

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

PRINTED: 05/21/2012
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 C 05/07/2012
NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245		
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated and partial extended survey was initiated on 05/03/12 and concluded on 05/07/12. KY18293 was substantiated and Immediate Jeopardy was identified on 05/04/12 and determined to exist on 05/01/12. Resident #1 was admitted to the facility on 04/25/12, status post a fall with a Subdural Hematoma. On 05/01/12 Resident #1 exited the facility through the front door without staff knowledge. The resident was found by a contract pharmacy courier, wet and kneeling on one knee in the flower bed, fifteen feet from the front door. The pharmacy courier had to alert facility staff the resident was outside by utilizing the facility's after hour doorbell. The facility's surveillance video revealed the resident left the facility at 1:30 AM and was brought back into the facility at 2:11 AM. The facility assessed the resident and identified a change in the resident's pupils reaction to light. The resident was transported to the hospital for evaluation and was diagnosed with a new Subdural Hematoma. The facility readmitted Resident #1 on 05/02/12.</p> <p>The facility was notified of the Immediate Jeopardy on 05/04/12 with deficiencies cited at 42 CFR 483.20 (F281) S/S of "J" and 42 CFR 483.25 (F323) S/S of "J" and Substandard quality of care was identified in 42 CFR 483.25 (F323). The facility was notified of the Immediate Jeopardy and Substandard Quality of Care on 05/04/12.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 05/07/12 alleging Immediate Jeopardy was removed on 05/05/12. The State Agency verified Immediate Jeopardy was</p>	F 000			

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

TITLE

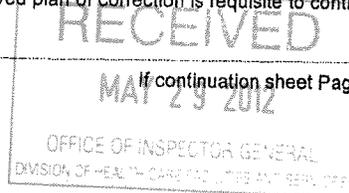
(X8) DATE

M. Burke Stegner

Administrator

5/27/12

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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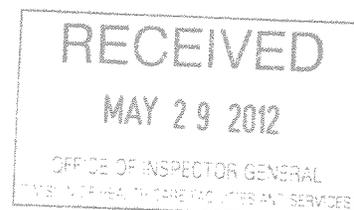
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F 281 SS=J	<p>removed on 05/05/12 as alleged, prior to exit of the survey on 05/07/12. The S/S was lowered to a "D" for 42 CFR 483.25 Quality of Care (F323) and CFR 483.20 Resident Assessment (F281), while the facility develops and implements the Plan of Correction to establish and maintain an effective system to ensure residents receive adequate supervision/monitoring to prevent accidents.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT Is not met as evidenced by: Based on interview, record review, and review of facility care guidelines it was determined the facility failed to provide care and services in accordance with the facility's Standard of Care Guidelines for one (1) of seven (7) sampled residents. The facility failed to revise the resident's initial care plan when the resident exhibited increased confusion, and failed to perform visual checks for Resident #1 every two hours per facility practice to ensure the resident's safety and care issues were met. Resident #1 was admitted to the facility on 04/25/12, status post a fall with a Subdural Hematoma. On 05/01/12 Resident #1 exited the facility through the front door without staff knowledge. The resident was found by a contract pharmacy courier, wet and kneeling on one knee in the flower bed, fifteen feet from the front door. The pharmacy courier had to alert facility staff the resident was outside by utilizing the facility's after hour doorbell. The facility's surveillance video</p>	F 281	<p>Corrective Action for resident #1 included returned to room, assessed, neuro checks implemented, roam alert bracelet applied, and sent to hospital when neuro checks revealed a change in pupillary reaction to light. Upon return from hospital resident #1 was relocated to a room closer to the nurse's station, and a new admission care plan and Certified Nurse Aide (CNA) plan of care (POC) was implemented. A roam alert bracelet remained in place.</p> <p>All nursing staff involved in this incident was immediately retrained by the Director of Nursing (DON) on making proper rounds, specifically during the night, visualizing each resident for safety. Nurses involved in this</p>	5/11/12	

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F 281	<p>Continued From page 2</p> <p>revealed the resident left the facility at 1:30 AM and was brought back into the facility at 2:11 AM. The facility assessed the resident and identified a change in the resident's pupils reaction to light. The resident was transported to the hospital for evaluation and was diagnosed with a new Subdural Hematoma. The facility's failure to revise the initial care plan and follow facility Standard of Care Guidelines placed residents in a situation that was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 05/04/12 and was found to exist on 05/01/12.</p> <p>The facility provided a credible Allegation of Compliance (AOC) on 05/07/12 and the state agency verified Immediate Jeopardy was removed on 05/05/12 prior to exit on 05/07/12. The scope and severity was lowered to a "D" at 42 CFR 483. 20 Resident Assessment (F281) and 42 CFR 483.25 Quality of Care (F323) while the facility's Quality Assurance committee monitors the effectiveness of staff education and monitors the effectiveness of the new nursing rounds checklist implemented on 05/05/12.</p> <p>Refer to F323.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Care Plans", with an effective date of 08/30/04, revealed the care plan reflects the services provided by the facility to maintain the resident's highest practicable physical, mental and psychosocial well-being and must be oriented toward preventing avoidable decline. Upon admission a care plan will be initiated based on the resident's</p>	F 281	<p>incident were counseled and retrained by the DON to supervise and direct the CNAs in carrying out the POC, as well as updating the care plan and CNA POC when changes occur. This was completed May 1, 2012.</p> <p>To identify other residents having the potential to be affected by the same deficient practice a 100% review of all residents for elopement assessment, care plan and CNA POC accuracy was completed by the DON, the Director of Education, and the nurse unit managers on May 4, 2012. All care plans and CNA POCs are current and accurate. There are no other facility residents at risk for the same deficient practice.</p> <p>Measures and systemic changes made to ensure the deficient practice does not recur included</p>		



