

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 80804	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/22/2025
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NAME OF PROVIDER OR SUPPLIER CHARLOTTE BAY REHAB AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4033 BEAVER LANE PORT CHARLOTTE, FL 33952
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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N 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey for complaint #2025002491, #2025002946, and #2025003458 was conducted on _____ through _____ at Charlotte Bay Rehab and Care Center, a skilled nursing facility in Port Charlotte, Florida.</p> <p>Complaint #2025002946 was unsubstantiated.</p> <p>Complaint #2025003458 was substantiated with a citation at N201.</p> <p>Complaint #2025002491 was substantiated with citations at N201, and N204.</p> <p>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 residents' 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, _____ (low _____) with a temperature of 100.2 Fahrenheit (F). Resident #1 was intubated and admitted to the _____.</p> <p>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 _____.</p>	N 000		
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AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: _____ TITLE: _____ (X8) DATE: _____
Electronically Signed _____ /25

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N 000	<p>Continued From page 1</p> <p>from associated , or injury. This failure resulted in the determination of Class I deficiencies at N201 and N204.</p> <p>Class I deficiencies are those which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that or serious physical harm would result therefrom.</p> <p>On at 4:45 p.m., the facility's Administrator was informed of the determination of the Class I deficiencies.</p> <p>The facility census was 158 with 12 residents with</p> <p>The following is a description of the deficiencies.</p>	N 000		
N 204 SS=J	<p>400.022(1)(o), FS Right to be Free from , etc</p> <p>400.022, F. S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following:</p> <p>(o) The right to be free from mental and , neglect, corporal punishment, extended involuntary , and , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are</p>	N 204		

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N 204	<p>Continued From page 2</p> <p>necessitated by an emergency. In case of an emergency, _____ may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of _____, and, in the case of use of a chemical _____, a physician shall be consulted immediately thereafter. _____ may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review, review of facility's policies and procedures, family members and staff interviews, the facility failed to protect residents' rights to be free from neglect, by failing to appropriately monitor the _____ output after insertion of an _____ and failing to monitor the resident's condition with acute onset of copious _____, and clots for 1 (Resident #1) of 5 residents with _____ reviewed.</p> <p>Resident #1 was admitted to the facility on _____ with diagnoses including prostatic hyperplasia (enlarged _____). Resident #1 had an _____ (_____ inserted in the _____ to drain _____).</p> <p>On _____ at approximately 5:30 a.m., Resident #1's _____ was changed. There was no documentation Resident #1 was monitored to ensure the _____ was properly inserted and draining.</p> <p>On _____ at approximately 4:30 p.m., Resident #1 had no _____ output. The _____ was removed. Resident #1 experienced copious</p>	N 204	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> Resident #1 is no longer a resident. An AHCA Federal Immediate Report with a corresponding investigation was completed by the facility prior to this survey. <p>2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p> <ul style="list-style-type: none"> 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. 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 	
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N 204	<p>Continued From page 3</p> <p>amount of _____ and clots. There was no documentation the facility monitored Resident #1's status, including obtaining vital signs (temperature, _____ and _____) with the acute change in condition.</p> <p>On _____ at approximately 10:00 p.m., Resident #1 was emergently transferred to an acute care hospital. The resident was unresponsive, had no _____ output and was _____.</p> <p>The facility's failure to provide the necessary care and services to prevent neglect created a likelihood of serious harm, injury, or _____ of Resident #1 and other residents with an _____ from _____ associated complications, including _____ from _____ insertion, _____, and _____.</p> <p>This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of _____ (J) starting on _____.</p> <p>On _____ at 4:45 p.m., the Administrator was informed of the determination of Immediate Jeopardy.</p> <p>The findings included:</p> <p>Review of the facility's policy and procedures titled, " _____, Neglect, _____, Misappropriation, Mistreatment, Injury of unknown source and Investigations" with an effective date of _____ revealed, "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, _____, mental anguish, or emotional distress . . . The facility shall conduct their own internal investigation including but not limited to staff . . .</p>	N 204	<p>provider and family notification completed.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</p> <p>Education:</p> <ul style="list-style-type: none"> • The facility's Administrator and Director of Nursing were reeducated by Regional Nurse Consultant on: <ul style="list-style-type: none"> o The components of the regulation: F600 Free from _____ and Neglect o _____, Neglect, _____, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) with indicators of neglect. o Facility standard and guideline P&P Neglect and Investigations to include: <ul style="list-style-type: none"> o Screening o Training o Prevention o Identification o Investigation o Protection o Reporting • The facility's Staff Development Coordinator/Designee completed education with facility staff on _____ and Neglect with an emphasis on the following F600 noncompliance: The facility failed to protect resident rights to be free from neglect by failing to appropriately monitor the resident's _____ output and failure to monitor the resident when the _____ was discontinued. On _____ at approximately 4:30 p.m. resident's _____ was discontinued. Resident _____ 	
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N 204	<p>Continued From page 4</p> <p>resident, and family/resident representative interview, medical record reviews, 24 hours reports reviews, full body skin exam, etc. The resident's representative and physician should be notified that there is an on-going investigation regarding the alleged incident . . . The facility shall take all necessary corrective actions depending on the results of their investigation and must notify the proper agencies as well as licensing authorities any incidents that would indicate an employee is unfit for service. The facility shall analyze the occurrences to determine what changes are needed, if any, to the resident's care plan or policies and procedures to prevent further occurrences."</p> <p>Review of the facility's policy and procedures titled, "Nursing- Care-" with an effective date of and a revision date of revealed, "Observe the resident for complications associated with . . . Check the for unusual appearance (i.e., color, , etc.) . . . Notify the physician or supervisor in the event of . . . , or if the is accidentally removed . . . Observe for signs and symptoms of or retention. Report findings to the physician or supervisor immediately . . ."</p> <p>Review of the clinical record revealed Resident #1 was admitted to the facility on from an acute care hospital. Diagnoses included prostatic hyperplasia (enlarged ,) with symptoms. Resident #1 was admitted with an ({ inserted in the . . . to drain).</p> <p>Review of the Treatment Administration Record (TAR) for revealed on Licensed Practical Nurse (LPN) staff B changed Resident #1's</p>	N 204	<p>experienced copious and was passing clots through his penis. The facility neglected to monitor resident's status including vital signs with a significant change in condition.</p> <ul style="list-style-type: none"> 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 competencies with CNAs and licensed nurses on the proper obtaining of resident vital signs including temperature, and and on a live member of staff. Vital signs obtained for an identified change in condition will be documented in the and vitals tab in PCC. This allows for these vitals to populate accurately in the SBAR/Change in Condition evaluation. 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: 	

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N 204	<p>Continued From page 5</p> <p>The clinical record lacked documentation LPN Staff B verified the _____ was properly inserted and draining _____.</p> <p>On _____ at 10:59 p.m., LPN Staff A documented in a progress note for an effective date of _____ at 5:00 p.m., Resident #1's _____ was removed per the Advanced Practice Registered Nurse (APRN) order due to _____ and clots, 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."</p> <p>The clinical record lacked documentation Resident #1's condition was monitored, including an evaluation of the resident, amount of vital signs or _____ output.</p> <p>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." The transcribed order did not include to monitor for _____ and clots.</p> <p>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 a shift 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 continued. Staff B documented "clots continued, no _____ (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified."</p> <p>Review of the documentation in the clinical record, including licensed nurses and Certified Nursing Assistant (CNA) notes and entries revealed the last _____ output was documented</p>	N 204	<ul style="list-style-type: none"> 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. • 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 	
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N 204	<p>Continued From page 6</p> <p>on at 10:00 p.m. There was no documentation of _____ output for the night shift of _____, the day shift of _____ and the evening shift of _____.</p> <p>Review of the Emergency Medical Services () Prehospital Care Report revealed the unit was notified by dispatch on _____ at 9:51 p.m. The narrative noted Resident #1 was found lying supine (_____ up) in bed with a facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a _____ (_____) 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.</p> <p>The report noted under patient condition the primary complaint type was "unresponsive", and "other. _____ from penis with large clots."</p> <p>The date and time of symptom onset was at 6:07 p.m.</p> <p>Review of the local hospital record revealed Resident #1 was initially seen in the ER on _____ at 10:22 p.m. The ER progress note documented Resident #1 arrived at the Emergency Department from the facility for complaint of _____ clots after _____ removal. Upon _____ arrival, Resident #1 was unresponsive to painful stimuli, and had a temperature of 100.2.</p> <p>The hospital History and Physical noted, "The</p>	N 204	<p>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.</p> <ul style="list-style-type: none"> 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 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. <p>System Change:</p> <ul style="list-style-type: none"> The facility reviewed all _____ orders. _____ 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 daily clinical meeting form was edited to include: <ul style="list-style-type: none"> o Review of 24-hour report for change in condition. o The review of vital signs and the timely transfer of all 	

