STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105363	A. BUILDING _____ B. WING _____	R-C 03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE BAY REHAB AND CARE CENTER	4033 BEAVER LANE PORT CHARLOTTE, FL 33952

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{F 000}	INITIAL COMMENTS An unannounced revisit survey was conducted at Charlotte Bay Rehab and Care Center on through , a skilled nursing facility in Port Charlotte Florida. This was the follow up to the recertification survey conducted on . This survey was completed in conjunction with a complaint survey revisit and a new complaint survey. noncompliance at Immediate Jeopardy level (scope and severity "J") was identified at: §483.25(e) (ii) (F690). Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause injury, harm, , , or to a resident. During the survey, substandard quality of care was identified at: §483.25(e) (ii) (F690). A partial extended survey was conducted. Resident #1 was an , male admitted to the facility on with an , for prostatic hyperplasia (enlarge ,). On at approximately 5:30 a.m., Resident #1's was changed. The facility failed to monitor for , output. On at approximately 4:30 p.m., the was removed due to no , output. Resident #1 experienced copious amount of , and clots. The facility failed to monitor the resident's condition, including vital signs. On at	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1	{F 000}		

approximately 10:00 p.m., Resident #1 was emergently transferred to the hospital via Emergency Medical Services ( ). The hospital record noted upon arrival the resident was unresponsive to painful stimuli, ,, (low ,) with a temperature of 100.2 Fahrenheit (F). Resident #1 was intubated and admitted to the .

The facility's failure to adequately monitor Resident #1 with a significant change in condition resulted in the neglect of Resident #1 and created a likelihood of serious harm, serious injury or of other residents with from associated , , injury.

This failure resulted in the determination of Immediate Jeopardy (IJ).

The Immediate Jeopardy began on .

On at 4:45 p.m., the facility's Administrator was informed of the determination of Immediate Jeopardy and provided the IJ templates.

The facility census was 158 with 12 residents with .

On , after verification of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of . The scope and severity were reduced to "D", no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.

Charlotte Bay Rehab and Care Center is not in compliance with the Code of Federal Regulations

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{F 000}	Continued From page 2 (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is a description of the noncompliance: Refer to 0WYB11.	{F 000}		
{F 690} SS=J	/ , , CFR(s): 483.25(e)(1)-(3) §483.25(e) . §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain. §483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary; (ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and (iii) A resident who is of receives appropriate treatment and services to prevent and to restore to the extent possible. §483.25(e)(3) For a resident with fecal , based on the resident's	{F 690}		

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{F 690}	Continued From page 3 comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide necessary and appropriate care and services to prevent complications from an for 5 (Residents #1, #4, #5, #8 and #61) of 5 residents reviewed. The facility failed to provide care to meet the needs of 1 (Resident #999) of 3 sampled residents reviewed. Record review showed Resident #1 had a diagnosis of prostatic hyperplasia (enlarged). Resident #1 had an (inserted in the to drain). On at 5:30 a.m., Resident #1's was changed. Nursing Staff did not document confirming free flow of to verify the proper positioning of the within the . The nursing staff waited until at 4:30 p.m. to notify the practitioner of the lack of output. Upon removal of the , significant and clots were observed. The nursing staff failed to obtain vital signs, failed to monitor Resident #1 for continuous or increased and significant changes in condition warranting immediate physician's notification and interventions.	{F 690}	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: • Resident #1 no longer resides in the facility. • Residents #4, # 5, #8, & #61 had an RN assessment completed. • Resident #999 was provided with care at the time of grievance. 2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: • Current residents with an had a evaluation completed. • Current residents had an RN assessment completed including a set of vital signs and observation for output and patency. Any changes identified were communicated to the provider and family notification completed. • Facility residents with a score of 13 or greater were interviewed regarding the facility's provision of goods and services. • Facility residents with a score of	

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{F 690}	Continued From page 4 On at 10:00 p.m., Resident #1 was unresponsive and emergently transferred to an acute care hospital. The facility failure to have processes in place to ensure ongoing assessment of residents to prevent complications from created a likelihood of serious harm, serious injury, or of Resident #1 and other residents with from associated retention and from improperly inserted . This failure resulted in the determination of Immediate Jeopardy. On at 4:45 p.m., the facility Administrator was notified of the determination of Immediate Jeopardy. The findings included: Cross reference to F600, F726, F835. Review of the facility's policy and procedure titled, "Nursing- Care- ," with an effective date of and revision date of revealed, "Observe the resident for complications associated with . If the resident indicates that his or her is full or that she or she needs to (urinate), notify the physician and supervisor. Check the for unusual appearance (i.e., color, , etc.). Notify the physician or supervisor in the event of , or if the is accidentally removed. Report any complaints the resident may have of , tenderness, or in the area. Observe for other signs and symptoms of or retention. Report findings to the physician or supervisor immediately."	{F 690}	12 or less had skin evaluations completed. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: Education: • The facility's Staff Development Coordinator/Designee completed competencies with CNAs on emptying and measuring , output for residents with . This competency was conducted using a mannequin with an to simulate the actual emptying of the . • The facility's Staff Development Coordinator/Designee completed education with CNAs to ensure that any notable changes in , output for residents with and any residents experiencing a change in condition are reported immediately to the nurse. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on the necessary completion of a change in condition evaluation when the following occur: o Accidents resulting in injury, or the potential to require physician intervention. o A significant change in the resident s physical, mental, or condition such as a deterioration in health, mental,	