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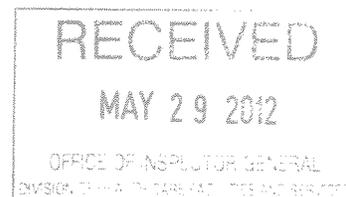
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F 281	<p>Continued From page 3</p> <p>diagnosis, admission assessment and other required admission scores. Continued review of the Care Plan revealed the care plan must be updated quarterly at a minimum. Upon readmission and/or a temporary or permanent change in status, the care plan should be reviewed for changes.</p> <p>Review of the Standards of Care Guidelines, not dated, revealed under the section CARE DELIVERY, the staff should assist residents with Activities of Daily Living as required by resident needs, and turn or encourage the resident to turn and position every 2 hours.</p> <p>Interview, on 05/04/12 at 2:20 PM, with the Director of Nursing and Staff Development Nurse, revealed it was a standard of practice to visualize the resident every two hours checking for care and safety issues.</p> <p>On 05/01/12 Resident #1 exited the facility without staff knowledge. Review of the facility's surveillance video revealed Resident #1 left the unit and walked around the common area from 1:12:28 AM until 1:27:58 AM and exited the facility through the front door at 1:30:15 AM. At 2:11:17 AM the resident was found by a pharmacy courier outside during wet and rainy weather and a temperature of 62 degrees. The resident was found approximately 15 feet from the front door, kneeling on one knee in the flower bed, and holding onto the rail of the side porch. The pharmacy courier alerted facility staff for assistance by utilizing the facility's after hour doorbell. Per the facility's surveillance video, the resident was brought back into the facility at 2:11:17 AM by two facility staff utilizing hands on</p>	F 281	<p>an emergency QA meeting on May 4, 2012, with the Medical Director, Administrator, Asst Administrator, DON, Nurse Unit Manager, CNA, Director of Social Services, and Director of Education to determine an immediate course of action. It was determined that the Facility Standards of Care guidelines should be modified clarifying that q 2 hour rounds requires CNAs to "make rounds every 2 hours visually checking each resident during nighttime sleeping hours." All nursing staff was trained on the Standards of Care with the modification. In addition all nursing staff was retrained on following the care plan and CNA POC with emphasis on communicating any identified changes in resident condition. Nurses received additional training on supervising CNA rounds and monitoring for resident safety. This was completed by the Director of Nursing and the Director of Education on May 4, 2012. Any</p>		



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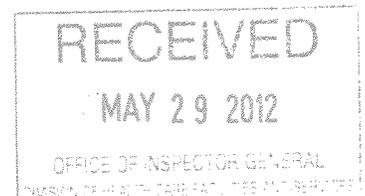
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F 281	<p>Continued From page 4 assistance.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 04/25/12, status post a Fall with a Subdural Hematoma, and diagnoses to include Weakness, and End Stage Renal Disease with Hemodialysis. On admission, the facility assessed Resident #1 as cognitively intact and not a risk for elopement. The Initial Care Plan dated 04/25/12 revealed the resident was weak and required assistance of one for transfers and locomotion. Continued review of the resident's clinical record revealed on 04/30/12 at 9:00 PM, the nurse detailed the resident was having periods of confusion. However, review of the initial care plan dated 04/25/12 and the CNA assignment sheets revealed no evidence the initial care plan was revised to provide direction to staff to monitor for changes in mental status.</p> <p>On 04/30/12, the facility's Occupational Therapist (OT) detailed in the Occupational Therapy notes that Resident #1 was lethargic, and unable to distinguish right from left without cueing. Interview with the OT, on 05/07/12 at 11:15 AM, revealed she reported her concerns regarding Resident #1's cognition status to RN #1.</p> <p>Interview with RN #1, on 05/01/12 at 12:50 PM, revealed she assessed the resident after OT reported to her a change in Resident #1's cognition; however, her assessment did not agree with the OT's. Based on her assessment the initial care plan was not updated nor were the CNA's notified to monitor. Per interview, the oncoming nurse (Licensed Practical Nurse, LPN #2) was informed of the OT's concerns.</p>	F 281	<p>staff not available for training has been identified and will be trained by the Director of Education before being allowed to return to work. All new hires will be trained on the Standards of Care and care plan process by the Director of Education at the time of their orientation.</p> <p>Measures to monitor facility performance to ensure the solutions are sustained include facility held a QA meeting May 4, 2012, with the Medical Director to determine and approve initial measures to ensure immediate compliance. Subsequent to that meeting we implemented a temporary new nursing rounds checklist verifying documentation of q 2 hour rounds with visual check of every resident. The checklist developed by the DON and Director of Education, requires signatures by both CNAs and nurses responsible for rounds with a check mark every 2 hours indicating rounds were completed correctly. The nurses and CNAs were instructed on use of the</p>		