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N 204	<p>Continued From page 7</p> <p>nursing staff at the facility stated that due to decreased _____ output they switched the _____ out and received large amounts of and clots shortly after that the patient became unresponsive The patient was found immediately _____ and hypoxic requiring airway _____ support with _____.</p> <p>Resident #1 was admitted to the _____ with _____ support on _____.</p> <p>The assessment and plan was: _____ (life threatening _____), _____ function due to imbalance in metabolism), Hematuria (_____ in _____), _____ retention.</p> <p>Review of the facility's incident investigations revealed on _____ at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a _____ and _____ that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation of neglect and started an investigation.</p> <p>The investigation noted that on the morning of _____ Resident #1's _____ was changed per the physician order. Resident was later noted to have no _____ output and his _____ was irrigated with _____ clots observed. New orders were obtained from the APRN to remove the _____ at which time further _____ clots were noted by nursing staff. Additional orders were then obtained to hold _____ and _____ (prevents clots from forming) and to transfer resident out if no _____ output was observed and clots continued. Nursing continued to evaluate resident with no _____ output identified with continued _____ clots and resident was subsequently</p>	N 204	<p>residents that returned to the hospital.</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> • Licensed Nurses and CNAs will complete competencies on _____ care at the time of orientation and annually with the facility's Staff Development Coordinator. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on ensuring new orders for _____ include placement, patency/drainage, irrigation, _____ securement device, _____ care Qshift, and to record the output Qshift. <p>4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> • 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 	
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N 204	<p>Continued From page 8</p> <p>transferred to the hospital.</p> <p>Review of the nursing staff statements obtained as part of the investigation revealed:</p> <p>LPN Staff B documented in an undated statement she worked on _____ from 7:00 p.m. to 7:00 a.m. She used sterile technique to change Resident #1's _____. LPN Staff B wrote at 5:50 a.m., she informed Resident #1 she was going to change the _____. She documented, "Sterile technique used to remove _____ (_____) . No retention or _____. Resident #1 denied _____ or discomfort. _____ provided and sterile technique used to insert _____, no resistance noted. No complaints of discomfort from resident _____. Writer stated, "I will come to check on you". Resident alert and thankful. Writer followed up with resident approximately 0630 (6:30 a.m.), no _____ output. Writer palpated abdomen, no distention, Resident #1 denied discomfort or _____. 0700 (7:00 a.m.) report given to day shift. Writer told nurse the time of insertion, and stated there was no resistance noted and that resident was denying discomfort, no output noted yet."</p> <p>LPN Staff A's statement dated _____ noted on _____ at approximately 3:00 p.m., Resident #1's spouse called her to the room and voiced concerns about no _____ in the _____ drainage bag. LPN Staff A said Resident #1 was alert, oriented, very pleasant and _____. His abdomen was not distended, was not tender to touch. Resident #1 had no complaints or discomfort. LPN Staff A flushed the _____ with _____ and there was a return of small clots passing in drainage tubing. Staff A said she called the APRN while at the bedside. The APRN gave an order to hold the _____ and _____ for three _____</p>	N 204	<p>weeks, biweekly x 2 months, then monthly thereafter until substantial compliance is determined by the QAPI committee.</p> <ul style="list-style-type: none"> The facility initiated the completion of audits seven days a week including weekends documentation of _____ output for all residents with _____ <p>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.</p>		

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N 204	Continued From page 9 days and keep the _____ out. The APRN said not to send the resident to the hospital, to just monitor him for _____ output without the _____. If Resident #1 did not _____ and "continued to clot" send him out for further evaluation. On _____ at 2:18 p.m., in an email addressed to the Director of Nursing, LPN Staff C documented on _____ at 3:26 p.m., he took over Resident #1's care and received shift report from LPN Staff A. LPN Staff A was irrigating Resident #1's _____. The resident's spouse told him "He still has no pee." LPN Staff C documented he contacted the APRN about the resident not passing _____ and passing one _____ clot from irrigating the _____. The APRN gave an order to remove and reinsert the _____. LPN Staff C said he removed the _____, and "copious amount of _____ came from penis." He immediately applied pressure to the penis region. LPN Staff C documented, "Writer asked spouse to put on gloves and apply pressure to the area and asked the patient if he had any _____. Patient denied _____ or discomfort to lower region still nondistended." Staff C documented he had to call the doctor. "While spouse was applying pressure to penis region writer rushed to nurse's station to get LPN Staff A for assistance. Writer sanitized _____ and applied gloves. Spouse removed _____ and writer continued to apply pressure. Writer waited approximately 5 minutes and stopped applying pressure. . . . Patient released a quarter size _____ clot after writer stopped applying pressure." He applied pressure to penis region and ask LPN Staff A to call the APRN. The APRN gave a verbal order to not reinsert the _____, hold _____, monitor _____ output. If no _____ (_____ output), and clots continue to pass, then send resident to the ER. LPN Staff C documented he stopped	N 204			

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NAME OF PROVIDER OR SUPPLIER CHARLOTTE BAY REHAB AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4033 BEAVER LANE PORT CHARLOTTE, FL 33952		
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N 204	<p>Continued From page 10</p> <p>applying pressure, the _____ and clot passing stopped.</p> <p>LPN Staff B documented in the witness statement dated _____ at 7:00 p.m., she received a shift report from the previous nurse that Resident #1 had no _____ output during the day. The _____ was irrigated (flushed), and the resident had passed a _____ clot during removal of the _____. Staff B documented she checked on the resident at the beginning of the shift and asked the Certified Nursing Assistant (CNA) to "keep an _____ on resident's output." At 8:50 p.m., she documented the resident's vital signs and _____ were "within normal limits." The resident had no _____ or _____ in his brief. At approximately 9:45 p.m., she checked on Resident #1. She called the resident by name. Resident #1 was alert. Resident #1 appeared _____. LPN Staff B documented again she took the resident's vital signs and they were "within normal limits." LPN Staff B and the CNA checked the resident's brief and observed a medium size _____ clot. The CNA remained in the room with another CNA to change the resident's brief while LPN Staff B called 911.</p> <p>The facility's investigation noted, "Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted _____. Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on _____ care upon receiving this allegation _____."</p> <p>On _____ the Administrator provided In-service</p>	N 204			

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N 204	<p>Continued From page 11</p> <p>Attendance Record Signature sheets dated _____, _____, and _____, for the neglect education to the nursing staff.</p> <p>The content of the education was, "Neglect is the failure to provide goods and services to maintain the residents' physical mental and _____ wellbeing. This includes but not limited to providing showers, turning and positioning, ADL (Activities of Daily Living) care and _____ care is also on this list. _____ care is to be provided a minimum of once a shift by the CNA. For residents' _____ of _____ after the _____ is cleaned then _____ care needs to be provided again. Also making sure the tubing and bag are positioned properly and not touching the floor."</p> <p>The education did not include failing to appropriately monitor the resident's _____ output and failure to monitor the resident's condition, amount of _____, obtaining vital signs with the acute onset of _____ constituted neglect.</p> <p>14 of 33 nurses employed by the facility signed that they attended the in-service.</p> <p>On _____ at 8:30 a.m., in a telephone interview Resident #1's daughter said on _____ her mother was at the facility. She complained to facility staff several times that he was not passing _____ after the _____ was changed that morning. On _____ at 10:00 p.m., a nurse called and told her mother that he was unresponsive and had been transferred to the hospital. Her father (Resident #1) was placed on a _____ and admitted. Her mother complained to the Administrator about the care he received.</p> <p>On _____ at 10:00 a.m., in a telephone interview LPN Staff B said she had a physician's order to change the _____. On _____ at approximately 5:30 a.m., there was no _____ in the _____</p>	N 204		
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N 204	<p>Continued From page 12</p> <p>drainage bag when she changed the . She said she got "a small amount of return" when she changed the . and saw no</p> <p>On at 12:21 p.m., in a telephone interview, the Consulting Physician said he was not aware of the incident involving Resident #1. He said Staff should have obtained Resident #1's vital signs at least every shift and with any change in condition. He said Resident #1 should have been sent to the hospital within eight hours of no output. He said staff should have notified the physician if Resident #1 was not having a minimum of 30 milliliters of output hourly.</p> <p>On at 1:00 p.m., in a telephone interview the APRN said staff never told her Resident #1 had no output for more than eight hours. She would have sent the resident to the hospital immediately. She 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 (large) amounts of came out. She told them to hold the (medication to prevent clots). She gave the order to wait an hour, call her or send the resident to the Emergency Room if he did not urinate or continued to pass clots. The APRN said she never told the nurse to wait two hours.</p> <p>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</p>	N 204		
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N 204	<p>Continued From page 13</p> <p>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 _____ and send the resident to the ER if he kept _____ or had no _____ output. LPN Staff C said he did not know Resident #1 had no _____ output since the previous night.</p> <p>On _____ at 2:00 p.m., in an interview Unit Manager LPN Staff D said on _____ she was assigned to Resident #1 from 7:00 a.m., to 2:00 p.m. She said LPN Staff B who worked the night shift did not tell her the resident had no _____ output. She said the CNAs empty the _____ drainage bag at the end of each shift. The CNA who worked the day shift on _____ did not tell her Resident #1 had no _____ output. Staff D said she could not remember if she checked the resident's _____ or drainage bag.</p> <p>On _____ at 3:00 p.m., in an interview LPN Staff A verified on _____ Resident #1's spouse told her there was no _____ in the drainage bag. When she checked on the resident on _____ at approximately 4:00 p.m., the drainage bag was empty. She said no one told her the resident had no _____ output all day.</p> <p>On _____ at 8:30 a.m., in an interview LPN Staff B said there was no _____ in Resident #1's _____ bag before she changed the _____ on _____ at 5:30 a.m. She said when she left work on _____ at 7:00 a.m., there was no _____ in the drainage bag. 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 _____ LPN Staff</p>	N 204		
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N 204	<p>Continued From page 14</p> <p>B verified the APRN's orders to monitor the resident and send him out if he did not stop . . . were not transcribed until . . . at 10:00 p.m. She said she took Resident #1's vital signs twice during her shift but did not document them. She said Resident #1 was alert but . . . when . . . arrived. She could not remember when Resident #1 became . . .</p> <p>On . . . at 3:05 p.m., in a telephone interview Resident #1's spouse said on . . . she spent the whole day at her husband's bedside. At 9:00 a.m., she noticed there was no . . . in the . . . drainage bag. At approximately 11:00 a.m., 12:00 p.m., she told LPN Staff D the . . . was not draining . . . LPN Staff D told her she was busy and would come later. She never came to the room and left at 2:00 p.m. On . . . at approximately 4:00 p.m., LPN Staff A tried to flush the . . . and said, "it was . . ." LPN Staff C came in the room and removed the . . . A large . . . clot came out.</p> <p>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 the facility's neglect investigation related to Resident #1's care and emergent transfer to the hospital. The Regional Nurse Consultant said she could not argue with 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, and timely transfer of Resident #1 when he had not passed . . . for more than eight</p>	N 204		
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N 204	<p>Continued From page 15</p> <p>hours.</p> <p>On at 5:05 p.m., in an interview Registered Nurse Staff F said she has been the Staff Educator at the facility for 11 years and was responsible for competencies of the nursing staff. She said the facility has not been doing care competencies, including ensuring the nurses were knowledgeable to insert and monitor residents with She said, "We will now."</p> <p>Class I</p>	N 204		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey for complaint #2025002491, #2025002946, and #2025003458 was conducted on _____ through _____ at Charlotte Bay Rehab and Care Center, a skilled nursing facility in Port Charlotte, Florida.</p> <p>Complaint #2025002946 was unsubstantiated.</p> <p>Complaint #2025003458 was substantiated with a citation at F690.</p> <p>Complaint #2025002491 was substantiated with citations at F600, F690, F726 and F835.</p> <p>_____ noncompliance at Immediate Jeopardy level (scope and severity "J") was identified at:</p> <p>§483.12 Freedom from _____, Neglect, and _____ (F600).</p> <p>§483.25(e) (ii) _____ (F690).</p> <p>§483.35 Nursing Services (F726), and</p> <p>§483.70 Administration (F835).</p> <p>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.</p> <p>During the survey, substandard quality of care was identified at:</p> <p>§483.12, Freedom from _____, Neglect, and _____ (F600) and,</p>	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	<p>Continued From page 1</p> <p>§483.25(e) (ii) (F690).</p> <p>A partial extended survey was conducted.</p> <p>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 residents' 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, (low) with a temperature of 100.2 Fahrenheit (F). Resident #1 was intubated and admitted to the</p> <p>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.</p> <p>This failure resulted in the determination of Immediate Jeopardy (IJ).</p> <p>Immediate Jeopardy began on</p> <p>On at 4:45 p.m., the facility's</p>	F 000		

