

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

PRINTED: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/23/2014
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NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY	515 NERINX ROAD NERINX, KY 40049
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F 000	INITIAL COMMENTS	F 000		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan to address a history of positive reaction to tuberculin skin testing for one (1) of fifteen (15) sampled residents (Resident #6).</p>	F 279	<p>F279</p> <p>The corrective action for resident found to have been affected by deficient practice was the immediate update of the Care Plan for Resident #6 on 10/13/14 to address the positive PPD skin test. The DON verified that Resident # 6 had received appropriate assessment upon admission and ongoing nursing services are provided to monitor for development of symptoms related to the positive PPD skin test even though it was not previously addressed on the Care Plan.</p> <p>To identify other residents having the potential to be affected by the same deficient practice, the DON reviewed Care Plans on 10/23/14 for all other residents identified as having a history of positive PPD skin test to ensure appropriate approaches were listed and that all had received appropriate assessment and services related to the positive PPD skin test.</p> <p>Measures put in place to ensure that the deficient practice will not recur include screening of potential new residents by DON or admitting nurse for evidence of tuberculosis</p>	11/03/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Ewers</i>	TITLE <i>ADMINISTRATOR</i>	(X8) DATE <i>11/13/14</i>
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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 279	<p>Continued From page 1</p> <p>The findings include:</p> <p>A review of the Comprehensive Care Plan policy (updated May 2012) revealed the comprehensive care plan was an interdisciplinary communication tool that must include measurable objectives and timeframes and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised on an ongoing basis to reflect changes in the resident and the care that the resident was receiving.</p> <p>A review of the "Identification and Management of TB," (not dated) revealed residents with a history of a positive skin test shall be monitored for development of pulmonary symptoms such as cough, sputum production, or chest pain.</p> <p>Review of the medical record revealed the facility admitted Resident #6 on 04/29/14 with diagnoses including Benign Hypertension, Alzheimer's disease, Chronic Anxiety, Malaise and Fatigue, and Esophageal Reflux. A review of the immunization record revealed the resident had a history of a positive reaction to the Purified Protein Derivative (PPD) skin test (test to determine the presence of the bacteria that causes tuberculosis) dated 04/29/14.</p> <p>Review of the comprehensive care plan for Resident #6 dated 04/29/14 revealed the facility failed to develop a plan of care to address the resident's past positive PPD history to include monitoring for complications or signs/symptoms of tuberculosis.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 279	<p>screening or documentation of therapy and a determination as non-infectious will be obtained before admission. If it is determined that a resident has a history of positive PPD skin test or a PPD skin test produces a positive result after admission, the resident Care Plan will address the positive PPD skin test and implement approaches for appropriate assessment and services which includes monitoring for complications or signs/symptoms of tuberculosis. See updated policy "Identification and Management of TB", attachment A.</p> <p>The facility will monitor its performance to ensure that solutions are sustained with the development of Comprehensive Care Plans upon admission which are reviewed by the interdisciplinary team on an on-going basis and at least quarterly with the MDS assessment. The Quality Assurance committee will conduct resident chart audits to ensure each resident's Care Plan is Comprehensive and includes the resident's problems, risks, and issues. See updated policy "Resident Assessment and Care Plan", attachment B.</p>		

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F 279	Continued From page 2 10/23/14 at 10:30 AM revealed the DON was also the infection control nurse and was responsible for developing Resident #6's plan of care but failed to ensure Resident #6's care plan addressed monitoring for signs and symptoms of tuberculosis.	F 279			
F 282 SS=E	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 observation, interview, record review, facility policy review, and a review of the facility's fall investigations, it was determined the facility failed to ensure staff implemented care plan Interventions to prevent falls for three (3) of fifteen (15) sampled residents (Resident #4, Resident #5, and Resident #13). Resident #4 sustained falls on 01/27/14 and 05/22/14. Prior to the fall on 01/27/14, staff failed to ensure the resident was wearing regular shoes as required by the resident's care plan and on 05/22/14, staff failed to ensure Resident #4's chair alarm was on prior to the resident's fall. Resident #5 required the assistance of two (2) staff persons for activities of daily living; however, on 05/09/14, one staff person was assisting Resident #5 with a shower and the resident slid out of the shower chair in the shower room. Resident #13 required a Dycem Pad (non-slip padding) while in a chair. On 06/30/14 and 08/03/14, the facility failed to ensure the Dycem Pad was in the resident's chair	F 282	F282 Corrective action for residents found to be affected by the deficient practice: 1. Corrective action following Resident #4 fall on 1/27/14 included retraining of staff responsible for transfer on the importance of resident wearing regular shoes rather than slippers; all other care plan interventions were appropriately in place. Corrective action following Resident #4 fall on 5/22/14 included disciplinary action for staff responsible for ensuring bed alarm was on while resident was in bed. Staff responsible was educated on the appropriate use of alarms specifically that alarms do not prevent falls but rather alert staff that a resident may be at risk. 2. Interventions put in place after Resident #5 fell on 5/9/14, Included use of reclining shower chair due to resident falling forward out of shower chair. Care Plan updated with new approaches to prevent	11/17/14	

