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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 04/25/2012
NAME OF PROVIDER OR SUPPLIER: CARTER NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 250 MCDAVID BLVD GRAYSON, KY 41143	

(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 An abbreviated survey, to investigate KY 18223, was initiated on 04/24/12 and concluded on 04/25/12. The allegation was found to be Substantiated. Deficiencies were cited with the highest scope and severity of an "G" with the facility having the opportunity to correct before remedies would be imposed.	F 000	To the best of my knowledge and belief, as an agent of Carter Nursing & Rehab Center, the following plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements. Preparation and execution of this plan of correction does not constitute and admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement the written plan of care for indwelling catheter care for one (1) of six (6) sampled and two (2) unsampled residents. The facility developed a care plan to monitor Resident #1's catheter use with staff to observe for symptoms of a Urinary Tract Infection (UTI) which included: reduced urine output, reduced fluid intake, fever, odor, and notify the physician of any changes. On 03/14/12, the facility inserted a catheter for bladder distention and on 03/18/12 the resident was diagnosed with a UTI. Treatment was obtained for ten (10) days. Another urinalysis was obtained on 04/12/12 with positive findings of bacteria for a UTI. An additional care plan was developed on 04/14/12 for the use of an antibiotic medication to treat a UTI. This care plan had approaches to obtain and record temperatures	F 282	It is the policy of Carter Nursing and Rehabilitation Center to ensure that services be provided or arranged by the facility utilizing qualified persons in accordance with each resident's written plan of care. Resident #1 was transferred to the hospital on 4/16/2012 and discharged from the facility to another SNF on 4/22/2012. The IDCPT will review the plan of care for each current resident to ensure that the interventions are reflective of the resident's current care needs. If required,	6/5/12

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Samuel R. Wright II
TITLE: X Administrator
(X6) DATE: X 5-23-12

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 282	Continued From page 1 every shift, observe urine for color/consistency, and to observe and document resident's condition at least every shift or as otherwise specified. However, the facility failed to monitor the resident's temperature and urine output according to the written plan of care. On 04/16/12, the resident was found unresponsive, hypotensive, pulse of 141, temperature of 101.8 degrees Fahrenheit (F) with mottled legs. The resident had no urine output. The facility called Emergency Medical Services (EMS) and the resident was transported to the hospital for emergency treatment. The resident was discharged from the facility to the hospital on 04/16/12. The hospital diagnosed the resident with sepsis secondary to UTI, fever (102 degrees F.), altered mental status, and dehydration. The facility's failure to monitor the resident's temperature and urine output per the resident's plan of care caused the resident harm and required hospitalization. (Refer to F315) The findings include: Interview with the Assistant Director of Nursing, on 04/25/12 at 10:40 AM, revealed the facility utilized the Resident Assessment Instrument (RAI) Manual for development, revision, and implementation of the written plan of care. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 03/09/12 with the following diagnoses: Encephalopathy; Dementia; Atrial Fibrillation; Convulsions; Congestive Heart Failure; and Muscle Weakness. The resident did not have an indwelling catheter on admission. On 03/14/12, the facility documented the resident's abdomen	F 282	the care plan will be revised/updated to reflect any changes by 6/4/2012. Additionally, the IDCPT will complete walking rounds for each resident by 6/4/2012 utilizing the reviewed/revised plan of care to ensure that all interventions have been implemented as written by the IDCPT. The walking care plan rounds will continue on a weekly basis. The nurse who notified the MD of the lab results incorrectly and failed to record the resident on the antibiotic list for monitoring was terminated by the Administrator and DON on 5/11/2012. LPN #3 received a disciplinary suspension by the DON on 5/11/2012. LPN #4 received one-on-one education by the DON on 5/1/2012 regarding the importance of monitoring I&O on residents with a foley catheter in place. The DON provided all licensed staff with additional education regarding the importance of implementing interventions as recorded on the plan of care for each resident by 6/4/2012. The DON or ADON will monitor at least five care plans per week for four weeks	