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{F 690}	Continued From page 5 Review of the facility's policy and procedure titled, "Nursing-Change in Condition" with an effective date of and a revision date of revealed the purpose is to identify and communicate changes in condition to the physician and other employees to implement pertinent interventions to prevent further deterioration and possibly prevent hospitalization. The procedure noted, "All staff are encouraged to promptly report any changes in condition to the charge nurse, supervisor or DNS (Director of Nursing Services)/ADNS (Assistant Director of Nursing Services) or designee immediately. This may include but not be limited to: . . . Significant change in the resident's physical, mental or , , condition such as deterioration in health, mental or , , status. This may include: Life threatening complications. Circumstances that may require a need to alter treatment. This may include . . . acute condition or worsening of condition. A complete assessment may need to be conducted of all systems including but not limited to . . . (,)/ evaluation . . . Vital signs. The Physician/Nurse Practitioner shall be made aware of the condition change and pertinent assessment findings. The resident shall be monitored until condition significantly improves. . ." 1. Review of the clinical record revealed Resident #1 was admitted to the facility from an acute care hospital on . Diagnoses included prostatic hyperplasia (enlarged ,). Resident #1 was admitted with a (,) . The admission physician orders as of included to change the once a month as	{F 690}	or , , status. o This may include life-threatening conditions, or clinical complications and changes in , output including color, consistency, and output. o Circumstances that may require a need to alter treatment. This may include new treatment and/or discontinue of current treatment due to an acute condition or a worsening of a condition. o A complete nursing evaluation must be conducted and documented in the medical record of systems including but not limited to functional status, , , evaluation, , evaluation, evaluation/ , , / evaluation, skin evaluation, , evaluation, and vital signs. o The physician/NP shall be made aware of pertinent evaluation findings. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on vital sign documentation, and on following timely transfer to a higher level of care upon directive from physician. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on care to include insertion, monitoring output, and proper documentation of output, including documenting this output on the resident's MAR. The licensed nurse must perform a	

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{F 690}	Continued From page 6 needed for "dislodge or leaks", measure and record the 's output every shift. On at 9:20 a.m., in an interview Registered Nurse Staff E said the facility's policy is for the nurses to get the output from the Certified Nursing Assistants (CNAs) every shift and document on the Treatment Administration Record (TAR). Review of the TAR for revealed the output documented on the TAR differed from the output documented by the CNAs. The output documented on the TAR showed: On the output was 250 cc (night shift). On the output was 50 cc (day shift), and 400 cc (night shift). On the output was 350 cc (day shift), and 400 cc (night shift). On the output was 400 cc (day shift), and 250 cc (night shift). On the output was 250 cc (day shift), and 300 cc (night shift). On the output was 800 cc (day shift), and 200 cc (night shift). No output was documented on the TAR for . Review of the CNAs output documentation for Resident #1 showed: : 1400 cc. : 700 cc. : "Response not required." : 1000 cc. : 1050 cc. No output was documented for , and . The CNA documentation and the Licensed	{F 690}	visual observation of the color and clarity of output each shift. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on the nurses' requirement to notify the provider of any notable changes in resident condition. • The facility's Staff Development Coordinator/Designee completed competencies with licensed nurses on the proper insertion of with return demonstrations. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on the requirement of detailed communication during shift to shift report to include any changes in condition, any new physician orders, and review of any new or existing devices including . • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on ensuring new orders for include placement, patency/draining, irrigation, securement device, care Qshift, and to record the output Qshift. • The facility's Staff Development Coordinator completed competencies on the proper insertion of with return demonstrations for staff A,B,C, & D. • The facility's Staff Development Coordinator/Designee completed education on the identification of a change in condition with staff A,B,C, & D. • The facility's Staff Development	

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{F 690}	Continued From page 7 Nurses documentation on the TAR showed no output was documented after 12:00 a.m., on . Review of the physician's order dated at 5:59 p.m., revealed to, "Change once a month as needed, one time a day starting on the 28th and ending on the 28th every month AND as needed for dislodge or leaks." On the TAR showed LPN Staff B changed Resident #1's . The clinical record lacked documentation of the size of the re-inserted, observation of flow verifying the was positioned in the or how the resident tolerated the procedure. On at 10:00 a.m., in a telephone interview LPN Staff B said she followed the physician's order to change Resident #1's . On at approximately 5:30 a.m., when she changed the , there was no in the drainage bag. She said she got "a small amount of return" when she inserted the and no . She verified she left work on at 7:00 a.m., Resident #1 had no in the drainage bag. She did not write a progress note for the change, including the "small amount of return". On at 2:00 p.m. in an interview LPN Staff D (Unit Manager) said she was assigned to Resident #1 on from 7:00 a.m., until 2:00 p.m. She said LPN Staff B never told her Resident #1 had no output. She said she could not remember if she checked the resident's bag for output that day. She left work on at 2:00 p.m., and the CNA who	{F 690}	Coordinator/Designee completed education with CNAs on completing the required ADL documentation. • The facility's Staff Development Coordinator/Designee completed education with Nurse Unit Managers and RN Weekend Supervisor on monitoring the completion of ADL documentation. System Change: • output was added to the MAR to ensure nursing documentation. • CNAs will be responsible for emptying output for residents with and will report this number to the licensed nurse, who then will be responsible for recording the output value on the MAR three times a day. • The facility added to the orientation agenda that all newly hired licensed nurses will complete competencies on the proper insertion of with return demonstration prior to providing resident care. • The facility implemented staff huddles lead by Nurse Unit Managers to address ADL documentation completion. 4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur: • The facility initiated the completion of audits seven days a week including weekends and off hours on all residents to ensure vital sign orders and the proper documentation of these vital signs. These audits will be monitored by DON/designee	

