STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375540	A. BUILDING _____ B. WING _____	02/05/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTEVISTA REHABILITATION AND SKILLED CARE	7604 QUANAH PARKER TRAILWAY LAWTON, OK 73505

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 02/02/15, an immediate jeopardy (IJ) was determined to exist due to the facility's failure to notify the physician and family member in a timely manner concerning the resident's increased pain and increased bleeding from his Foley catheter. The IJ situation was verified with the Oklahoma State Department of Health (OSDH). At 2:45 p.m., the administrator and the director of nurses (DON) were notified of the above IJ situation. At 5:08 p.m., an acceptable plan of removal was presented to the survey team. The plan of removal documented: 1. All residents with foley catheters will be assessed by an RN (registered nurse) by 9:00 p.m. 02/02/15 2. Licensed nurses will be checked for competency in providing catheter care, to include, insertion, removing, the changing of a catheter, when to call the MD (medical doctor). When to pull the catheter and when not to pull the catheter. Licensed nurses to be completed by 02/02/15 at midnight. If they cannot come in, they will not work any shift until they are checked off. 3. In-service will be done regarding catheter care, physician notification, monitoring of residents on anticoagulant therapy for signs, and symptoms of bleeding, and pain management to be completed by 02/02/15 at midnight. 4. The Director of Nursing/Designee will monitor during daily clinical stand up to ensure policy is followed. 5. Catheter care and physician notification will be reported to the QA&A (quality assurance) committee for follow up and recommendation. On 02/04/15 at 1:15 p.m. thru 4:30 p.m., the nursing staff from the day and afternoon shifts who attended the in-service were interviewed. They were knowledgeable in regard to guidelines for notifying physicians and family members of clinical problems. The IJ was removed effective 02/02/15 at 10:00 p.m., although the deficient practice remained at actual harm, at a patten. Based on Interview and record review it was determined the facility failed to ensure the physician and a family member was notified in a timely manner concerning the increased pain and increased bleeding from a Foley catheter for one (#1) of 6 residents reviewed for Foley catheter care. Resident #1 was on anticoagulant therapy. This resulted in actual harm when the resident was admitted to the hospital and required surgery. This had the potential to affect all 8 residents with Foley catheters. Findings: The 5-day assessment, dated 01/07/15, documented the resident's cognition was intact. Ambulation had not occurred: he was totally dependent upon staff for transfers. He required extensive assistance for dressing, limited assistance for hygiene and supervision for eating. His range of motion was impaired on one side. The resident had a suprapubic catheter. His [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The resident had received the [MEDICATION NAME] from 10/10/14 thru 12/31/14. The facility's policy for notifying physicians of clinical problems documented, .Immediate notification (Acute) Problems, The following symptoms, signs . should prompt immediate notification of the physician, after an appropriate nursing evaluation. #3 (a) Sudden onset or a marked change compared.to usual status and are (b) unrelieved by measures which have already been prescribed. A nurse's note dated 12/23/14, (late entry without a time) documented, 12/22/14 - Pt. (patient) c/o (complains of) f/c (Foley catheter) leaking @ 1600 (4:00 p.m.). Urine and scant amt blood noted on underwear. F/C re-positioned and cath guard applied. Pt c/o the same issue again @ 1800 (6:00 p.m.). F/C changed with 16FR (french) with immediate return of bloody urine. Pt with severe muscle cramps BLE (bilateral lower extremities). Medicated with [MEDICATION NAME] per prn orders and muscle rub applied BLE. Re-checked F/C @ 1840 (6:40 p.m.) with bloody urine in bag and clear yellow urine in tubing. A nurse's note, dated 12/22/14 at 7:56 p.m., documented [MEDICATION NAME] was not given until this time and not at 6:00 p.m. The administration of this [MEDICATION NAME] was 1 hour and 56 minutes later than documented it had been given. A nurse's note, dated 12/22/14 at 9:34 p.m., documented Tylenol 325 mg tablet, 2 tablets were given. A nurse's note, dated 12/22/14 at 11:40 p.m., documented, Residents Foley catheter was changed earlier today on day shift. Dark red blood noted draining from Foley and coming from groin area. Resident complaining of pain. PRN (as needed) [MEDICATION NAME] was given about 1800 (6:00 p.m.), asked resident would he like his Tylenol, resident refused on more than one occasion. Called another nurse for assistance. Resident agreed to take Tylenol to ease the pain. Resident was taken back to his room where his foley was flushed but continued to have dark red blood. Patient urinated just a small amount. Bladder