

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

PRINTED: 01/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/29/2011
NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245	
(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 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>A standard health survey was conducted on 12/27-12/29/11. A Life Safety Code Survey was conducted on 12/28/11. The health survey cited deficiencies with the highest scope and severity of an "D" with the facility having the opportunity to correct before remedies would be imposed. The LSC survey found the facility in compliance.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the clinical record and Care Plan policy, it was determined the facility failed to follow interventions for care planning for two (2) of twenty-four (24) sampled residents. Resident #4 and #16 were care planned to have heels floated off the bed. Resident #4 was also care planned for Thrombo Embolic Deterrent (TED) hose to be applied daily in the morning and off at bedtime. In addition, a L'Nard Splint was care planned to be applied to the resident's right leg while in bed. However, observation during all three (3) days of the survey revealed Residents #4, and #16 did not have heels floated off the bed. The L'Nard Splint and TED hose were not applied as ordered for Resident #4.</p> <p>The findings include:</p>	<p>Oaklawn provides care and services by qualified persons in accordance with each residents' written plan of care.</p> <p>Immediate corrective action was taken by the RN unit manager for residents #4 and #16 to ensure floating heels, and to apply resident #4's TED hose and L'nard splint. CNA # 1's written assignment was reviewed by the RN unit manager, and application of the L'nard splint was listed on the plan of care. On 12/29/11 the RN unit manager counseled and trained the CNA#1 to follow the CNA POC .</p> <p>On 12/29/11 CNA #2 was counseled and trained by the RN unit manager to follow the CNA POC.</p> <p>LPN #1 was counseled by the RN unit manager to document interventions only after observing that devices are in place according to doctor's orders. Counseling was done 12/29/11.</p>	<p>1/31/12 2-1-12 Per Burke Stephens by PB 1-20-12</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