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F 282	<p>Continued From page 3</p> <p>and the resident sld/scooted from the chair and sustained falls.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Resident Assessment and Care Plan Policy and Procedure," dated May 2012, revealed the Care Plan was an interdisciplinary communication tool and would identify interventions and treatments which would be implemented to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks. However, the policy did not address how often staff was required to review the Plan of Care.</p> <p>1. Observation of Resident #4 on 10/21/14, at 4:15 PM, revealed the resident was in a low bed with a bed alarm.</p> <p>Review of the medical record for Resident #4 revealed the facility admitted the resident on 02/13/03, with diagnoses that included Alzheimer's Dementia, Anxiety, and Depression.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated 08/13/14, revealed the resident had been assessed to require the extensive assistance of two staff persons for transfers. The MDS also revealed the facility had assessed the resident to be severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 5.</p> <p>Review of the Plan of Care for Resident #4 dated 12/05/12, revealed the resident was to have a chair alarm when in the resident's bedroom and was also to wear regular shoes with all ambulation and transfers.</p>	F 282	<p>future falls. Disciplinary action completed on the staff person providing shower due to failure to follow care plan in not using 2 staff persons when providing care. Nursing staff informed of updated care plan approaches, new fall intervention and mandatory use of 2 staff persons with all care.</p> <p>3. Corrective action following Resident #13 fall on 6/30/14 included disciplinary action for staff responsible for ensuring non-skid pad was in wheelchair along with reminders to staff to utilize wheelchair for transport and not to leave resident sitting in wheelchair for a long time period. Corrective action for fall on 8/3/14 included disciplinary action for staff responsible for ensuring non-skid pad was in dayroom chair and encouraged use of rocker-glider chair when in dayroom to allow movement while sitting to reduce restlessness.</p> <p>The facility will identify other residents having the potential to be affected by the same deficient practice with the implementation of an SRNA care plan tool which will require the SRNA to review and sign for each resident he/she is responsible for. The SRNA care plan will list Resident Care Plan interventions that the SRNA is</p>	

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F 282	<p>Continued From page 4</p> <p>Review of a facility investigation dated 01/27/14, at 6:15 PM, revealed while Resident #4 was being transferred from the wheelchair to a recliner by State Registered Nursing Assistant (SRNA) #2 and Licensed Practical Nurse (LPN) #4 the resident slipped and had to be lowered to the floor by the staff. According to the investigation, Resident #4 was wearing house slippers and not regular shoes as directed in the Plan of Care. Documentation revealed the resident sustained no injury. The investigation revealed the SRNAs were in-serviced on ensuring Resident #4 was wearing regular shoes.</p> <p>Interview conducted with SRNA #2 on 10/23/14, at 7:08 PM revealed she was required to check the Plan of Care at the beginning of her shift. The SRNA stated Resident #4 should have had on regular shoes instead of house slippers and did not recall why Resident #4 did not have regular shoes on.</p> <p>Interview conducted with LPN #4 on 10/23/14, at 7:20 PM, revealed she was required to check the Plan of Care at the beginning of her shift. The LPN stated she vaguely remembered the incident with Resident #4 but the resident should have had on regular shoes instead of house slippers, and she did not recall why Resident #4 did not have regular shoes on.</p> <p>Review of a facility investigation dated 05/22/14, at 4:45 AM, revealed Resident #4 was found sitting on the resident's bathroom floor. Documentation revealed the resident sustained no injury. According to the investigation, Resident #4's alarm was not turned on and both SRNA #3 and SRNA #4 were provided with</p>	F 282	<p>responsible for implementing. Compliance rounds will be conducted by Nurse Supervisors to ensure interventions listed on the SRNA care plan are implemented. If a resident falls, the Resident Fall Investigation report will be completed as soon as possible by Nurse Supervisor. As a part of the Root Cause Analysis, the Nurse Supervisor will review the Resident Care Plan to verify that all interventions were in place at the time of the fall. If the Nurse determines that any Resident Care Plan interventions were not in place at the time of the fall, the Administrator is to be contacted immediately. The Administrator (or DON in Administrator's absence) will assist the Nurse Supervisor in completing the investigation on why interventions were not in place, determine appropriate corrective action and ensure that the staff involved has implemented appropriate Care Plan interventions on other residents.</p> <p>Measures put in place to ensure that the deficient practice will not recur are a new system of communicating Resident Care Plan interventions to SRNA staff along with compliance rounds. The SRNA Care Plan has been implemented to ensure SRNAs review applicable care plan interventions and are accountable</p>		

