

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

PRINTED: 12/10/2015
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 R-C 12/07/2015
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH & 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 Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/07/15 as alleged.	{F 000}			

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185455	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/7/2015
Name of Facility OAKLAWN HEALTH & REHABILITATION CENTER	Street Address, City, State, Zip Code 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC _____	Correction Completed 12/07/2015	ID Prefix F0309 Reg. # 483.25 LSC _____	Correction Completed 12/07/2015	ID Prefix F0514 Reg. # 483.75(l)(1) LSC _____	Correction Completed 12/07/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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Reviewed By <i>MZ</i> State Agency	Reviewed By <i>VT</i>	Date: <i>12/10/15</i>	Signature of Surveyor: <i>Millic Zornstein</i>	Date: <i>12/17/15</i>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 11/16/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=D	<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 observation, interview, record and policy review, it was determined the facility failed to develop and initial care plan to meet the needs of one (1) of five (5) sampled residents, (Resident #2). The staff failed to develop an initial care plan that encompassed all aspects of the care and management of Resident #2's indwelling urinary catheter.</p> <p>The findings include:</p> <p>Review of the facility's document titled Care Planning, not dated, revealed the initial care plan was initiated on admission and completed within 24 hours. The initial care plan directed the care of the resident until the comprehensive care plan was developed.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident on 11/04/15 with diagnoses of Congestive Heart Failure,</p>	F 281	<p>This preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This plan of correction is prepared and executed solely because it is required by Federal and State law.</p> <p>F 281</p> <p>On 11-16-15 the care plan for Resident #2 was reviewed and updated to include the care and management of the indwelling urinary catheter. This was completed by the Unit Manager</p> <p>Resident #2 was discharged home on 11-14-15</p> <p>On 11-17-15 the Unit Managers for all 4 units reviewed the care plans for all residents with catheters to ensure the care plan was complete and accurate. They reviewed the orders for each resident to ensure the order was transcribed accurately. They also checked the TARs to ensure that any treatment orders were in place and signed.</p>	

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

TITLE

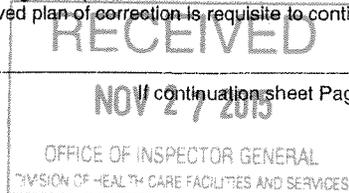
(X6) DATE

x Donnie Cantwell

x Acting Administrator

11-27-15

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.

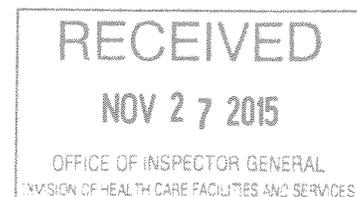


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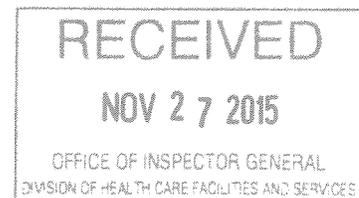
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F 281	<p>Continued From page 1</p> <p>Hypertension, Atrial Flutter, Normocytic Anemia, a history of a Recurrent Bladder Mass, Chronic Kidney Disease Stage IV, Generalized Muscle Weakness, a history of Methicillin Resistant Staphylococcus Aureus of the Urine, and Clostridium Difficile. The resident had been hospitalized until his/her admission to the facility and had an indwelling catheter in place upon admission to the facility.</p> <p>Review of the hospital Discharge Summary, dated 11/04/15, which listed patient instructions and orders for Resident #2 revealed an order for the daily irrigation of the resident's indwelling catheter with sterile water.</p> <p>Review of the Initial Care Plan, prepared by the facility for Resident #2, not dated, revealed the resident's Foley catheter was to be irrigated daily with sterile water, but the care plan did not list the amount of sterile water to be used for the irrigation. An additional intervention to change the resident's catheter every three (3) weeks was also listed under the bladder elimination section of the initial care plan.</p> <p>Observation, on 11/10/15 at 4:20 PM, revealed Resident #2 was seated in a chair beside his/her bed. Resident #2's catheter drainage bag was attached to the resident's rolling walker, and clear to light yellow urine was collecting in the bag. Interview with Resident #2 at this time revealed he/she had been transferred to the hospital earlier that day for evaluation of an elevated blood pressure and chest discomfort, but had returned to the facility that afternoon.</p>	F 281	<p>Licensed staff will be re-educated on the care of residents with catheters. This education will include reviewing physician orders on admission, reviewing discharge instructions and the discharge summary to get the details related to the catheter. Instruction will include the process of documenting all treatments related to the care of the catheter including catheter size, irrigation orders if indicated, and change orders. Instruction will also include the implementation of the care plan and communication regarding the care plan. This education will be completed prior to 12-6-15 and will be under the direction of the ADON.</p> <p>Unit Managers will check all new admissions who have catheters within 48 hours to ensure all orders related to the use of the catheter were identified, clarified, and communicated appropriately. They will review the physician orders, the discharge instructions and the discharge summary as well as the initial care plan and the TAR. This will continue for 4 weeks. Any discrepancies will be addressed immediately and re-education provided as indicated. ADON to check all residents with catheters weekly for 4 weeks then monthly for 6 months to ensure orders were obtained, clarified and implemented accurately. She will review the care plans and the TARs for accuracy. Results of her reviews will be presented to the facility QA committee that meets no less than quarterly.</p> <p>Date of completion 12-7-15</p>		