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{F 690}	Continued From page 8 worked with Resident #1 was supposed to empty the drainage bag around 3:00 p.m. The next nursing progress note was dated at 10:59 p.m., for an effective date of at 5:00 p.m. LPN Staff A documented that Resident #1's was removed per the Advanced Practice Registered Nurse (APRN) order due to , clots, and no output. The nurse documented, "order given to monitor output for a couple of hours if no and clots continue send resident to ER (Emergency Room) for further evaluation." Review of the physician's orders revealed LPN Staff A did not transcribe the APRN's order until at 10:02 p.m., five hours after receiving the order. The order read, "Send out to ER (Emergency Room) if resident does not within a couple hours." On at 1:00 p.m., in a telephone interview the APRN said on at 4:15 p.m., LPN Staff C sent her a text message to let her know Resident #1 had no output. She told the nurse to irrigate the and call her . They told her Resident #1 passed clots when they tried to irrigate the . She gave an order to remove and reinsert the . When they removed the , copious amount of came out. She told them to hold the . She gave the order to wait an hour, call her or send the resident to the ER if the resident did not urinate or continued to pass clots. She said she never told the nurse to wait for two hours. Staff never told her Resident #1 had no output for more than eight hours. She would have sent the resident to the hospital immediately.	{F 690}	and reviewed by the QAPI committee. These audits will be completed weekly x 4 weeks, biweekly x 2 months, then monthly thereafter until substantial compliance is determined by the QAPI committee. • The facility initiated the completion of audits seven days a week including weekends documentation of output for all residents with . These audits will be monitored by DON/designee and reviewed by the QAPI committee. These audits will be completed weekly x 4 weeks, biweekly x 2 months, then monthly thereafter until substantial compliance is determined by the QAPI committee. • The daily clinical meeting form was edited to include: o Review of 24-hour report for change in condition. o The review of vital signs and the timely transfer of all residents that returned to the hospital. o The review of all new admissions and existing residents with to ensure orders to monitor output are in place. o The review of vital signs and the review of the nurse's change of condition evaluation for all residents that had a change in condition. o The review of vital signs for all residents per physician order. o The review of PCC ADL Documentation	

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{F 690}	Continued From page 9 On at 1:30 p.m., in a telephone interview LPN Staff C said on at approximately 3:30 p.m., he observed Staff A attempting to irrigate Resident #1's . The APRN was giving orders. He said there was no in the drainage bag. He removed Resident #1's and a copious amount of and clots came out. The APRN gave an order to LPN Staff A to stop all (medications to prevent formation of clots) and send the resident to the Emergency Room if he kept or had no output. LPN Staff C said he did not know Resident #1 had no output since the previous night. On at 3:00 p.m., in an interview LPN Staff A said on Resident #1's spouse told her there was no in the drainage bag. She checked on Resident #1 on at approximately 4:00 p.m., and verified the drainage bag was empty. She said no one told her the resident had no output all day. On at 11:36 p.m., LPN Staff B documented in a progress note for an effective date of at 10:00 p.m., she received report from the dayshift nurse to send Resident #1 to the hospital per the APRN order if Resident #1 was not able to and clots continues. Staff B documented, "clots continued, no , (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified." Review of the (emergency medical services) Prehospital Care Report revealed the unit was notified by dispatch on at 9:51 p.m. The primary complaint type was "unresponsive", and "other. from penis with large	{F 690}		

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{F 690}	Continued From page 10 clots." The date and time of symptom onset was at 6:07 p.m. The narrative noted Resident #1 was found lying supine (up) in bed with facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a , (,) removed and since has been having penile , with clots and was recommended by the facility provider to call if the does not improve. The nurse also stated that she's been unable to wake patient up, patient is normally awake and verbal. Last seen normal three hours ago. documented that the resident was unresponsive, breathing fast with a radial , skin hot and clammy, noted on abdomen. Review of the hospital record revealed Resident #1 was initially seen in the ER on at 10:22 p.m. The ER physician documented Resident #1 came from the facility with and hematuria. found the patient with a temperature of 100.2, , rate of 30, rate between 100 and 120, and initial room air (,) saturation of 86%, improved to 98% on 6 Liters (,) . "Patient arrives he is moaning with movement only, responding only with moaning to painful stimuli." On at 8:30 a.m., in an interview LPN Staff B verified on at 5:30 a.m., there was no in Resident #1's , bag before she changed the and when she left work on at 7:00 a.m. When she returned to work on at 7:00 p.m., LPN Staff A told her Resident #1 had no output since the previous evening. He only passed and clots when they tried to irrigate the . She said	{F 690}		

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{F 690}	Continued From page 11	{F 690}		

Resident #1 was alert but when arrived. She could not remember when Resident #1 became . She verified there was no documentation she monitored Resident #1's for changes in condition, including continuous or increase , vital signs, and physician's notification Resident #1 had no output for more than eight hours.