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F 282	<p>Continued From page 5 disciplinary action.</p> <p>Interview conducted with the DON on 10/23/14, at 7:30 PM, revealed both SRNA #3 and SRNA #4 had resigned, and the facility had no phone numbers to reach the SRNAs. The DON stated the alarm for Resident #4 should not have been turned off.</p> <p>2. Observation of Resident #5 on 10/21/14, at 4:10 PM, revealed the resident was sitting in a recliner resting with his/her eyes closed.</p> <p>Review of the medical record for Resident #5 revealed the facility admitted the resident on 01/27/09, with diagnoses that included Alzheimer's Dementia, Delusions, Anxiety, and Depression.</p> <p>Review of Resident #5's most recent quarterly MDS assessment dated 08/27/14, revealed the facility assessed the resident to have severely impaired cognition. The MDS also revealed the resident was assessed to require the total assistance of two persons for transfers.</p> <p>Review of the Plan of Care for Resident #5 dated 02/03/09, revealed Resident #5 required the assistance of two staff persons when providing all care.</p> <p>Review of a facility investigation dated 05/09/14, at 5:45 AM, revealed Resident #5 slid out of the shower chair in the shower room, and SRNA #6 was the only staff member with the resident. Documentation revealed Resident #5 sustained an abrasion to the left side of the forehead, a skin tear to the left elbow, and a skin tear to the left knee.</p>	F 282	<p>for implementing those interventions. An SRNA Care Plan document, listing the resident's care plan interventions and preferences applicable to direct care staff, will be kept in the resident room in a confidential manner. This document will be reviewed each shift and signed by the responsible SRNA verifying that all applicable care plan interventions are in place. This is a fluid document that will be updated as the Resident Care Plan is updated and will give SRNA staff an opportunity to have increased input on the care plan interventions in place for the residents they provide care for. Nursing staff attended mandatory training on the new SRNA Care Plan document the week of 11/10/14 to ensure all understand their responsibility to implement Resident Care Plan interventions. See "SRNA Care Plan example" document, attachment C, and "Resident Assessment and Care Plan" policy, attachment B.</p> <p>The facility will monitor its performance to ensure that solutions are sustained with compliance rounds conducted by the Nurse Supervisor to review the SRNA Care Plan to ensure care plan interventions are implemented. If a Resident Care Plan Intervention is not in place, the Nurse Supervisors will make an immediate correction,</p>	

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F 282	<p>Continued From page 6</p> <p>Interview conducted with SRNA #6 on 10/23/14, at 7:25 PM, revealed she was required to check the Plan of Care at the beginning of every shift. The SRNA stated she should have had a second staff member with her when bathing Resident #5 but could not recall why another staff person was not present.</p> <p>3. Observation of Resident #13 on 10/23/14, at 3:10 PM, revealed the resident was sitting in a rocking chair in the activity room listening while other residents were singing.</p> <p>Review of the medical record for Resident #13 revealed the facility admitted the resident on 12/02/13, with diagnoses that included Alzheimer's Dementia, Seizures, and Anxiety.</p> <p>Review of the most recent quarterly MDS assessment dated 09/03/14, revealed the facility assessed the resident to require the extensive assistance of two persons for transfers. The MDS also revealed the facility had assessed the resident to have severely impaired cognition.</p> <p>Review of the Plan of Care for Resident #13 dated 12/02/13, revealed a Dycem Pad was required to be in the resident's chair.</p> <p>Review of a facility investigation for Resident #13 dated 06/30/14, at 7:15 PM, revealed Resident #13 slid out of a chair in the activity room and sustained two skin tears to the left elbow. Documentation revealed the Dycem Pad was not in Resident #13's chair.</p> <p>Interview conducted with SRNA #1 on 10/23/14, at 6:40 PM, revealed she was responsible for</p>	F 282	<p>educate SRNA responsible, and will complete Employee Performance Report. This report is submitted to the DON for appropriate corrective action.</p> <p>The Quality Assurance Resident Focus Committee will audit monthly SRNA Care Plan documents to ensure SRNA staff are reviewing care plan interventions each shift as demonstrated by their Initials signed off for each day/shift, will complete compliance rounds in addition to the compliance checks completed by the Nurse Supervisor, and will monitor performance.</p>		