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F 282	Continued From page 2 as distended and tender. An order to "straight cath" (a procedure where the catheter is inserted in to the bladder and then removed) the resident was received and when the nurse performed the procedure, 2000 ml of urine was obtained from the resident's bladder. The physician ordered for the catheter to remain in place. A care plan was developed to address the catheter use on 03/14/12. Interventions directed staff to observe for symptoms of a Urinary Tract Infection (UTI) which included: reduced urine output, reduced fluid intake, fever, odor, and notify the physician of any changes. Further review of the clinical record revealed on 03/18/12 Resident #1 was diagnosed with a UTI and an order for antibiotic therapy was obtained for 10 days. Review of the admission Minimum Data Set (MDS) assessment, dated 03/20/12, revealed the facility assessed the resident to have severe cognitive impairment and to require extensive assistance with toileting needs. The MDS assessment revealed the resident was currently experiencing a UTI with treatment. On 04/12/12 another urinalysis was obtained with findings of bacterial growth indicating a UTI. An additional care plan was developed on 04/14/12 for the use of antibiotic medication to treat the UTI. This care plan had approaches to obtain and record temperatures every shift, observe urine for color/consistency, and to observe and document resident's condition at least every shift or as otherwise specified. Interview with LPN #3, #4, and #5, on 04/25/12 at 11:45 AM, 2:00 PM, and 2:10 PM respectively revealed the nurses had failed to obtain a	F 282	to ensure that interventions have been implemented by direct care staff. The care plans will be compared to visual observations on the floor, patient interview, staff interview and any other means necessary to determine that implementation has occurred. Any discrepancy noted will be forwarded to the IDCPT for immediate resolution. The results of these audits will be forwarded to the monthly CQI (Continuous Quality Improvement) Committee for further monitoring and continued compliance. The CQI Committee will review audits to ensure that services are being provided or arranged by the facility utilizing qualified persons in accordance with each resident's written plan of care. After four weeks, the CQI Committee will determine, based on results of the audits, how often the audits should be continued. At a minimum, the DON or ADON will continue to audit at least five care plans per month to ensure that care plan interventions are current and are implemented as recorded on the plan of care. Any area of concern will be addressed by the DON, ADON, or RN Supervisor as appropriate.	

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F 282	Continued From page 3 temperature or monitor Resident #1's urine output on 04/15/12 and 04/16/12 per the resident's plan of care. On 04/16/12 at 8:09 PM, Resident #1 was found unresponsive with no urine output. The resident's temperature was 101.8 degrees F., blood pressure 106/66, Pulse of 141, and Respirations of 26. The resident's bilateral lower extremities were documented as mottling with no urine output noted. Emergency Medical Services (EMS) was called and the resident was transferred to the hospital for emergency treatment. Review of the hospital documentation (History and Physical) revealed the resident was unconscious upon arrival with a recorded temperature of 102 degrees F. The hospital documented when the indwelling catheter was removed, the resident had 200 ml of purulent discharge from the urethra. With insertion of a new catheter, 1300 ml of urine was obtained. The hospital admitted the resident with diagnoses of Sepsis secondary to a UTI, Fever, Dehydration, and Altered Mental Status. Interview with the Assistant Director of Nursing, on 04/25/12 at 10:40 AM, revealed it was the facility's practice to place the residents' names that were currently taking an antibiotic on the daily report. This would alert nurses to obtain a temperature and monitor the resident every shift. She stated the nurse who took the order for the antibiotic for Resident #1 on 04/14/12, had failed to place the resident's name on the antibiotic list. She stated through investigation it was found the nurses had failed to obtain a temperature or monitor the resident's urine every shift according	F 282		