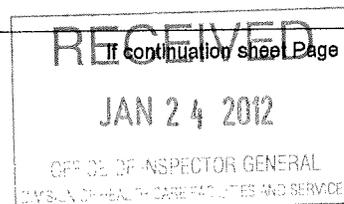
(X6) DATE

M Burke Stephens

Administrator

1-20-12

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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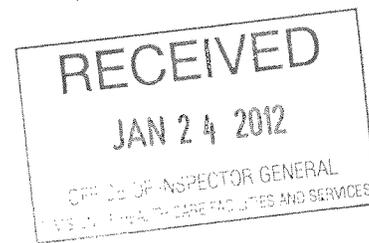
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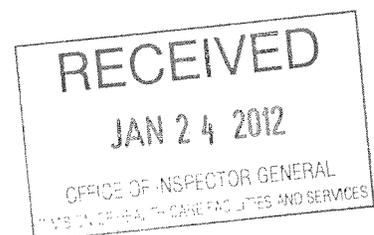
F 282	<p>Continued From page 1</p> <p>Review of the facility's policy entitled "Care Plans", effective date 08/30/04, revealed the care plan will have measurable objectives that are identified in the comprehensive assessment. If a resident refuses a treatment option, alternative means to address the problem must be discussed and education provided. Documentation of the resident's refusal must include the reason for refusal.</p> <p>1. Review of the most recent Nursing Care Plan for Resident #4, dated 11/21/11, revealed the facility identified the resident at risk for skin breakdown related to being admitted with a pressure ulcer on the right buttock and a decline in functional abilities following a recent CVA (stroke). The facility developed care plan interventions to include floating heels, TED hose, and application of a L'Nard Splint to the right lower leg.</p> <p>Observation on 12/27/11 at 11:20 AM, revealed Resident #4 lying in bed without heels floated and no TED hose or L'Nard Splint applied. Continued observation, on 12/27/11 at 3:30 PM, revealed the resident lying in bed with no TED hose or L'Nard splint applied. The resident's wife was present during the observation and upon interview revealed she visits often and does not see the TED hose applied often.</p> <p>Observations of Resident #4, on 12/28/11 at 9:30 AM and 11:40 AM, revealed the TED hose and L'Nard splint was not in place.</p> <p>Observation during a skin assessment performed by Licensed Practical Nurse #1, on 12/29/11 at</p>	F 282	<p>identification of other residents potentially affected by same deficient practice;</p> <p>All resident s and their records were reviewed by the DON and unit managers for adherence to plan of care for pressure relieving interventions and devices, as well as documentation of same in residents' records. There were no other residents found to be affected by the same deficient practice.</p> <p>To ensure the deficient practice does not reoccur;</p> <p>The director of education will reeducate all nursing staff on following the plan of care as written. The director of education will re-train all nurses on supervising CNAs, and documenting that interventions are completed according to doctors' orders. The</p>	
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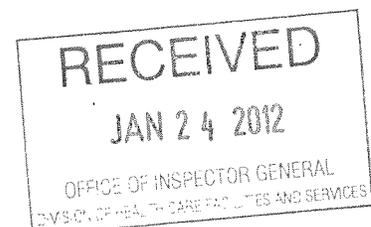
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F 282	<p>Continued From page 2</p> <p>11:00 AM, revealed the resident was lying in bed without heels floated and no TED hose or L'Nard Splint applied.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 12/29/11 at 11:10 AM, revealed CNA#1 was not aware that Resident #4 was to have a L'Nard Splint applied to the right lower leg. CNA #1 stated she did not see the L'Nard splint on the CNA Care Plan. She indicated the resident had refused the TED hose yesterday; however, she did not inform the nurse when the resident refused.</p> <p>Interview with the Nurse Unit Manager of the Chestnut Oak Terrace Unit, on 12/29/11 at 11:30 AM, revealed it is standard care for all residents to have heels floated when in bed. The Unit Manager stated she was unaware that Resident #4 had orders for TED hose or a L'Nard Splint. The Unit Manager stated staff nurses should check to ensure TED hose, splints and heels are floated as care planned. She stated it was her responsibility to ensure physician orders and care plans are followed. If a resident refuses care, the nurse should document the refusal.</p> <p>Interview with LPN #1, on 12/29/11 at 12:10 PM, revealed she should not have initialed Resident #4 was wearing TED hose and the L'Nard Splint. She revealed she had not observed the resident wearing these items. She indicated she did not know where the L'Nard splint was located. (The L'Nard splint was not in the room during the above observations). LPN #1 revealed that it was her responsibility to ensure the CNA's perform all of the tasks on their CNA Care Plans; however, the nurse failed to provide oversight and</p>	F 282	<p>training of all nursing staff will also include actions to take if a resident refuses an intervention, and the necessary documentation and/or alternative interventions to implement. This will be completed January 31, 2012</p> <p>To monitor to ensure the solution is sustained;</p> <p>A random sample of 20% of residents will be observed monthly by the unit managers to determine if the care provided matches the CNA POC and resident care plan. The same sample will be observed by the unit managers to determine if the licensed nurses correctly supervised and documented that the interventions were applied, or new interventions implemented based on resident preference or refusal. The results of the study will be reported to the Quality Assurance committee on a quarterly basis until substantial</p>	



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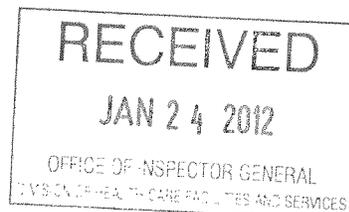
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F 282	Continued From page 3 documented the task was completed without observing the resident. 2. Review of the most recent Nursing Care Plan for Resident #16, dated 11/22/11, revealed the facility identified Resident #16 at risk for skin breakdown related to frequent incontinence and decline in mobility. The facility developed interventions to prevent skin breakdown to include float heels when in bed. Observation of Resident #16, on 12/28/11 at 2:50 PM, revealed the resident lying in bed without heels floated. On 12/29/11 at 9:00 AM and 10:35 AM, observations revealed the resident lying in bed without heels floated. Interview with CNA#2, on 12/29/11 at 11:55 AM, revealed the resident was suppose to have the heels floated when in bed. The CNA stated she thought the resident's heels were floated on pillows prior to breakfast in the dining room. She stated she should have placed the pillows back under the resident's feet when the resident was returned to bed.	F 282	compliance is achieved and maintained for 2 quarters.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	Corrective action for the affected residents during the survey include; Resident #4's heels were floated and TED and L'nard splints were applied by	1/31/12 2-1-12 Per Burke Stephens by RB 1-26-12



