STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365702	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'Neill Healthcare Middleburg Heights	7250 Old Oak Blvd Middleburg Heights, OH 44130

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36650 Based on closed medical record review, Emergency Medical Service (EMS) run sheet review, hospital record review, review of Medscape guidance, facility policy review and interview, the facility failed to ensure comprehensive monitoring and timely identification of a change in Resident #80's condition related to the use of an indwelling urinary catheter. This resulted in Immediate Jeopardy, actual harm and subsequent death beginning on [DATE] at approximately 7:00 A.M. when Resident #80 had decreased urine output with only a total of 200 milliliters (ml) over three nursing shifts. However, the nursing staff did not follow up to comprehensively assess the resident during this time period or follow up with State tested Nursing Assistant (STNA) staff to inquire about the resident's urine output during their shifts. The nursing staff did not notify the physician Resident #80 had zero to 100 ml of urine output each nursing shift. On [DATE] at 11:25 P.M., the resident's family requested the resident be transferred to the emergency room . Upon arrival at the hospital, the resident was assessed to have a firm abdomen, abdominal distension and pain in the lower stomach region with the resident moaning and wincing in pain on palpitation of lower abdomen. The resident's indwelling catheter was replaced and began draining dark, thick, purulent urine. The resident had 2000 ml of urine output after the indwelling catheter was replaced. The resident was diagnosed with altered mental status, a urinary tract infection (UTI) and septic shock. Resident #80 was subsequently discharged to an inpatient hospice center and expired on [DATE]. The resident's death certificate noted cause of death was bacteremia due to septic shock and heart disease. This affected one resident (#80) of three residents reviewed for catheter care. The facility identified seven additional residents (#17, #42, #45, #47, #55, #57, and #62) with urinary catheters. On [DATE] at 2:18 P.M., the Administrator, Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #325 were notified the Immediate Jeopardy began on [DATE] at approximately 7:00 A.M. when Resident #80 had decreased urine output with only a total of 200 ml over three nursing shifts. However, the nursing staff did not follow up to comprehensively assess the resident or follow up with STNA staff to inquire about the resident's urine output during their shifts. The nursing staff did not notify the physician Resident #80 had zero to 100 ml of urine output each nursing shift. On [DATE] at 11:25 P.M., the resident's family requested the resident be transferred to the emergency room . Upon arrival at the hospital, the resident was assessed to have a firm abdomen, abdominal distension and pain in the lower stomach region with moaning and wincing in pain on palpitation of lower abdomen. The resident was diagnosed with a UTI and septic shock. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective action: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the facility identified two charge nurses, LPN #307 and LPN #308 who failed to identify the resident's condition and assess Resident #80 appropriately and timely. LPN #307 and LPN #308 received disciplinary action and education regarding urinary devices, output monitoring, resident assessments, interventions, notification to family and physician, and documentation. STNA #315 and STNA #312 were identified as the STNAs involved in Resident #80's care on [DATE] and [DATE]. STNA #315 and STNA #312 were educated on notification of change in resident urine output including amount, color, odor, or complaints of pain from resident. On [DATE], RDCS #325 provided education to the DON regarding urinary devices, output monitoring, resident assessments, interventions, notifications to family and physician/nurse practitioner (NP) and documentation. Education was completed to include monitoring of resident with urinary devices related to change in urinary output (decreased ml out, change in characteristics such as color/odor), completing focused urinary assessment (obtaining vital signs, checking abdomen for distention/tenderness, asking resident if any complaints of pain in abdomen, flank, or back, checking condition of catheter drainage for tubing for clot, kinks, sediment, and initiating interventions as needed. The DON educated the two Unit Managers (LPN #301 and #309) on the same above topics. The DON and Unit Managers educated all 26-nursing staff on the above topics. On [DATE], the facility identified seven residents (#17, #42, #45, #47, #55, #57, and #62) with urinary devices. The DON assessed the seven residents for signs and symptoms of dehydration, urine output outside of resident baseline parameters, and complaints related to urinary status, and reviewed their medical records. Residents #17, # 42, #57, and #62 were stable and no interventions were indicated. Residents #45, #47, and #55 had no urine output documented, and a physician order was obtained to document urine output on each shift. Residents #45, #47, and #55 had sufficient urine output and no other interventions were indicated. On [DATE], the