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F 282	Continued From page 7 placing the Dycem Pad on Resident #13's chair on 06/30/14, and had not. The SRNA stated she was required to check the Plan of Care at the beginning of every shift. Review of a facility investigation for Resident #13 dated 08/03/14, at 11:05 AM, revealed the resident scooted out of the chair in the activity room. Documentation revealed the resident sustained no injury from the fall. However, the documentation revealed a Dycem Pad was not in the resident's chair at the time of the fall. Interview conducted with LPN #1 on 10/23/14, at 7:30 PM, revealed she was responsible for ensuring the Dycem Pad was on the chair for Resident #13 on 10/23/14. The LPN stated it was just an oversight and the Dycem pad should have been underneath the resident. Interview conducted with the DON on 10/23/14, at 8:00 PM, revealed all fall investigations were reported to her and she attended a falls committee meeting every week during which resident falls were discussed. The DON stated staff was required to review residents' Plans of Care at the beginning of every shift. The DON stated she made compliance rounds daily and random spot checks to ensure care was being provided as directed on the resident's Plan of Care. The DON stated she had not identified any concerns with resident care plans being followed.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	F323 Corrective action for residents found to be affected by the deficient practice:	11/17/14	

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F 323	<p>Continued From page 8</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and a review of the facility's fall investigations, it was determined the facility failed to ensure assistive devices to prevent falls were implemented for three (3) of fifteen (15) sampled residents (Resident #4, Resident #5, and Resident #13). On 01/27/14, Resident #4 slipped while being transferred by staff. The facility failed to ensure the resident was wearing regular shoes prior to transferring the resident. Resident #4 sustained another fall on 05/22/14. The facility failed to ensure the resident's chair alarm was turned on as required by the resident's Plan of Care prior to the fall. On 05/09/14, Resident #5 slid out of a shower chair in the shower room with one staff member present, instead of two (2) staff members, which was required according to the resident's Plan of Care. Resident #13 sustained falls on 06/30/14 and 08/03/14, when the resident slid from a chair. The facility failed to ensure a Dycem Pad (non-slip padding) was in the resident's chair as directed by the resident's Plan of Care prior to the falls.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Assessing Falls and Their Causes," undated, revealed an incident report with the initial investigation would be completed no later than twenty-four (24) hours</p>	F 323	<p>1. Corrective action following Resident #4 fall on 1/27/14 included retraining of staff responsible for transfer on the importance of resident wearing regular shoes rather than slippers; all other care plan interventions were appropriately in place. Corrective action following Resident #4 fall on 5/22/14 included disciplinary action for staff responsible for ensuring bed alarm was on while resident was in bed. Staff responsible was educated on the appropriate use of alarms specifically that alarms do not prevent falls but rather alert staff that a resident may be at risk.</p> <p>2. Interventions put in place after Resident #5 fell on 5/9/14, included use of reclining shower chair due to resident falling forward out of shower chair. Care Plan updated with new approaches to prevent future falls. Disciplinary action completed on the staff person providing shower due to failure to follow care plan in not using 2 staff persons when providing care. Nursing staff informed of updated care plan approaches, new fall intervention and mandatory use of 2 staff persons with all care.</p> <p>3. Corrective action following Resident #13 fall on 6/30/14 included disciplinary action for staff responsible for ensuring non-skid</p>		

