

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

PRINTED: 04/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/02/2015
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NAME OF PROVIDER OR SUPPLIER  GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY00023021 was initiated on 03/30/15 and concluded on 04/02/15. KY00023021 was substantiated with deficiencies cited at a highest Scope and Severity of a "G".</p> <p>On 03/18/15 some time between 7:00 PM and 8:00 PM, Resident #1 experienced a fall when CNA #1 lowered the resident to the floor as a result of the resident's left leg giving out. CNA #1 reported she did not have any assistance with transferring the resident from his/her wheelchair to his/her bed, even though the resident was care planned for transfers of two (2) staff members. Additionally, the resident was care planned for pain in which the resident was at risk for alterations in comfort related to an History of a Hip Fracture, GERD, Osteoporosis, and Parkinson's. On 03/18/15 after the fall Resident #1 complained of pain to staff by verbalizing, "my back, my back". On 03/19/15 at 4:52 AM, Licensed Practical Nurse (LPN) #1, noted the resident complained of pain to hip and knee area on the left side an inward rotation to his/her leg. At 8:15 AM staff documented the resident complained "my hip, my hip, my hip", the left leg was noted to be rotated inward and swollen around the knee and upper thigh area. There was no documented evidence the resident was given his/her has needed (PRN) pain medication. The Physician was notified and the resident was transported to the hospital's emergency room (ER), where after assessment and diagnostic testing, the resident was diagnosed with a Left Femur Fracture. Upon arrival to the ER, the resident's vitals were stable; however the resident's heart rate would evaluate every time</p>	F 000	<p>Grant Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p>	<p>APR 24 2015</p> <p>RECEIVED APR 24 2015</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/24/15
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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 000	Continued From page 1 his/her leg was touched. The resident was administered 4 mg of morphine.	F 000			
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents Comprehensive Care Plans were implemented for one (1) of five (5) sampled residents (Resident #1).  Resident #1 was care planned to have assistance with ADL's, which included transfers, and the "care card" (Kardex) utilized by the facility's Certified Nursing Assistants (CNAs) revealed the resident required two (2) person extensive physical assist with transfers. However, on 03/18/15, between 7:00 and 8:00 PM, Resident #1 experienced a fall as a result of being transferred with assistance of only one (1) staff, CNA #1.  Additionally, Resident #1 was care planned for pain with interventions which included to administer medications as ordered and observe for nonverbal signs and symptoms (s/s) of pain. After Resident #1 experienced the fall on 03/18/15, sometime between 7:00 and 8:00 PM, the resident complained of pain by verbalizing, "my back, my back", and continued to complain of	F 282	F 282  1. Resident #1's comprehensive care plan was updated to reflect current transfer status, including assistance required, on 4/6/15 by the Director of Nursing.  Certified Nursing Assistant #1 was re-educated regarding transfer assist compliance as documented on the Kardex and a Post-test will be given by 5/6/15 by the Director of Nursing, Assistant Director of Nursing and /or Unit Manager to validate understanding with a required 80% to pass; to be graded by the Director or Assistant Director of Nursing.  Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #1, RN#2, and RN#3 will be re-educated by Director of Nursing or Assistant Director of Nursing by 5/6/15 to ensure that interventions identified on the resident's comprehensive care plan are performed to ensure relief of resident's pain and a Post-test will be given to validate understanding, with a required 80% to pass.		