scan showed he still had more than 500 ccs (cubic centimeters) of urine retention. Attempted to change and insert catheter once again, but he continued to bleed. MD called and notified, with an order to send resident to (local hospital) ER (emergency room). Daughter (name deleted) called and notified. ADON notified. (name deleted ambulance service) called. Report given to ER Nurse. The resident's operative report from the local hospital, dated 12/24/14, documented: .Preoperative Diagnoses: [REDACTED]. On 01/23/15, at 10:25 a.m., resident #1 stated After (name withheld) changed out my catheter, it started bleeding, I told (name withheld) I was hurting. She told me she would leave a note for the next shift. It started hurting real bad, I told (name withheld) it was hurting real bad. She said I already had my pain medication and I couldn't have any more for 6 hours. She offered me Tylenol, I told her I was hurting too bad that Tylenol wouldn't help it, so a little bit later I went and told her again I was hurting really really bad and my clothes were soaked in blood. The nurses just ignored me and didn't pay any attention to me when I kept telling them about all the pain. (Name withheld) asked me if I wanted to go to the ER. She told me I had to decide that. I told her that was not my decision to make. She stated she was not making that decision, she didn't want to do all that paperwork. The surveyor asked the resident if his pain had resolved before he went to the ER. He stated, No it wasn't, I was still in a lot of pain. On 02/02/15 at 10:30 a.m., licensed practical nurse (LPN) #1 was asked, what she had done for the resident's pain. She stated, I gave him a muscle relaxer, I worked on his legs, he was frogging up with muscle spasms, I'm not sure if pain meds were given at this time or not. She was asked if after seeing the blood and knowing he was in pain, had she called the physician? She stated, No, I wasn't concerned at that time about the blood. On 01/23/15 at 4:10 p.m., LPN #2 was interviewed and stated, When I was in report they said (resident #1's) catheter was changed earlier that day. The nurse I was relieving said it was bleeding after she changed the catheter. She said she tried to flush it but it wouldn't flush. I started working on the EMAR (electronic medication administration system). Then I was told by the certified nurses aides (CNA's) (resident #1) wanted to talk to me. The CNA told me his Foley bag was clotted off with blood. I don't remember what time I went into his room. I got the blood from the tube to go down in to the bag, then I went back to doing what I was doing before. Every time he was bleeding we changed him. He kept sitting in different positions to help with the pain. So I got (LPN #3) and then he took some Tylenol, then (LPN #3) took him back to his room. She tried to change his Foley again, but it only kept bleeding. He kept saying he had to pee, so he peed a small amount and then would bleed again. Then (LPN #3) tried to put the Foley back in but kept getting resistance. On 01/23/15 at 3:20 p.m., LPN #3 was interviewed and stated, LPN #2 had called her around 10:00 p.m. I was working on the skilled nursing side. I went over to the long term care side. The resident was sitting at the nurse's station in his wheel chair, his Foley was almost completely full of blood, no urine, all blood. We took him to his room, he complained it was hurting really bad. I used the bladder scan and it showed he had a little over 900 cc's of urine, so I removed the catheter and turned him on his side and massaged his bladder, he would void a small amount, and then blood would come out, then void

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

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) a small amount then blood again, he complained of burning and pain. The CNA ran and got a new Foley. I tried to put a new Foley in and only got blood clots out, no urine. They were really huge blood clots, not little ones. I decided because of the large amount of blood, we should send him out. I massaged his bladder again and he voided some more before he left. I used the bladder scan again before he left and it was showing around 500 cc's urine. He left to the ER without a Foley in. This had been going on for almost 5 hours before he was sent out. At 3:45 p.m. CNA #1 was interviewed and stated, Around 6:00 p.m. I noticed his Foley bag only had blood in it, it was about half full. I went and told (LPN #1) that the bag was full of blood. She replied, 'I know it's full of blood, it just has to drain thru before the urine comes out.' She didn't seemed concerned. After supper he said he was in a lot of pain. We went and told (LPN #1) again. She said the same thing, the blood just has to pass thru before the urine gets in the catheter. The resident kept calling us back into his room because he was in so much pain and blood kept getting on his sheets. By this time, (LPN #1) had given repot to (LPN #2). Me and the other CNA were freaking out because of all the blood, we changed his sheets 