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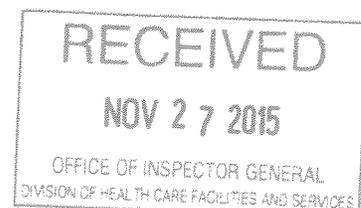
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F 281	Continued From page 2 Observation, on 11/12/15 at 10:15 AM, revealed Resident #2 was abed with his/her eyes closed. There was clear to light yellow urine in the catheter tubing and in the collection bag. Observation, on 11/12/15 at 4:00 PM, revealed Resident #2 was seated in a chair by his/her bed. Interview with Resident #2 at this time revealed he/ she had just returned from therapy, but stated early that morning the nurse entered his/her room and said she would be irrigating the resident's catheter that day. However, Resident #2 also stated, it was now 4 o'clock and the catheter had not been irrigated. Resident #2 stated the staff just seemed to be so busy. Review of the catheter care instructions/orders on Resident #2's Treatment Administration Record (TAR), revealed the resident's indwelling catheter was to be irrigated with sterile water, but the quantity of water to be used for the irrigation was not listed. In addition, Resident #2's TAR revealed his/her catheter had only been irrigated once since the resident's admission on 11/04/15, and that one irrigation was documented on 11/12/15. Interview, on 11/13/15 at 9:00 AM, with Licensed Practical Nurse (LPN) #3 revealed she was a new employee and had completed her orientation period. LPN #3 stated she had been assigned to Resident #2 the past few days and was on duty when Resident #2 was transferred to the hospital Emergency Department for evaluation of chest discomfort on 11/10/15. LPN #3 stated she was	F 281			



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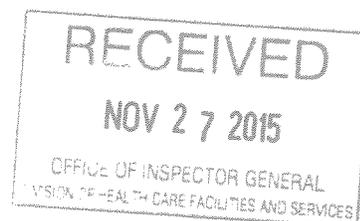
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F 281	<p>Continued From page 3</p> <p>aware Resident #2 had an indwelling catheter and that the resident had the catheter upon admission to the facility. LPN #3 stated the Certified Nursing Assistants (CNAs) performed perineal (peri) care and recorded the resident's urinary output when they emptied the drainage bag.</p> <p>Interview, on 11/13/15 at 9:30 AM, with UM for Chestnut Oak Terrace (COT), revealed she reviewed Resident #2's clinical record on 11/10/15, just after the resident returned from a brief trip to the hospital Emergency Department for evaluation of some chest discomfort. The UM stated she also reviewed the original hospital Discharge Summary, dated 11/04/15, provided to the facility when the resident was admitted. The UM stated she discovered instructions for daily irrigation of Resident #2's catheter and for changing the catheter every three (3) weeks within the Discharge Summary of 11/04/15.</p> <p>The UM stated at that time (11/10/15), she added the catheter irrigation and the intervention for changing the catheter every 3 weeks to the resident's Initial Care Plan.</p> <p>The UM stated the catheter care instructions did not get added to the initial care plan with 24 hours of the resident's admission to the facility because they were overlooked by the admitting nurse who reviewed Resident #2's hospital discharge summary, dated 11/04/15. The UM stated she thought Resident #2's catheter should be irrigated daily because of the resident's history of bladder cancer with blood clots in the bladder. The UM stated the admitting nurse should review all orders/instructions received upon a resident's</p>	F 281			



