine was. A Progress Note dated 8/16/24 at 11:56 AM documented Resident #1 had a shaking temperature of 97.1 degrees. A phone call was placed to the ARNP with a new order to draw labs, complete blood count (CBC) and basic metabolic panel (BMP). Family was made aware of the new order. A Progress Note dated 8/16/24 at 12:28 PM documented blood was drawn and sent to the lab. A Progress Note dated 8/16/24 at 1:29 PM documented Resident #1 was in bed and had an emesis. Resident #1 lung sounds were diminished in all fields and his oxygen saturation was 79%. The note documented oxygen was applied at 2 liters. The ARNP was notified and a new order was received to send Resident #1 to the emergency room (ER). The note indicated 911 was called and ambulance arrived at 1:35 PM to transport Resident #1 to the ER. A Progress Note dated 8/16/24 at 11:11 PM documented Resident #1 daughter reported her dad was going to be admitted to the intensive care unit (ICU). A Progress Note dated 8/16/24 at 5:18 AM documented the facility received a call from the hospital reported Resident #1 had passed away at 4:52 AM. A Progress Note dated 8/19/24 at 7:58 AM documented a late entry for 8/14/24 indicating CNA's (Certified Nursing Assistants) attempted to get a urine specimen on the commode using a hat. The note further documented that afternoon a CNA and the nurse laid Resident #1 down in bed and placed a urinal without success. The note documented the nurse informed next nurse in report of not being able to obtain the UA as Resident #1 was incontinent of urine throughout the day. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	A Progress Note dated 8/19/24 at 7:35 PM documented a late entry for 8/13/24 6 AM to 6 PM shift indicating CNA's attempted to obtain UA with Resident #1 sitting on the commode and with the urinal, both attempts unsuccessful. The note documented Resident #1 was incontinent when another attempt was made. Resident #1 urine was darker yellow in color with no foul odor. Resident #1 was incontinent large amounts. A Hospital Laboratory Specimen Report for Resident #1 UA collected at the facility on 8/16/24 10:30 AM revealed the following abnormalities: cloudy appearance, 100 mg/dl glucose, small bilirubin, large amounts of blood, trace amounts of protein. 2.0 E.U/dl of urobilinogen, positive nitrates, large amounts of leukocyte esterase, 5-10/hpf RBC (red blood cells) and packed field of WBC (white blood cells). A Hospital ER Documentation on 8/16/24 at 2:00 PM revealed Resident #1 initial vital signs were the following: Temperature 102.6 degrees, Pulse 160 beats/minute, Respirations 36 per minute, Blood pressure 119/60, Pulse oximeter 81% on 15 liters nonrebreather. A Hospital Discharge Summary dated 8/17/24 documented Resident #1 was admitted for treatment of septic shock presumably due to urosepsis. The summary documented the following: Resident #1 urine was growing gram-negative bacilli although his blood cultures were preliminarily positive for gram-positive cocci. He was given aggressive IV fluid resuscitation and broad-spectrum antibiotics but continued to have persistent hypotension (low blood pressure) and organ dysfunction. He had a had a central and arterial line placed and was titrated up on max doses of Levophed (used to treat life threatening low blood pressure) and vasopressin (used to increased blood pressure) with persistent hypotension and tachycardia (increased heart rate). He was requiring heated high flow nasal cannula to maintain oxygen saturations and was minimally responsive. The Provider discussed with family the option of transferring to a higher level of care or continuing aggressive maximal therapy but as he was failing to improve they did not want to see him suffer any longer and elected to pursue comfort care instead. Blood pressure support was removed and Resident #1 passed away within 5 hours, time of death at 4:52 AM. The preliminary cause of death was septic shock. The Certificate of Death for Resident #1 dated 8/20/24 documented the immediate cause of death was septic shock due to or as a consequence of E Coli Urosepsis. Review of Task documentation for behavior monitoring for Resident #1 revealed the following behaviors from 8/9/24 to 8/15/24: 8/9- repeats movement, yelling/screaming 8/10- repeats movement, yelling/screaming, abusive language 8/11- frequent crying, yelling/screaming, abusive language 8/12- repeats movement, yelling/screaming 8/13- yelling/screaming, wandering 8/14- repeats movements, yelling screaming (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	8/15- repeats movement The August 2024 Medication Administration Record (MAR) directed staff to check UA with C&S if indicated with a start date of 8/12/24. The MAR directed the order not to be discontinued until the UA was obtained. The MAR revealed 9 was documented on 8/12, 8/13, 8/14, and 8/15 indicating the UA was not obtained and to see the progress notes. Review of Progress Notes from 8/12 to 8/15 lacked documentation the UA was obtained or attempted to be obtained. The progress notes lacked documentation the ARNP was notified (after her visit at the facility on 8/13) until 8/16 that the UA had not been obtained. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 11:52 AM, Staff A, LPN (Licensed Practical Nurse) reported on the morning of 8/14/24, the aides had tried to get the UA specimen on the commode with a hat and were not successful. She stated that afternoon herself and another CNA laid Resident #1 down in bed and placed a urinal. She stated they could not get any urine and within 30 minutes Resident #1 wanted to get up. She stated Resident #1 had been incontinent during the day. She stated she passed on in report to the night nurse the UA had not been obtained. She stated she did not document the attempts to obtain the UA and the ADON (Assistant Director of Nursing) asked her to do a late entry to take credit for what had been done. Staff A reported the ADON was asking anybody working that week for witness statements. Staff reported she did not notify the Provider that she was not able to obtain the UA. She stated she did not try to do a straight catheter as there was not an order for a catheter and she did not reach out to the Provider requesting an order for a straight catheter. Staff A reported Resident #1 was a little fidgety after the attempt to obtain the UA with the urinal. She reported it was his birthday that day. She stated his sister and a friend came to visit. She stated he did not remember they had left and was looking for them. She stated he was wheeling around in his wheelchair. She stated she tried to give him some dominos to stack up. Staff A reported on 8/16/24, the ADON reported the UA had still not been obtained so she called the ARNP and got an order to insert a retention catheter. She stated the order directed to insert the catheter and leave it in place until the UA was obtained and then remove it. Staff A stated around 10 AM therapy and a CNA attempted one more time to obtain the UA and sat Resident #1 on the commode. She stated it was not successful so they laid him down in bed. Staff A stated she inserted the catheter and got a little bit of urine back but not enough for a specimen. She stated she blew up the balloon. She stated she left and came back 5-10 minutes later and there was no urine. She stated she deflated the balloon and advanced the catheter and then got urine. She stated she took the specimen from the catheter tube and then removed the catheter. She stated the urine did not look too bad. She stated the urine was thick and yellow in color. She reported the urine did not have an odor. Staff A stated Resident #1 did not have a fever that morning during her assessment. She stated Resident #1 did get Tylenol at breakfast for general discomfort. She reported at lunch her and another nurse, Staff B saw Resident #1 was shivering. Staff A reported Resident #1 vitals were okay. She stated Staff B called the Provider and got labs ordered. Staff A reported she took the labs to the hospital and then went on lunch break. Staff A stated after the break, she walked by Resident #1 room. She stated she could smell and observed vomit all over his chest. She stated it appeared some of the vomit came out around the opening around his peg tube. She stated she got help right away and cleaned him up. She stated he also had a large, soft bowel movement at that time. She stated the other nurse, Staff B came down and did a quick assessment. She stated Staff B called for oxygen and then called the ARNP to send him to the ER. She stated Staff B had talked to the daughter earlier that morning. Staff A reported she called for the ambulance and about the same time the ambulance came, the daughter was at the facility. She stated Resident #1 also vomited when the EMT's (emergency medical technicians) were at the facility. Staff A reported she had heard Resident #1 had a fever when the EMT's checked but that is hearsay. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 1:14 PM, Staff B, RN (Registered Nurse) reported she was not Resident #1 charge nurse on 8/15. When asked why she had signed off the UA on the MAR with a 9 on 8/15/24, she stated she was trying to help out the other nurse and work together. She reported she knew Staff C did not obtain the UA on the 15th. Staff B stated she knew staff were sitting Resident #1 on the commode and trying to use the urinal. Staff B stated on Friday morning she had gotten Resident #1 vitals and he was acting normal. She stated in between breakfast and lunch time around 11:15 AM Resident #1 started shivering. She stated she called the ARNP due to his change in condition. She stated the ARNP ordered labs, a CBC and BMP. She stated she drew the labs and Staff A took the labs to the hospital. Staff B stated later she was asked to come down to Resident #1 room as he had vomited. She stated his lungs were diminished, oxygen saturation was 79% and could not remember what his temperature was but it was not greater than 99 degrees. She stated she went back to the office to call the ARNP to get an order to send Resident #1 to the ER and to fill out the transfer form. She stated she told a CNA to get the oxygen concentrator. She stated she did not actually see the oxygen applied but thought Staff A and the CNA applied it. Staff B reported on Thursday she was not in charge of obtaining the UA and did not call the ARNP for an order for a straight catheter. When asked what the facility expectation was for notifying the Provider when a UA was ordered and unable to be obtained, Staff B stated she did not know and would need to check the policy. Staff B acknowledged 