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F 282	Continued From page 4 to the care plan. The nurse who took the physician order was not available for interview.	F 282		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure one (1) of six (6) sampled and two (2) unsampled residents received the appropriate treatment and services to prevent urinary tract infections (UTI). The facility admitted Resident #1 without an indwelling catheter. On 03/14/12, the facility inserted a catheter for bladder distention and obtained over 2000 milliliters (ml) of residual urine. After insertion of the catheter, the resident experienced a UTI on 03/18/12 and treatment was obtained for ten (10) days. Another urinalysis was obtained on 04/12/12 with positive findings of bacteria for a UTI. The results were reported to the facility on 04/14/12. The nurse called the lab results to the resident's physician; however, the nurse failed to report the correct findings. The nurse's failure to report correct lab findings resulted in the	F 315	It is the policy of Carter Nursing and Rehabilitation that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident #1 was transferred to the hospital on 4/16/2012 and discharged from the facility to another SNF on 4/22/2012. The RN Supervisor on each wing reviewed resident records by 4/30/2012 to ensure that any resident with a foley catheter had an appropriate diagnosis recorded in the medical record to support the use of a foley catheter. On 4/26/2012, the DON retrieved a list of residents from the Electronic Medical Record that were currently utilizing antibiotics for Urinary Tract Infections to ensure that each resident was listed on the antibiotic list for monitoring.	6/5/12

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F 315	Continued From page 5 physician ordering an antibiotic that did not treat the UTI effectively. In addition, the facility failed to monitor the resident's temperature according to the facility's protocol for any resident placed on an antibiotic and failed to monitor the resident's urine output. The resident had a decrease in urine output from 475 ml on 04/15/12 down to 10 ml on 04/16/12 at 1:49 PM. On 04/16/12 at 8:00 PM, a Certified Nursing Assistant (CNA) found the resident with no urine output and unresponsive. The nurse's assessment, on 04/16/12 at 8:09 PM, found the resident unresponsive, hypotensive, pulse of 141, temperature of 101.8 degrees Fahrenheit (F) with mottled legs. The facility called Emergency Medical Services (EMS) and the resident was transported to the hospital for emergency treatment. The hospital diagnosed the resident with sepsis secondary to UTI, fever (102 degrees F.) altered mental status, and dehydration. The resident was discharged from the facility on 04/16/12 to the hospital. The facility's failure to monitor the resident's temperature, urine output, and obtain the correct antibiotic caused the resident harm and required hospitalization. The findings include. Review of the facility's policy regarding "Catheter" (Indwelling Utilization Policy), revised 12/01/10, revealed catheter care must be performed. The policy did not direct the staff in monitoring of a resident with an indwelling catheter. Review of the facility's policy regarding "Intake and Output Procedure", effective 12/01/10, revealed the purpose of the procedure was to	F 315	The RN Supervisor on each wing visually assessed each resident's foley catheter by 4/30/2012 to determine that there were no undocumented signs of urinary related infections and that each catheter was patent and draining without difficulty. The DON reviewed the current intake and output on each resident with a foley catheter on 4/26/2012 to determine that intake and output on each resident was sufficient based on each resident's individual needs. The Infection Control reports for the last six months were reviewed by the ADON and the IDCPT no later than 6/4/2012 to determine that any resident with a history of UTI's has appropriate interventions recorded and implemented as required, based on the individual needs of each resident. The nurse who notified the MD of the lab results incorrectly and failed to record the resident on the antibiotic list for monitoring was terminated by the Administrator and DON on 5/11/2012. LPN #3 received a disciplinary suspension by the DON on 5/11/2012.	