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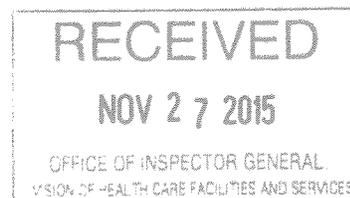
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F 281	<p>Continued From page 4 admission, list those items on a physician's order form, and the admitting nurse should begin filling in the initial plan of care.</p> <p>Interview, on 11/16/15 at 11:15 AM, with LPN #5 revealed she admitted Resident #2 to the facility. She stated her usual process was to review and transcribe any instructions and orders from the hospital Discharge Summary into an initial care plan.</p> <p>Interview, on 11/13/15 at 3:30 PM, with the DON revealed the intital care plan was the the tool for communication of a resident's care needs until the interdisciplinary care plan was completed by the Minimum Data Set (MDS) nursing staff. The initial care plan should include all physician ordered interventions for care of the indwelling catheter until the interdisciplinary care plan was completed by the twenty-first (21st) day of the resident's admission. If nurses detected abnormalities during daily assessments of the resident, these issues would be reported to the physician and any additional orders for care would be added under the urinary elimination component of the intital care plan.</p> <p>Continued interview, on 11/16/15 at 11:55 AM, with the DON revealed newly hired nurses were oriented to have a second nurse review the transcribed admission orders before the physician was contacted to verify/approve the order set. The staff should be sure all orders and instructions on the discharge summary were accurately communicated to the physician and that the newly admitted resident received all</p>	F 281			



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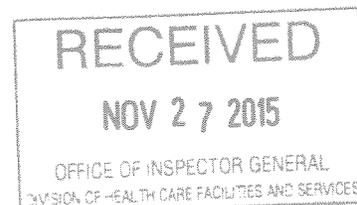
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F 281	Continued From page 5 necessary care. The goal was to ensure the resident's clinical record, including the Initial Care Plan, accurately reflected the immediate care needs of the resident upon admission to the facility.	F 281			
F 309 SS=D	483.25 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 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure the staff completed physician orders as directed for one (1) of five (5) sampled residents, (Resident #2). The nursing staff failed to irrigate Resident #2's indwelling catheter daily as ordered. The findings include: The facility did not provide a policy for indwelling catheter care and irrigation. However, the facility provided a copy of Lippincott's Nursing Procedures, Fifth Edition, 2004 and referenced the chapter titled, Renal and Urologic Care. Review of the chapter revealed irrigation of an	F 309	F 309 On 11-16-15 the care plan for Resident #2 was reviewed and updated to include the care and management of the indwelling urinary catheter. This was completed by the Unit Manager Resident #2 was discharged home on 11-24-15 On 11-17-15 the Unit Managers for all 4 units reviewed the care plans for all residents with catheters to ensure the care plan was complete and accurate. They reviewed the orders for each resident to ensure the order was transcribed accurately. They also checked the TARs to ensure that any treatment orders were in place and signed.		