On at 4:10 p.m., a interview was conducted with the Administrator, the Director of Nursing (DON) and the Regional Nurse Consultant to discuss Resident #1's care and services related to the and emergent transfer to the hospital on .
The Regional Nurse Consultant said she could not argue the fact that there was no vital signs taken and no assessment documented for Resident #1.
The DON said she interviewed the nurses as part of the investigation but did not interview the CNAs. She verified that no corrective actions were implemented related to the lack of assessment, vital signs, timely physician notification of pertinent findings, and change in condition. The DON said the nurses are required to notify the supervisor in charge for any resident's change in condition. She said she could not remember if she was the supervisor on call on .

2. Review of the clinical record for Resident #5 revealed an admission date of . Resident #5 was a male. Diagnoses included and (blocked flow). Resident #5 had an

The physician's orders dated included to monitor the output every shift.

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	105363	A. BUILDING _____ B. WING _____	R-C 03/22/2025

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CHARLOTTE BAY REHAB AND CARE CENTER	4033 BEAVER LANE PORT CHARLOTTE, FL 33952

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{F 690}	Continued From page 12 On , review of the TAR for failed to show documentation of output on for the 7:00 p.m., to 7:00 a.m. shift. 3. Review of the clinical record for Resident #4 revealed an admission date of . Resident #4 was an male. Diagnoses included , hematuria (in), and prostatic hyperplasia. Resident #4 had an The physician's orders dated included to monitor the resident's output every shift. Review of the TAR for failed to reveal documentation of output on , and for the 7:00 a.m., to 7:00 p.m. shift. 4. Review of the clinical record for Resident #61 revealed an admission date of . Resident #61 was a female. Diagnoses included , and . Resident #61 had an . The physician's orders dated included to monitor the resident's output every shift. Review of the TAR for failed to show documentation of output for , for the 7:00 a.m., to 7:00 p.m. shift, and on for the 7:00 p.m., to 7:00 a.m. shift. 5. Review of the clinical record for Resident #8 revealed an admission date of . Resident #8 was an male. Diagnoses included of the ( ), and . Resident #8 had an . The physician's orders dated included to monitor output every shift. Review of the TAR for failed to show	{F 690}		

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{F 690}	Continued From page 13 documentation of output for and for the 7:00 a.m. shift, to 7:00 p.m. shift. On at approximately 5:00 p.m., in an interview the Director of Nursing said she had not reviewed the clinical records of current residents with and physician's order to monitor output every shift. The DON said she was not aware staff were not monitoring the output as ordered by the physician. Review of the clinical record for Resident #999 revealed and admission date of . Diagnoses included nondisplaced of the right and of . The Nursing Admission evaluation dated noted the resident was alert, oriented to person, place, time and situation. Resident #999 was friendly, , , talkative and answered questions readily. The assessment noted the resident was of and a three day diary was initiated. The care plan initiated on revealed the resident has activities of daily living self-care	{F 690}		

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{F 690}	Continued From page 14 related to of the right , general , , mobility, , and , the interventions noted Resident #999 required assistance by staff for toileting. Review of the CNA documentation in the electronic clinical record revealed instruction to document every hour. There was one entry on the diary for , seven entries on , no entries on or . The CNA documentation for total number of showed no entries On , , and for the morning shift. On for the night shift the documentation showed, "Response not required." On at 1:15 p.m., in an interview Resident #999 said she was of . When she uses the call light to request toileting assistance, "they do not come to help." Resident #999 said no one has come to speak to her regarding the grievance her daughter voiced on . On at 1:30 p.m., in an interview CNA Staff Z said Resident #999 does not refuse care. She last changed her at 10:00 a.m. She said Resident #999 always says "not right now, I am dry" when she asks if she needs to be changed. Review of the grievance log revealed on Resident #999's daughter filed a grievance that she found her mother laying in and feces at 2:00 p.m. The grievance form noted it was assigned to the Assistant Director of Nursing (ADON) for	{F 690}		

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{F 690}	Continued From page 15	{F 690}		

investigation and resolution on , three days after the grievance was filed. The grievance investigation noted the assigned CNA had to find another staff member to assist so he had to wait. In the meantime he went to answer a call light. By the time he went to the resident's room, the other CNAs were attending to her.
The form noted the resident was satisfied with the care provided. Resident #999 felt the facility needed more staff.
The form noted the results of the grievance investigation were communicated verbally to Resident #999. No date or time was entered for the verbal communication with the resident.

On at approximately 2:15 p.m., the ADON said the Unit Manager was responsible to ensure the residents received care.

On at approximately 2:30 p.m., in an interview the B wing Unit Manager said she did not know how to check the diary documentation for Resident #999.

On after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of .

The Immediate actions implemented by the facility and verified by the survey team included:

On the facility completed a 100% audit of 155 residents to ensure that all residents have

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{F 690}	Continued From page 16	{F 690}		

physician's orders for vital signs in place that were transcribed to their medication administration record (MAR). Long term care residents have vitals assessed and documented weekly. Short term rehab residents' vitals are obtained daily.

On the surveyor verified through record review of 3 randomly selected residents the facility was obtaining and recording the vital signs on the MAR.

On the facility reviewed all orders. output was added to the MAR on to ensure nursing documentation.

On the facility began CNA competencies on emptying and measuring from with reporting of amount to the nurse. As of , CNAs had completed the competency.

On the surveyor confirmed through interviews with 3 CNAs at the facility, they were re-educated on , observing the character, measuring and reporting amount to the nurse immediately with any notable changes.