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F 282	Continued From page 2 pain. On 03/19/15 at 4:52 AM, Resident #1 was noted to complain of pain to the left hip and knee area, and at 8:15 AM, the resident was stating, "my hip, my hip, my hip", with the left leg noted to be rotated inward and swollen around the knee and upper thigh area. However, there was no documented evidence staff had administered Resident #1's as necessary (PRN) pain medications for relief of the resident's pain, as per the care plan. Resident #1 was sent to the hospital emergency room (ER) where he/she was given Morphine (a narcotic pain reliever) for pain and diagnosed with a left femur fracture. (Refer to F309 and F323)  The findings include:  Review of the facility's policy titled, "Care Plans", with a revision date of 01/02/14, revealed the comprehensive, Individualized care plan would be developed by the interdisciplinary team (IDT) for each resident. Review revealed the care plan would include measurable objectives and goals as identified by the assessment process. The Policy revealed the purpose of the care plan was to provide necessary care and services to attain or maintain the patient's highest practicable physical, mental, and psychosocial well being.  1. Record review revealed the facility admitted Resident #1 on 12/11/09, with diagnoses which included a Personal History of Falls, Osteoporosis, Generalized Pain, Depressive Disorder and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/12/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status score of three (3), which indicated he/she was severely cognitively impaired. Continued review	F 282	2. All residents have the potential to be affected. A review of the residents' care plans and kardexes will be completed by the Director of Nursing, Assistant Director of Nursing, and /or Unit Manager to determine that they are reflective of residents current transfer status, including assistance required, and pain interventions by Director of Nursing, Assistant Director of Nursing, and /or Unit Manager, by 5/6/15 with corrective action and re-education if indicated.  3. Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, or Weekend Supervisor, will conduct a one-time transfer observation on all residents that require transfer assistance by 5/6/15. All RNs, LPNs, and CNAs will be re-educated regarding comprehensive care plans and kardex compliance to include the assistance required for transfers and the provision of pain intervention by Director of Nursing, Assistant Director of Nursing, Unit Manager, and/or Weekend Supervisor by 5/6/15. Re-education includes a post-test to determine understanding with a required 80% to pass: to be graded by the Director or Assistant Director of Nursing. RNs, LPNs, and CNAs not available during this time frame will be provided re-education upon return to work by the Director of Nursing, Assistant Director of Nursing, Unit Manager, and/or Weekend Supervisor.	

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F 282	<p>Continued From page 3</p> <p>of the MDS revealed the facility assessed Resident #1 to require extensive physical assist of two (2) staff for transfers and bed mobility.</p> <p>Review of Resident #1's Comprehensive Care Plan, revised 03/05/15, revealed the facility care planned the resident for requiring assistance with activities of daily living (ADLs) which included for transfers. Continued review revealed the goal was for staff to anticipate and meet Resident #1 ADL care needs in order to maintain the highest practicable level of functioning and physical well-being. Further review revealed interventions which included staff to assist Resident #1 with ADLs as needed and adjust the level of care as needed. Review of the MDS Kardex, (CNAs care plan), dated March 2015, revealed Resident #1 was an extensive assist of two (2) staff with transfers.</p> <p>Review of the facility's Risk Management System (RMS) Incident Report, completed on 03/31/15 at 10:03 AM, revealed Resident #1 had fallen on 03/18/15 at 7:30 PM, when being transferred from wheel chair to bed and was lowered to the floor. Per the Incident Report, Resident #1 denied pain and was assisted to bed per two (2) staff. The Incident Report revealed CNA #1 and CNA #2 were witnesses of the fall. Review of the corrective action section of the Incident Report revealed Resident #1 was assessed by a nurse with no signs or symptoms (s/s) of pain or discomfort, x-rays were ordered at 5:00 AM and canceled due to the resident being sent to the ER at 8:15 AM. Further review revealed the hospital called the facility to report Resident #1 had a left femur fracture.</p> <p>Interview, on 04/01/15 at 2:58 PM, with CNA #1</p>	F 282	<p>4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, or Weekend Supervisor will conduct five transfer observation audits across all shifts three times per week, then three transfer observation audits across all shifts for four weeks and then as determined by the monthly Performance Improvement Committee to ensure that residents are transferred with the required assistance as indicated by the comprehensive care plan and kardex with corrective action and re-education as indicated. Findings will be reported to the Director of Nursing.</p> <p>The Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, or Weekend Supervisor will review nursing progress notes daily across all shifts for two weeks, then three times a week across all shifts for two weeks, then as determined by the monthly Performance Improvement Committee to ensure that pain interventions are provided as per the comprehensive care plans are provided with corrective action and re-education if indicated. Findings will be reported to the Director of Nursing.</p>	
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F 282	<p>Continued From page 4</p> <p>revealed she cared for Resident #1 regularly, and stated the resident was care planned to be a two (2) person assist, but could bear weight. Per interview, it helped to have two (2) people to assist when transferring Resident #1. Continued interview revealed on the night of 03/18/15, at approximately 8:00 PM, she was attempting to transfer Resident #1 by herself from the wheelchair to the bed, when the resident slumped over onto her and leaned forward. CNA #1 stated she eased Resident #1 to a sitting position on the floor. She reported Resident #1's left leg was turned inward facing his/her right knee, and "didn't look normal" CNA #1 further revealed she should have asked for assistance when transferring Resident #1, as the care plan noted he/she was a two (2) person assist and she should have followed it. CNA #1 stated "If there was another CNA to assist, I'm sure the resident would not have fallen or hurt" himself/herself.</p> <p>Interview, on 03/31/15 at 5:18 PM, with CNA #2, revealed it was known among staff Resident #1 was a two (2) person assist, and the resident was care planned to be a two (2) person assist. Per interview, CNA #1 told her Resident #1 could bear weight and often assisted her with transfers. She stated CNA #1 told her she was trying to transfer Resident #1 on her own because the resident normally helped her. Continued interview revealed however, if a resident was care planned to be an assist of two (2) staff, then staff should seek assistance from another aide before transferring the resident. Additionally, CNA #1 reported she would not try to transfer a resident on her own because "it's just too risky". Further interview revealed it was important to follow residents' care plans to ensure the resident's or staff were not hurt. The CNA stated Resident</p>	F 282	<p>The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.</p> <p>Completion Date by 5/6/15.</p>	5/6/15