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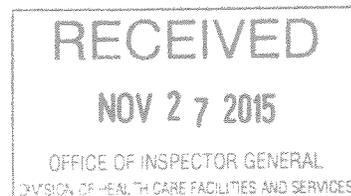
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F 309	<p>Continued From page 6</p> <p>indwelling catheter was performed to remove any obstruction such as a blood clot. Equipment would include the ordered irrigation solution, a sterile basin, alcohol pads, disposable gloves, a linen saver pad, and a 30-60 milliliter (ml) syringe. Whenever possible, the catheter should be irrigated through a closed system to decrease the risk of infection. The protocol detailed implementation of the irrigation procedure and documentation including the patient's tolerance of the procedure, the amount, color, and consistency of return urine flow, and any resistance during instillation of the ordered irrigation solution.</p> <p>Review, of Resident #2's clinical record revealed the facility admitted the resident on 11/04/15 with diagnoses of Congestive Heart Failure, Hypertension, Atrial Flutter, Normocytic Anemia, a history of a Recurrent Bladder Mass, Chronic Kidney Disease Stage IV, Generalized Muscle Weakness, a history of Methicillin Resistant Staphylococcus Aureus of the Urine, and Clostridium Difficile. The resident had been hospitalized until his/her admission to the facility and had an indwelling catheter in place upon admission to the facility.</p> <p>Review of the hospital Discharge Summary, dated 11/04/15, listed patient instructions and orders for Resident #2 revealed an order for daily irrigation of the resident's indwelling catheter with sterile water.</p> <p>Review of the Initial Care Plan, prepared by the</p>	F 309	<p>Licensed staff will be re-educated on the care of residents with catheters. This education will include reviewing physician orders on admission, reviewing discharge instructions and the discharge summary to get the details related to the catheter. Instruction will include the process of documenting all treatments related to the care of the catheter including catheter size, irrigation orders if indicated, and change orders. Instruction will also include the implementation of the care plan and communication regarding the care plan. This education will be completed prior to 12-6-15 and will be under the direction of the ADON.</p> <p>Unit Managers will check all new admissions who have catheters within 48 hours to ensure all orders related to the use of the catheter were identified, clarified, and communicated appropriately. They will review the physician orders, the discharge instructions and the discharge summary as well as the initial care plan and the TAR. This will continue for 4 weeks. Any discrepancies will be addressed immediately and re-education provided as indicated. ADON to check all residents with catheters weekly for 4 weeks then monthly for 6 months to ensure orders were obtained, clarified and implemented accurately. She will review the care plans and the TARs for accuracy. Results of her reviews will be presented to the facility QA committee that meets no less than quarterly.</p> <p>Date of completion 12-7-15</p>		



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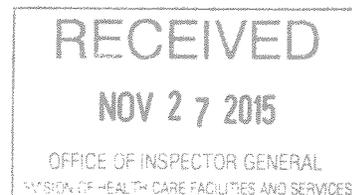
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F 309	<p>Continued From page 7</p> <p>facility for Resident #2, not dated, revealed the resident's indwelling catheter was to be irrigated daily with sterile water, but did not list the amount of sterile water to be used for the irrigation.</p> <p>Observation, on 11/10/15 at 4:20 PM, revealed Resident #2 was seated in a chair beside his/her bed. Resident #2's catheter drainage bag was attached to the resident's rolling walker, and clear to light yellow urine was collecting in the bag. Interview with Resident #2 at this time revealed he/she had been transferred to the hospital earlier that day for evaluation of an elevated blood pressure and chest discomfort, but had returned to the facility that afternoon.</p> <p>Observation, on 11/12/15 at 10:15 AM, revealed Resident #2 was abed with his/her eyes closed. There was clear to light yellow urine in the catheter tubing and in the collection bag.</p> <p>Observation, on 11/12/15 at 4:00 PM, revealed Resident #2 was seated in a chair by his/her bed. Interview with Resident #2 at this time revealed he/ she had just returned from therapy, but stated early that morning the nurse entered his/her room and said she would be irrigating the resident's catheter that day. Resident #2 also stated, but it was now 4 o'clock and the catheter had not been irrigated. Resident #2 stated the staff just seemed to be so busy.</p> <p>Review of the catheter care instructions/orders on Resident #2's Treatment Administration Record (TAR), revealed the resident's indwelling catheter</p>	F 309			



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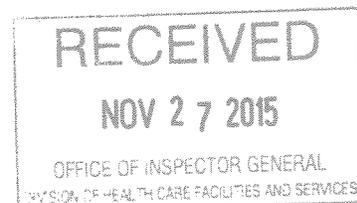
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F 309	Continued From page 8 was to be irrigated with sterile water, but the quantity of water to be used for the irrigation was not listed. In addition, Resident #2's TAR revealed his/her catheter had only been irrigated once since the resident's admission on 11/04/15, and that one irrigation was documented on 11/12/15. Interview, on 11/13/15 at 9:00 AM, with Licensed Practical Nurse (LPN) #3, revealed she was aware Resident #2 had an indwelling catheter, and that the resident had the catheter upon admission to the facility. LPN #3 stated she thought Resident #2 had a history of bladder cancer. LPN #3 stated she was not aware of other necessary care for Resident #2's catheter, but today she noted that irrigation of the resident's catheter had been added to the TAR on 11/11/15. LPN #3 stated when she reviewed Resident #2's TAR, she saw the order for daily catheter irrigation with sterile water, but the TAR did not specify how much water to use. LPN #3 stated since the order was not specific, she asked the Unit Manager (UM) to clarify the order. LPN #3 stated the UM said she would notify Resident #2's physician and get an order for the amount of sterile water to be used for the catheter irrigation. LPN #3 said she also asked the UM if the facility had a protocol for the amount of sterile water to be used for catheter irrigation, but the UM did not provide information about Resident #2's catheter irrigation before the end of her shift. LPN #3 stated she did not irrigate Resident #2's catheter on her shift which ended on 11/11/15 around 2:00 PM. LPN #3 stated when she reviewed Resident #2's TAR on 11/13/15, there was an order to irrigate the resident's catheter, daily, with 30 ml of sterile water.	F 309			