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F 000	Continued From page 2 Administrator was informed of the determination of Immediate Jeopardy and provided the IJ templates. The facility census was 158 with 12 residents with 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 (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities. The following is a description of the noncompliance. Refer to GCDD12	F 000			
F 600 SS=J	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and The resident has the right to be free from neglect, misappropriation of resident property, and as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , corporal punishment, or involuntary ;	F 600			

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F 600	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on family and staff interviews and record review, the facility failed to protect residents' rights to be free from neglect. The facility failed to appropriately monitor the _____ output after insertion of an _____ and failed to monitor the resident's change of condition for 1 (Resident #1) of 5 residents with _____ reviewed.</p> <p>Resident #1 was admitted to the facility on _____ with diagnoses including prostatic hyperplasia (enlarged _____). Resident #1 had an _____ (_____ inserted in the _____ to drain _____).</p> <p>On _____ at approximately 5:30 a.m., Resident #1's _____ was changed. There was no documentation Resident #1 was monitored to ensure the _____ was properly inserted and draining _____.</p> <p>On _____ at approximately 4:30 p.m., Resident #1 had no _____ output. The _____ was removed. Resident #1 experienced copious amount of _____ and clots.</p> <p>There was no documentation the facility monitored Resident #1's status, including obtaining vital signs (temperature, _____, _____ and _____) with the acute change in condition.</p> <p>On _____ at approximately 10:00 p.m., Resident #1 was emergently transferred to an acute care hospital. The resident was unresponsive, had no _____ output and was _____.</p> <p>The facility's failure to provide the necessary care</p>	F 600	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Resident #1 is no longer a resident. An AHCA Federal Immediate Report with a corresponding investigation was completed by the facility prior to this survey. <p>2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p> <ul style="list-style-type: none"> • 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. • 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. <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</p> <p>Education:</p> <ul style="list-style-type: none"> • The facility's Administrator and Director 	

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F 600	<p>Continued From page 4</p> <p>and services to prevent neglect created a likelihood of serious harm, injury, or of Resident #1 and other residents with an _____ from _____ associated complications, including _____ from _____ insertion, _____, and _____.</p> <p>This failure resulted in the determination of Immediate Jeopardy (IJ) at a scope and severity of _____ (J) starting on _____.</p> <p>On _____ at 4:45 p.m., the Administrator was informed of the determination of Immediate Jeopardy.</p> <p>The findings included:</p> <p>Review of the facility's policy and procedures titled, " _____, Neglect, Misappropriation, Mistreatment, Injury of unknown source and Investigations" with an effective date of _____ revealed, "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, _____, mental anguish, or emotional distress The facility shall conduct their own internal investigation including but not limited to staff . . . resident, and family/resident representative interview, medical record reviews, 24 hours reports reviews, full body skin exam, etc. The resident's representative and physician should be notified that there is an on-going investigation regarding the alleged incident The facility shall take all necessary corrective action(s) depending on the results of their investigation and must notify the proper agencies as well as licensing authorities of any incidents that would indicate an employee is unfit for service. The</p>	F 600	<p>of Nursing were reeducated by Regional Nurse Consultant on:</p> <ul style="list-style-type: none"> o The components of the regulation: F600 Free from and Neglect o _____, Neglect, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) with indicators of neglect. o Facility standard and guideline P&P Neglect and Investigations <p>to include:</p> <ul style="list-style-type: none"> o Screening o Training o Prevention o Identification o Investigation o Protection o Reporting <ul style="list-style-type: none"> • The facility's Staff Development Coordinator/Designee completed education with facility staff on _____ and Neglect with an emphasis on the following F600 noncompliance: The facility failed to protect resident rights to be free from neglect by failing to appropriately monitor the resident's _____ output and failure to monitor the resident when the _____ was discontinued. On _____ at approximately 4:30 p.m. resident's _____ was discontinued. Resident experienced copious _____ and was passing clots through his penis. The facility neglected to monitor resident's status including vital signs with a significant change in condition. • The facility's Staff Development Coordinator/Designee completed competencies with CNAs on emptying 		

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F 600	<p>Continued From page 5</p> <p>facility shall analyze the occurrences to determine what changes are needed, if any, to the residents' care plan or policies and procedures to prevent further occurrences."</p> <p>Review of the facility's policy and procedures titled, "Nursing- Care- ." with an effective date of . and a revision date of . revealed, "Observe the resident for complications associated with . . . Check the . . . for unusual appearance (i.e., color, . . . etc.) . . . Notify the physician or supervisor in the event of . . . or if the . . . is accidentally removed . . . Observe for signs and symptoms of . . . or . . . retention. Report findings to the physician or supervisor immediately . . ."</p> <p>Review of the clinical record revealed Resident #1 was admitted to the facility on . . . from an acute care hospital. Diagnoses included prostatic hyperplasia (enlarged . . .) with symptoms. Resident #1 was admitted with an . . . (. . . inserted in the . . . to drain . . .).</p> <p>Review of the Treatment Administration Record (TAR) for . . . revealed on Licensed Practical Nurse (LPN) staff B changed Resident #1's . . .</p> <p>The clinical record lacked documentation LPN Staff B verified the . . . was properly inserted and draining . . .</p> <p>On . . . at 10:59 p.m., LPN Staff A . . . documented in a progress note for an effective date of . . . at 5:00 p.m., Resident #1's . . . was removed per the . . . Advanced Practice Registered Nurse (APRN)</p>	F 600	<p>and measuring . . . output for residents with . . . This competency was conducted using a mannequin with an . . . to simulate the actual emptying of the . . .</p> <ul style="list-style-type: none"> • 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 competencies with CNAs and licensed nurses on the proper obtaining of resident vital signs including temperature, . . . and . . . and . . . on a live member of staff. Vital signs obtained for an identified change in condition will be documented in the . . . and vitals tab in PCC. This allows for these vitals to populate accurately in the SBAR/Change in Condition evaluation. • 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: <ul style="list-style-type: none"> 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 600	<p>Continued From page 6</p> <p>order due to _____ and clots, 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." The clinical record lacked documentation Resident #1's condition was monitored, including an evaluation of the resident, amount of _____ vital signs or _____ output.</p> <p>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." The transcribed order did not include to monitor for _____ and clots.</p> <p>On _____ at 11:36 p.m., LPN Staff B documented in a progress note with an effective date of _____ at 10:00 p.m., she received shift report from the dayshift nurse to send Resident #1 to the hospital per the APRN order if Resident #1 was not able to _____ and clots continue. Staff B documented "clots continued, no _____ (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified."</p> <p>Review of the documentation in the clinical record, including licensed nurses and Certified Nursing Assistant (CNA) notes and entries revealed the last _____ output was documented on _____ at 10:00 p.m. There was no _____ documentation of _____ output for the night shift (of _____ the day shift of _____ and the evening shift of _____.</p> <p>Review of the Emergency Medical Services (_____) Prehospital Care Report revealed the unit was notified by dispatch on _____ at 9:51 p.m.</p>	F 600	<p>or _____ status.</p> <p>o This may include life-threatening conditions, or clinical complications and changes in output including color, consistency, and output.</p> <p>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.</p> <p>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.</p> <p>o The physician/NP shall be made aware of pertinent evaluation findings.</p> <ul style="list-style-type: none"> • 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 600	<p>Continued From page 7</p> <p>The narrative noted Resident #1 was found lying supine () up) in bed with a facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a () 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 the patient up, patient is normally awake and verbal." He was last seen normal three hours ago. () documented that the resident was unresponsive, breathing fast with a radial () skin hot and clammy, () noted on abdomen. The report noted under patient condition the primary complaint type was "unresponsive", and "other, () from penis with large clots."</p> <p>The date and time of symptom onset was at 6:07 p.m.</p> <p>Review of the local hospital record revealed Resident #1 was initially seen in the ER on () at 10:22 p.m. The ER progress note documented Resident #1 arrived at the Emergency Department from the facility for complaint of () clots after () removal. Upon () arrival, Resident #1 was unresponsive to painful stimuli, and had a temperature of 100.2.</p> <p>The hospital History and Physical noted, "The nursing staff at the facility stated that due to decreased () output they switched the () out and received large amounts of and clots shortly after that the patient became unresponsive . . . The patient was found immediately () and hypoxic requiring airway () support with ()"</p>	F 600	<p>visual observation of the color and clarity of () output each shift.</p> <ul style="list-style-type: none"> 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 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. <p>System Change:</p> <ul style="list-style-type: none"> The facility reviewed all () orders. () 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 daily clinical meeting form was edited to include: <ul style="list-style-type: none"> 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 	