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F 315	Continued From page 6 decrease the susceptibility of residents who are predisposed to urinary tract infections. Review of the clinical record for Resident #1 revealed the facility admitted the resident on 03/09/12 with the following diagnoses: Encephalopathy; Dementia; Atrial Fibrillation; Convulsions; Congestive Heart Failure; and Muscle Weakness. Continued review of the record revealed the resident did not have an indwelling catheter in place when admitted. Review of the nurses' notes and physician's progress notes for 03/14/12 revealed the resident's abdomen was distended and tender. An order to "straight cath" (a procedure to insert a catheter in to the bladder and then remove) the resident was received and when the nurse performed the procedure, 2000 ml of urine was obtained from the resident's bladder. The physician ordered the catheter to remain in place. The care plan, dated 03/14/12, revealed the staff were to observe for symptoms of UTI (reduced urine output, reduced fluid intake, fever, odor, and notify the physician of any changes). The record revealed a urinalysis report with findings positive for a UTI were reported to the facility on 03/18/12 and an antibiotic treatment was obtained for 10 days. Review of the admission Minimum Data Set (MDS) assessment, dated 03/20/12, revealed the facility assessed the resident to have severe cognitive impairment and to require extensive assistance with toileting needs. The resident was currently experiencing a UTI with treatment. Record review revealed on 04/12/12 another urinalysis was obtained. On 04/14/12 the findings	F 315	LPN #4 received one-on-one education by the DON on 5/1/2012 regarding the importance of monitoring I&O on residents with a foley catheter in place. The facility has implemented a computer generated I&O sheet to be utilized by the nursing staff. This report will lists the cumulative intake and output for each resident on the same sheet rather than listing it in two separate sections of the electronic record. This report is to be generated each day by the charge nurse. Nursing staff will monitor the intake and output report daily for the 24 hour period and notify the RN Supervisor on call if output is insufficient as compared to the 24 hour intake of the resident. If the resident has less the 200 cc's out, the RN Supervisor on call will be notified. The MD will be notified based on the RN Supervisor's assessment of the condition of the resident. If the RN on call cannot be reached, the charge nurse is to notify the DON or the MD. The facility has implemented new documentation protocols for foley catheters. Charge nurses will visually monitor and document a narrative note in the medical record at least two times	

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F 315	Continued From page 7 of the urinalysis, which was positive for bacteria, were reported to the facility by the lab. The nurse called the lab result to the physician; however, she incorrectly reported a medication (Bactrim) was resistant to the bacteria. Therefore, the antibiotic ordered (Bactrim DS twice a day for 10 days) was ineffective in treating the UTI. Review of the Medication Administration Record (MAR) for April revealed Resident #1 received five (5) doses of Bactrim DS on 04/14/12 at 7:00 PM through 04/16/12 at 7:00 AM. An additional care plan was developed on 04/14/12 for the use of antibiotic medication to treat the UTI. This care plan had approaches to obtain and record temperatures every shift, observe urine for color/consistency, and to observe and document resident's condition at least every shift or as otherwise specified. Review of the urine output records for Resident #1 dated 04/01/12 through 04/14/12 revealed the resident's urine output averaged 700-1300 ml per day. On 04/15/12 the resident's urine output had decreased to 475 milliliter (ml) from 5:39 AM to 9:52 PM. From 9:52 PM on 04/15/12 to 6:04 AM on 04/16/12 the resident's urine output was only 50 ml for eight (8) hours, and from 6:04 AM to 1:49 PM on 04/16/12, the resident's urine output was 10 ml. Review of the nurses' notes, dated 04/16/12 at 8:09 PM, revealed the nurse was called to the resident's room and found the resident with a increased temperature of 101.8 degrees F., blood pressure 106/66, Pulse of 141, and Respirations of 26. The resident's bilateral lower extremities was documented as mottling with no urine output	F 315	per week describing the basic characteristics of the foley catheter. An RN will look at the foley at least one time a week and document a narrative note regarding the characteristics of the foley in the resident medical record. Nursing education was initiated on 4/26/2012 following surveyor exit. It has been ongoing and will be completed by 6/4/2012. The DON and Staff Development Coordinator will provide additional education to all nurses by 6/4/2012 regarding facility protocols related to the utilization of the antibiotic list and the importance of recording all new antibiotics on this list as orders are received so that the list remains current at all times and that temperature and I&O, at a minimum, will be monitored. They will receive additional education regarding interpretation of lab sheets and the importance of relaying reliable information to the physician. The nurses will also be educated regarding the new I&O sheet and its utilization. The new documentation protocols for assessing the foley catheters and recording a note at least two times per week by the charge nurse and weekly RN documentation will be covered. Education will also include general information regarding foley catheters.	