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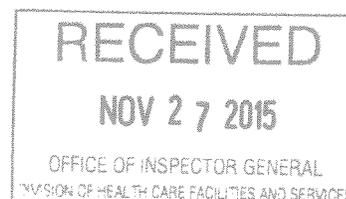
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F 309	Continued From page 9 Review of Resident #2's TAR with the revised order which included the quantity of sterile water for irrigation, revealed a nurse had initialed that the catheter had been irrigated on 11/12/15. Interview, on 11/13/15 at 9:30 AM with UM for Chestnut Oak Terrace (COT), revealed when she was reviewing Resident #2's clinical record on 11/10/15, she discovered the instructions for Resident #2's catheter irrigation within the Discharge Summary received on the day the resident was admitted to the facility (11/04/15). The UM stated, at that time, she added the catheter irrigation to the resident's TAR and to the resident's initial care plan. The UM stated she did not notify the physician or the Advanced Practice Registered Nurse (APRN) that the resident's catheter had not been irrigated since his/her admission to the facility. The UM stated she should have notified the physician or the APRN on 11/10/15 when discovered that the resident's catheter irrigation instructions in the resident's hospital discharge summary. She stated she thought the facility would expect nurses to notify physicians when instructions for care had not been implemented. The UM stated she contacted the APRN on 11/12/15, but the order for the amount of sterile water to use was not clairified until about 6:00 PM on 11/12/15. After the order was obtained, the UM stated a licensed nurse on the unit irrigated Resident #2's catheter. The UM further stated she failed to inform the APRN on 11/12/15 that the resident's catheter had not been irrigated daily per the instructions in the hospital Discharge Summary. The UM stated she thought Resident #2's catheter should be irrigated daily because of the resident's history of bladder	F 309			



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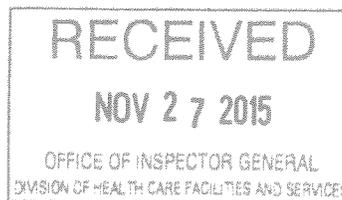
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F 309	<p>Continued From page 10</p> <p>cancer with blood clots in the bladder. The UM stated the admitting nurse should review any orders received upon a resident's admission, list those orders on a physician order form, and call the physician who would be in charge of the resident's care to get the orders approved. The UM stated LPN #5 admitted Resident #2 on 11/04/15 and the admitting nurse was supposed to get a second nurse in the facility to review the hospital Discharge Summary and the transcribed orders to ensure accuracy before the physician was contacted.</p> <p>Review of the physician's order sheet completed by LPN #5, dated 11/04/15, did not reveal a second nurse had signed that he/she had reviewed the orders.</p> <p>Interview, on 11/16/15 at 11:15 AM, with LPN #5 revealed she admitted Resident #2 to the facility. She stated her usual process was to review and transcribe any instructions and orders from the hospital Discharge Summary. LPN #5 stated she usually had a second nurse review the order set before calling the physician, but she and the second nurse had several admissions that day, and she was not sure if the other nurse reviewed/compared Resident #2's hospital Discharge Summary with the physician's order sheet she prepared. LPN #5 stated the Director of Nursing (DON), provided some re-education and instructed her to be sure a second nurse reviewed the orders transcribed from any discharge summaries before contacting the physician to approve the orders.</p>	F 309			