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F 600	<p>Continued From page 8</p> <p>Resident #1 was admitted to the with support on .</p> <p>The assessment and plan was: (life threatening), (function due to imbalance in metabolism), Hematuria (in), retention.</p> <p>Review of the facility's incident investigations revealed on at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a and that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation of neglect and started an investigation.</p> <p>The investigation noted that on the morning of Resident #1's was changed per the physician order. The resident was later noted to have no output, and his was irrigated with clots observed. New orders were obtained from the APRN to remove the at which time further clots were noted by nursing staff. Additional orders were then obtained to hold and (prevents clots from forming) and to transfer resident out if no output was observed and clots continued. Nursing continued to evaluate the resident with no output identified with continued clots and Resident #1 was subsequently transferred to the hospital.</p> <p>Review of the nursing staff statements obtained as part of the investigation revealed:</p> <p>LPN Staff B documented in an undated statement</p>	F 600	<p>monitor output are in place.</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> • Licensed Nurses and CNAs will complete competencies on care at the time of orientation and annually with the facility's Staff Development Coordinator. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on ensuring new orders for include placement, patency/drainage, irrigation, securement device, care Qshift, and to record the output Qshift. <p>4) How will the corrective action(s) be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> • 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. 	

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F 600	<p>Continued From page 9</p> <p>she worked on _____ from 7:00 p.m. to 7:00 a.m. She used sterile technique to replace Resident #1's _____ LPN Staff B wrote at 5:50 a.m., she informed Resident #1 she was going to change the _____. She documented, "Sterile technique used to remove _____ (_____) No retention or _____. Resident #1 denied, _____ or discomfort. _____ was provided and sterile technique used to insert _____, no resistance noted". No complaints of discomfort from resident _____. LPN Staff B wrote, "I will come to check on you", resident was alert and thankful. Writer followed up with the resident at approximately 0630 (6:30 a.m.), no _____ output. Writer palpated abdomen, no distention, resident denied discomfort or _____. 0700 (7:00 a.m.) report given to day shift. LPN Staff B told the on coming nurse "at the time of insertion, no resistance was noted, and the resident was denying discomfort, no _____ output noted yet."</p> <p>LPN Staff A's statement dated _____ noted on _____ at approximately 3:00 p.m., Resident #1's spouse called her to the room and voiced concerns about no _____ in the _____ drainage bag. LPN Staff A said Resident #1 was alert, oriented, very pleasant and _____. His abdomen was not distended, was not tender to touch. Resident #1 had no complaints or discomfort. LPN Staff A flushed the _____ with _____ with return of small clots passing in drainage tubing. Staff A said she called the APRN while at the bedside. The APRN gave an order to hold the _____ and _____ for three days and keep the _____ out. The APRN said not to send the resident to the hospital, to just monitor him for _____ output without the _____. If Resident #1 did not _____ and "continued to clot" send him out for further evaluation.</p>	F 600	<p>• 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.</p>	

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F 600	Continued From page 10 On at 2:18 p.m., in an email addressed to the Director of Nursing, LPN Staff C documented on at 3:26 p.m., he took over Resident #1's care and received report from LPN Staff A. LPN Staff A was irrigating Resident #1's . The resident's spouse told him "he still has no pee." LPN Staff C documented he contacted the APRN about the resident not passing and passing one clot from irrigating the . The APRN gave an order to remove and reinsert the . LPN Staff C said he removed the , and "copious amount of came from penis." He immediately applied pressure to the penis region. LPN Staff C documented, "Writer asked spouse to put on gloves, apply pressure to the area, and asked the patient does he have any ? Patient denied , or discomfort to lower region still nondistended." Staff C documented he had to call the doctor. "While spouse was applying pressure to penis region writer rushed to nurse's station to get LPN Staff A for assistance. The writer sanitized his and applied gloves. Resident #1's Spouse removed her and writer continued to apply pressure. Writer waited approximately 5 minutes and stopped applying pressure . . . Patient released a quarter size clot after writer stopped applying pressure." He applied pressure to the penis region and ask LPN Staff A to call the APRN. The APRN gave a verbal order to not reinsert the , hold , monitor output. If the resident has not , and clots continue to pass then send the resident to the ER. LPN Staff C documented he stopped applying pressure, the , and clot passing stopped. LPN Staff B documented in the witness statement	F 600		

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F 600	<p>Continued From page 11</p> <p>on _____ at 7:00 p.m., she received a report from the previous nurse that Resident #1 had no _____ output during the day. The _____ was irrigated, and the resident had passed a clot during removal of the _____. Staff B documented she checked on the resident at the beginning of the shift and asked the Certified Nursing Assistant (CNA) to "keep an _____ on resident's output." At 8:50 p.m., she documented the resident's vital signs and _____ were "within normal limits." The resident had no _____ or _____ in his brief. At approximately 9:45 p.m., she checked on Resident #1. She called the resident by name. Resident #1 was alert. Resident #1 appeared _____. LPN Staff B documented again she took the resident's vital signs, and they were "within normal limits." LPN Staff B and the CNA checked the resident's brief and observed a medium size _____ clot. The CNA remained in the room with another CNA to change the resident's brief while LPN Staff B called 911.</p> <p>The facility's investigation noted, "Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted . . . Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on _____ care upon receiving this allegation . . ."</p> <p>On _____ the Administrator provided In-service Attendance Record Signature sheets dated _____, and _____, for inservice education for neglect provided to the nursing staff.</p>	F 600		

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F 600	<p>Continued From page 12</p> <p>The content of the education was, "Neglect is the failure to provide goods and services to maintain the residents' physical mental and _____ wellbeing. This includes but is not limited to providing showers, turning and positioning, ADL (Activities of Daily Living) care and _____ care is also on this list. _____ care is to be provided a minimum of once a shift by the CNA. For residents' _____ of _____ after the _____ is cleaned then _____ care needs to be provided again. Also making sure the tubing and bag are positioned properly and not touching the floor."</p> <p>The education did not include failing to appropriately monitor the resident's _____ output and failure to monitor the resident's condition, amount of _____ obtaining vital signs with the acute onset of _____ constituted neglect.</p> <p>14 of 33 nurses employed by the facility signed that they attended the in-service.</p> <p>On _____ at 8:30 a.m., in a telephone interview Resident #1's daughter said on _____ her mother was at the facility. She complained to facility staff several times that he was not passing _____ after the _____ was changed that morning. On _____ at 10:00 p.m., a nurse called and told her mother that he was unresponsive and had been transferred to the hospital. Her father (Resident #1) was placed on a _____ and admitted. Her mother complained to the Administrator about the care he received.</p> <p>On _____ at 10:00 a.m., in a telephone interview LPN Staff B said she had a physician's order to change the _____. On _____ at approximately 5:30 a.m., there was no _____ in the drainage bag when she changed the _____.</p>	F 600			

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F 600	<p>Continued From page 13</p> <p>She said she got "a small amount of return" when she changed the and there was no .</p> <p>On at 12:21 p.m., in a telephone interview, the Consulting Physician said he was not aware of the incident involving Resident #1. He said Staff should have obtained Resident #1's vital signs at least every shift and with any change in condition. He said Resident #1 should have been sent to the hospital within eight hours of no output. He said staff should have notified the physician if Resident #1 was not having a minimum of 30 milliliters of output hourly.</p> <p>On at 1:00 p.m., in a telephone interview the APRN said staff never told her Resident #1 had no output for more than eight hours. She would have sent the resident to the hospital immediately. She 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 amounts of came out. She told them to hold the (medication to prevent clots). She gave the order to wait an hour, call her or send the resident to the Emergency Room if he did not urinate or continued to pass clots. The APRN said she never told the nurse to wait two hours.</p> <p>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</p>	F 600		

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F 600	<p>Continued From page 14</p> <p>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 _____ and send the resident to the ER if he kept _____ or had no _____ output. LPN Staff C said he did not know Resident #1 had no _____ output since the previous night.</p> <p>On _____ at 2:00 p.m., in an interview Unit Manager LPN Staff D said on _____ she was assigned to Resident #1 from 7:00 a.m., to 2:00 p.m. She said LPN Staff B who worked the night shift did not tell her the resident had no output. She said the CNAs empty the _____ drainage bag at the end of each shift. The CNA who worked the day shift on _____ did not tell her Resident #1 had no _____ output. Staff D said she could not remember if she checked the resident's _____ or drainage bag.</p> <p>On _____ at 3:00 p.m., in an interview LPN Staff A verified on _____ Resident #1's spouse told her there was no _____ in the drainage bag. When she checked on the resident on _____ at approximately 4:00 p.m., the drainage bag was empty. She said no one told her the resident had no _____ output all day.</p> <p>On _____ at 8:30 a.m., in an interview LPN Staff B said there was no _____ in Resident #1's _____ bag before she changed the _____ on _____ at 5:30 a.m. She said when she left work on _____ at 7:00 a.m., there was no _____ in the drainage bag. 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</p>	F 600		