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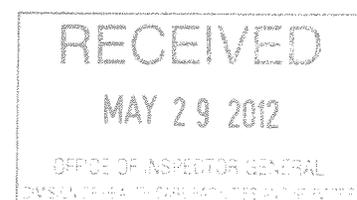
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F 281	<p>Continued From page 5</p> <p>Interview, on 05/07/12 at 2:00 PM, with LPN #2 revealed RN #1 did not inform her of any changes with Resident #1 during the shift change report on 04/30/12. Therefore, she did not update the CNA plan of care nor did she inform the CNAs of any changes. However, continued review of the resident's clinical record revealed, on 04/30/12 at 9:00 PM, LPN #2 detailed the resident as having periods of confusion.</p> <p>Review of the Certified Nurse Aide (CNA) care plan, dated 04/30/12 for the evening shift and 05/01/12 dated for the night shift, revealed Resident #1 was Independent in the room, alert, oriented times three and speech was clear. The facility assessed the resident with no cognitive deficit and was not confused.</p> <p>Interview, on 05/03/12 at 5:15 AM, with CNA #1 revealed she was working the unit, where Resident #1 resided, on 04/30/12 during the night shift. She stated she and CNA #2 had performed the rounds every two hours together at 11:30 PM and 1:30 AM. She continued to state they had no knowledge of Resident #1's confusion. Interview with CNA #2, on 05/03/12 at 9:30 AM, validated the CNAs had made rounds together, and had no knowledge of Resident #1's documented confusion. However, interview with the CNAs revealed a visual check was not conducted at 1:30 PM per facility practice.</p> <p>Interview, on 05/03/12 at 7:00 AM, with License Practical Nurse (LPN) #2 revealed she was working the unit where Resident #1 resided on 04/30/12, during the night shift. She stated, she last visualized the resident around 11:30 PM. She further stated, she was unaware Resident #1</p>	F 281	<p>checklist by the DON and the Director of Education. Plans were to begin the checklist on May 4 and continue to use the checklist for at least a week and longer if necessary, to achieve substantial compliance.</p> <p>On May 7 we evaluated compliance with rounds and found 100% compliance with the modifications added to the Standards of Care. This was discussed with the Medical Director, Administrator, and DON on May 8, 2012. Use of the rounds checklist was recommended and continued on a 24 hour basis until May 11, 2012, when we again evaluated and found 100% compliance of round-the-clock rounds.</p> <p>Effective May 4, 2012 All resident care plans and CNA plans of care have been checked daily to ensure that all are up to date and reflect any changes in resident conditions and/or care needed. This care plan audit has been conducted by the Nurse Unit Managers and Unit Secretaries with 100 % compliance achieved and ongoing as of May 4, 2012 through May 11, 2012. Care</p>		



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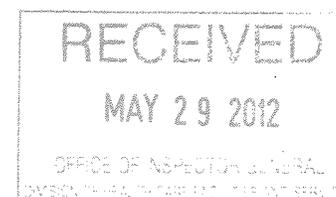
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F 281	<p>Continued From page 6</p> <p>had exited the building until another staff member returned him/her to the unit. She stated, her initial observation of Resident #1 revealed a wet patch on the knee.</p> <p>Interview, on 05/03/12 at 5:10 AM, with LPN #4 (House Supervisor) revealed she was working as House Supervisor on 04/30/12, on the night shift. She stated, she was unaware Resident #1 had exited the facility. She continued to state her observation of Resident #1 immediately upon re-entry into the facility revealed the resident's pants were muddy. She further stated being unaware of Resident #1's noted confusion on 04/30/12.</p> <p>Further interview, on 05/04/12 at 2:20 PM, with the Director of Nursing and Staff Development Nurse, revealed the resident's increased confusion should have triggered the staff to increase supervision due to safety issues.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility took the following Immediate actions:</p> <ol style="list-style-type: none"> 1. Upon return to the facility on 04/30/12 the resident was assessed and found no new bruises, or obvious injuries. A code alert bracelet was applied. 2. Neuro checks where initiated on 04/30/12 and conducted every fifteen minutes for one hour, then every thirty minutes for one hour, then every two hours for the next twenty-two hours. At 8:25 AM, 05/01/12 the resident was sent to the hospital because the nurse assessed his/her pupils as sluggish in reaction. 	F 281	<p>exchanges were audited for all residents to verify that residents are receiving adequate supervision to prevent accidents, and nurses are supervising the care provided by the CNAs. This audit was completed by the Unit Managers and House Supervisors as directed by the Director of Nursing and reported to the Administrator. Substantial compliance was demonstrated as of May 11, 2012, although continued surveillance of updated care plans and monitoring for safety of residents is ongoing.</p> <p>Our ongoing QA measures include interviews by the DON and Unit Managers of 75 residents and 49 nursing staff members. Residents were asked if they had been checked every 2 hours during the night. There were no negative responses. Nurses and CNAs were asked if they knew the Standard of Care and the seriousness of performing q 2hr visual checks. There were no negative responses. Results of the interviews were reported by the DON to the Quarterly QA committee on May 23, 2012, attended by the Medical</p>		