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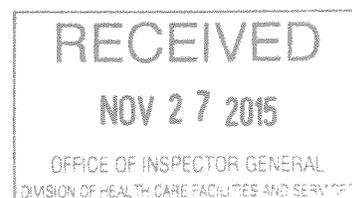
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F 309	<p>Continued From page 11</p> <p>Interview, on 11/13/15 at 3:30 PM, with the DON revealed it was not mandatory for a second nurse to review the orders/instructions before the physician was called to verify the admission orders, but she would like for that to happen when residents were admitted to the facility. The DON stated she was concerned the irrigation of Resident #2's catheter was listed on the TAR, but there was no documentation, until 11/12/15, that the resident's catheter had been irrigated. The DON stated the nurse assigned to care for Resident #2 should follow orders for the catheter irrigation to ensure an unobstructed flow of urine from the bladder and through the catheter.</p> <p>Interview, on 11/16/15 at 11:28 AM, with APRN #7, revealed she was called by the UM of the COT Unit and she gave an order for the nurses to irrigate Resident #2's catheter daily with 30 ml of sterile water. Advanced Practice Nurse #7 stated she was not sure why Resident #2's catheter was to be irrigated, but a history of blood clots in the bladder may have been the reason for the irrigation order as it appeared on the hospital Discharge Summary.</p> <p>Continued interview, on 11/16/15 at 11:55 AM with the DON, revealed newly hired nurses were oriented to have a second nurse review the transcribed admission orders before the physician was contacted to verify/approve the order set. The purpose would be to ensure the orders were complete and accurate and that care interventions for newly admitted residents were not missed. The DON stated in this particular situation, the facility's system did not work</p>	F 309			



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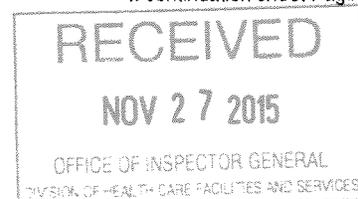
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F 309	Continued From page 12 because orders and instructions were overlooked by the nurse who reviewed and transcribed the orders and instructions from the hospital discharge summary, and a second nurse did not review the transcribed orders before the physician was notified for approval of the admission orders. The DON stated she did not get a report that the COT unit was unusually busy with admissions on the day Resident #2 was admitted to the facility.	F 309			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514			



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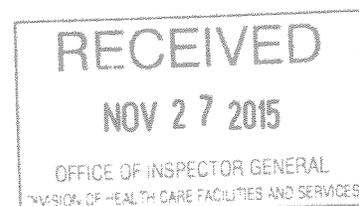
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F 514	Continued From page 13 and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure the clinical record was complete and accurately documented for one (1) of five (5) sampled residents, (Resident #2). The nursing staff failed to clarify a physician's order, failed to review transcribed orders, and failed to document the completion of a daily irrigation of Resident #2's indwelling catheter as ordered. The findings include: Review, of Resident #2's clinical record revealed the facility admitted the resident on 11/04/15 with diagnoses of Congestive Heart Failure, Hypertension, Atrial Flutter, Normocytic Anemia, a history of a Recurrent Bladder Mass, Chronic Kidney Disease Stage IV, Generalized Muscle Weakness, a history of Methicillin Resistant Staphylococcus Aureus of the Urine, and Clostridium Difficile. The resident had been hospitalized until his/her admission to the facility and had an indwelling catheter in place upon admission to the facility. Review of the hospital Discharge Summary, dated 11/04/15, listed patient instructions and orders for Resident #2 revealed an order for daily irrigation of the resident's indwelling catheter with	F 514	F 514 On 11-16-15 the care plan for Resident #2 was reviewed and updated to include the care and management of the indwelling urinary catheter. This was completed by the Unit Manager Resident #2 was discharged home on 11-24-15 On 11-17-15 the Unit Managers for all 4 units reviewed the care plans for all residents with catheters to ensure the care plan was complete and accurate. They reviewed the orders for each resident to ensure the order was transcribed accurately. They also checked the TARs to ensure that any treatment orders were in place and signed.	