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F 600	<p>Continued From page 15</p> <p>when they tried to irrigate the . LPN Staff B verified the APRN's orders to monitor the resident and send him out if he did not stop . were not transcribed until at 10:00 p.m. She said she took Resident #1's vital signs twice during her shift but did not document them. She said Resident #1 was alert but when arrived. She could not remember when Resident #1 became .</p> <p>On at 3:05 p.m., in a telephone interview Resident #1's spouse said on she spent the whole day at her husband's bedside. At 9:00 a.m., she noticed there was no in the , drainage bag. At approximately 11:00 a.m., 12:00 p.m., she told LPN Staff D the was not draining . LPN Staff D told her she was busy and would come later. She never came to the room and left at 2:00 p.m. On at approximately 4:00 p.m., LPN Staff A tried to flush the and said, "it was ." LPN Staff C came in the room and removed the . A large . clot came out.</p> <p>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 the facility's neglect investigation related to Resident #1's care and emergency transfer to the hospital. The Regional Nurse Consultant said she could not argue with the fact that there were no vital signs taken and no assessment documented for Resident #1. The DON said she interviewed the nurses as part of the investigation but did not interview the CNAs. She verified that no corrective actions were implemented related to the lack of assessment, and timely transfer of Resident #1</p>	F 600		

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F 600	<p>Continued From page 16</p> <p>when he had not passed for more than eight hours.</p> <p>On at 5:05 p.m., in an interview Registered Nurse Staff F said she has been the Staff Educator at the facility for 11 years and was responsible for competencies of the nursing staff. She said the facility had not been doing care competencies, including ensuring the nurses were knowledgeable to insert and monitor residents with . She said, "We will now."</p> <p>On after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of</p> <p>The Immediate actions implemented by the facility and verified by the survey team included:</p> <p>On at 2:04 p.m. during an interview with the Director of Nursing (DON) she said she has completed education for almost all of the nursing staff. The remaining staff will be educated before the start of their next scheduled shift. She said there have been several in-person live events and there have been over the phone education for (2 nurses) and they will complete their competencies before their next working shift. She said there were no new hires for nursing staff. They are re-educating the Certified Nursing Assistants (CNAs), Registered Nurses (RNs) and</p>	F 600			

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F 600	<p>Continued From page 17</p> <p>Licensed Practical Nurses (LPNs).</p> <p>On the facility Administrator and Director of Nursing were re-educated by the Regional Nurse Consultant on: The components of the regulation F600 Free from and Neglect, Misappropriation, Mistreatment and Injury of Unknown Origin with indicators of Neglect including screening, training, prevention, identification, investigation, protection, and reporting.</p> <p>On the facility began staff education on and Neglect with the emphasis on failure to protect resident rights to be free of neglect by failing to monitor output and to monitor the resident when the was discontinued. staff members have received this education by . All remaining staff will receive this education prior to returning to work.</p> <p>The facility neglected to monitor the residents' status, including vital signs with a significant change in condition.</p> <p>On the facility completed a facility wide audit of 155 residents to ensure that all residents have physician's orders to take vital signs was in place and transcribed to the medication administration record (MAR). Long term care resident vital signs are obtained on a weekly basis and short-term rehab residents vital signs are obtained daily.</p> <p>On the facility reviewed all orders. output was added to the medication administration record (MAR) on to ensure nursing documentation.</p>	F 600		

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F 600	<p>Continued From page 18</p> <p>On . . . CNA education was initiated to ensure any changes in . . . output for residents with . . . , and any residents experiencing a change in condition must be reported immediately to the nurse. 77 of 82 CNAs were educated by . . . All remaining CNAs will be educated prior to working their next scheduled shift.</p> <p>On . . . the facility initiated vital sign assessment competencies including temperature, . . . , and . . . on staff members.</p> <p>On . . . the surveyor verified through a record review of 3 randomly selected residents that the facility was monitoring the vital signs for the selected short and long term residents.</p> <p>On . . . interviews with 3 Certified Nursing Assistants (CNA), and 3 nurses verified they had been re-educated on . . . care including measuring, reporting, and documenting the amount on the MAR.</p> <p>On . . . the surveyor verified through record review of 3 randomly selected residents with . . . the facility was monitoring and documenting vital signs every shift. The nursing staff was measuring and recording the amount of . . . for residents with . . .</p> <p>On . . . the surveyor confirmed through interview with 3 random CNAs they were educated to report to the nurse any changes in . . . output for residents with . . . , and to report changes in resident condition immediately to the nurse.</p>	F 600			

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F 600	<p>Continued From page 19</p> <p>On the surveyor verified through record reviews of 3 random residents that the facility was documenting the vital signs on the MAR twice a day.</p> <p>On the facility educated their licensed nurses on completing a "Change in Condition Assessment" on residents. The education included identifying conditions that required an assessment including: Accidents resulting in injury; significant change in the resident's physical or mental condition, deterioration in health, mental or status; life threatening conditions or clinical complications including changes in output including color, consistency and output; circumstances that require an alteration in treatment including acute and conditions. A complete nursing evaluation must be conducted and documented in the medical record of systems. The nurses were educated to obtain a new set of vital signs and document them in the electronic record in that the Change in Condition Assessment would contain the most recent and relevant vital signs. The provider shall be notified of pertinent evaluation findings. Nurses must visualize for amount of output, color and clarity during each shift.</p> <p>On the facility daily clinical meeting agenda was edited to include the review of all residents with changes in condition to ensure vital signs and a timely transfer was completed; review of all new and existing residents with had monitoring and documentation of output amount in place.</p> <p>On the facility conducted RN assessments of every current resident including</p>	F 600		

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F 600	Continued From page 20 vital signs and observations for output and patency. Any changes were reported to the family and the provider. On the facility initiated audits of residents in the facility to ensure the nursing staff completed proper documentation of those vital signs. On the facility completed a 7-day audit for residents with to ensure measuring and documenting of the output was completed on each shift. 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 meeting included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Director, Minimum Data Set nurse, Nurse, CNA. On 48 of 50 nurses were re-educated. The remaining nurses will be educated prior to working their next shift. On a review of three random resident records was completed to ensure accurate assessment and interventions were in place to prevent neglect related to the care of residents with and for those who experience a change in condition.	F 600			
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with	F 726			

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F 726	<p>Continued From page 21</p> <p>the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.</p> <p>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>§483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility's policies and procedures, and staff interviews the facility failed to ensure Licensed Nurses had the skills set to safety care for residents with _____, including inserting the _____, monitor residents, recognize significant changes in condition and complications from _____ requiring immediate physician notification and interventions</p>	F 726	<p>1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> • Resident #1 no longer resides at the facility. • The facility's Staff Development Coordinator completed competencies on 	

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F 726	<p>Continued From page 22 to prevent further deterioration.</p> <p>On _____ at approximately 5:30 a.m., Licensed Practical Nurse (LPN) Staff B changed Resident #1's _____ and did not ensure free flow of _____ to verify the tip of the _____ was in the appropriate location in the _____.</p> <p>On _____, Unit Manager LPN Staff D did not monitor Resident #1 from 7:00 a.m., to 2:00 p.m. to ensure the _____ was functioning and draining _____.</p> <p>On _____ at approximately 5:00 p.m., LPN Staff A received a practitioner's order to monitor Resident #1 and send him to the hospital when the _____ was removed and the resident had significant _____ and was passing clots from his penis. She did not monitor Resident #1 and did not transcribe the order until _____ at 10:00 p.m., five hours after receiving the order.</p> <p>On _____ at 10:00 p.m., Resident #1 was unresponsive and _____ through his penis and was emergently transferred to an acute care hospital via Emergency Medical Services (_____). Resident #1 was intubated in the Emergency Room and admitted to the _____.</p> <p>The facility failure to ensure Licensed Nurses had the skill sets and were competent to provide safe care to residents with _____ placed Resident #1 and other residents with _____ at a likelihood of significant harm, injury or _____ from _____ associated complications such as _____ from improper insertion, _____, and _____.</p>	F 726	<p>the proper insertion of _____ with return demonstrations for staff A,B,C, & D.</p> <ul style="list-style-type: none"> • The facility's Staff Development Coordinator/Designee completed education on the identification of a change in condition with staff A,B,C, & D. <p>2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken:</p> <ul style="list-style-type: none"> • 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. • Current residents with an _____ had a _____ evaluation completed. <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</p> <p>Education:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> o Accidents resulting in injury, or the potential to require physician intervention. o A significant change in the resident s 	

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F 726	<p>Continued From page 23</p> <p>This failure resulted in the determination of Immediate Jeopardy.</p> <p>On _____ at 4:45 p.m., the Administrator was notified in the determination of Immediate Jeopardy.</p> <p>The findings included:</p> <p>Cross reference to F600, F690 and F835</p> <p>Review of the Facility Assessment Tool revealed the purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. "Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility, at least annually per requirement."</p> <p>The Facility Assessment Tool noted the facility accepts residents with _____ system diagnoses such as _____ (lack of control due to a _____ or _____ cord condition), _____ prostatic hyperplasia (enlarged _____), _____ (blockage of _____ tract). _____ The assessment noted services and care offered based on resident needs included intermittent or _____ or other _____.</p> <p>1. Review of the facility's incident investigations revealed on _____ at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a _____ and _____ that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation</p>	F 726	<p>physical, mental, or _____ condition such as a deterioration in health, mental, or _____ status.</p> <ul style="list-style-type: none"> o This may include life-threatening complications, or clinical 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 	