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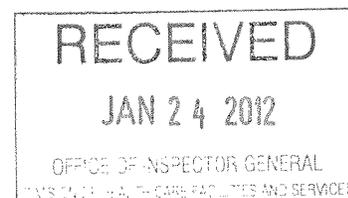
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F 309	Continued From page 4 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the clinical record, it was determined the facility failed to provide the necessary care and services according to the plan of care in regards to following physician orders for one (1) of twenty-four (24) sampled residents. Resident #4 had physician's orders for Thrombo Embolic Deterrent (TED) hose and for a L'Nard Splint that were not applied as ordered. The findings include: The facility could not provide a specific policy for care and treatment. The facility follows standards of care. Review of the medical record revealed the facility admitted Resident #4 on 11/11/11 with diagnoses of Cerebral Vascular Accident (stroke) with right sided Hemiparesis (paralysis), Hypertension, and Atrial Fibrillation. The record revealed physician orders, dated 11/14/11, for bilateral TED hose to be applied every morning and removed at bedtime. In addition there a physician order for a L'Nard Splint to be applied to the resident's right lower extremity while in bed. Observation on 12/27/11 at 11:20 AM, revealed Resident #4 lying in bed with no TED hose or L'Nard Splint applied. Continued observation on	F 309	the CNA and the unit manager. 12/29/11 Resident #16's heels were floated by the CNA and the unit manager. 12/29/11 Identification of other residents affected by the same deficient practice; Unit managers reviewed all residents with pressure relieving interventions on their care plans to ensure the measures are in place and carried out according to the care plan and physicians orders. There were no other residents affected by the same deficient practice. Measures to ensure the deficient practice does not reoccur; All facility nurses and CNAs will be retrained on following physicians'	



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F 309	<p>Continued From page 5</p> <p>12/27/11 at 3:30 PM, revealed the resident lying in bed with no TED hose or L'Nard Splint applied.</p> <p>Observation of Resident #4, on 12/28/11 at 11:40 AM, revealed the resident sitting in a wheelchair without the TED hose applied. On 12/29/11 at 11:00 AM, observation during a of skin assessment, revealed the resident lying in bed with no TED hose or L'Nard Splint applied.</p> <p>Review of the December Treatment Administration Record (TAR) revealed the nursing staff had documented the TED hose had been applied on 12/27/11, 12/28/11 and 12/29/11 at 6:00 AM and removed at bedtime on 12/27/11 and 12/28/11. In addition, the nursing staff documented the resident's L'Nard Splint was applied to the resident's right lower extremity on 12/27/11, and 12/28/11 at 6:00 AM and 6:00 PM. However, interview with LPN #1, on 12/29/11 at 12:10 PM, revealed she should not have initialed Resident #4 was wearing TED hose and a L'Nard Splint. She revealed she had not observed the resident wearing these items. LPN #1 revealed that it was her responsibility to ensure the CNA's perform all of the tasks on their CNA Care Plans; however, the nurse failed to provide oversight and documented the task was completed without observing the resident.</p> <p>During interview with Certified Nursing Assistant (CNA) #1, on 12/29/11 at 11:10 AM, CNA#1 revealed she thought the TED hose are only to be worn when a resident was sitting up in a chair and the resident's legs are below the heart. The CNA stated Resident #4 had refused to wear the TED hose yesterday, however, she did not inform the nurse.</p>	F 309	<p>orders in the form of interventions on the care plan. The training will include procedures to follow regarding documentation in the care tracker and documentation on the TAR when the care is provided .Training will also include measures to take, and documentation expected, when a resident refuses an intervention that is ordered by the physician. The training will be conducted by the Director of Education, and will be completed by January 31, 2012.</p> <p>To monitor the above to ensure the solution is sustained, the Director of Nursing will monitor, on a monthly basis, a random sample of 20% of residents with pressure relieving measures on their care plan to ensure the interventions are being followed, documented appropriately , or changed per resident or physician preference. Results will be reported to the quarterly</p>		



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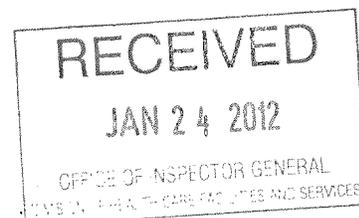
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F 309	Continued From page 6 Interview with the Unit Manager (UM) on the Chestnut Oak Terrace Unit, on 12/29/11 at 11:30 AM, revealed if a resident refuses care, the CNA should document on the Care Tracker and inform the nurse. The nurse should circle the TAR and explain on the back page of the TAR when a procedure was not done. The UM revealed the CNA's are trained to report to the nurse if a resident refuses care. The UM revealed she was responsible to see that physician orders are followed.	F 309	Quality Assurance committee until substantial compliance is achieved and sustained for two quarters.	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2005</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) per floor (story).</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Automatic (wet) sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/28/11. Oaklawn Nursing & Rehabilitation Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
M. Burke Stephens *Administrator* *1-20-12*

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