4 or 5 times, this went on almost my entire shift. We got him up to the chair, we put a brief and a sheet over him. He kept complaining about pain. He told us something's not right. So we reported to (LPN #2) that he was in a lot of pain. I told her the catheter is not working, the resident said he feels like he has to pee. (LPN #2) said, 'Ok, I'll check him in a little while' and she kept passing medication. he called me and the other CNA in to his room [ROOM NUMBER] or 3 more times before (LPN#2) responded. By this time (resident #1) started getting upset because no licensed nurse was responding to him. It was around 9 by the time (LPN #2) went in and checked on him. There was so much blood. After (LPN#2) checked on him, she kept saying she didn't know what to do. So we put him back in bed. He kept complaining of a ton of pain and the need to urinate. I just kept reporting to (LPN #2, then around 10:00 p.m., (LPN #3) came over. She used the bladder scanner, it showed around 900 cc's. She took the catheter out and tried to recath him. but only big blood clots were coming out. Blood was everywhere, he was still in a lot of pain and shaking, I thought he was going to pass out or go into shock. (LPN #3) said something's not right cause she couldn't put the catheter back in. So (LPN #3) told (LPN#2) to send him to the ER. This went on almost my entire shift, (LPN #1 and #2) would not make a decision. They both just passed it off, finally (LPN #3) made the decision to send him out. On 02/02/15, at 10:58 a.m., the ADON was asked if she was called at any time on the night of 12/22/14 concerning resident #1's pain and bleeding related to his foley catheter. She stated, No, I did not get a call from staff, but only received a text at 11:24 p.m. that stated Sent (resident #1) to (local hospital) Fyi. She was asked if the nurse's should have called her. She stated, Yes, but they wouldn't call me to insert a catheter. She was asked if any training had been done with the licensed staff regarding catheter care, insertion. She stated, No. She hadn't had time to. She stated, she had spoke to the staff about it, but had no documentation regarding the incident. She was asked if the potential still existed for problems related to Foley catheters to re-occur. She stated Yes. The residents's physician was interviewed and stated he was not notified of the resident's condition until sometime between 10:00 p.m. and 11:00 p.m. on 12/22/14. The resident's family member stated she was not notified of the resident's condition until 11:15 p.m. on 12/22/14. On 02/05/15 at 10:00 p.m. the DON was in agreement staff should have notified the physician and the family immediately with any change of condition.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 02/02/15, an immediate jeopardy (IJ) was determined to exist due to the facility's failure to thoroughly assess, monitor and appropriately intervene in a timely manner, after resident #1 experienced increased bleeding and increased pain following the replacement of his Foley catheter. The IJ situation was verified with the Oklahoma State Department of Health (OSDH). At 2:45 p.m., the administrator and the director of nurses (DON) were notified of the above IJ situation. At 5:08 p.m., an acceptable plan of removal was presented to the survey team. The plan of removal documented: 1. All residents with foley catheters will be assessed by an RN (registered nurse) by 9:00 p.m. 02/02/15 2. Licensed nurses will be checked for competency in providing catheter care, to include, insertion, removing, the changing of a catheter, when to call the MD (medical doctor). When to pull the catheter and when not to pull the catheter. Licensed nurses to be completed by 02/02/15 at midnight. If they cannot come in, they will not work any shift until they are checked off. 3. In-service will be done regarding catheter care, physician notification, monitoring of residents on anticoagulant therapy for signs, and symptoms of bleeding, and pain management to be completed by 02/02/15 at midnight. 4. The Director of Nursing/Designee will monitor during daily clinical stand up to ensure policy is followed. 5. Catheter care and physician notification will be reported to the QA&A (quality assurance) committee for follow up and recommendation. On 02/04/15 at 1:15 p.m. thru 4:30 p.m., the nursing staff from the day and afternoon shifts who attended the in-service were interviewed. They were knowledgeable in regard to guidelines for notifying physicians and family members of clinical problems. The IJ was removed effective 02/02/15 at 10:00 p.m., although the deficient practice remained at actual harm, at a patten. Based on interview and record review, it was determined the facility failed to ensure one (#1) of six residents was thoroughly assessed, monitored and provided appropriate care in a timely manner, after he experienced increased bleeding (was receiving anticoagulant therapy) and increased pain following the replacement of his Foley catheter. This resulted in actual harm when the resident was admitted to