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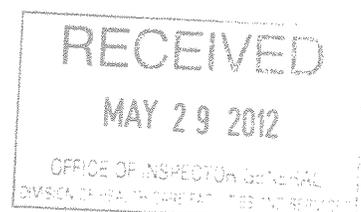
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F 281	Continued From page 7 3. Upon return to the facility on 05/02/12, the resident's room was relocated next to the nurses station. 4. On 05/04/12 all resident Initial care plans and CNA plans of care were reviewed and updated the plans were appropriate. 5. The facility conducted an investigation on 05/04/12, and found an issue related to the procedure for making rounds specifically during the nighttime hours. The CNAs had failed to visualize the resident while making rounds. 6. The Certified Nurse Aide Standards of Care Guidelines were clarified to include the following more specific language, "make rounds every two hours visually checking the resident during the nighttime sleeping hours, of 10 PM to 6 AM. 7. All nurses and CNA were re-trained on 05/04/12 regarding the CNA Standards of Care regarding rounds, and the nurses supervision of CNA care. 8. QA measures were put into place on 05/04/12 to audit rounds every two hours specifically during night time hours. An audit tool (unnamed) was developed to record supervision and observations. Nurses are required to document on the audit tool every two hours when rounds were completed according to standards of care. Both the nurse supervisor and CNA must sign the form. 9. On 05/04/12 the facility conducted a quality assurance meeting with the Medical Director on	F 281	Director. In addition, at the May 23 meeting, the QA committee heard report by the DON of an audit of 100% residents conducted by the Nurse House supervisor on May 14, 15, and 16 on the night shift. The audit assessed compliance with q 2 hour rounds, visual safety checks, verification that care provided matches the plan of care, and nurses adequately supervising and directing care. Results of this audit revealed 100% compliance. Going forward this QA study will be repeated checking q 2 hour rounds on each shift. In addition we will check that the Care Plan and CNA POC is current with all updates listed as indicated. The audit will also verify that nurses are supervising and directing the CNAs and monitoring resident safety, and that the care provided is according to the plan of care. The sample will consist of 10 residents on each of the 4 units, on each of the 3 shifts, for a total sample of 33% of facility residents and their care givers. The audit will be conducted by the Unit Nurse Managers, Director of Education,	



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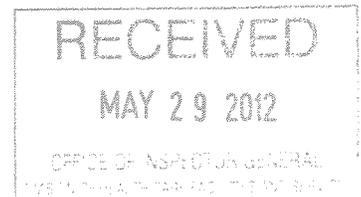
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F 281	<p>Continued From page 8</p> <p>conference call. He agreed with the facility's plan of corrections.</p> <p>The State Agency validated the AOC on 05/07/12 as follows:</p> <ol style="list-style-type: none"> 1. The State Agency validated through record review the assessment of Resident #1 on 05/01/12 was documented in the nurses notes. Observation on 05/03/12 revealed Resident #1 with a code alert bracelet attached to the right wrist. 2. The State Agency validated through record review evidence of neuro checks completed for Resident #1 on 05/01/12 until discharge to the hospital. 3. The State Agency validated through observation the resident was moved to a room next to the nurses station on 05/02/12. 4. The State Agency validated through record review evidence the facility reviewed and updated care plans for all residents including the CNA plans of care. 5. The State Agency validated through record review evidence of education provided to staff which included polices for: CNA Standard of Care regarding rounds and nurses supervision of CNA care. Training was completed on 05/04/12. 6. The State Agency validated through record review and interviews evidence of every two hour rounds were completed with CNAs and nurses signature to indicate completion. Review of the audits revealed they began on 05/04/12 at 10:30 	F 281	<p>and the DON. The Administrator and the Asst Administrator will hold those responsible for the audits accountable.</p> <p>We will complete the audits on a bi-weekly basis, and report results to a QA subcommittee consisting of the DON, Administrator, Asst Administrator, 2 Nurse Managers, and 2 CNAs. The subcommittee will review results and create and implement a corrective action plan if indicated. Corrective action will consist of additional staff education, supervision, and/or coaching and disciplinary action as indicated. Corrective action will be the responsibility of the Facility Administrator.</p> <p>The Asst Administrator will report the findings of the subcommittee to the Administrator, the Medical Director, and the members of the QA committee at the next quarterly QA meeting in August, 2012, and each quarter thereafter. The Medical Director, and QA committee members will determine if the frequency of audits should be further modified from biweekly to monthly, based</p>		



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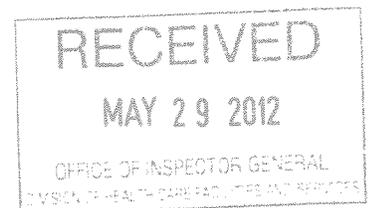
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F 281	Continued From page 9 PM and continued through 05/07/12. 7. Interview, on 05/07/12 at 3:00 PM, with four (4) CNAs, two (2) LPNs, and two (2) RNs, revealed all staff members were trained and knowledgeable on how to complete the new audit sheet for making rounds on residents. The State Agency validated through interview with the staff and record review that the revision of the Standards of Care Guidelines were completed and provided to the staff. 8. The State Agency validated through interview and record review the QA measures put in place on 05/04/12 to audit the nightly rounds on the residents were in place and staff were knowledgeable of the signatures required. A Quality Assurance meeting via telephone was held with the Medical Director on 05/04/12. 9. The State Agency validated through record review the completion of an investigation by the facility on 05/04/12.	F 281	on the level of compliance. Reporting on quality assurance activities for this deficiency will continue for the next 4 quarters or until substantial compliance is demonstrated for 4 quarters.		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	Corrective action for resident #1 included retraining and counseling of all nursing staff responsible for this incident. Training included requirement to visually check every resident on q 2 hour rounds. The training was completed May 1, 2012 by the DON.	5/11/12	



