

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

PRINTED: 08/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/14/2014
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY00022074 was initiated on 08/12/14 and concluded on 08/14/14. KY00022074 was substantiated with deficiencies cited.

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D 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.

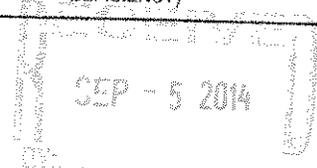
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents received timely treatment of Urinary Tract Infections (UTIs), for one (1) of four (4) sampled residents (Resident #1). Resident #1, who had an indwelling urinary catheter, had a Physician's Order dated 07/31/14 for a urinalysis (U/A) and a culture and sensitivity (C&S) to be performed on the morning of 08/01/14; however, the U/A and C&S were not collected until 08/04/14, and was not picked up by the lab for analysis until 08/05/14.

The findings include:

F 000

F 315 #1 Resident #1 was treated for UTI per physician order after UA C and S was obtained on 8/5/14. Resident #1 physician was made aware that UA was not taken to the lab on 8/4/2014 by Assistant Director of Nursing. Family was notified of new orders on 8/4/2014.

#2 A one time audit of all labs ordered for past 30 days (8/1/14 thru 9/1/14) will be completed by Director of Nursing/Assistant Director of Nursing/MDS/Staff Development Coordinator/charge nurse to identify any lab not completed per physician order. Any issue identified will be immediately reported to the physician and family, completed by 9/16/2014. Director of Nursing/Executive Director to review lab procedure for storage and pickup to identify and address when/where lab pickups are held, what process for staff to follow when a specimen is obtained and not picked up timely. Completion date is 9/10/2014. The procedure will be updated to include when/where lab pickups are held and what process staff will follow to ensure labs are obtained timely and picked up for evaluation per physician order.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bill Jones</i>	TITLE ED	(X6) DATE 9/5/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 315	<p>Continued From page 1</p> <p>Review of the facility's "Lab Procedure" policy, undated, revealed when a laboratory (lab) order was obtained, a nurse was to write the lab order on the resident's Treatment Administration Record (TAR), and block off the date and time when the specimen was due, for the night shift staff to obtain. The "Lab Procedure" policy further noted after collection, the lab specimen was to be picked up by lab company personnel. Lab results were to be faxed to the facility from the lab, and the nurse was responsible for reviewing the results and documenting pertinent resident information on the report, such as current medications and vital signs, prior to the report being delivered to the Physician's office by Medical Record personnel. Continued review of the "Lab Procedure" policy revealed it did not address when lab pick-ups were made, how/where specimens were to be held in the facility, or what process staff were to follow when specimens were obtained after the lab had come and gone from the facility.</p> <p>Observation of Resident #1, on 08/12/14 at 2:00 PM, revealed an indwelling urinary catheter drainage bag was hanging on the side of the resident's wheelchair.</p> <p>Record Review revealed the facility admitted Resident #1 on 05/02/13, and readmitted the resident on 01/08/14 with diagnoses which included Retention of Urine and UTI. Review of the Annual Minimum Data Set (MDS) Assessment dated 07/09/14, revealed the facility assessed Resident #1 to have an indwelling urinary catheter in place. Review of the Nursing Notes for 07/31/14 at 5:08 AM revealed Resident #1 experienced a fall and the Physician was notified. Review of the Physician's Orders</p>	F 315	<p>Beginning 8/15/2014, Director of Nursing/Assistant Director of Nursing, charge nurse or Staff Development Coordinator to monitor lab refrigerator to identify any lab in refrigerator not picked up by lab at least daily seven days a week x 2 weeks by 5pm.</p> <p>Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator /MDS to complete a one time audit of treatment records for August 2014 to identify any lab written on treatment record and not signed as completed. Any issue identified will be reported to physician immediately.</p> <p>#3 Staff Development Coordinator/Assistant Director of Nursing to re-educate licensed nurses regarding where/when labs are to be stored for pick up and what to do if lab does not pick up timely, what overall lab procedure is, following physician orders and obtaining labs per physician orders. A written test to be performed for competency, score must be 90% or greater. This will be completed by 9/16/2014. Any licensed nurse education not completed by 9/16/14 will be reeducated prior to working. Assistant Director of Nursing/Director of Nursing to complete an audit of treatment records 3x a week beginning week of 9/16/14 x 4 weeks, then 2 times a week for 4 weeks to ensure labs are signed and noted on treatment record per procedure.</p>		

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revealed an order, dated 07/31/14 at 2:30 PM, for Resident #1 to have a urine collected for a U/A with C&S in the morning on 08/01/14. Continued review of the Nursing Notes, dated 07/31/14 at 2:45 PM, revealed the nurse had received the order for a U/A and C&S for Resident #1.