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F 323	<p>Continued From page 9</p> <p>after a fall occurs. The policy revealed the facility would begin to identify possible causes of the incident.</p> <p>1. Observation of Resident #4 on 10/21/14, at 4:15 PM, revealed the resident was in a low bed with a bed alarm.</p> <p>A review of Resident #4's medical record revealed the facility admitted the resident on 02/13/03, with diagnoses that included Alzheimer's Dementia, Anxiety, and Depression.</p> <p>A review of a quarterly Minimum Data Set (MDS) assessment dated 08/13/14 revealed the facility assessed the resident to have severely impaired cognition and required the extensive assistance of two staff persons for transfers.</p> <p>A review of Resident #4's Plan of Care dated 12/05/12, revealed the resident was required to have a chair alarm when the resident was in his/her bedroom and was to wear regular shoes with all ambulation and transfers.</p> <p>A review of a facility Investigation dated 01/27/14, at 6:15 PM, revealed State Registered Nursing Assistant (SRNA) #2 and Licensed Practical Nurse (LPN) #4 were transferring Resident #4 from the wheelchair to a recliner when the resident slipped and staff had to lower the resident to the floor. Documentation revealed Resident #4 was wearing house slippers and not regular shoes as directed in the Plan of Care. Documentation revealed the resident sustained no injury.</p> <p>An interview conducted with SRNA #2 on 10/23/14, at 7:08 PM, revealed she should have</p>	F 323	<p>pad was in wheelchair along with reminders to staff to utilize wheelchair for transport and not to leave resident sitting in wheelchair for a long time period. Corrective action for fall on 8/3/14 included disciplinary action for staff responsible for ensuring non-skid pad was in dayroom chair and encouraged use of rocker-glider chair when in dayroom to allow movement while sitting to reduce restlessness.</p> <p>The facility will identify other residents having the potential to be affected by the same deficient practice with the implementation of an SRNA care plan tool which will require the SRNA to review and sign for each resident he/she is responsible for. The SRNA care plan will list Resident Care Plan Interventions that the SRNA is responsible for implementing. Compliance rounds will be conducted by Nurse Supervisors to ensure interventions listed on the SRNA care plan are implemented. If a resident falls, the Resident Fall Investigation report will be completed as soon as possible by Nurse Supervisor. As a part of the Root Cause Analysis, the Nurse Supervisor will review the Resident Care Plan to verify that all interventions were in place at the time of the fall. The Nurse</p>		

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F 323	<p>Continued From page 10</p> <p>ensured resident #4 had on regular shoes prior to transferring the resident.</p> <p>An interview conducted with LPN #4 on 10/23/14, at 7:20 PM, revealed she checked the Plan of Care at the beginning of her shift. The LPN stated she vaguely remembered the incident with Resident #4. She stated the resident should have had on regular shoes, instead of house slippers, prior to transferring the resident and did not recall why Resident #4 did not have on regular shoes.</p> <p>A review of a facility investigation dated 05/22/14, at 4:45 AM, revealed Resident #4 was found sitting on the resident's bathroom floor. The investigation revealed the resident sustained no injury. Documentation revealed Resident #4's alarm was not turned on and both SRNA #3 and SRNA #4 were provided with disciplinary action.</p> <p>Interview conducted with the DON on 10/23/14, at 7:30 PM, revealed SRNA #3 and SRNA #4 had resigned, and the facility had no phone numbers to reach the SRNAs. The DON stated the alarm for Resident #4 should not have been turned off.</p> <p>2. Observation of Resident #5 on 10/21/14, at 4:10 PM, revealed the resident was sitting in a recliner with his/her eyes closed.</p> <p>A review of the medical record for Resident #5 revealed the facility admitted the resident on 01/27/09, with diagnoses that included Alzheimer's Dementia, Anxiety, Depression, and Delusions.</p> <p>A review of the most recent quarterly MDS assessment for Resident #5 dated 08/27/14</p>	F 323	<p>Supervisor will implement new interventions as needed to ensure adequate supervision and assistive devices to prevent accidents. If the Nurse determines that any Resident Care Plan interventions were not in place at the time of the fall, the Administrator will be contacted immediately. The Administrator (or DON in Administrator's absence) will assist the Nurse Supervisor in completing the investigation on why interventions were not in place, determine appropriate corrective action and ensure that the staff involved has implemented appropriate Care Plan interventions on other residents. See "Resident Safety Clinical Protocol", attachment D.</p> <p>Measures put in place to ensure that the deficient practice will not recur are a new system of communicating Resident Care Plan interventions to SRNA staff along with compliance rounds. The SRNA Care Plan has been implemented to ensure SRNAs review applicable care plan interventions and are accountable for implementing those interventions. An SRNA care plan document, listing the resident's care plan interventions including safety and use of assistive devices, will be kept in the resident room in a confidential manner. This document will be reviewed each shift and</p>		