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F 726	<p>Continued From page 24</p> <p>of neglect and started an investigation. The investigation noted that on the morning of Resident #1's was changed per the physician order. The resident was later noted to have no output, and his was irrigated with clots observed. New orders were obtained from the Advanced Practice Registered Nurse to remove the at which time further clots were noted by nursing staff. Additional orders were then obtained to hold and and to transfer resident out if no output was observed and clots continued. Nursing continued to evaluate resident with no output identified with continued clots and resident was subsequently transferred to the hospital.</p> <p>The facility's investigation noted, "Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted . . . Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on care upon receiving this allegation . . ."</p> <p>Review of the clinical record revealed Resident #1 was admitted to the facility on from an acute care hospital. Diagnoses included prostatic hyperplasia (enlarged) with symptoms. Resident #1 was admitted with an the to drain). (inserted in</p> <p>Review of the Treatment Administration Record (TAR) for revealed on</p>	F 726	<p>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.</p> <ul style="list-style-type: none"> • 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 CNAs and licensed nurses on the proper obtaining of resident vital signs including temperature, and on a live member of staff. Vital signs obtained for an identified change in condition will be documented in the and vitals tab in PCC. This allows for these vitals to populate accurately in the SBAR/Change in Condition evaluation. • The facility's Staff Development Coordinator/Designee completed competencies with licensed nurses on the proper insertion of with return demonstrations. • 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's Staff Development Coordinator/Designee completed education with licensed nurses on the requirement of detailed communication during shift to shift report to include any 	

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F 726	<p>Continued From page 25</p> <p>Licensed Practical Nurse (LPN) staff B changed Resident #1's</p> <p>The clinical record lacked documentation LPN Staff B verified the _____ was properly inserted and draining</p> <p>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 had 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".</p> <p>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 [shift] 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."</p> <p>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 _____</p>	F 726	<p>changes in condition, any new physician orders, and review of any new or existing devices including</p> <ul style="list-style-type: none"> • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on ensuring new orders for _____ include placement, patency/drainage, irrigation, _____, securement device, _____ care Qshift, and to record the output Qshift. • 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. <p>System Change:</p> <ul style="list-style-type: none"> • The daily clinical meeting form was edited to include: <ul style="list-style-type: none"> 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 _____ 	

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F 726	<p>Continued From page 26</p> <p>(Emergency Medical Services) 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.</p> <p>Review of the facility's employee list revealed LPN Staff B's date of hire was . . . The orientation for LPN Staff B did not include care of residents with including verification LPN Staff B was able to safely and correctly insert an in a male or female resident.</p> <p>On at 10:59 p.m., LPN Staff A documented in a progress note dated . . . at 5:00 p.m., Resident #1's was removed per the Advanced Practice Registered Nurse (APRN) order due to and clots, 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."</p> <p>The clinical record lacked documentation Resident #1's condition was monitored, including an evaluation of the resident, amount of vital signs or output.</p> <p>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." The transcribed order did not include to monitor for and clots.</p>	F 726	<p>to ensure orders to monitor output are in place.</p> <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> • 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. • Licensed Nurses and CNAs will complete competencies on care at the time of orientation and annually with the facility's Staff Development Coordinator. <p>4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> • 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 	

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F 726	<p>Continued From page 27</p> <p>On at 3:00 p.m., in an interview LPN Staff A verified on Resident #1's spouse told her there was no in the drainage bag. When she checked on the resident on at approximately 4:00 p.m., the drainage bag was empty. She said no one told her the resident had no output all day.</p> <p>Review of the facility's staff roster revealed LPN Staff A's date of hire was . The orientation, competency and skills checklist completed on did not include .</p> <p>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 amounts 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.</p> <p>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</p>	F 726	<p>determined by the QAPI committee.</p> <ul style="list-style-type: none"> 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. 	

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F 726	<p>Continued From page 28</p> <p>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. There was no documentation LPN Staff C obtained vital signs, monitored Resident #1 for continuous or increased Review of the facility's employee roster revealed LPN Staff C's date of hire was LPN Staff C's orientation and competency evaluation did not include management of residents with complications, and significant change in condition from a warranting immediate physician notification.</p> <p>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. She verified the lack of documentation verifying she monitored Resident #1 for adequate output, complications and significant change in condition.</p> <p>Review of the facility's employee roster revealed LPN Staff D's date of hire was LPN Staff D's competency validation dated did not include management of residents with complications, and significant change in condition from a warranting immediate physician notification.</p>	F 726			

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F 726	<p>Continued From page 29</p> <p>On at 5:05 p.m., in an interview RN Staff F said she had been the Staff Educator at the facility for 11 years and was responsible to ensure the competency of the nursing staff. She said LPN Staff B has been employed at the facility since and did not have a skills competency completed to ensure she had the skills to properly insert and monitor the residents for complications.</p> <p>RN Staff F provided a list titled, "Tasks that must be observed/deemed competent in performing" and a list titled "Daily tasks (This is not a complete list)". She said the items on the list are covered on day 2 of orientation for nurses. The list did not include insertion of monitoring and prompt identification of and change of condition from complications of</p> <p>She said the facility has not been doing care competencies, and did not ensure the nurses were knowledgeable to insert and monitor residents with. She said, "We will now."</p> <p>She provided a skills checklist which she said the facility started to use on to verify the nurse's competency on. She said the facility uses a mannequin for the competency demonstration.</p> <p>Review of the competency evaluation for LPN Staff B dated included insertion for male and female and Straight (In and Out). The Staff Educator checked "P" for previous experience, "D" for "Demonstrated and/or instructed by the Department, Supervisor or Mentor/ , and "RD" for "Return</p>	F 726		

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F 726	<p>Continued From page 30</p> <p>demonstration by the orientee and/or meets Performance Objective."</p> <p>The Staff Educator said she checked the boxes "D" and "RD" on the checklist without observing LPN Staff B inserting the _____ to ensure competency.</p> <p>On _____ at 5:35 p.m., in an interview the Director of Nursing said Resident #1's spouse voiced multiple complaints related to his care, including the _____. She said she investigated her complaints, but she did not focus on _____ output, the lack of assessment and vital signs when Resident #1 experienced acute _____. She said she discussed the concerns this week in an Ad Hoc (Unplanned) Quality Assurance and Performance Improvement Plan on _____.</p> <p>On _____ after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of _____.</p> <p>The Immediate actions implemented by the facility and verified by the survey team included:</p> <p>On _____ the facility educated their licensed</p>	F 726			

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F 726	<p>Continued From page 31</p> <p>nurses on completing a Change in Condition Assessment on residents. The education included identifying conditions that required an assessment including:</p> <p>Accidents resulting in injury; significant change in the resident's physical or mental condition, deterioration in health, mental or status; life threatening conditions or clinical complications including changes in output including color, consistency and output; circumstances that require an alteration in treatment including acute and conditions.</p> <p>A complete nursing evaluation must be conducted and documented in the medical record of systems. The nurses were educated to obtain a new set of vital signs and document in the electronic record in that the Change in Condition Assessment would contain the most recent and relevant vital signs. The provider shall be notified of pertinent evaluation findings. Nurses must visualize for amount of output, color and clarity during each shift.</p> <p>48 out of 50 licensed nurses were educated by . All remaining licensed nurses will be educated prior to working their next scheduled shift.</p> <p>On the facility began CNA and licensed nurse competencies on obtaining vital signs. Vital signs obtained for a change in condition are to be documented in the electronic record under the and vitals tab, so they populate in the change in condition assessment. As of 40 out of 82 CNAs and 22 out of 50 nurses were educated.</p> <p>On the facility completed audits including weekends and off hours to ensure the proper documentation of vital signs for all residents.</p>	F 726		

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F 726	<p>Continued From page 32</p> <p>On _____ the facility initiated the completion of audits 7 days a week and off hours to include _____ output for all residents with _____.</p> <p>On _____ the surveyor randomly selected 6 residents in the facility to ensure the facility was obtaining and documenting vital signs and output.</p> <p>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.</p> <p>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.</p> <p>On _____ the facility began 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.</p> <p>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.</p>	F 726		

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F 726	<p>Continued From page 33</p> <p>On the facility began education with licensed nurses on the requirement of detailed communication during shift-to-shift report to include any changes in condition, new orders, and review any existing devices including . . . 39/50 licensed nurses were educated as of . . . All remaining nurses to be re-educated prior to their next shift. The education was also added to the orientation for all newly hired nurses.</p> <p>On the facility began educating nurses on ensuring new orders for . . . will include placement, . . . patency/draining, irrigation, . . . securement, . . . care every shift and recording of output on the MAR. Verified 37 nurses out of 50 were educated by . . . Verified through observation and interview, nurses were educated prior to working their next shift.</p> <p>On the surveyor verified through interview with the DON and review of audits completed, interviews with 3 CNAs, 3 nurses and review of 6 random residents records to ensure proper nursing care and services for residents with . . . and those experiencing changes in condition.</p> <p>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.</p>	F 726			

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F 835 F 835 SS=J	Continued From page 34 Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Administration failed to utilize resources effectively to ensure nursing staff were trained, knowledgeable and competent to prevent the neglect of residents with diagnoses, including insertion of and monitoring for complications from the Resident #1 was an -male admitted to the facility with a diagnosis of prostatic hyperplasia (enlarged). Resident #1 had an (inserted in the to drain). On at 5:30 a.m., nursing staff changed Resident #1's and failed to ensure the was properly inserted and draining. Nursing staff neglected to notify the physician until at approximately 4:30 p.m. that Resident #1 had no output since the was inserted. On at approximately 4:30 p.m., Resident #1 experienced a copious amount of and clots when the was removed. Nursing staff neglected to take vital signs (Temperature, and	F 835 F 835	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. 2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken: • The VP of Operations re-reviewed the job description of the Administrator with Nursing Home Administrator. During this review it was discussed in detail that the administrator must ensure that each resident receives necessary care and services to attain and maintain the highest practical physical, mental, and wellbeing consistent with the resident's comprehensive assessment and plan on care. • The VP of Operations and NHA re-reviewed the job description of the Director of Nursing with the Director of Nursing. During this review it was		