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F 315	Continued From page 8 noted. Emergency Medical Services (EMS) was called and the resident was transferred to the hospital for emergency treatment. Review of the hospital documentation (History and Physical) revealed the resident was unconscious upon arrival with a recorded temperature of 102 degrees F. The hospital documented when the indwelling catheter was removed, the resident had 200 ml of purulent discharge from the urethra. When a new catheter was inserted, 1300 ml of urine was obtained. The hospital admitted the resident with diagnoses of Sepsis secondary to a UTI, Fever, Dehydration, and Altered Mental Status. Interview with LPN #4, on 04/25/12 at 11:45 AM, revealed she had worked the night shift (10 PM- 6 AM) for 04/15/12 - 04/16/12. She stated she did not receive any information in report regarding Resident #1. She stated the resident's low urine output (50 ml) was not reported to her; therefore, she did not report those findings to the day shift nurse. She said she did not check the catheter, did not assess the resident, nor obtained a temperature during her shift. She stated she did not know the resident was on an antibiotic because Resident #1 had not been placed on the antibiotic list. On 04/25/12 at 11:55 AM, interview with CNA #2 revealed she had worked the 6 AM-2 PM shift on 04/16/12. She stated Resident #1's urine output was very low (10 ml) during her shift and she had reported the low urine output to LPN #3. She said the resident had not yelled or cried out during care that day; and that was very unusual for this resident.	F 315	Included will be appropriate diagnosis for foley catheters, care of foleys, procedures for insertion, removal, flushing and trouble shooting, signs and symptoms of infection, and best practice guidelines for monitoring catheters. The DON and Staff Development Coordinator will provide additional education to all nursing staff by 6/4/2012 regarding the prevention of UTI's and protocols for monitoring and reporting information to appropriate supervisors for further interventions as necessary. The DON or RN Supervisor will monitor the intake and output sheets of residents with a foley catheter daily (M-F) for six weeks to ensure that the physician is notified of any concerns. The DON or ADON will visually monitor at least two foley catheters a day (M-F) for six weeks to ensure that any signs of infection or abnormal functioning of the catheter is recorded and discussed with the MD if necessary. The DON or ADON will monitor the foley catheter documentation two times per week for six weeks to ensure that documentation is timely and reflective of the current status of the foley catheter. The DON or ADON will monitor the antibiotic list at least two	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185253		C 04/25/2012

NAME OF PROVIDER OR SUPPLIER: CARTER NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 250 MCDAVID BLVD, GRAYSON, KY 41143

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F 315	Continued From page 9 Interview with LPN #3, on 4/25/12 at 2:20 PM, revealed she worked the 6 AM-2 PM shift on 04/16/12. She said CNA #2 came up to her at the end of the shift and told the nurse Resident #1's urine output was low (10 ml). "I thought I told the oncoming nurse, but I can't really recall." She stated she did not know about the resident's low urine output of 50 ml at the start of her shift. She revealed she did not assess the resident or the catheter and did not obtain a temperature. She said the resident was not on the antibiotic list. Interview with LPN #5, on 04/25/12 at 2:10 PM, revealed she had worked the evening shift 2:00 PM to 10:00 PM on 04/16/12 when Resident #1 was sent to the hospital. During report from the day shift nurse, she stated she did not receive any information regarding Resident #1's low urine output. (10 ml) She did not know the resident was on an antibiotic; therefore, she did not obtain a temperature nor did she assess the resident's catheter. At 8:00 PM, the nurse said CNA #6 came to her and reported the resident had no urine output and was unresponsive. The nurse said she found the resident in bed, unresponsive, and no urine was observed to be in the catheter drainage bag or tubing. LPN #5 stated she tried to arouse the resident, but was unsuccessful. She revealed the resident's legs were mottled and she thought the resident was dying. She called for the RN Supervisor to stay with the resident while she called EMS. Interview with the RN Supervisor (RN #1), on 04/24/12 at 5:00 PM, revealed she was called to Resident #1's room by LPN #5 on 04/16/12 at around 8:00 PM. She stated she found the	F 315	times per week (M-F) and compare it to the computer generated list of residents receiving antibiotics to ensure that the list is current and up to date. The RN Supervisors on each wing will review all labs for six weeks (M-F) to ensure that the antibiotic ordered by the physician is appropriate for the organism identified as the cause of infection. The SDC will monitor and quiz at least five direct care staff members each week for six weeks regarding Best Practices for the prevention of UTI's and reporting early signs to their supervisor. These audits will be forwarded to the monthly CQI Committee Meeting for further review and continued compliance. The committee will review the audits to ensure that any resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. After six weeks, the CQI Committee will determine, based on audits reviewed, how often the audits should continue. At a minimum, the DON	

