STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITCHFORD FALLS HEALTHCARE	8200 LITCHFORD ROAD RALEIGH, NC 27615

(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 315 SS=D	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 record review and staff interviews the facility failed to obtain a urine specimen as ordered by the physician for 1 of 2 (resident #1) sampled residents reviewed for urinary tract infections. Findings include: Resident #1 was admitted to the facility on 8/12/11 with cumulative diagnoses of cerebrovascular accident (CVA) and anemia. Resident #1's admission Minimum Data Set (MDS) dated 8/17/11 indicated that Resident #1 had severe cognitive impairment and was incontinent of bladder. Resident #1 was dependent on one person for assistance with toileting. Resident #1 did not reject care. Review of the Physician's Telephone Orders dated 8/18/11 showed an order to obtain a urine specimen due to increased confusion. The order also indicated that an in and out catheter (a small tube connected to a container that could be	F 315	Preparation and /or execution of this plan of correction Does not constitute admission or agreement by the provider Of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required under federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shaula Kozlowski	Administrator	9/23/11

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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inserted in the bladder) could be used to obtain the sample.

Review of the Nurses Notes dated 8/18/11 at 7:20 AM revealed that an attempt to collect the urine specimen had been unsuccessful. There was no documentation on subsequent days that attempts had been made to collect a urine sample from Resident #1.

Review of the 24 Hour Report for unit 100 West dated 8/19/11 indicated that Resident #1 needed a urine specimen for increased confusion. There was no further documentation on subsequent days on the 24 Hour Report that a urine specimen was needed or had been obtained for Resident #1.

Review of the Physician's Telephone Orders dated 8/26/11 showed an order to place a urinary catheter.

Review of the Nurses Notes dated 8/26/11 at 7:20 AM revealed a urinary catheter had been inserted into Resident #1's bladder and a urine sample had been obtained and sent to the laboratory for analysis.

Review of the Laboratory Results dated 8/29/11 indicated that Resident #1 had a urinary tract infection.

Review of the Physician's Telephone Orders sheet dated 8/30/11 revealed that Resident #1 was placed on an antibiotic for the urinary tract infection.

In an interview on 9/1/11 at 5:45 PM with the

1. Resident #1 urine was obtained on 08/26/2011. Treatment was rendered per MD order received on 08/30/2011. UTI resolved and treatment was completed per order on 09/06/2011.

2. Any resident requiring a urine specimen be collected can be affected by this practice. Therefore the DON or will identify any resident who has urine collection ordered and ensure that it is collected and that appropriate follow up is provided in a timely fashion.

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F 315	Continued From page 2	F 315		

Director of Nurses (DON), she stated that she would have expected her nurses to pass on in report that urine collection was needed for Resident #1. She indicated that she would have expected the 24 hour report to reflect that urine still needed to be collected for Resident #1. She indicated that if the task was not on the 24 hour report she would have assumed that it had been done. She indicated it was the responsibility of the 11-7 nurse to carry over information onto the 24 hour report. She stated that if the nurses had been unable to obtain a specimen after 2-3 tries they should have come to her so she could have made the attempt. If she had been unable to collect the sample she would have called the physician and made him aware. She indicated that in any case the physician should have been notified within 2-3 days that a sample had not been collected.

In an interview on 9/2/11 at 10:35 AM with nurse #1, she indicated that when a telephone order was received the nurse would write the order on the Physician's Telephone Order sheet. The order would then be documented in the chart and put on the 24 hour report sheet. If the order was for a laboratory specimen it should be input into the laboratory computer. The nurse should then attempt to collect the specimen. If the specimen was collected the nurse would write that it had been collected on the 24 hour report sheet. If the specimen had not been collected after several tries then the physician should be notified. It should be passed on in report to each shift until the specimen was collected. She stated that the nurse who received the order should check daily to see if the specimens had been collected or were still pending.

Nurses, med techs, and med aides will be inserviced on

09/14/2011 by DON/SDC on use of 24 hr report, timely f/u of urine collection, shift to shift verbal report, and general documentation skills. Nurses 1-5 have received written verbal counseling r/t lack of appropriate f/u concerning urine collection.

3. The DON /SDC will review orders for the previous day each morning to ascertain any pending urine collections that may have been ordered. The DON or will note resident name, date of order, that order was entered into the lab system, date urine collected, that 24 hr report was used to notify oncoming/ off going shift of pending urine collections/tx, that urinalysis was completed with MD notification, and family was notified if treatment was rendered. DON or will complete this daily for 12 weeks.

4. Results of weekly audits will be reviewed by DON at monthly QA meetings for 3 months

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In an interview on 9/2/11 at 1:35 PM with nurse #2, she indicated that report was received from the out-going nurse at the beginning of the shift. If a specimen was needed it should be passed on in each shift report. She stated that she had attempted to obtain a urine specimen from Resident #1 but had been unsuccessful. She indicated that she did not document the attempt but she should have. She stated that the physician should have been called after 2 days if the specimen had not been collected and that she had not notified the physician. She indicated that a lack of communication and documentation had been the cause of the specimen not being collected.

In an interview on 9/2/11 at 2:25 PM with nurse #3, she stated report was given at the beginning of the shift. The nurses would find out what was needed by the residents in report. If a urine sample was needed but was unable to be collected the physician should be notified within 2 days. Alternate methods could have been tried. She indicated that the nurses should check the laboratory computer every day to see what labs are pending.

In an interview on 9/2/11 at 3:05 PM with nurse #4, he indicated that report was received first thing from the out-going nurse. He stated he attempted to collect a urine specimen from Resident #1 on two different days but was unsuccessful. He indicated that he had not documented his attempts in Resident #1's chart. He passed on in report that he was unable to obtain the specimen but did not call the physician to notify him that staff had been unable to obtain

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F 315	Continued From page 4 the specimen. In an interview on 9/2/11 at 11:25 PM with nurse #5, she indicated that she was responsible for transferring information onto the 24 Hour Report sheet on the 11-7 shift. She stated that if the urine had not been collected it should have been written on the 24 Hour Report sheet. Since it was not on the sheet she assumed that it had been collected. She indicated that she had tried once on 8/18/11 to obtain the specimen from Resident #1 but had been unsuccessful. She indicated that it was not unusual for an order to be missed and that the physician should have been notified by day 3 that the specimen had not been collected.	F 315		