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NAME OF PROVIDER OR SUPPLIER CHARLOTTE BAY REHAB AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4033 BEAVER LANE PORT CHARLOTTE, FL 33952		
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F 835	<p>Continued From page 35</p> <p>pressure) and monitor the resident with acute and significant</p> <p>On at 10:00 p.m., Resident #1 was emergently transferred to the hospital via Emergency Medical Services. The resident was unresponsive, and from his penis. Resident #1 had no documented output since at 10:00 p.m.</p> <p>The failure of the facility Administration to ensure nursing staff had the appropriate knowledge and competencies to safely care for residents with created a likelihood of serious harm, rehospitalization and of Resident #1 and other residents with from associated from from improper insertion and resulted in the determination of Immediate Jeopardy.</p> <p>On at 4:45 p.m., the Administrator was notified of the determination of Immediate Jeopardy.</p> <p>The findings included:</p> <p>Cross Reference to F600, F690, and F726.</p> <p>Review of the Administrator's job description signed on revealed, "The primary purpose of this position is to direct the day-to-day functions of the facility in accordance with current federal state and local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to residents at all times." The duties and responsibilities of the Administrator included, "Ensure that an adequate number of</p>	F 835	<p>discussed in detail that the purpose of her position is to plan, organize, develop, and direct the overall operation of the nursing services department in accordance with federal, state, and local standards, guidelines, and regulations to ensure the highest degree of quality care is maintained at all times.</p> <p>3) What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:</p> <p>Education:</p> <ul style="list-style-type: none"> • 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 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: <ul style="list-style-type: none"> o Accidents resulting in injury, or the potential to require physician intervention. o A significant change in the resident's physical, mental, or 		

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F 835	Continued From page 36 appropriately trained, competent, licensed professionals and non-licensed personnel are on duty at all times to meet the needs of the residents." The Director of Nursing job description signed on noted, "the primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator, or the Medical Director to ensure that the highest degree of quality care is maintained at all times." The Director of Nursing duties and responsibilities included, "Develop, implement, and maintain an ongoing quality assurance program for the nursing service department . . . Assist the Quality Assessment & Assurance committee in developing and implementing appropriate plans of action to correct identified deficiencies . . . Assist in developing plans of action to correct potential or identified problem areas . . . Nursing Care Functions . . . Ensure that direct nursing care be provided by LPN (Licensed Practical Nurses), CNA's (Certified Nursing Assistants), and/or a nurse aide trainee qualified to perform the procedure . . . Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to care, and that such care is provided in accordance with the resident's wishes . . . Develop and participate in the planning, conducting and scheduling of timely in-service training classes that provide instructions on "how to do the job" and ensure a well-educated nursing service department . . . develop, implement and maintain an effective orientation program that	F 835	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. • 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	

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F 835	<p>Continued From page 37</p> <p>orients the new employee to the department, its policies and procedures, and to his/her job position and duties. . ."</p> <p>Review of the Facility Assessment Tool revealed the facility accepts residents with system diagnoses such as (lack of control due to a or cord condition), prostatic hyperplasia (enlarged), (blockage of tract),</p> <p>The assessment noted services and care offered based on residents needs included intermittent or other</p> <p>1. Review of the clinical record revealed Resident #1 was admitted to the facility on Diagnoses included prostatic hyperplasia. Resident #1 had an (inserted in the to drain),</p> <p>The physician's orders as of included to measure and record [. ,] output every shift.</p> <p>The CNA's output documentation for Resident #1 differed from the output documented by the Licensed Nurses on the Treatment Administration Record (TAR), making it difficult to determine Resident #1's output for the following days:</p> <p>On at 10:56 p.m., the CNA documented the output was 1400 cc. The Licensed Nurse documented on the TAR the output was 250 cc.</p> <p>On at 8:57 p.m., the CNA documented the output was 700 cc. The Licensed Nurse documented the output was 450 cc.</p> <p>On the CNA documented at 2:59 p.m.,</p>	F 835	<p>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.</p> <ul style="list-style-type: none"> 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 Administrator and Director of Nursing were reeducated by Regional Nurse Consultant on: <ul style="list-style-type: none"> The components of the regulation: F600 Free from and Neglect Neglect, Neglect, <p>Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) with indicators of neglect.</p> <ul style="list-style-type: none"> Facility standard and guideline P&P Neglect and Investigations to include: <ul style="list-style-type: none"> Screening Training Prevention Identification Investigation Protection Reporting The facility's Staff Development Coordinator/Designee completed education with facility staff on and Neglect with an emphasis on the following F600 noncompliance: The facility failed to protect resident rights to be free from neglect by failing to appropriately monitor the resident's output and failure to monitor the resident when the 	

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F 835	<p>Continued From page 38</p> <p>"Response not required." The Licensed Nurses documented a total of 750 cc.</p> <p>On _____ the CNA documentation showed a total of 1000 cc. The Licensed Nurses documented a total of 650 cc.</p> <p>On _____ the CNA documentation showed a total of 700 cc. The Licensed Nurses documented a total of 550 cc.</p> <p>On _____ there was no CNA documentation of _____ output. The Licensed Nurses documented a total of 1000 cc.</p> <p>There was no _____ output documented for the night shift of _____, the day shift of _____, or the evening shift of _____</p> <p>On _____ at 9:20 a.m., in an interview Registered Nurse Staff E said the facility policy was to document intake and output on the Treatment Administration Record (TAR). He said the nurses get the output from the CNAs each shift and document the total output on the TAR.</p> <p>On _____ at 4:10 p.m., a _____ interview was conducted with the Administrator, the Director of Nursing and the Regional Nurse Consultant to discuss Resident #1's care and emergent transfer to the hospital on _____.</p> <p>The Regional Nurse Consultant verified the documentation of _____ output for Resident #1 was not accurate.</p> <p>The Director of Nursing said the best practice would be for the nurses to monitor the _____ and the output and document on the TAR. She verified she did not review Resident #1's clinical record for accuracy of the documentation when he was transferred to the hospital until the concerns voiced this week</p>	F 835	<p>_____ was discontinued. On _____ at approximately 4:30 p.m. resident's _____ was discontinued. Resident _____ experienced copious _____ and was passing clots through his penis. The facility neglected to monitor resident's status including vital signs with a significant change in condition.</p> <ul style="list-style-type: none"> • The DON and Nurse Management Team were educated by the Regional Nurse Consultant on the components of the management of _____ with an emphasis on _____ output monitoring and ANEMI. • The facility's Staff Development Coordinator/Designee completed education with licensed nurses on ensuring new orders for _____ include placement, patency/drainage, irrigation, securement device, _____ care Qshift, and to record the output Qshift. • 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 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. 		

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F 835	<p>Continued From page 39</p> <p>related to the accuracy and lack of CNA documentation of output.</p> <p>Review of the Treatment Administration Record (TAR) for revealed on Licensed Practical Nurse (LPN) Staff B changed Resident #1's . The clinical record lacked documentation LPN Staff B verified the was properly inserted and draining There was no output documented for the day shift of , or the evening shift of</p> <p>On at 10:59 p.m., LPN Staff A documented in a progress note for an effective date of at 5:00 p.m., Resident #1's was removed per the Advanced Practice Registered Nurse (APRN) order due to and clots, 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."</p> <p>LPN Staff A did not transcribe the APRN's order until at 10:02 p.m., five hours after receiving the order, and after Resident #1 was transferred to the hospital. The order read, "Send out to ER (Emergency Room) if resident does not within a couple hours." The order did not include to monitor for , and clots.</p> <p>Review of the nursing progress notes revealed on a 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 day shift nurse to send Resident #1 to the hospital per the Advanced Practice Registered Nurse (APRN) order if Resident #1 was not able to and</p>	F 835	<p>System Change:</p> <ul style="list-style-type: none"> • The daily clinical meeting form was edited to include: <ul style="list-style-type: none"> 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. • Licensed Nurses and CNAs will complete competencies on care at the time of orientation and annually with the facility's Staff Development Coordinator. • The Director of Nursing/designee will operate as the lead investigator on all clinical investigations to ensure that the review of the care provided to facility residents meets standards. • The Administrator and Director of Nursing will complete a comprehensive investigation to include a 72 hour look of events to ensure no deprivation of care or services occurred. On the Administrator and Director of Nursing were educated by the regional nurse 	

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F 835	<p>Continued From page 40</p> <p>clots continued. LPN Staff B documented, "Clots continued, no (patient) sent to hospital at 2200 (10:00 p.m.) for further evaluation. Family notified."</p> <p>The clinical record lacked documentation Resident #1 was monitored, vital signs obtained, and amount of assessed and documented to promptly identify significant changes requiring physician notification.</p> <p>Review of the Emergency Medical Services () Prehospital Care Report revealed the unit was notified by dispatch on at 9:51 p.m. The narrative noted Resident #1 was found lying supine (up) in bed with a facility nurse at his side. Resident #1 was unresponsive but breathing. The facility nurse stated that earlier today Resident #1 had a () 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. The report noted under patient condition 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.</p> <p>Review of the local hospital record revealed Resident #1 was initially seen in the ER on at 10:22 p.m. The ER progress note documented Resident #1 arrived at the</p>	F 835	<p>consultant on utilizing an investigation checklist to ensure all elements and facts are thoroughly reviewed and completed.</p> <ul style="list-style-type: none"> All facility investigations related to ANEMI will be reviewed in detail with the facility's Medical Director to ensure all areas of the investigation were completed and that the facility has identified the root cause of the incident. <p>4) How will the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> 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. 	