the hospital and required surgery. This had the potential to affect all 8 residents with Foley catheters. Findings: The 5-day assessment, dated 01/07/15, documented the resident's cognition was intact. Ambulation had not occurred: he was totally dependent upon staff for transfers. He required extensive assistance for dressing, limited assistance for hygiene and supervision for eating. His range of motion was impaired on one side. The resident had a suprapubic catheter. His [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The resident had received the [MEDICATION NAME] from 10/10/14 thru 12/31/14. The facility's policy for notifying physicians of clinical problems documented, .Immediate notification (Acute) Problems, The following symptoms, signs . should prompt immediate notification of the physician, after an appropriate nursing evaluation. #3 (a) Sudden onset or a marked change compared.to usual status and are (b) unrelieved by measures which have already been prescribed. A nurse's note dated 12/23/14, (late entry without a time) documented, 12/22/14 - Pt. (patient) c/o (complains of) f/c (Foley catheter) leaking @ 1600 (4:00 p.m.). Urine and scant amt blood noted on underwear. F/C re-positioned and cath guard applied. Pt c/o the same issue again @ 1800 (6:00 p.m.). F/C changed with 16FR (french) with immediate return of bloody urine. Pt with severe muscle cramps BLE (bilateral lower extremities). Medicated with [MEDICATION NAME] per prn orders and muscle rub applied BLE. Re-checked F/C @ 1840 (6:40 p.m.) with bloody urine in bag and clear yellow urine in tubing. A nurse's note, dated 12/22/14 at 7:56 p.m., documented [MEDICATION NAME] was not given until this time and not at 6:00 p.m. The administration of this [MEDICATION NAME] was 1 hour and 56 minutes later than documented it had been given. A nurse's note, dated 12/22/14 at 9:34 p.m., documented Tylenol 325 mg tablet, 2 tablets were given. A nurse's note, dated 12/22/14 at 11:40 p.m., documented, Residents Foley catheter was changed earlier today on day shift. Dark red blood noted draining from Foley and coming from groin area. Resident complaining of pain. PRN (as needed) [MEDICATION NAME] was given about 1800 (6:00 p.m.), asked resident would he like his Tylenol, resident refused on more than one occasion. Called another nurse for assistance. Resident agreed to take Tylenol to ease the pain. Resident was taken back to his room where his foley was flushed but continued to have dark red blood. Patient urinated just a small amount. Bladder scan showed he still had more than 500 ccs (cubic centimeters) of urine retention. Attempted to change and insert catheter once again, but he continued to bleed. MD called and notified, with an order to send resident to (local hospital) ER (emergency room). Daughter (name deleted) called and notified. ADON notified. (name deleted ambulance service) called. Report given to ER Nurse. The resident's operative report from the local hospital, dated 12/24/14, documented: .Preoperative Diagnoses: [REDACTED]. On 01/23/15, at 10:25 a.m., resident #1 stated After (name withheld) changed out my catheter, it started bleeding, I told (name withheld) I was hurting. She told me she would leave a note for the next shift. It started hurting real bad, I told (name withheld) it was hurting real bad. She said I already had my pain medication and I couldn't have any more for 6 hours. She offered me Tylenol, I told her I was hurting too bad that Tylenol wouldn't help it, so a little bit later I went and told her again I was hurting really really bad and my clothes were soaked in blood. The nurses just ignored me and didn't pay any attention to me when I kept telling them about all the pain. (Name withheld) asked me if I wanted to go to the ER. She told me I had to decide that. I told her that was not my decision to make. She stated she was not making that decision, she didn't want to do all that paperwork. The surveyor asked the resident if his pain had resolved before he went to the ER. He stated, No it wasn't, I was still in a lot of pain. On 02/02/15 at 10:30 a.m., licensed practical nurse (LPN) #1 was asked, what she had done for the resident's pain. She stated, I gave him a muscle relaxer, I worked on his legs, he was frogging up with muscle spasms, I'm not sure if pain meds were given at this time or not. She was asked if after seeing the blood and knowing he was in pain, had she called the physician? She stated, No, I wasn't concerned at that time about the blood. On 01/23/15 at 4:10 p.m., LPN #2 was