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F 282	<p>Continued From page 5</p> <p>#1's care plan should have been followed by CNA #1.</p> <p>Interview, on 04/02/15 at 7:58 AM, with CNA #5, revealed Resident #1 was care planned for a two (2) person assist and should not be transferred with an assist of one (1). She stated Resident #1 could not bear weight, and it would be difficult to transfer the resident by yourself. Per CNA #5, "if a resident was a fall risk, then bad things could happen to them" if the care plan was not followed. She stated staff should follow the care plan like it was their bible.</p> <p>Interview, on 04/01/15 at 12:32 PM with Licensed Practical Nurse (LPN) #2 and at 6:42 PM with Registered Nurse (RN) #1, and on 04/02/15 at 10:45 AM with RN #3 and at 3:29 PM with RN #2, revealed they all stated Resident #1 was a two (2) person assist with transfers. RN #1 and RN #3 revealed Resident #1's Comprehensive Care Plan noted to assist Resident #1 with ADLs as needed and adjust care to his/her individual needs. Per RN #1 and RN #3, the CNA's "care cards" (Kardex) noted the assistance residents required, and RN #1 stated Resident #1's "care card" indicated the resident was an assist of two (2) staff for transfers. Per RN #1, Resident #1 was sometimes a one (1) person assist because he/she could bear weight; however, it was important the care plan was followed by staff.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator and the Clinical Reimbursement Coordinator (CRC), on 04/02/15 at 2:07 PM, revealed the Comprehensive Care Plan was a tool used to guide and direct the care for the residents. When reviewing Resident #1's Care Plan, they reported the intervention related to</p>	F 282		

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F 282 Continued From page 6  
transfers was not specific as to the number of staff required to complete the transfer; however, the Kardex, (CNAs care plan), specified Resident #1 required extensive assist of two (2) staff persons to transfer the resident. The MDS and CRC stated the nursing staff and CNAs should be referring to the care plan and Kardex to direct the care of the resident. Additionally, they both stated Resident #1's care plan should have been followed.

Interview with the Assistant Director of Nursing (ADON), acting for the Director of Nursing (DON), and the Administrator, on 04/02/15 at 4:45 PM, revealed Resident #1 was care planned to be a two (2) person assist and should not have been assisted by one (1) staff member. Both the Administrator and the ADON stated it was their expectation, the Care Plan would be followed by staff.

2. Continued review of Resident #1's Quarterly MDS, dated 03/12/15, revealed the facility assessed the resident to have moderate pain during the last five (5) days, which made it hard to sleep at night.

Continued review of Resident #1's Comprehensive Care Plan, revised 03/05/15, revealed the facility care planned the resident as at risk for alterations in comfort with a goal for the resident not to exhibit nonverbal indicators of pain. Further review of the care plan revealed the interventions included to administer medications as ordered and to observe for nonverbal signs and symptoms (s/s) of pain.