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F 835	<p>Continued From page 41</p> <p>Emergency Department from the facility for complaint of clots after removal. Upon arrival, Resident #1 was unresponsive to painful stimuli, and had a temperature of 100.2.</p> <p>Review of the facility's incident investigations revealed on at approximately 11:50 a.m., Resident #1's spouse reported to the facility that her husband was on life support at the hospital as a result of a and, that he acquired during his stay at the facility due to improper care. The Administrator noted the facility recognized this statement as an allegation of neglect and started an investigation.</p> <p>The investigation noted that on the morning of Resident #1's was changed per the physician order. Resident #1 was later noted to have no output and his was irrigated (flushed) with clots observed. New orders were obtained from the Advanced Practice Registered Nurse to remove the at which time further clots were noted by nursing staff. Additional orders were then obtained to hold and and to transfer resident out if no output was observed and clots continued. Nursing continued to evaluate Resident #1 with no output identified with continued clots and resident was subsequently transferred to the hospital.</p> <p>As part of their investigation, the facility obtained statements from LPN Staff A, LPN Staff B and LPN Staff C. The facility's investigation did not include statements from the Certified Nursing Assistants who took care of Resident #1 on and and did not document output.</p>	F 835		

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F 835	<p>Continued From page 42</p> <p>The facility's investigation noted, "Conclusions: After a complete and thorough investigation, this allegation of neglect cannot be verified. The facility provided care to (Resident #1) in adherence with physician orders. Due to (Resident #1) health status he was subsequently sent to the hospital at which time he was admitted . . . Summary of all corrective actions taken: Nursing staff education has been initiated r/t (related to) neglect with an emphasis on care upon receiving this allegation . . ."</p> <p>The facility's investigation did not include the lack of monitoring of Resident #1's output, LPN Staff B's lack of documentation of return verifying correct placement of the , the resident's condition including vital signs (Temperature, and) with the acute onset of copious , the passing of clots, and amount of , and the change in mental status not addressed by the nursing staff.</p> <p>On at 8:30 a.m., in an interview LPN Staff B said on at 5:30 a.m., there was no in Resident #1's bag before she changed the . She said when she left work on at 7:00 a.m., there was no in the drainage bag. 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 . LPN Staff B verified the Advanced Practice Registered Nurse gave orders to monitor the resident and send him out if he did not stop on at approximately 5:00 p.m., but she did not transcribe the orders until at 10:00 p.m. She said she took Resident #1's vital signs twice during her shift but did not document them.</p>	F 835		

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F 835	<p>Continued From page 43</p> <p>She said Resident #1 was alert but when Emergency Medical Services () arrived. She could not remember when Resident #1 became . . .</p> <p>On at 5:05 p.m., in an interview RN Staff F said she had been the Staff Educator at the facility for 11 years and was responsible to ensure the competency of the nursing staff. She said LPN Staff B had been employed at the facility since and did not have a competency to ensure she had the skills to properly insert and monitor the residents for complications. She said the facility had not been doing care competencies, and did not ensure the nurse's were knowledgeable to insert and monitor residents with . She said, "We will now."</p> <p>She provided a skills checklist which she said the facility started to use on to verify the nurses competency on . She said the facility uses a mannequin for the competency demonstration.</p> <p>Review of the competency evaluation for LPN Staff B dated included insertion for male and female and Straight (In and Out). The Staff Educator checked "P" for previous experience, "D" for "Demonstrated and/or instructed by the Department , Supervisor or Mentor/ , and "RD" for "Return demonstration by the orientee and/or meets Performance Objective. "The Staff Educator said she checked the boxes "D" and "RD" on the checklist without observing LPN Staff B inserting the to ensure competency.</p>	F 835		

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F 835	<p>Continued From page 44</p> <p>On _____ at 5:35 p.m., in an interview the Director of Nursing said Resident #1's spouse voiced multiple complaints. In the investigation she did not focus on _____ output, the lack of assessment and vital signs when Resident #1 experienced acute _____. She verified she discussed the concerns identified this week in an Ad Hoc (Unplanned) Quality Assurance and Performance Improvement Plan on _____.</p> <p>On _____ after verification of implementation of an acceptable Immediate Jeopardy removal plan, the Immediate Jeopardy was removed as of _____.</p> <p>The Immediate actions implemented by the facility and verified by the survey team included:</p> <p>On _____ the Vice President of Operations reviewed their job descriptions with the Nursing Home Administrator (NHA) and Director of Nursing (DON). During this review it was discussed in detail that the administrator must ensure that each resident receives necessary care and services to attain and maintain the highest practical physical, mental and _____ well-being consistent with the resident's comprehensive assessment and plan of care.</p> <p>On _____ the Vice President of Operations and NHA re-reviewed the job description of the DON with the DON. It was discussed in detail that the purpose of her position is to plan, organize, develop, and direct the overall operation of the</p>	F 835			

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NAME OF PROVIDER OR SUPPLIER CHARLOTTE BAY REHAB AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4033 BEAVER LANE PORT CHARLOTTE, FL 33952	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	<p>Continued From page 45</p> <p>nursing services department in accordance with regulations and standards, guidelines, and to ensure the highest degree of care is maintained at all times.</p> <p>As of _____, the DON will be lead investigator on all clinical investigations to ensure resident care met all accepted standards. This investigation will include a 72-hour look _____ in time to include additional information on the events leading to the event.</p> <p>As of _____ the investigations on Neglect, _____, Misappropriation, and Injury will be reviewed in detail with the medical director to ensure all areas of the investigation were completed and that the facility has identified the root cause analysis of the incident.</p> <p>As of _____ the NHA and DON will complete a comprehensive investigation to include a 72-hour look _____ on events to ensure no deprivation of care or services occurred. On _____ the NHA and DON were educated by the regional nurse consulted on utilizing an investigation checklist to ensure all elements and facts are thoroughly reviewed and completed.</p> <p>On _____ the facility conducted an unplanned (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, _____, Director, Minimum Data Set nurse, Nurse, CNA. The meeting addressed the adequate monitoring of _____ output for residents with _____ and the adequate monitoring</p>	F 835		

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F 835	<p>Continued From page 46</p> <p>of vital signs for residents with changes in condition. The DON rereviewed the facility assessment and identified the facility's clinical capabilities included caring for residents with without nurse competency for completed.</p> <p>On the facility initiated training to the nurses for insertion and return demonstration for 42 of 50 nurses with all nurses to be retrained prior to working their next shift. Verified the retraining and return demonstration for Staff A, LPN, Staff C, LPN, Staff B, LPN, and Staff D.</p> <p>On the facility added to the orientation plan of all newly hired nurses to include complete competencies on the proper insertion of with return demonstration prior to providing resident care.</p> <p>On CNA education was initiated to ensure the following: any notable changes in output for residents with and those residents experiencing a change in condition must be reported immediately to the nurse. CNAs were educated by . All remaining CNAs are to be educated prior to working their next shift.</p> <p>On the facility educated their licensed nurses on completing a Change in Condition Assessment on residents. The education included identifying conditions that required an assessment including:</p> <p>Accidents resulting in injury; significant change in the resident's physical or mental condition,</p>	F 835			

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F 835	<p>Continued From page 47</p> <p>deterioration in health, mental or status; life threatening conditions or clinical complications including changes in output including color, consistency and output; circumstances that require an alteration in treatment including acute and conditions. A complete nursing evaluation must be conducted and documented in the medical record of systems. The nurses were educated to obtain a new set of vital signs and document in the electronic record in that the Change in Condition Assessment would contain the most recent and relevant vital signs. The provider shall be notified of pertinent evaluation findings. Nurses must visualize for amount of output, color and clarity during each shift.</p> <p>On nurses were re-educated. The remaining nurses will be educated prior to working their next shift.</p> <p>On the facility initiated audits of residents in the facility to ensure the nursing staff was recording vital signs and proper documentation of those vital signs.</p> <p>On the facility initiated audits of residents with 7 days a week to ensure the measuring and documenting of the output each shift.</p> <p>On the facility edited the daily clinical meeting to include the review of all residents with changes in condition to ensure vital signs and a timely transfer was completed; review of all new and existing residents with had monitoring and documenting of output amount in place; review of vital signs for all residents per physician order.</p>	F 835		

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F 835	<p>Continued From page 48</p> <p>On the Nursing Home Administrator (NHA) and Director of Nursing (DON) were re-educated on the policy and procedure for Neglect, and by the Regional Clinical Nurse. The education included screening, training staff to prevent neglect and . All allegations of neglect are to be reported to the NHA or the person in charge immediately. Investigation, protection, and reporting to follow.</p> <p>On the facility began staff in-service training and education on and Neglect with the emphasis on failure to protect resident rights to be free of neglect by failing to monitor output and to monitor the resident when the was discontinued. The resident experienced copious amounts of , and clots through his penis. The facility failed to monitor vital signs with a significant change in condition. 141 of 171 staff members received this education by All remaining staff would be educated prior to working their next shift.</p> <p>On the DON and nurse management team was re-educated by the regional clinical director on the components of the management of with an emphasis on Neglect, , Misappropriation, and Injury.</p> <p>On the facility initiated education with licensed nurses to ensure new orders for included placement, patency/drainage, irrigation, securement, care each shift and recording of output on the MAR.</p>	F 835			

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F 835	<p>Continued From page 49</p> <p>37 nurses out of 50 were educated by</p> <p>On the surveyor verified through interviews that the nurses were educated prior to working their next shift.</p> <p>On for educating nurses on the requirement of detailed communication during shift-to-shift report will include any changes in condition, any new orders, and review any new or existing devices including</p> <p>Verified the training of 39/50 nurses by</p> <p>All remaining licensed nurses will be educated prior to working their next shift. This education has also been added to the orientation agenda for all newly hired licensed nurses to be provided prior to resident care.</p> <p>On an (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting was held, and a root cause analysis of the incident was done. Attendees of the QAPI included the Medical Director, Director of Nursing, Administrator, Human Resources, Social Service, Activities, Director, Minimum Data Set nurse, Nurse, CNA.</p> <p>On the surveyor verified through interviews with the DON and facility staff, review of the audits, and review of 6 random resident records to ensure accurate assessment of resident vital signs, obtaining and documenting output and proper documentation for residents experiencing a change in condition.</p>	F 835			