On the licensed nurses were re-educated on when they complete a change in condition assessment: Accidents with injury, significant changes in mental and physical condition such as deterioration in health, mental or , status; life threatening conditions or clinical complications and changes in output including color, consistency and output; circumstances requiring alteration in treatment including acute changes and worsening of a condition. A complete nursing evaluation

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{F 690}	Continued From page 17 must be conducted and documented in the medical record of systems including but not limited to functional, , skin, and vital signs. Vital signs must be documented at the time of the change and timely transfer of resident upon direction from the provider. care to include insertion, monitoring and documenting output, and visualization of the for color and clarity during each shift. Notify provider of any changes. On 48 out of 50 nurses received the re-education. All remaining nurses would be educated prior to working the next shift. On the facility began auditing resident records for vital sign orders and proper documentation and output for all residents with . On the surveyor verified through selection of 3 random residents the facility was obtaining vital signs and documenting them on the MARS. Three residents with were reviewed for documentation including order and measuring and documenting amount each shift. On the daily clinical meeting form was edited to include review of the 24-hour report for change in condition; vital signs and timely transfer to a higher level if necessary; for new and existing residents to ensure orders to monitor output were in place; review of the nurses' Change in condition Assessment to include current vital signs during the change, and review of the vital signs for all residents per the physician's orders.	{F 690}		

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{F 690}	Continued From page 18 On the RN assessed all residents currently at the facility for vital signs and output if indicated. Any changes were communicated to the provider and family. On the facility began verifying competencies on the proper insertion of licensed nurses had completed by . The remaining licensed nurses would complete the competency prior to working their next scheduled shift. On the facility added to the orientation agenda for newly hired licensed nurses they will complete competency on the proper insertion of with return demonstration prior to resident care. On an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Director, Minimum Data Set nurse, Nurse, CNA. On the surveyor verified through interview of the DON and audits completed and review of 3 random resident records the facility was ensuring proper care and services for residents with	{F 690}		

Agency for Health Care Administration

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{N 000}	INITIAL COMMENTS An unannounced follow-up survey to a recertification survey on was conducted on through at Charlotte Bay Rehab and Care Center, a skilled nursing facility in Port Charlotte, Florida. Resident #1 was an male admitted to the facility on with an for prostatic Hyperplasia (enlarge ,). On at approximately 5:30 a.m., Resident #1's was changed. The facility failed to monitor for output. On at approximately 4:30 p.m., the was removed due to no output. Resident #1 experienced copious amount of and clots. The facility failed to monitor the resident's condition, including vital signs. On at approximately 10:00 p.m., Resident #1 was emergently transferred to the hospital via Emergency Medical Services ( ). The hospital record noted upon arrival the resident was unresponsive to painful stimuli, hypertensive (low ,) with a temperature of 100.2 Fahrenheit (F). Resident #1 was intubated and admitted to the . The facility's failure to adequately monitor Resident #1 with a significant change in condition resulted in the neglect of Resident #1 and created a likelihood of serious harm, serious injury or of other residents with from associated , , or injury. This failure resulted in the determination of Class I deficiencies at N201 and N204. Class I deficiencies are those which the agency determines present an imminent danger to the residents or guests of the facility or a substantial	{N 000}		

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{N 000}	Continued From page 1 probability that or serious physical harm would result therefrom. On at 4:45 p.m., the facility's Administrator was informed of the determination of the Class I deficiencies. The facility census was 158 with 12 residents with The following is a description of the deficiencies.	{N 000}		
{N 201} SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide necessary and appropriate care and services to prevent complications from an for 5 (Residents #1, #4, #5, #8 and #61) of 5 residents reviewed. The facility failed to provide care to meet the needs of 1 (Resident #999) of 3 sampled residents reviewed. Record review showed Resident #1 had a diagnosis of prostatic hyperplasia (enlarged). Resident #1 had an	{N 201}	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: >Resident #1 no longer resides in the facility. >Residents #4, # 5, #8, & #61 had an RN assessment completed. >Resident #999 was provided with care at the time of grievance. 2) How you will identify other residents	

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{N 201}	Continued From page 2 (inserted in the to drain). On at 5:30 a.m., Resident #1's was changed. Nursing Staff did not document confirming free flow of to verify the proper positioning of the within the . The nursing staff waited until at 4:30 p.m. to notify the practitioner of the lack of output. Upon removal of the , significant and clots were observed. The nursing staff failed to obtain vital signs, failed to monitor Resident #1 for continuous or increased and significant changes in condition warranting immediate physician's notification and interventions. On at 10:00 p.m., Resident #1 was unresponsive and emergently transferred to an acute care hospital. The facility failure to have processes in place to ensure ongoing assessment of residents to prevent complications from created a likelihood of serious harm, serious injury, or of Resident #1 and other residents with from associated , , retention and from improperly inserted . This failure resulted in the determination of Immediate Jeopardy. On at 4:45 p.m., the facility Administrator was notified of the determination of Immediate Jeopardy. The findings included: Cross reference to F600, F726, F835.	{N 201}	having potential to be affected by the same practice and what corrective actions will be taken: >Current residents with an had a evaluation completed. >Current residents had an RN assessment completed including a set of vital signs and observation for output and patency. Any changes identified were communicated to the provider and family notification completed. >Facility residents with a score of 13 or greater were interviewed regarding the facility's provision of goods and services. >Facility residents with a score of 12 or less had skin evaluations completed. 3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: Education: >The facility's Staff Development Coordinator/Designee completed competencies with CNAs on emptying and measuring output for residents with . This competency was conducted using a mannequin with an to simulate the actual emptying of the . >The facility's Staff Development Coordinator/Designee completed education with CNAs to ensure that any notable changes in output for residents with and any residents experiencing a change in	