Review of the March 2015 Physician's Orders revealed Resident #1 was to be monitored for

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F 282	<p>Continued From page 7</p> <p>pain and had an order for Mobic (a pain reliever) scheduled daily for pain to be given at breakfast. Continued review revealed Resident #1 also had as necessary (PRN) Acetaminophen and Hydrocodone/Acetaminophen ordered every six (6) hours PRN for pain.</p> <p>Review of the March 2015 Medication Administration Record (MAR) revealed no documented evidence the two (2) PRN pain medications were administered on 03/18/15 and 03/19/15 after Resident #1 experienced pain from the fall.</p> <p>Review of the computerized Nurse's Notes dated 03/18/15 at 9:30 PM, noted by RN #1 revealed Resident #1 had an "accident/incident fall" in the past seventy-two (72) hours, which was witnessed during a transfer. Continued review of the Note revealed Resident #1 was not demonstrating symptoms of pain.</p> <p>Interview, on 04/01/15 at 6:42 PM, with RN #1 revealed Resident #1 expressed his/her back was hurting by stating, "my back, my back". However, RN #1 stated she did not give Resident #1 pain medication, as she didn't know if the resident was truly expressing pain. RN #1 revealed unless a resident asked her for a pain medication, she would not give the resident anything for pain. Continued interview with RN #1 revealed she was not familiar with Resident #1's care plan and often got her information from shift report.</p> <p>Review of the 03/19/15 at 4:52 AM, Nurse's Note documented by LPN #1 revealed Resident #1 complained of pain to the left hip and knee when moved, with an inward rotation of the leg. Review of Nurse's Notes dated 03/19/15 at 4:56 AM,</p>	F 282		
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F 282	Continued From page 8  documented by LPN #1 revealed it was a follow-up note from the "accident/incident/fall" Resident #1 had experienced in the past seventy-two (72) hours. The Note revealed Resident #1 now complained of pain to hip and knee area on the left side noted an inward rotation to leg. Per the Note, an order was received to get a "stat" (as soon as possible) x-ray. However, there was no documented evidence Resident #1's PRN pain medication was administered for the resident's pain, as per the care plan.  Interview with LPN #1, on 04/01/15 at 11:28 PM, revealed if she determined the resident was in pain she would check for PRN pain medication orders, and administer the PRN. However, even though LPN #1 documented Resident #1 complained of pain, LPN #1 failed to administer the resident's PRN pain medication, per the resident's plan of care.  Review of the "Late Entry" Nurse's Note dated 03/19/15 at 8:00 AM, documented by RN #3 revealed Resident #1's left leg was swollen at the thigh and the knee was disfigured, and LPN #2 was told to send the resident "out", to the hospital.  Interview, on 04/02/15 at 10:45 AM, with RN #3 revealed she was told by RN #2, Resident #1 expressed he/she was in pain by stating, "my hip, my hip". RN #3 reported she did not give the resident anything for pain because the resident did not express to her that he/she was in pain. Continued interview with RN #3 revealed she would have given Resident #1 something for pain had she heard the resident say he/she was in pain; however the resident did not say anything	F 282			

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F 282	<p>Continued From page 9</p> <p>when she went to the resident's room. RN #3 revealed the resident was care planned for pain; however, revealed the "paper" was the last thing she looked at, adding the interventions were something they already did. Additionally, RN #3 stated the care plan should have been followed. RN #3 reported that the potential for psychological harm to the resident when the pain went untreated would be, "If left untreated, it would be internalized or emotional to the resident and the resident could shut down".</p> <p>Review of LPN #2's Nurse's Note dated 03/19/15 at 8:15 AM, revealed Resident #1's left leg was rotated inward and swollen around knee and upper thigh area. Further review revealed Resident #1 was stating, "my hip, my hip, my hip". The Note revealed the Physician was called and an order received to send Resident #1 to the ER. However, there was no documented evidence Resident #1's PRN pain medication was administered for pain, as per the care plan.</p> <p>Interview, on 04/01/15 at 12:32 PM, with LPN #2 revealed when she checked on Resident #1 the morning of 03/19/15 between 7:00 AM and 7:30 PM, the resident was touching his/her left hip repeating, "my hip, my hip, my hip". LPN #2 reported she knew Resident #1 was in pain by the way he/she was grabbing his/her hip. Continued interview with LPN #2 revealed she did not give Resident #1 his/her PRN pain medications because she was more concerned about sending the resident out.</p> <p>Interview with the ADON, acting for the DON, on 04/02/15 at 4:02 PM, revealed it would be her expectation that staff would follow Resident #1's care plan regarding pain. She reported staff, on</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER  GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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F 282	Continued From page 10 each shift, should be asking the resident, "Are you in Pain?". The ADON reported it would have been her expectation that staff would have provided the resident his/her PRN pain medications when he/she expressed he/she was in pain.  Interview with the ADON and the Administrator, on 04/02/15 at 4:45 PM, revealed Resident #1 was care planned for PRN pain medication and it should have been administered. Per the Administrator and the ADON, it was their expectation the care plan would be followed by staff.	F 282		
F 309 SS=G	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 interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure monitoring residents for pain for one (1) of five (5) sampled residents (Resident #1).  Resident #1 experienced a fall on 03/18/15, sometime between 7:00 and 8:00 PM, and the resident complained of pain to staff by	F 309		