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F 323	<p>Continued From page 10</p> <p>Based on observation, interview, record review, and review of the facility's Standard of Care Guidelines, it was determined the facility failed to provide adequate supervision/monitoring for one (1) of seven (7) sampled residents. The facility's Standard of Care Practices were to check on residents every two hours to provide assistance and safety. On 04/30/12, the facility staff failed to perform visual checks for Resident #1 during the 11:30 PM check. Resident #1 was admitted to the facility on 04/25/12, status post a fall with a Subdural Hematoma. On 05/01/12 Resident #1 exited the facility through the front door without staff knowledge. The resident was found by a contract pharmacy courier, wet and kneeling on one knee in the flower bed, fifteen feet from the front door. The pharmacy courier had to alert facility staff the resident was outside by utilizing the facility's after hour doorbell. The facility's surveillance video revealed the resident left the facility at 1:30 AM and was brought back into the facility at 2:11 AM. The facility assessed the resident and identified a change in the resident's pupils reaction to light. The resident was transported to the hospital for evaluation and was diagnosed with a new Subdural Hematoma. The facility readmitted Resident #1 on 05/02/12. The facility's failure to provide adequate supervision/monitoring placed residents at risk in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 05/04/12 and was found to exist on 05/01/12.</p> <p>The facility provided a credible Allegation of Compliance (AOC) on 05/07/12 and the state agency verified Immediate Jeopardy was removed on 05/05/12 prior to exit on 05/07/12.</p>	F 323	<p>Resident #1 was reassessed by the nurse and immediate interventions put in place to ensure his safety including a roam alert bracelet, frequent visual checks, neuro checks and relocating to a room closer to the nurses' station after readmission from the hospital.</p> <p>To identify other residents having the potential to be affected by the same deficient practice a 100% review of all residents for safety/ elopement assessment, care plan and CNA POC accuracy was completed by the DON, the Director of Education and the nurse unit managers on May 4, 2012. All care plans and CNA POCs are current and accurate. There are no other facility residents at risk for the same deficient practice.</p> <p>Measures and systemic changes made to ensure the deficient practice does not recur included an emergency QA meeting on May</p>		



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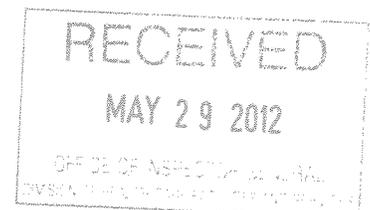
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F 323	<p>Continued From page 11</p> <p>The scope and severity was lowered to a "D" at 42 CFR 483. 20 Resident Assessment (F281) and 42 CFR 483.25 Quality of Care (F323) while the facility develops and implements the Plan of Correction to establish and maintain an effective system to ensure residents receive adequate supervision/monitoring to prevent accidents.</p> <p>The findings include:</p> <p>Review of the facility's Standard of Care Guidelines (undated) revealed residents were to receive care/assistance every two (2) hours.</p> <p>Interview, on 05/04/12 at 2:20 PM, with the Director of Nursing and Staff Development Nurse, revealed it was a standard of practice to visualize the resident every two hours when checking for care and safety issues.</p> <p>On 05/01/12, Resident #1 exited the facility without staff knowledge. Review of the facility's surveillance video revealed Resident #1 left the unit and walked around the common area from 1:12:28 AM until 1:27:58 AM and exited the facility through the front door at 1:30:15 AM. At 2:11:17 AM the resident was found by a pharmacy courier outside during wet and rainy weather and a temperature of 62 degrees. The resident was found approximately 15 feet from the front door; kneeling on one knee in the flower bed; and, holding onto the rail of the side porch. The pharmacy courier alerted facility staff for assistance by utilizing the facility's after hour doorbell. Per the facility's surveillance video, the resident was brought back into the facility at 2:11:17 AM. The facility assessed the resident as having sustained no injuries. However, on</p>	F 323	<p>4, 2012, with the Medical Director, Administrator, Asst Administrator, DON, Nurse Unit Manager, CNA, Director of Social Services, and Director of Education to determine an immediate course of action. It was determined that the Facility Standards of Care guidelines should be modified clarifying that q 2 hour rounds requires CNAs to "make rounds every 2 hours visually checking each resident during nighttime sleeping hours." All nursing staff was trained on the Standards of Care with the modification. In addition all nursing staff was retrained on following the care plan and CNA POC with emphasis on communicating any identified changes in resident condition. Nurses received additional training on supervising CNA rounds and monitoring for resident safety. This was completed by the Director of Nursing and the Director of Education on May 4, 2012. Any staff not available for training has</p>		