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{N 201}	Continued From page 3 Review of the facility's policy and procedure titled, "Nursing- Care- ," with an effective date of and revision date of revealed, "Observe the resident for complications associated with . If the resident indicates that his or her is full or that she or she needs to (urinate), notify the physician and supervisor. Check the for unusual appearance (i.e., color, , etc.). Notify the physician or supervisor in the event of , or if the is accidentally removed. Report any complaints the resident may have of , tenderness, or in the area. Observe for other signs and symptoms of or retention. Report findings to the physician or supervisor immediately." Review of the facility's policy and procedure titled, "Nursing-Change in Condition" with an effective date of and a revision date of revealed the purpose is to identify and communicate changes in condition to the physician and other employees to implement pertinent interventions to prevent further deterioration and possibly prevent hospitalization. The procedure noted, "All staff are encouraged to promptly report any changes in condition to the charge nurse, supervisor or DNS (Director of Nursing Services)/ADNS (Assistant Director of Nursing Services) or designee immediately. This may include but not be limited to: . . . Significant change in the resident's physical, mental or , condition such as deterioration in health, mental or , status. This may include: Life threatening complications. Circumstances that may require a need to alter treatment. This may include . . . acute condition or worsening of condition. A complete assessment may need to be conducted of all	{N 201}	condition are reported immediately to the nurse. >The facility's Staff Development Coordinator/Designee completed education with licensed nurses on the necessary completion of a change in condition evaluation when the following occur: o Accidents resulting in injury, or the potential to require physician intervention. o A significant change in the resident s physical, mental, or , condition such as a deterioration in health, mental, or , status. o This may include life-threatening conditions, or clinical complications and changes in output including color, consistency, and output. o Circumstances that may require a need to alter treatment. This may include new treatment and/or discontinue of current treatment due to an acute condition or a worsening of a condition. o A complete nursing evaluation must be conducted and documented in the medical record of systems including but not limited to functional status, , evaluation, evaluation, evaluation/ , / evaluation, skin evaluation, , evaluation, and vital signs. o The physician/NP shall be made aware of pertinent evaluation findings.	

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{N 201}	Continued From page 4 systems including but not limited to . . . ( )/ evaluation . . . Vital signs. The Physician/Nurse Practitioner shall be made aware of the condition change and pertinent assessment findings. The resident shall be monitored until condition significantly improves. . ." 1. Review of the clinical record revealed Resident #1 was admitted to the facility from an acute care hospital on . Diagnoses included prostatic hyperplasia (enlarged ,). Resident #1 was admitted with a ( ) The admission physician orders as of included to change the once a month as needed for "dislodge or leaks", measure and record the 's output every shift. On at 9:20 a.m., in an interview Registered Nurse Staff E said the facility's policy is for the nurses to get the output from the Certified Nursing Assistants (CNAs) every shift and document on the Treatment Administration Record (TAR). Review of the TAR for revealed the output documented on the TAR differed from the output documented by the CNAs. The output documented on the TAR showed: On the output was 250 cc (night shift). On the output was 50 cc (day shift), and 400 cc (night shift). On the output was 350 cc (day shift), and 400 cc (night shift). On the output was 400 cc (day shift), and 250 cc (night shift).	{N 201}	>The facility's Staff Development Coordinator/Designee completed education with licensed nurses on vital sign documentation, and on following timely transfer to a higher level of care upon directive from physician. >The facility's Staff Development Coordinator/Designee completed education with licensed nurses on care to include insertion, monitoring output, and proper documentation of output, including documenting this output on the resident's MAR. The licensed nurse must perform a visual observation of the color and clarity of output each shift. >The 's Staff Development Coordinator/Designee completed education with licensed nurses on the nurses requirement to notify the provider of any notable changes in resident condition. >The facility's Staff Development Coordinator/Designee completed competencies with licensed nurses on the proper insertion of with return demonstrations. >The facility's Staff Development Coordinator/Designee completed education with licensed nurses on the requirement of detailed communication during shift to shift report to include any changes in condition, any new physician orders, and review of any new or existing devices including . >The facility's Staff Development Coordinator/Designee completed education with licensed nurses on ensuring new orders for include placement, patency/draining, irrigation,	

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{N 201}	Continued From page 5 On the output was 250 cc (day shift), and 300 cc (night shift). On the output was 800 cc (day shift), and 200 cc (night shift). No output was documented on the TAR for . Review of the CNAs output documentation for Resident #1 showed: : 1400 cc. : 700 cc. : "Response not required." : 1000 cc. : 1050 cc. No output was documented for , and . The CNA documentation and the Licensed Nurses documentation on the TAR showed no output was documented after 12:00 a.m., on . Review of the physician's order dated at 5:59 p.m., revealed to, "Change once a month as needed, one time a day starting on the 28th and ending on the 28th every month AND as needed for dislodge or leaks." On the TAR showed LPN Staff B changed Resident #1's . The clinical record lacked documentation of the size of the re-inserted, observation of flow verifying the was positioned in the or how the resident tolerated the procedure. On at 10:00 a.m., in a telephone interview LPN Staff B said she followed the physician's order to change Resident #1's . On at approximately 5:30 a.m., when she changed the , there was no in the drainage bag. She said she got "a small amount	{N 201}	securement device, care Qshift, and to record the output Qshift. >The facility's Staff Development Coordinator completed competencies on the proper insertion of with return demonstrations for staff A,B,C, & D. >The facility's Staff Development Coordinator/Designee completed education on the identification of a change in condition with staff A,B,C, & D. >The facility's Staff Development Coordinator/Designee completed education with CNAs on completing the required ADL documentation. >The facility's Staff Development Coordinator/Designee completed education with Nurse Unit Managers and RN Weekend Supervisor on monitoring the completion of ADL documentation. System Change: > output was added to the MAR to ensure nursing documentation. >CNAs will be responsible for emptying output for residents with and will report this number to the licensed nurse, who then will be responsible for recording the output value on the MAR three times a day. >The facility added to the orientation agenda that all newly hired licensed nurses will complete competencies on the proper insertion of with return demonstration prior to providing resident care. >The facility implemented staff huddles lead by Nurse Unit Managers to address ADL documentation completion.	