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) interviewed and stated, When I was in report they said (resident #1's) catheter was changed earlier that day. The nurse I was relieving said it was bleeding after she changed the catheter. She said she tried to flush it but it wouldn't flush. I started working on the EMAR (electronic medication administration system). Then I was told by the certified nurses aides (CNA's) (resident #1) wanted to talk to me. The CNA told me his Foley bag was clotted off with blood. I don't remember what time I went into his room. I got the blood from the tube to go down in to the bag, then I went back to doing what I was doing before. Every time he was bleeding we changed him. He kept sitting in different positions to help with the pain. So I got (LPN #3) and then he took some Tylenol, then (LPN #3) took him back to his room. She tried to change his Foley again, but it only kept bleeding. He kept saying he had to pee, so he peed a small amount and then would bleed again. Then (LPN #3) tried to put the Foley back in but kept getting resistance. On 01/23/15 at 3:20 p.m., LPN #3 was interviewed and stated, LPN #2 had called her around 10:00 p.m. I was working on the skilled nursing side. I went over to the long term care side. The resident was sitting at the nurse's station in his wheel chair, his Foley was almost completely full of blood, no urine, all blood. We took him to his room, he complained it was hurting really bad. I used the bladder scan and it showed he had a little over 900 cc's of urine, so I removed the catheter and turned him on his side and massaged his bladder, he would void a small amount, and then blood would come out, then void a small amount then blood again, he complained of burning and pain. The CNA ran and got a new Foley. I tried to put a new Foley in and only got blood clots out, no urine. They were really huge blood clots, not little ones. I decided because of the large amount of blood, we should send him out. I massaged his bladder again and he voided some more before he left. I used the bladder scan again before he left and it was showing around 500 cc's urine. He left to the ER without a Foley in. This had been going on for almost 5 hours before he was sent out. At 3:45 p.m. CNA #1 was interviewed and stated, Around 6:00 p.m. I noticed his Foley bag only had blood in it, it was about half full. I went and told (LPN #1) that the bag was full of blood. She replied, 'I know it's full of blood, it just has to drain thru before the urine comes out.' She didn't seemed concerned. After supper he said he was in a lot of pain. We went and told (LPN #1) again. She said the same thing, the blood just has to pass thru before the urine gets in the catheter. The resident kept calling us back into his room because he was in so much pain and blood kept getting on his sheets. By this time, (LPN #1) had given repot to (LPN #2). Me and the other CNA were freaking out because of all the blood, we changed his sheets 4 or 5 times, this went on almost my entire shift. We got him up to the chair, we put a brief and a sheet over him. He kept complaining about pain. He told us something's not right. So we reported to (LPN #2) that he was in a lot of pain. I told her the catheter is not working, the resident said he feels like he has to pee. (LPN #2) said, 'Ok, I'll check him in a little while' and she kept passing medication. he called me and the other CNA in to his room [ROOM NUMBER] or 3 more times before (LPN#2) responded. By this time (resident #1) started getting upset because no licensed nurse was responding to him. It was around 9 by the time (LPN #2) went in and checked on him. There was so much blood. After (LPN#2) checked on him, she kept saying she didn't know what to do. So we put him back in bed. He kept complaining of a ton of pain and the need to urinate. I just kept reporting to (LPN #2, then around 10:00 p.m., (LPN #3) came over. She used the bladder scanner, it showed around 900 cc's. She took the catheter out and tried to recath him. but only big blood clots were coming out. Blood was everywhere, he was still in a lot of pain and shaking, I thought he was going to pass out or go into shock. (LPN #3) said something's not right cause she couldn't put the catheter back in. So (LPN #3) told (LPN#2) to send him to the ER. This went on almost my entire shift, (LPN #1 and #2) would not make a decision. They both just passed it off, finally (LPN #3) made the decision to send him out. On 02/02/15, at 10:58 a.m., the ADON was asked if she was called at any time on the night of 12/22/14 concerning resident #1's pain and bleeding related to his foley catheter. She stated, No, I did not get a call from staff, but only received a text at 11:24 p.m. that stated Sent (resident #1) to (local hospital) Fyi. She was asked if the nurse's should have called her. She stated, Yes, but they wouldn't call me to insert a catheter. She was asked if any training had been done with the licensed staff regarding catheter care, insertion. She stated, No. She hadn't had time to. She stated, she had spoke to the staff about it, but had no documentation regarding the incident. She was asked if the potential still existed for problems related to Foley catheters to re-occur. She stated Yes. The residents's physician was interviewed and stated he was not notified of the resident's condition until sometime between 10:00 p.m. and 11:00 p.m. on 12/22/14. On 02/05/15 at 10:00 p.m. the DON was in agreement staff should have notified the physician and the family immediately with any change of condition.