Review of the TAR revealed the order for the U/A with C&S was placed on the TAR on 07/31/14, the date of the Physician's Order. Continued review of the TAR revealed a check mark in the space for 08/01/14, the date the test was ordered to be completed. However, further review revealed an "X" was placed on the same spot for 08/01/14, and initials were documented in the space for 08/04/14, three (3) days after the specimen was to be obtained. Additional review of the TAR revealed no documentation related to why the U/A with C&S was not obtained on 08/01/14, according to the Physician's Order dated 07/31/14.

Interview with the Director of Clinical Services (DCS), on 08/14/14 at 1:15 PM, revealed the Interdisciplinary Team (IDT) met on the morning of 08/04/14, and were unable to find the lab results of the U/A and C&S that was ordered on 07/31/14.

Review of the laboratory reports for Resident #1 revealed no report was present related to a U/A and C&S ordered for collection on 08/01/14. Continued review revealed a U/A report was sent to the facility on 08/05/14 at 10:02 AM, and was noted to have been received by the nurse at 10:30 AM on 08/05/14. Further review revealed Resident #1's urine was positive for the organism *Proteus Mirabilis*, a bacteria not commonly found in the urinary tract. (*Proteus Mirabilis* is

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Director of Nursing/Assistant Director of Nursing/charge nurse/and or Executive Director to monitor lab refrigerator daily by 5pm x 30 days beginning 9/15/14 to ensure labs are picked up timely.

Director of Nursing/MDS/Assistant Director of Nursing or charge nurse to audit 15 records weekly x 6 weeks beginning week of 9/15/14 then 10 records weekly for 3 weeks to ensure labs are obtained, picked up, and result given to physician timely. Any issue will result in immediate re-education for identified nurse.

#4 Quality Assurance committee consisting of Executive Director, Director of Nursing, Assistant Director of Nursing, MDS, Staff Development Coordinator, Social Service Staff to review all audit findings weekly x 2 weeks beginning week of 9/19/14, then monthly until considered resolved and make recommendations to revise plan according to audit findings.

5 Date of Compliance: 9/19/14.

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commonly associated with UTIs for persons with complicated urinary tracts, such as a resident with long-term use of an indwelling urinary catheter.)

Further review of the Nursing Notes revealed no documented evidence of the collection of a urine specimen for the UA and C&S until a note dated 08/05/14 at 3:59 AM, when the nurse documented a "Late Entry" for 08/04/14 which indicated a urine sample was collected for Resident #1 and was "sent to the lab this AM". Review of the Nursing Note dated 08/07/14, six (6) days after the test was to be performed, revealed Resident #1 was ordered to receive Rocephin, 1 gram intramuscularly (by injection into the muscle) daily for five (5) days. (Rocephin is an antibiotic for the treatment of infection).

Interview with RN #1, on 08/14/14 at 3:00 PM, revealed she collected the urine specimen for Resident #1 on 08/01/14 and placed it in the refrigerator to be picked up by the lab. She stated she thought the lab had already made the pickup for 08/01/14 and it must have slipped her mind to call the lab to come back.

Interview with the Director of Nursing (DON), on 08/14/14 at 2:50 PM, revealed Registered Nurse (RN) #1 collected a urine sample for Resident #1 on 08/01/14; however, lab personnel had already made their morning run and the specimen sat in the refrigerator all weekend. She stated if staff had called the lab, they would have come back and picked the specimen up. Subsequent interview, on 08/14/14 at 4:15 PM, revealed the U/A and C&S was ordered because Resident #1 exhibited mental status changes and had experienced a fall on 07/31/14, not because of

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F 315	Continued From page 4 any other signs of a UTI. Additional interview, on 08/14/14 at 5:30 PM, revealed the IDT met on 08/04/14 and determined the results of Resident #1's U/A and C&S had not been reported. She stated the urine sample was recollected and picked up by the lab on 08/05/14, and the Physician was notified. Continued interview revealed when the results of the C&S were received on 08/07/14, Resident #1 was ordered the Rocephin after it was determined the bacteria in the resident's urine was sensitive to that antibiotic. Interview with the Administrator, on 08/14/14 at 4:10 PM, revealed he was not concerned that the UA and C&S were not sent out until 08/04/14. He stated he did not think it an urgent matter for the lab specimen to be collected sooner because Resident #1 did not have any signs and symptoms of a UTI.	F 315			