8/12 to 8/16 was a long time to obtain a UA. Staff B stated Resident #1 was not showing any urinary symptoms. She stated the reason they were trying to get a UA was due to his behaviors. She stated Resident #1 seemed his normal self until Friday afternoon. She stated he did not have a temp, no pain and no urinary symptoms. On 8/21/24 at 2:15 PM, Staff C, RN reported she worked on 8/13/24. She stated Resident #1 was acting no differently during the day time but the night shift reported he was more agitated. She stated on 8/13 she made the CNA's aware that a UA was needed. She stated Resident #1 was incontinent so they tried to put him on the commode and use a urinal to obtain the UA. She stated the 3rd time they tried he was incontinent. She stated she did not notify the Physician that they were unable to get the UA. She stated she passed it on in report the UA was not obtained and it was on the MAR not to discontinue the order until the UA was obtained. When asked what the facility policy was on when to ask for an order for a straight catheter for a resident who is incontinent, she stated she honestly did not know. She said common sense would say 24 hours depending on how urgent it was. She stated Resident #1 did not have a temperature, he was voiding, drinking and there was nothing out of the ordinary. She stated she did not think the straight catheter was necessary at the time. She reported the UA was ordered due to increased agitation at night. She stated Resident #1 when in bed was busy but pretty cooperative and compliant on the day shift. She stated she had not heard much about agitation until right before the UA was ordered. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 2:53 PM, the ADON reported she does a lot of monitoring resident's intakes and fluids and working closely with the dietician and the ARNP. She stated she was monitoring Resident #1 intakes due to the gastrostomy tube and the family wanting the tube removed. She stated the tube could not be removed until there were improvements. She stated she sent the ARNP an email asking to increase the water flushes due to decreased fluid intake. She stated Resident #1 hated the thicken liquids. The ADON stated she was not concerned about a UTI. She stated Resident #1 did not complain to her about any urinary symptoms. The ADON stated on the morning of 8/16/24 she obtained an order for the retention catheter. She stated she figured since the UA had not been obtained that something else needed to be done so she got the order. When asked if the facility had a policy on a time frame for obtaining a UA, she stated she would have to look. She stated she learned in nursing school the UA should be obtained in 24 hours. She stated Resident #1 daughter was blowing up her phone Friday night, 8/16 into Saturday, 8/17 about the situation. She reported the family wanted Resident #1 on medications for his delusions. She stated she had seen Staff A in Resident #1 room with UA supplies. She reported she had Staff A make a late entry in the progress notes. She stated she completed her own investigation to figure out why the UA was not completed until Friday, 8/16. She stated she learned several staff members had tried to obtain the UA during the week. She stated Resident #1 was either incontinent, removed the urinal or overshot the commode. She stated she got the order for the UA on the 12th, the Provider was at the facility on the 13th and knew the UA had not been obtained and that the facility was working on obtaining it. She stated on the 16th the catheter was done. She stated her expectations are for staff to obtain the UA within 24 hours, same with lab work. She stated she would expect staff to document the attempts to obtain the UA in the progress notes and if unable to obtain the UA to notify the Physician to get further direction. She stated Resident #1 had no urinary symptoms until 8/16 when Staff B and herself both noticed he was shivering. She stated Resident #1 did not have a fever at the time. She stated labs were drawn and he was sent to ER. She stated Resident #1 daughter had reported to her that she didn't believe he did not have a temperature at the facility as the EMT's reported Resident #1 temperature was 102 degrees. The ADON reported the facility completed education with the nurses on UTI's. On 8/22/24 at 9:32 AM, Staff C, RN stated she worked on 8/15/24 and knew Resident #1 had an order to obtain a UA. She stated she tried multiple times to get the UA when she was giving him his pills, ice water and when the CNA's were taking him to the bathroom. She stated she would ask him if he needed to go and would be in the room when the CNA's were giving him the urinal. She stated Resident #1 was incontinent most of the time. She stated on 8/15 she did not see anything that would indicate Resident #1 was septic. Staff C stated he was at his baseline and had no concerns. She stated she had passed on to other nurses and aides that Resident #1 still needed the UA to be obtained. She stated she did not notify the ARNP and did not think about a straight catheter at the time. She stated she had never done a straight catheter before and would have needed help. She stated she usually would document on the MAR if the UA was obtained or not. She stated she normally does not document the attempts to get the UA in the progress notes. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	On 8/22/24 at 9:04 AM, the facility ARNP reported the facility had called her on 8/12/24 for a verbal order for the UA. She stated she saw Resident #1 on 8/13 and had a conversation with him. She stated Resident #1 denied any urinary symptoms. She reported she was aware on 8/13 during her visit that the UA had not been obtained. She stated Resident #1 was at his baseline. She stated the family wanted him started on some medications for his anxiety and she wanted to rule out anything acute before starting him on medications. She stated later that day she got a phone call that the family wanted to start medication even though there were no UA results. She reported she got a call on 8/16 the UA had not been obtained and that was when the catheter was ordered. She stated she had briefly looked over the hospital notes. She reported she was not sure if the UA obtained earlier would have made a difference, she stated that was a hard question to answer. She stated Resident #1 had vomited, had a coughing episode and his oxygen had dropped on 8/16. She stated that was partially why he was sent to the hospital. She stated she was concerned with possible aspiration pneumonia. She stated the facility had called her a couple of times that morning to report on Resident #1. She reported prior to that she had been told he was acting normal and had been without a fever. She stated she was getting the UA to rule out anything acute before starting him on new medications. She stated that was common in her practice. She stated when she had seen him on the 13th he denied any burning with urination and he did identify he had been more agitated. The ARNP stated she would like a phone call earlier if the sample was not able to be obtained. She stated if the sample was not obtained after 24 hours she would like to be notified. On 8/22/24 at 11:00 AM, the DON (Director of Nursing) reported the reason the UA was ordered was because of Resident #1 behavior. She stated there was no urgency to obtain the UA as Resident #1 did not meet criteria for the UA and did not have any signs or symptoms of a UTI. She stated his behaviors had improved during the week. She stated if the facility would have called the ARNP during the week she probably would have discontinued the UA because his behaviors had improved and he did not meet the criteria to have a UA completed. The DON reported the expectation to obtain the UA in 24 hours was a new expectation. On 8/26/24 at 10:30 AM, Resident #1 daughter reported her biggest concern was how long it took to obtain the UA (8/12 to 8/16/24). She stated on Friday when the UA was obtained her dad was already having symptoms. She stated through text messages with the ADON and visiting the facility a couple of times during the week, she would ask about the urinalysis and where the facility was at with obtaining it. She stated she was told anytime the staff would catheterize him, they couldn't get any urine and that her dad was incontinent. She stated the facility did not do any blood work all week until he had symptoms on Friday. She stated the ADON told her that her dad had been catheterized two times. She stated she did not know when those times were. She stated she knew her dad was catheterized on Friday as he had a blood clot on his penis in the hospital. She stated she was told he had been catheterized twice so she assumed Friday was the second time. An untitled facility education form dated 8/19/24 directed Nurses to make sure to update the doctor if unable to get a urine or a lab draw within 24 hours. The form also instructed the nurses to review the signs and symptoms of a urine infection and sepsis included on the form. The form also included an attachment of the McGeers criteria checklist for the nurses to review when asking for a UA for a resident. The signs and symptoms of a urine infection and sepsis documented on the education form included: *A strong urge to urinate that doesn't go away (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165231	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Park Nursing & Rehab Center of Carroll	500 East Valley Drive Carroll, IA 51401

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 0658 Level of Harm - Actual harm Residents Affected - Few	*A burning feeling when urinating *Urinating often, and passing small amounts of urine *Urine that looks cloudy *Urine that appears red, bright pink or cola-colored-signs of blood in the urine *Strong-smelling urine *Pelvic pain, in women- especially in the center of the pelvis and around the area of the pubic bone The symptoms of urosepsis documented on the education form included: *pain near the kidneys, on the lower sides of the back *nausea with or without vomiting *extreme fatigue *reduced urine volume or no urine *trouble breathing or rapid breathing *confusion or brain fog *unusual anxiety levels *changes in heart rate, such as palpitations or a rapid heartbeat *weak pulse *high fever or low body temperature *profuse sweating A facility policy titled Culture Tests revised January 2012 documented should the attending Physician order cultures, they shall be obtained and completed as soon as practical. All test results shall be reported to the Physician as soon as the results are obtained.