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F 315	Continued From page 10 resident unresponsive with no urine output. The resident's vital signs were abnormal as documented in the record and the resident's legs were mottled. She indicated she stayed with the resident while LPN #5 called EMS. Continued review of the clinical record revealed no documented evidence the facility obtained or recorded a temperature every shift according to the care plan. Review of a computer generated flow sheet revealed, on 04/11/12 at 6:58 PM, the facility recorded a temperature of 99.6 degrees F. Another temperature (101.8 F.) was not obtained until 04/16/12 at 8:00 PM, when the CNA found the resident unresponsive with no urine output. Interview with the Assistant Director of Nursing, on 04/25/12 at 10:40 AM, revealed she reviewed the shift report forms, dated 04/11/12 - 04/16/12, and could not find where the urinalysis results were discussed or when the physician ordered the antibiotic. She stated it was the facility's practice to put the residents' names who were on an antibiotic on the daily report to alert nurses to obtain a temperature and monitor the resident every shift. She stated the nurse who took the order for the antibiotic for Resident #1 was responsible for placing the resident's name on the list. Review of the report forms for April 11 - 16, 2012 revealed Resident #1's name was not included on the antibiotic list. Interview with the Director of Nursing (DON), on 04/24/12 at 5:15 PM, revealed the facility identified the nurse had given the wrong lab findings to the physician during an audit on 04/17/12. The DON conducted an investigation and found the nurse reported the bacteria was	F 315	or ADON will continue to monitor the areas weekly for compliance. The weekly monitoring will continue until the CQI Committee feels confident that monthly monitoring is sufficient. In addition to the CQI Committee, these audits will be reviewed weekly at the Focus Committee Meeting (a sub-committee of the CQI Committee that meets weekly to discuss high risk areas) to ensure that audits are completed and identify any areas for concern. Any area of concern will be addressed by the DON, ADON, or RN Supervisor as appropriate.	

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F 315	Continued From page 11 sensitive to Bactrim, not resistant as indicated on the lab report. Therefore, the physician ordered the wrong antibiotic. She revealed the lab results were not faxed but called to the physician. In addition, the DON stated during the investigation, it was found the resident had decreased urine output. She stated nurses were suppose to review intake and output records and act on any changes. Continued interviewed with the DON, on 05/25/12 at 4:00 PM, revealed the facility had not identified the failure to place Resident #1 on the antibiotic list; therefore, no temperatures were obtained according to facility protocol. She revealed there was no specific policy regarding obtaining temperatures when a resident was on an antibiotic. She indicated there was a lack of communication between the nurses in regard to the resident's urine output. She said the shift report needed to be more thorough. Interview with Resident #1's primary physician at the nursing facility, on 04/24/12 at 4:50 PM, revealed she was given the wrong information regarding the urine culture and ordered an antibiotic that was resistant not sensitive to the bacteria found in the resident's urine. The physician stated the resident was drinking well; however, she was prone to UTI's and the resident had experienced a UTI in March 2012. She indicated the facility discovered the mistake and informed her; however, the resident was already in the hospital at that time.	F 315		

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