DON/Unit Mangers educated all 31 STNAs on urinary devices, output monitoring, and notification to the charge nurse of any observed change in resident's baseline status. On [DATE], an ad hoc Quality Assurance and Performance Improvement (QAPI) was held to review the findings of Resident #80's change in condition and decreased urine output. Beginning [DATE], the DON/designee would review all new physician orders and notes to ensure any change in condition or potential risk of infection were addressed appropriately and notifications were completed. Audits would be completed daily for four weeks and randomly thereafter for a total of four months to ensure appropriate assessment, documentation, and notification. Beginning [DATE], the DON/designee would complete audits on all residents with an indwelling urinary catheter weekly for a period of four weeks and randomly thereafter for a total of four months to ensure appropriate assessment, documentation and notification. This audit would include physical assessment of catheter, documentation review of urine output, monitoring of signs and symptoms of infection including urine color being collected. All findings will be reviewed by the QAPI committee with the Medical Director weekly (if necessary) or on a monthly basis. Although the Immediate Jeopardy was removed on [DATE], the facility remains out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. (continued on next page)

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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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Findings include: Review of the closed medical record for Resident #80 revealed an admitted [DATE] with diagnoses including history of UTIs, low back pain, hematuria, retention of urine, and heart disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 had intact cognition and had an indwelling urinary catheter. Resident #80 required one assistance from staff for toileting. Review of the plan of care dated [DATE] revealed Resident #80 was at risk for infection and/or trauma related to the use of Foley (indwelling urinary) catheter related to urinary retention. Interventions included to assess the resident for pain/discomfort every shift, check Foley catheter for patency, kinks in tubing, urinary output every shift, monitor and record output every shift and notify nurse if no output noted and monitor for signs and symptoms of UTI (burning on urination, flank pain, hematuria, decreased urinary output, change in mental status, change in behavior, fever, change in color, clarity and odor of urine). Review of Resident #80's physician orders dated [DATE] revealed an order for Foley catheter care every shift, monitor Foley patency every shift, may irrigate Foley catheter per house protocol, as needed if leaking or obstructed. Review of the Medication Administration Record (MAR) for [DATE] revealed Resident #80 refused his lidocaine patches (pain patch) to his bilateral hips on [DATE] and [DATE]. Record review revealed the resident also had physician orders for Tramadol 50 milligrams (mg) every 12 hours as needed for pain and Acetaminophen 325 mg (for mild pain) two tablets every four hours as needed for pain. Neither medication was documented as being administered to Resident #80 on [DATE] or [DATE]. Review of the meal and supplement intake for [DATE] and [DATE] revealed Resident #80 consumed 100 percent (%) of a magic cup supplement (high calorie supplement) four ounces (oz) at lunch on [DATE] and [DATE]; 100% of Boost glucose control (high calorie nutritional supplement) eight oz on [DATE] and [DATE] in the morning and 50% in the evening on [DATE] and 25% in the evening on [DATE]. Resident #80 was to receive a four oz house nutritional supplement if he consumed less than 50% of his meal. Resident #80 consumed the following meals: on [DATE], breakfast was zero % of meal and supplement, lunch was zero % meal and 100% of the four oz supplement and for dinner was 50% meal intake and 100% of the four oz supplement. On [DATE], breakfast was 100% meal intake and 100% four oz supplement, lunch was 50% meal intake and zero % supplement, and dinner was 25% meal intake and 100% of the four oz supplement. Review of Resident #80's Treatment Administration Record (TAR) for [DATE] revealed on [DATE] from 7:00 A.M. to 7:00 P.M., there was zero urine output documented under catheter care. On [DATE] from 7:00 P.M. to ([DATE]) 7:00 A.M., the record included the resident had 100 ml urine output for the shift. On [DATE] from 7:00 A.M. to 7:00 P.M., there was 100 ml of urine from the Foley catheter documented. On [DATE] from 7 P. M. to 7 A.M., it was marked with an X, and no urine output was noted. This was a total of 200 ml urine output in approximately 36 hours. Monitoring of the catheter's patency was documented as completed. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the progress note dated [DATE] at 11:25 P.M. revealed the nurse noticed a blue tint to the resident's outer extremities. The nurse assessed Resident #80's pulse ox (pulse oximetry is to monitor blood oxygen saturation) and it was unobtainable. After applying warm towels to the resident's hands and applying oxygen, his pulse ox was low at 67% at three liters per minute (LPM) via nasal cannula. Residents #80 was shivering, temperature was 98.3 Fahrenheit (F), blood pressure had been elevated ,d+[DATE] and started to come down after applying oxygen to ,d+[DATE]. The nurse contacted the primary care physician and was told if the family wished to send the resident to the hospital, follow their wishes. After speaking with the resident's grandson, Resident #80 would be sent to the hospital. On [DATE] at 1:00 A.M., Resident #80 was sent to the hospital via 911 due to all other transportation companies being unavailable until morning. Resident #80 was unresponsive to conversation or stimulation when leaving the facility, pulse ox was 88% on three LPM via nasal cannula, blood pressure was ,d+[DATE], heart rate was 96 beats per minute and respirations were 20. There was no documentation of issues with the Foley catheter or decreased urine output reflected in the documents reviewed. Review of the Emergency Medical Service (EMS) run sheet dated [DATE] at 1:30 A.M. revealed per staff, Resident #80 was normally alert and oriented times two with baseline confusion but starting yesterday evening, his mental status became more altered than normal with drops in his pulse ox saturation. Staff stated Resident #80 has also been refusing to eat or allow staff to care for him properly for several days. Staff stated the resident's family wished for him to be sent to the emergency room for evaluation. Staff stated they attempted to contact multiple private ambulance agencies prior to calling the fire department EMS. Review of the hospital records dated [DATE] revealed Resident #80 was brought into the hospital for altered mental status and low blood pressure. Chief complaint was sepsis/blood culture gram negative bacillus, acute kidney injury, leukocytosis (increase white blood cells), urinalysis showing pyuria (puss in urine) likely indication UTI and altered mental status. No fever, blood pressure was ,d+[DATE] (hypotensive) and pulse ox at 68% (low). Hospital diagnoses included altered mental status, UTI, and septic shock (when a bacterial infection causes low blood pressure and organ failure). On exam, Resident #80's abdomen was distended and firm below the umbilicus. Resident #80 moaned and winced in pain to palpation of lower abdomen. Resident #80 had an indwelling Foley catheter which was noted to be dry with no drainage. The nurse replaced the Foley catheter and Resident #80 began to drain dark, thick, purulent urine; 2,000 ml urinary output was obtained. Resident #80 became slightly more alert, and he said he felt better. Sepsis alert was called. Resident #80 was started on Zosyn (intravenous (IV) antibiotic) and IV fluids bolus. Resident #80's blood pressure initially responded to fluids and his blood pressure went up but once the fluids were finished, his blood pressure dropped again. Due to Resident #80 being comfort care (advance directive), status pressors (blood pressure medications) were not started. On re-examination, systolic blood pressure was critical (,d+[DATE]) (hypotensive), temperature 99.7 F (elevated), respirations 39 breaths per minute (elevated), pulse ox was 95% on four LPM. Resident #80 has persistent high lactate levels (body tissues are not getting enough oxygen), hypotension (low blood pressure), and remained obtunded (diminished responsiveness to stimuli). Prognosis was poor. On [DATE], Resident #80 was discharged to an inpatient hospice care center. Review of the death certificate dated [DATE] revealed Resident #80 passed away on [DATE] at 9:30 P.M. The cause of death was bacteremia (bacteria in the blood) due to septic shock and due to heart failure. The death certificate was signed by Physician #320 on [DATE]. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 12:11 P.M. with Resident #80's daughter denied knowledge of any family member or friend emptying Resident #80's Foley catheter while he was at the facility. Interview on [DATE] at 12:28 P.M. with Resident #80's grandson verified the cause of death on the resident's death certificate was bacteremia, septic shock and heart disease. Resident #80's grandson denied knowledge of any family member or family friend of emptying Resident #80's Foley catheter at any time. Interview on [DATE] at 2:57 P.M. with the DON revealed there was no facility protocol on what the nurse should do if a resident had no urinary output or low output through the catheter. However, there were orders as needed to flush the Foley catheter, change the catheter and notifying the physician that there were concerns with the Foley catheter. The DON stated LPN #307 told her the family was in and that they emptied the catheter bag. The DON verified LPN #307 and #308 should have assessed Resident #80's Foley catheter due to low urine output and not assumed he did not have any output because he was not drinking water. The DON verified LPN #307 and #308 should have notified the physician of Resident #80's decreased urine output. The DON also revealed the facility had a bladder scanner (device) at the nurse's station and it was working properly, and it could have been used for Resident #80 although nurses have to call the physician to get an order to use the bladder scanner. Interview via telephone on [DATE] at 3:00 P.M. with LPN #307 revealed when she went in to empty Resident #80's Foley catheter on [DATE], it was approximately 6:45 P.M. and his catheter bag was empty. She stated she thought it looked like it had been emptied and thought that the family