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{N 201}	Continued From page 6	{N 201}		

of return" when she inserted the and no . She verified she left work on at 7:00 a.m., Resident #1 had no in the drainage bag. She did not write a progress note for the change, including the "small amount of return".

On at 2:00 p.m. in an interview LPN Staff D (Unit Manager) said she was assigned to Resident #1 on from 7:00 a.m., until 2:00 p.m. She said LPN Staff B never told her Resident #1 had no output. She said she could not remember if she checked the resident's bag for output that day. She left work on at 2:00 p.m., and the CNA who worked with Resident #1 was supposed to empty the drainage bag around 3:00 p.m.

The next nursing progress note was dated at 10:59 p.m., for an effective date of at 5:00 p.m. LPN Staff A documented that Resident #1's was removed per the Advanced Practice Registered Nurse (APRN) order due to , clots, and no output. The nurse documented, "order given to monitor output for a couple of hours if no and clots continue send resident to ER (Emergency Room) for further evaluation."

Review of the physician's orders revealed LPN Staff A did not transcribe the APRN's order until at 10:02 p.m., five hours after receiving the order. The order read, "Send out to ER (Emergency Room) if resident does not within a couple hours."

On at 1:00 p.m., in a telephone interview the APRN said on at 4:15 p.m., LPN Staff C sent her a text message to let her know Resident #1 had no output. She told the

4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur:

>The facility initiated the completion of audits seven days a week including weekends and off hours on all residents to ensure vital sign orders and the proper documentation of these vital signs. These audits will be monitored by DON/designee and reviewed by the QAPI committee. These audits will be completed weekly x 4 weeks, biweekly x 2 months, then monthly thereafter until substantial compliance is determined by the QAPI committee.
>The facility initiated the completion of audits seven days a week including weekends documentation of , output for all residents with . These audits will be monitored by DON/designee and reviewed by the QAPI committee. These audits will be completed weekly x 4 weeks, biweekly x 2 months, then monthly thereafter until substantial compliance is determined by the QAPI committee.
>The daily clinical meeting form was edited to include:
o Review of 24-hour report for change in condition.
o The review of vital signs and the timely transfer of all residents that returned to the hospital.
o The review of all new admissions and existing residents with to ensure orders to monitor , output are in place.
o The review of vital signs and the

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{N 201}	Continued From page 7 nurse to irrigate the and call her . They told her Resident #1 passed clots when they tried to irrigate the . She gave an order to remove and reinsert the . When they removed the , copious amount of came out. She told them to hold the . She gave the order to wait an hour, call her or send the resident to the ER if the resident did not urinate or continued to pass clots. She said she never told the nurse to wait for two hours. Staff never told her Resident #1 had no output for more than eight hours. She would have sent the resident to the hospital immediately. On at 1:30 p.m., in a telephone interview LPN Staff C said on at approximately 3:30 p.m., he observed Staff A attempting to irrigate Resident #1's . The APRN was giving orders. He said there was no in the drainage bag. He removed Resident #1's and a copious amount of and clots came out. The APRN gave an order to LPN Staff A to stop all (medications to prevent formation of clots) and send the resident to the Emergency Room if he kept or had no output. LPN Staff C said he did not know Resident #1 had no output since the previous night. On at 3:00 p.m., in an interview LPN Staff A said on Resident #1's spouse told her there was no in the drainage bag. She checked on Resident #1 on at approximately 4:00 p.m., and verified the drainage bag was empty. She said no one told her the resident had no output all day. On at 11:36 p.m., LPN Staff B documented in a progress note for an effective	{N 201}	review of the nurse's change of condition evaluation for all residents that had a change in condition. o The review of vital signs for all residents per physician order. o The review of PCC ADL Documentation	

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{N 201}	Continued From page 8	{N 201}		

date of at 10:00 p.m., she received report from the dayshift nurse to send Resident #1 to the hospital per the APRN order if Resident #1 was not able to and clots continues. Staff B documented, "clots continued, no , (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified."

Review of the (emergency medical services) Prehospital Care Report revealed the unit was notified by dispatch on at 9:51 p.m. The primary complaint type was "unresponsive", and "other. from penis with large clots." The date and time of symptom onset was at 6:07 p.m.
The narrative noted Resident #1 was found lying supine (up) in bed with facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a ( ) removed and since has been having penile with clots and was recommended by the facility provider to call if the does not improve. The nurse also stated that she's been unable to wake patient up, patient is normally awake and verbal. Last seen normal three hours ago. documented that the resident was unresponsive, breathing fast with a radial , , skin hot and clammy, noted on abdomen.