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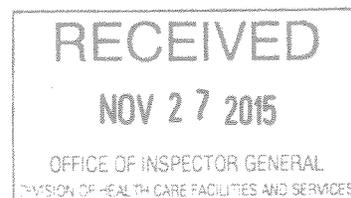
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F 514	<p>Continued From page 14 sterile water.</p> <p>Review of the physician's order sheet completed by LPN #5, dated 11/04/15, did not reveal a second nurse had signed that the transcribed orders had been reviewed.</p> <p>Review of Resident #2's TAR with the revised order which included the quantity of sterile water for irrigation, revealed a nurse had initialed that the catheter had been irrigated on 11/12/15.</p> <p>Interview, on 11/13/15 at 9:00 AM, with Licensed Practical Nurse (LPN) #3 revealed she was not aware of other necessary care for Resident #2's catheter, but today she noted that irrigation of the resident's catheter had been added to the TAR on 11/11/15. LPN #3 stated when she reviewed Resident #2's TAR, she saw the order for daily catheter irrigation with sterile water, but the TAR did not specify how much water to use. LPN #3 stated when she reviewed Resident #2's TAR on 11/13/15, there was an order to irrigate the resident's catheter with 30 ml of sterile water, daily.</p> <p>Interview, on 11/13/15 at 9:30 AM, with UM for Chestnut Oak Terrace (COT) revealed LPN #5 admitted Resident #2 on 11/04/15, and the admitting nurse was supposed to get a second nurse to review the hospital discharge summary and the transcribed orders to ensure accuracy before the physician was contacted.</p>	F 514	<p>Licensed staff will be re-educated on the care of residents with catheters. This education will include reviewing physician orders on admission, reviewing discharge instructions and the discharge summary to get the details related to the catheter. Instruction will include the process of documenting all treatments related to the care of the catheter including catheter size, irrigation orders if indicated, and change orders. Instruction will also include the implementation of the care plan and communication regarding the care plan. This education will be completed prior to 12-6-15 and will be under the direction of the ADON.</p> <p>Unit Managers will check all new admissions who have catheters within 48 hours to ensure all orders related to the use of the catheter were identified, clarified, and communicated appropriately. They will review the physician orders, the discharge instructions and the discharge summary as well as the initial care plan and the TAR. This will continue for 4 weeks. Any discrepancies will be addressed immediately and re-education provided as indicated. ADON to check all residents with catheters weekly for 4 weeks then monthly for 6 months to ensure orders were obtained, clarified and implemented accurately. She will review the care plans and the TARs for accuracy. Results of her reviews will be presented to the facility QA committee that meets no less than quarterly.</p> <p>Date of completion 12-7-15</p>	



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F 514	<p>Continued From page 15</p> <p>Interview, on 11/16/15 at 11:15 AM, with LPN #5 revealed she usually had a second nurse review the order set before calling the physician, but she and the second nurse on duty had several admissions that day, and she was not sure if the other nurse reviewed/compared Resident #2's hospital discharge summary with the physician's order sheet she prepared. LPN #5 stated, on 11/13/15, the Director of Nursing (DON), provided some re-education and instructed her to be sure a second nurse reviewed the orders transcribed from the hospital discharge summary before obtaining the physician's approval of the orders.</p> <p>Interview, on 11/16/15 at 11:55 AM, with the DON revealed newly hired nurses were oriented to have a second nurse review the transcribed admission orders before the physician was contacted to verify/approve the order set. The staff should be sure all orders and instructions on the discharge summary were accurately communicated to the physician and that the newly admitted resident received all necessary care. The goal was to ensure the resident's clinical record, including the TAR, accurately reflected the immediate care needs of the resident upon admission to the facility. The DON stated in this particular situation, the facility's system did not work because orders and instructions were overlooked by the nurse who reviewed and transcribed the orders and instructions from the hospital discharge summary, and a second nurse did not review the transcribed orders before the physician was notified for approval of the admission orders. The DON stated she did not get a report that the COT Unit was unusually busy with admissions on the day Resident #2 was</p>	F 514			



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F 514	Continued From page 16 admitted to the facility. Interview, on 11/16/15 at 12:05 PM, with the Acting Administrator, revealed during daily morning staff meetings all new physician orders were reviewed, and this was an additional opportunity for staff to ensure all orders for newly admitted and existing residents had been transcribed and approved by the physician or his/her designee. The Acting Administrator stated the staff at those daily morning meetings needed to be sure all new orders were reviewed completely, so that none were ever missed.	F 514			