or STNA had emptied the Foley catheter. LPN #307 stated had it been in the middle of her shift when she went to empty the catheter bag, she would have flushed his catheter or called the physician to do a bladder scan. No one was in the room to ask if someone had emptied the catheter bag. LPN #307 stated Resident #80 appeared to be at his baseline and did not have any more abdominal distention than normal. LPN #307 stated she told LPN #308 that Resident #80 had no output. On [DATE], LPN #307 worked her nursing shift from 7 A.M. to 7 P.M. Resident #80 had 100 ml of urine output but the LPN did not know what the urine looked like. LPN #307 felt this was accurate urine output because Resident #80 was not drinking much. The LPN stated Resident #80 was alert and oriented with confusion, did not show signs or symptoms of infection and did not have any complaints. LPN #307 stated she does not recall if LPN #308 told her about Resident #80 having a decrease in urine output. LPN #307 verified she did not call the physician related to Resident #80's decreased urinary output. Interview on [DATE] at 3:19 P.M. with LPN #308 revealed she worked the night shift on [DATE], [DATE], and [DATE] from 7 P.M. to 7 A.M. LPN #308 confirmed Resident #80 was on her assignment during these shifts. She stated Resident #80 was fine, asking about candy. The LPN stated Resident #80 did not like to drink water and would only drink water when he took his medications, and he would not drink his supplement drinks. LPN #308 stated she spoke to the STNAs regarding Resident #80's low urine output and to encourage fluids. The LPN stated the 100 ml urine output on [DATE] was accurate, but she could not remember what the urine looked like in appearance. The LPN also stated staff did encourage him to drink more water. LPN #308 stated on [DATE], Resident #80 did complain of back pain, but stated he always complained that his back was hurting all the time. On [DATE], LPN #308 did not remember what time he started with a change of condition, or his outer extremities started turning blue. She stated she seen him early in the shift, he was confused and did not want his candy. LPN #308 stated she called the physician related to Resident #80's mental status change but verified she did not inform the physician of any decreased urinary output. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview via telephone on [DATE] at 9:40 A.M. with STNA #312 revealed she was assigned to Resident #80 on her night shift assignments on [DATE] and [DATE]. STNA #312 stated it was normal for Resident #80 to have 100 to 200 ml urine output on nights. When she did her check and change and repositioned him, he would complain of back pain. She does not recall any abnormal pain. STNA #312 stated the family did not come in much and denied knowledge of anyone other than staff emptying his Foley catheter. STNA #312 stated she told the nurse that Resident #80 only had 100 ml out and did not tell her anything about what the urine looked like. STNA #312 stated she does not remember the appearance of his urine output. Interview on [DATE] at 12:34 P.M. with STNA #315 revealed she was assigned to Resident #80 on her day shift assignments on [DATE] and [DATE]. The STNA revealed Resident #80 was not acting different, but he was not putting out urine. STNA #315 stated she overheard the night shift nurse say Resident #80 was not putting out urine, so she was offering him fluids throughout the night. STNA #315 stated she offered fluids throughout the day. STNA #315 stated Resident #80 was a little agitated for the whole shift, more than usual. He said his back was hurting, but that was his usual. STNA #315 stated she told the nurse that he was complaining of pain. Resident #80 had no urine output on Saturday ([DATE]). STNA #315 stated she did not see any other family members. Interview on [DATE] at 3:40 P.M. with Physician #320 revealed he reviewed Resident #80's hospital record and tried to figure out how long the resident had been sick for. Physician #320 stated it was only an estimate of two weeks that Resident #80 was sick with bacteremia and sepsis. Bacteremia usually comes on slowly and is not identified until outward symptoms show. Review of the facility's undated policy titled Catheter Care, Urinary, revealed under general guidelines to observe the resident's urine level for noticeable increases or decreases, check the urine for unusual appearance (color, blood, sediment). Maintain an accurate record of the resident's daily output. Observe the resident for signs and symptoms of UTI and urinary retention. Under the area of documentation revealed the date and time that catheter care was given, all assessment data obtained when giving catheter care, character of urine such as color, clarity and odor. If the resident refuses the procedure, the reason why and the interventions are taken. Under reporting stated notify the supervisor if the resident refuses the procedure and reports other information in accordance with facility policy and professional standards of practice. Review of Medscape guidance titled Septic Shock dated [DATE] revealed sepsis was defined as life-threatening organ dysfunction due to dysregulated host response to infection. In sepsis, symptoms may include decreased urine output. This deficiency represents non-compliance investigated under Control Number OH00158291.