Review of the hospital record revealed Resident #1 was initially seen in the ER on at 10:22 p.m. The ER physician documented Resident #1 came from the facility with and hematuria. found the patient with a temperature of 100.2, , rate of 30, rate between 100 and 120, and initial room air ( ) saturation of 86%, improved to 98% on 6 Liters ( ) ."Patient arrives

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{N 201}	Continued From page 9 he is moaning with movement only, responding only with moaning to painful stimuli." On at 8:30 a.m., in an interview LPN Staff B verified on at 5:30 a.m., there was no in Resident #1's bag before she changed the and when she left work on at 7:00 a.m. When she returned to work on at 7:00 p,m., LPN Staff A told her Resident #1 had no output since the previous evening. He only passed and clots when they tried to irrigate the . She said Resident #1 was alert but when arrived. She could not remember when Resident #1 became . She verified there was no documentation she monitored Resident #1's for changes in condition, including continuous or increase , vital signs, and physician's notification Resident #1 had no output for more than eight hours. On at 4:10 p.m., a interview was conducted with the Administrator, the Director of Nursing (DON) and the Regional Nurse Consultant to discuss Resident #1's care and services related to the and emergent transfer to the hospital on . The Regional Nurse Consultant said she could not argue the fact that there was no vital signs taken and no assessment documented for Resident #1. The DON said she interviewed the nurses as part of the investigation but did not interview the CNAs. She verified that no corrective actions were implemented related to the lack of assessment, vital signs, timely physician notification of pertinent findings, and change in condition. The DON said the nurses are required to notify the supervisor in charge for any resident's change in condition. She said she	{N 201}		

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{N 201}	Continued From page 10 could not remember if she was the supervisor on call on . 2. Review of the clinical record for Resident #5 revealed an admission date of . Resident #5 was a male. Diagnoses included and , (blocked flow). Resident #5 had an . The physician's orders dated included to monitor the output every shift. On , review of the TAR for failed to show documentation of output on for the 7:00 p.m., to 7:00 a.m. shift. 3. Review of the clinical record for Resident #4 revealed an admission date of . Resident #4 was an male. Diagnoses included , hematuria (in), and prostatic hyperplasia. Resident #4 had an . The physician's orders dated included to monitor the resident's output every shift. Review of the TAR for failed to reveal documentation of output on , and for the 7:00 a.m., to 7:00 p.m. shift. 4. Review of the clinical record for Resident #61 revealed an admission date of . Resident #61 was a female. Diagnoses included , and , . Resident #61 had an . The physician's orders dated included to monitor the resident's output every shift. Review of the TAR for failed to show documentation of output for , for the 7:00 a.m., to 7:00 p.m. shift, and on for the 7:00 p.m., to 7:00 a.m. shift.	{N 201}		

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{N 201}	Continued From page 11 5. Review of the clinical record for Resident #8 revealed an admission date of . Resident #8 was an male. Diagnoses included of the ( ), and . Resident #8 had an . The physician's orders dated included to monitor output every shift. Review of the TAR for failed to show documentation of output for and for the 7:00 a.m. shift, to 7:00 p.m. shift. On at approximately 5:00 p.m., in an interview the Director of Nursing said she had not reviewed the clinical records of current residents with and physician's order to monitor output every shift. The DON said she was not aware staff were not monitoring the output as ordered by the physician. Review of the clinical record for Resident #999 revealed and admission date of . Diagnoses included nondisplaced of the right and of .	{N 201}		

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{N 201}	Continued From page 12 The Nursing Admission evaluation dated noted the resident was alert, oriented to person, place, time and situation. Resident #999 was friendly, , , talkative and answered questions readily. The assessment noted the resident was of and a three day diary was initiated. The care plan initiated on revealed the resident has activities of daily living self-care related to of the right , general , , mobility, , and , . the interventions noted Resident #999 required assistance by staff for toileting. Review of the CNA documentation in the electronic clinical record revealed instruction to document every hour. There was one entry on the diary for , seven entries on , no entries on or . The CNA documentation for total number of showed no entries On , , and for the morning shift. On for the night shift the documentation showed, "Response not required." On at 1:15 p.m., in an interview Resident #999 said she was of . When she uses the call light to request toileting assistance, "they do not come to help." Resident #999 said no one has come to speak to her regarding the grievance her daughter voiced on . On at 1:30 p.m., in an interview CNA Staff Z said Resident #999 does not refuse care.	{N 201}		

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{N 201}	Continued From page 13 She last changed her at 10:00 a.m. She said Resident #999 always says "not right now, I am dry" when she asks if she needs to be changed. Review of the grievance log revealed on Resident #999's daughter filed a grievance that she found her mother laying in and feces at 2:00 p.m. The grievance form noted it was assigned to the Assistant Director of Nursing (ADON) for investigation and resolution on , three days after the grievance was filed. The grievance investigation noted the assigned CNA had to find another staff member to assist so he had to wait. In the meantime he went to answer a call light. By the time he went to the resident's room, the other CNAs were attending to her. The form noted the resident was satisfied with the care provided. Resident #999 felt the facility needed more staff. The form noted the results of the grievance investigation were communicated verbally to Resident #999. No date or time was entered for the verbal communication with the resident. On at approximately 2:15 p.m., the ADON said the Unit Manager was responsible to ensure the residents received care. On at approximately 2:30 p.m., In an interview the B wing Unit Manager said she did not know how to check the diary documentation for Resident #999. Class I	{N 201}		