F 0490 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Be administered in an acceptable way that maintains the well-being of each resident .** Based on record review and interview, it was determined the facility was not being administered in an effective manner to ensure the following did not occur: 1) The facility failed to ensure the physician and a family member was notified in a timely manner concerning the increased pain and increased bleeding from a Foley catheter for one (#1) of 6 residents reviewed for Foley catheter care. Resident #1 was on anticoagulant therapy. This resulted in actual harm when the resident was admitted to the hospital and required surgery. This had the potential to affect all 8 residents with Foley catheters. Please refer to F157 2) The facility failed to ensure one (#1) of six residents was thoroughly assessed, monitored and provided appropriate care in a timely manner, after he experienced increased bleeding (was receiving anticoagulant therapy) and increased pain following the replacement of his Foley catheter. This resulted in actual harm when the resident was admitted to the hospital and required surgery. This had the potential to affect all 8 residents with Foley catheters. Please refer to F309
F 0514 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep accurate, complete and organized clinical records on each resident that meet professional standards** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility failed to ensure clinical records were complete and accurate for one (#1) of 6 sampled residents whose records were reviewed. This had the potential to affect all 92 residents who resided in the facility. Findings: The 5-day assessment, dated 01/07/15, documented the resident's cognition was intact. Ambulation had not occurred: he was totally dependent upon staff for transfers. He required extensive assistance for dressing, limited assistance for hygiene and supervision for eating. His range of motion was impaired on one side. The resident had a suprapubic catheter. His [DIAGNOSES REDACTED]. A nurse's note, dated 12/22/14 at 11:40 p.m., documented the resident's foley catheter was changed earlier that day on the day shift. Dark red blood noted draining from Foley and coming from groin area. Resident complaining of pain. PRN (as needed) [MEDICATION NAME] was given about 1800 (6:00 p.m.), asked resident would he like his Tylenol, resident refused on more than one occasion. Called another nurse for assistance. Resident agreed to take Tylenol to ease the pain. Resident was taken back to his room where his foley was flushed but continued to have dark red blood. Patient urinated just a small amount. Bladder scan showed he still had more than 500 cubic centimeters (cc's) of urine retention. Attempted to change and insert catheter once again, but he continue to bleed. MD called and notified, with an order to send resident to (local hospital) ER (emergency room). A nurse's note, dated 12/22/14 at 7:56 p.m., documented [MEDICATION NAME] was not given until this time and not at 6:00 p.m. The administration of this [MEDICATION NAME] was 1 hour and 56 minutes later than documented it had been given. A nurse's note, dated 12/22/14 at 9:34 p.m., documented administration of Tylenol 325 mg tablet, 2 tablets given. The ambulance service was contacted and reported the resident was transported to a local hospital at 10:44 p.m. The time the physician, ADON and ambulance were called was not documented. On 01/23/15 at 3:20 p.m., LPN #3 stated LPN #2 had called her around 10:00 p.m. I was working on the skilled nursing side. I went over to the long term care side. The resident was sitting at the nurse's station in his wheel chair, his foley was almost completely full of blood, no urine, all blood. We took him to his room, he complained it was hurting really bad. I used the bladder scan and it showed he had a little over 900 cc's of urine, so I removed the catheter and turned him on his side and massaged his bladder, he would void a small amount, and then blood would come out, then void a small amount then blood again, he complained of burning and pain. The CNA ran and got a new foley. I tried to put a new foley in and only got blood clots out, no urine. They were really huge blood clots, not little ones. I decided because of the large amount of blood, we should send him out. I massaged his bladder again and he voided some more before he left. I used the bladder scan again before he left and it was showing around 500 cc's urine. He left to the ER without a foley in. This had been going on for almost 5 hours before he was sent out. No documentation was found in the clinical record review for what LPN #3 stated she had done. On 02/05/15 at 12:10 p.m., the director of nurses was asked about these findings and was in agreement documentation should be better than what it is.