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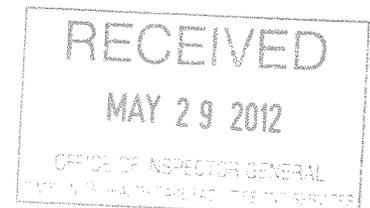
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F 323	<p>Continued From page 12</p> <p>05/01/12 at 7:10 AM a change in the resident's pupils reaction to light was identified. Resident #1 was transported to the Emergency Room on 05/01/12 at approximately 8:00 AM for a computed tomography (CT) scan of the head. The facility readmitted Resident #1 on 05/02/12 with a diagnosis of a new Subdural Hematoma.</p> <p>Observation, on 05/03/12 at 6:15 AM, of Resident #1 revealed facility staff in the room, assisting with transferring to the resident's bathroom. Further observation revealed staff needed to cue the resident on washing hands. The resident's skin had multiple areas of bruises and scratches on both upper and lower arms and legs.</p> <p>Observation, on 05/03/12 at 1:10 PM, in Resident #1's room revealed the resident lying in bed, moving from side to side, raising hands back and forth and speech not understandable. The family at bed side was touching and talking to the resident.</p> <p>Interview with the family member, on 05/03/12 at 1:10 PM, revealed Resident #1 had substained a fall at home. However, he/she was still driving himself/herself to dialysis, shopping and able to carry the groceries. The family member continued to state the resident was admitted to the facility from the hospital for rehabilitation strengthening. Upon admission to the facility the resident was alert and oriented and able to make his/her needs known.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 04/25/12, status post a Fall with a Subdural Hematoma, and diagnoses to include Weakness, and End Stage Renal Disease with Hemodialysis. On admission, the</p>	F 323	<p>been identified and will be trained by the Director of Education before being allowed to return to work. All new hires will be trained on the Standards of Care and care plan process by the Director of Education at the time of their orientation.</p> <p>Measures and systemic changes made to ensure the deficient practice does not recur include facility held a QA meeting May 4, 2012, with the Medical Director to determine and approve initial measures to ensure immediate compliance. Subsequent to that meeting we implemented a temporary new nursing rounds checklist verifying documentation of q 2 hour rounds with visual check of every resident. The checklist developed by the DON and Director of Education, requires signatures by both CNAs and nurses responsible for rounds with a check mark every 2 hours indicating rounds were completed correctly. The nurses and CNAs were instructed on use of the</p>	



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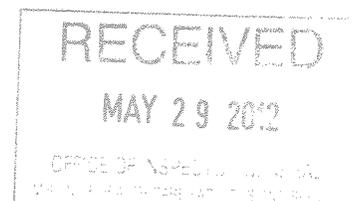
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F 323	<p>Continued From page 13</p> <p>facility assessed Resident #1 as cognitively intact and not a risk for elopement. The Initial Care Plan dated 04/25/12 revealed the resident was weak and required assistance of one for transfers and locomotion; however, there was no indication the resident was to be checked on every two hours. The facility assessed the resident to have no cognition deficient and was not confused.</p> <p>Record review revealed on 04/30/12, the facility's Occupational Therapist (OT) detailed in the Occupational Therapy notes that Resident #1 was lethargic and unable to distinguish right from left without cueing. Interview with the OT, on 05/07/12 at 11:15 AM, revealed she reported her concerns regarding Resident #1's cognitive status to Registered Nurse (RN) #1.</p> <p>Interview with RN #1, on 05/01/12 at 12:50 PM, revealed she assessed the resident after OT reported to her a change in Resident #1's cognition; however, her assessment did not agree with the OT's. Based on her assessment the initial careplan was not updated nor were the CNA's notified to monitor. Per interview, the oncoming nurse (Licensed Practical Nurse, LPN #2) was informed of the OT's concerns.</p> <p>Interview, on 05/07/12 at 2:00 PM, with LPN #2 revealed RN #1 did not inform her of any changes with Resident #1 during the shift change report on 04/30/12. However, continued review of the resident's clinical record revealed, on 04/30/12 at 9:00 PM, LPN #2 detailed the resident as having periods of confusion. However, there was no documented evidence the resident's initial care plan and CNA assignment sheet were revised to note the resident's confusion, to increase</p>	F 323	<p>checklist by the DON and the Director of Education. Plans were to begin the checklist on May 4 and continue to use the checklist for at least a week and longer if necessary, to achieve substantial compliance.</p> <p>On May 7 we evaluated compliance with rounds and found 100% compliance with the modifications added to the Standards of Care. This was discussed with the Medical Director, Administrator, and DON on May 8, 2012. Use of the rounds checklist was recommended and continued on a 24 hour basis until May 11, 2012, when we again evaluated and found 100% compliance of round-the-clock rounds.</p> <p>Effective May 4, 2012 All resident care plans and CNA plans of care have been checked daily to ensure that all are up to date and reflect any changes in resident conditions and/or care needed. This care plan audit has been conducted by the Nurse Unit Managers and Unit Secretaries with 100 % compliance achieved and ongoing as of May 4, 2012 through May 11, 2012. Care</p>		