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F 323	<p>Continued From page 11</p> <p>revealed the facility assessed the resident to have severely impaired cognition and to require the total assistance of two persons for transfers.</p> <p>A review of the Plan of Care for Resident #5 dated 02/03/09 revealed Resident #5 required the assistance of two staff persons when providing all care.</p> <p>A review of a facility investigation dated 05/09/14, at 5:45 AM, revealed Resident #5 slid out of the shower chair in the shower room, and SRNA #6 was the only staff member with the resident. The investigation revealed Resident #5 sustained an abrasion to the left side of the forehead, a skin tear to the left elbow, and a skin tear to the left knee.</p> <p>An interview conducted with SRNA #6 on 10/23/14, at 7:25 PM, revealed she should have had a second staff member with her when bathing Resident #5 but did not. The SRNA stated she could not recall why she had not had another staff person present.</p> <p>3. Observation of Resident #13 on 10/23/14, at 3:10 PM, revealed the resident was sitting in a rocking chair in the activity room while other residents were singing.</p> <p>A review of the medical record for Resident #13 revealed the facility admitted the resident on 12/02/13, with diagnoses that included Alzheimer's Dementia, Seizures, and Anxiety.</p> <p>A review of the most recent quarterly MDS assessment dated 09/03/14 revealed the facility assessed the resident to require extensive assistance of two persons for transfers. The</p>	F 323	<p>signed by the responsible SRNA verifying that all applicable care plan interventions are in place. Nursing staff attended mandatory training on the new SRNA care plan document the week of 11/10/14 to ensure all understand their responsibility to implement Resident Care Plan Interventions to prevent accidents and promote resident safety. See "SRNA Care Plan example" document, attachment C.</p> <p>The facility will monitor its performance to ensure that solutions are sustained with compliance rounds conducted by the Nurse Supervisor to review the SRNA Care Plan to ensure care plan interventions and safety measures are implemented. If a Resident Care Plan intervention is not in place, the Nurse Supervisors will make an immediate correction, educate SRNA responsible, and will complete Employee Performance Report. This report is submitted to the DON for appropriate corrective action. The Quality Assurance Resident Incident Committee reviews all Resident Fall Investigation reports, monitors interventions, and tracks trends. This committee audits the investigation conducted by the Nurse Supervisor, evaluates the use of root cause analysis to identify possible causes of fall, and reviews Resident Care Plan interventions to ensure the</p>	

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F 323	<p>Continued From page 12</p> <p>MDS also revealed the facility assessed the resident to have severely impaired cognition.</p> <p>A review of the Plan of Care for Resident #13 dated 12/02/13 revealed a Dycem Pad was to be in the resident's chair.</p> <p>A review of a facility investigation for Resident #13 dated 06/30/14, at 7:15 PM, revealed Resident #13 slid out of a chair in the activity room and sustained two skin tears to the left elbow. Documentation revealed the Dycem Pad was not in Resident #13's chair when the resident fell.</p> <p>An interview conducted with SRNA #1 on 10/23/14, at 6:40 PM, revealed she was responsible for placing the Dycem Pad on Resident #13's chair and had not.</p> <p>A review of a facility investigation for Resident #13 dated 08/03/14, at 11:05 AM, revealed Resident #13 scooted out of a chair in the activity room. Documentation revealed the resident sustained no injury from the fall. However, the documentation revealed a Dycem Pad was not in the resident's chair at the time of the fall.</p> <p>An interview conducted with LPN #1 on 10/23/14, at 7:30 PM, revealed she was responsible for ensuring the Dycem Pad was on the chair for Resident #13 on 10/23/14. The LPN stated it was just an oversight and the Dycem Pad should have been underneath the resident.</p> <p>An interview conducted with the DON on 10/23/14, at 8:00 PM, revealed all fall investigations were reported to her and she attended a falls committee meeting every week.</p>	F 323	resident environment is as free of hazards as is possible and to ensure adequate supervision and assistive devices are provided.	

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F 323	Continued From page 13 The DON stated staff was required to review residents' Plans of Care at the beginning of every shift and to ensure the Plans of Care were followed. The DON stated she made compliance rounds daily and conducted random spot checks to ensure care and adequate supervision to prevent accidents were being provided.	F 323		