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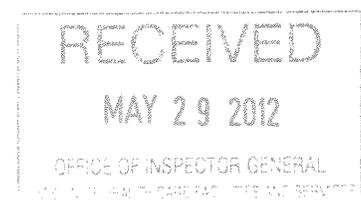
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F 323	<p>Continued From page 14</p> <p>supervision, or to monitor the resident for changes in mental status.</p> <p>Interview, on 05/03/12 at 5:15 AM, with CNA #1 revealed she was working the unit where Resident #1 resided on 04/30/12, during the night shift. She stated, she and CNA #2 had performed the rounds every two hours together. interview with CNA #2, on 05/03/12 at 9:30 AM, validated the CNAs had made rounds together at 11:30 PM and 1:30 AM. However, interview with the CNAs revealed a visual check was not conducted. The CNAs saw the resident's walker at the end of the bed from the doorway and did not physically go into the resident's room. Per interview, they assumed the resident was in the bed. Further interview revealed they were supposed to visually look at each resident every two hours to ensure the safety and well-being of the residents. Per interview, the CNAs revealed they were not knowledgeable of Resident #1 documented confusion on 04/30/12.</p> <p>Interview, on 05/03/12 at 7:00 AM, with LPN #2 revealed she last visualized the resident around 11:30 PM. She further stated, she was unaware Resident #1 had exited the building until another staff member returned him/her to the unit. She stated, her initial observation of Resident #1 revealed a wet patch on the knee. She continued to state the facility had no system to monitor the care and safety of residents by ensuring every two hour checks were completed.</p> <p>Interview, on 05/03/12 at 5:10 AM, with LPN #4 (House Supervisor) revealed she was working as House Supervisor on 04/30/12, during the night shift. She stated, she was unaware Resident #1</p>	F 323	<p>exchanges were audited for all residents to verify that residents are receiving adequate supervision to prevent accidents, and Nurses are supervising the care provided by the CNAs. This audit was completed by the Unit Managers and House Supervisors as directed by the Director of Nursing and reported to the Administrator. Substantial compliance was demonstrated as of May 11, 2012, although continued surveillance of updated care plans and monitoring for safety of residents is ongoing.</p> <p>Our ongoing QA measures include interviews by the DON and Unit Managers of 75 residents and 49 nursing staff members. Residents were asked if they had been checked every 2 hours during the night. There were no negative responses. Nurses and CNAs were asked if they knew the Standard of Care and the seriousness of performing q 2hr visual checks. There were no negative responses. Results of the interviews were reported by the DON to the Quarterly QA committee on May 23, 2012, attended by the Medical</p>		



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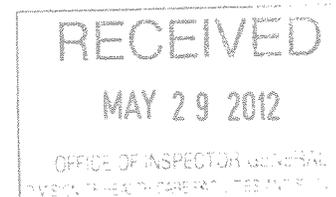
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F 323	<p>Continued From page 15</p> <p>had exited the facility. She continued to state her observation of Resident #1 immediately upon re-entry into the facility revealed the resident's pants were muddy. She further stated being unaware of Resident #1's noted confusion on 04/30/12.</p> <p>Interview with the Administrator, on 05/03/12 at 10:00 AM, revealed the staff failed to follow the Standards of Care Guidelines, related to care delivery. This would include making rounds every two (2) hours to provide care needs and to ensure residents safety. She further stated every two hour rounds required a physical visualization of the resident.</p> <p>Further interview, on 05/04/12 at 3:00 PM, with the Administrator revealed the facility had identified through their investigation an issue related to the procedure for making rounds, specifically during the nighttime hours, and had identified the CNAs did not visualize the resident while making rounds.</p> <p>Review of the Allegation of Compliance (AOC) revealed the facility took the following immediate actions:</p> <ol style="list-style-type: none"> 1. Upon return to the facility on 04/30/12 the resident was assessed and found no new bruises, or obvious injuries. A code alert bracelet was applied. 2. Neuro checks were initiated on 04/30/12 and conducted every fifteen minutes for one hour, then every thirty minutes for one hour, then every two hours for the next twenty-two hours. At 8:25 AM, 05/01/12 the resident was sent to the 	F 323	<p>Director. In addition, at the May 23 meeting, the QA committee heard report by the DON of an audit of 100% residents conducted by the Nurse House supervisor on May 14, 15, and 16 on the night shift. The audit assessed compliance with q 2 hour rounds, visual safety checks, verification that care plans are up to date, and that the care provided matches the plan of care, as well as verification that nurses are adequately supervising and directing care. Results of this audit revealed 100% compliance.</p> <p>Going forward this QA study will be repeated checking compliance on all shifts. The sample will consist of 10 residents on each of the 4 units, on each of the 3 shifts, for a total sample of 33% of facility residents care givers. The audit will be conducted by the Unit Nurse Managers, Director of Education, and the DON. The Administrator and the Asst Administrator will hold those responsible for the audits accountable. We will complete these ongoing audits on a bi-weekly basis, and report results to a QA</p>		



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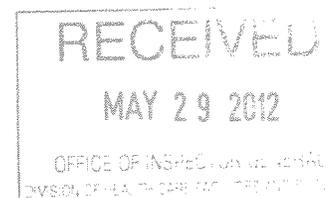
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F 323	Continued From page 16 hospital because the nurse assessed his pupils as sluggish in reaction. 3. Upon return to the facility on 05/02/12, the resident's room was relocated next to the nurses station. 4. Elopement risk assessments were completed on 05/04/12 with care plans and CNA plans of care updated. All facility residents were checked for elopement assessment completion on 05/04/12 to ensure the rationale and plan were appropriate. 5. No additional residents were found to be at risk for elopement. 6. All nursing staff was retrained on 05/04/12 regarding the elopement policy, assessment, and interventions for residents at risk for elopement. 7. The facility conducted an investigation on 05/04/12, and found an issue related to the procedure for making rounds specifically during the nighttime hours. The CNAs had failed to visualize the resident while making rounds. 8. The Certified Nurse Aide Standards of Care Guidelines were clarified to include the following more specific language, make rounds every two hours visually checking the resident during the nighttime sleeping hours, of 10PM to 6 AM. 9. All nurses and CNA were re-trained on 05/04/12 regarding the CNA Standards of Care regarding rounds, and the nurses supervision of CNA care.	F 323	subcommittee consisting of the DON, Administrator, Asst Administrator, 2 Nurse Managers, and 2 CNAs. The subcommittee will review results and create and implement a corrective action plan if indicated. Corrective action will consist of additional staff education, supervision, and/or coaching and disciplinary action as indicated. Corrective action will be the responsibility of the Facility Administrator. The Asst Administrator or Administrator will report the findings of the subcommittee to the Medical Director, and the members of the QA committee at the next quarterly QA meeting in August, 2012, and each quarter thereafter. The Medical Director, and QA committee members will determine if the frequency of audits should be further modified from biweekly to monthly, based on the level of compliance. Reporting on quality assurance activities for this deficiency will continue for the next 4 quarters or until substantial compliance is maintained for 4 quarters.		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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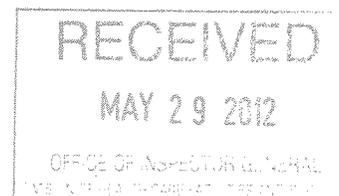
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/07/2012
NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, 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 323	<p>Continued From page 17</p> <p>10. All resident elopement risk assessments were reviewed on 05/04/12 for the second time for completion and correct interventions. All initial care plans and CNA plans of care were reviewed for appropriate interventions.</p> <p>11. QA measures were put into place on 05/04/12 to audit rounds every two hours specifically during night time hours. An audit tool (unnamed) was developed to record supervision and observations. Nurses are required to document on the audit tool every two hours when rounds were completed according to standards of care. Both the nurse supervisor and CNA must sign the form.</p> <p>12. On 05/04/12 the facility conducted a quality assurance meeting with the Medical Director on conference call. He agreed with the facility's plan of corrections.</p> <p>The State Agency validated the AOC on 05/07/12 as follows:</p> <ol style="list-style-type: none"> 1. The State Agency validated through record review the assessment of Resident #1 on 05/01/12 was documented in the nurses notes. Observation on 05/03/12 revealed Resident #1 with a code alert bracelet attached to the right wrist. 2. The State Agency validated through record review evidence of neuro checks completed for Resident #1 on 05/01/12 until discharge to the hospital. 3. The State Agency validated through observation the resident was moved to a room 	F 323		



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F 323	<p>Continued From page 18 next to the nurses station on 05/02/12.</p> <p>4. The State Agency validated through record review evidence the elopement assessments which included the complete resident census of one- hundred and twenty three (123) were completed. The residents scores were documented, and it was determined that four (4) of one-hundred and twenty three (123) were at risk for elopement. This was completed on 05/04/12. It was verified on 05/07/12, the facility reviewed and updated care plans for all four residents determined by the facility to be at risk for elopement.</p> <p>5. The State Agency validated through record review evidence of education provided to staff which included polices for: Elopement Policy, Assessment and Intervention for residents at risk for elopement, CNA Standard of Care regarding rounds and nurses supervision of CNA care. Training was completed on 05/04/12. The State Agency validated through record review evidence of education provided to staff which included polices for: Elopement of Presidents, Assessment and Intervention for residents at risk for elopement. The facility staff roster indicted there were one-hundred and twenty seven (127) staff and one- hundred and eighteen (118) had been educated by 05/04/12 on the policies and procedures. The facility provided documentation of a detailed plan to train the remainder of the staff prior to their date of return to work approximately 5 employees.</p> <p>6. The State Agency validated on 05/07/12 through observations of four residents who were found to be at risk for elopement, that each</p>	F 323		



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F 323	Continued From page 19 resident had a wander guard bracelet applied and was working properly. 7. The State Agency validated through record review and interviews evidence of every two hour rounds were completed with CNAs and nurses signature to indicate completion. Review of the audits revealed they began on 05/04/12 at 10:30 PM and continued through 05/07/12. 8. Interview, on 05/07/12 at 3:00 PM, with four (4) CNAs, two (2) LPNs, and two (2) RNs, revealed all staff members were trained and knowledgeable on how to complete the new audit sheet for making rounds on residents. 9. The State Agency validated through interview and record review the QA measures put in place on 05/04/12 to audit the nightly rounds on the residents were in place and staff were knowledgeable of the signatures required. 10. The State Agency validated through interview and record review the facility conducted a Quality Assurance meeting via telephone with the Medical Director on 05/04/12. 11. The State Agency validated through record review the completion of an investigation by the facility on 05/04/12. 12. The State Agency validated through interview with the staff and record review that the revision of the Standards of Care Guidelines were completed and provided to the staff.	F 323			