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F 309	<p>Continued From page 11</p> <p>verbalizing, "my back, my back". Resident #1 continued to complain of pain every time he/she was turned. Resident #1 had Physician's Orders for Acetaminophen (pain reliever) and Hydrocodone/Acetaminophen (a narcotic pain reliever) ordered for pain as necessary (PRN). However, there was no documented evidence Resident #1 received PRN pain medication. On 03/19/15 at 8:00 AM, Resident #1's left leg was noted to be swollen at the thigh and knee and "disfigured". At 8:15 AM, Resident #1 was saying, "my hip, my hip, my hip", the Physician was notified and an order received to transport the resident to the hospital emergency room (ER). Resident #1 was grimacing in pain on arrival to the ER, and his/her heart rate would elevate every time the left leg was touched. Morphine (a narcotic pain reliever) was ordered for the pain and administered in the ER. Resident #1 was diagnosed with a left femur fracture and admitted to the hospital. (Refer to F282)</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Pain Management", revised 01/02/14, revealed residents would be evaluated for pain on admission/re-admission, quarterly, with a change in condition or change in pain status. Per the Policy, the purpose was to maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat and evaluate pain. Review revealed "as a minimum of daily" residents would be evaluated for the presence of pain by inquiry or by observation for signs of pain. If a resident experienced a change in their pain status, the nurse was to complete a "Pain Screening and Evaluation Tool". In</p>	F 309	<p>F 309</p> <p>1. Resident #1 pain was assessed on 4/6/15 by Director of Nursing clinical findings are documented in the clinical record.</p> <p>Registered Nurse (RN) #1, Licensed Practical Nurse (LPN)#1, RN#2, and RN#3 will be re-educated by Director of Nursing or Assistant Director of Nursing by 5/6/15 to ensure that 1) residents are evaluated for pain daily at a minimum for presence of pain by inquiry or by observation for signs of pain, 2) Pain Evaluation is completed when a resident experiences a change in pain status, 3) the residents receive pain medication as ordered for verbal or observed signs of pain, and 4) that observations or reports of pain are to be reported to the nurse responsible for the resident. Re-education includes post-test to validate understanding with a required 80% to pass; to be graded by the Director of Nursing or Assistant Director of Nursing.</p> <p>2. All Residents have the potential to be affected. All residents' pain evaluations were completed by licensed nurses, documented in resident clinical records with corrective action by 4/13/15.</p>	
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F 309	<p>Continued From page 12</p> <p>addition, the Policy revealed facility staff would report any observation or communication of residents' pain to the nurse responsible for the resident.</p> <p>Medical record review revealed the facility admitted Resident #1 on 12/11/09, with diagnoses which included Generalized Pain, Anxiety, Personal History of Falls, Osteoporosis and Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/12/15, revealed the facility assessed Resident #1 as severely cognitively impaired, and to have moderate occasional pain in the past five (5) days which made it hard to sleep at night.</p> <p>Review of Resident #1's Comprehensive Care Plan, revised 03/05/15, revealed the facility care planned the resident as being at risk for alterations in comfort, with a goal for the resident not to exhibit non-verbal indicators of pain through the "next review". Review of the care plan revealed interventions which included "administer medications as ordered", encourage the resident to communicate presence of pain and observe for non verbal signs and symptoms (s/s) of pain.</p> <p>Review of the March 2015 Physician's Orders revealed Resident #1 was to be monitored for pain every shift, and had Mobic (pain reliever) 7.5 milligrams (mg) by mouth in the morning for pain daily with breakfast. Continued review of the Physician's Orders revealed Resident #1 also had orders for Acetaminophen Tablet 650 milligrams (mg) every six (6) hours PRN for pain and Hydrocodone/Acetaminophen 5/325 mg every six (6) hours PRN for pain.</p>	F 309	<p>3. RNs, LPNs, and CNAs will be re-educated by Director of Nursing, Assistant Director of Nursing, Unit Manager, and/ or Weekend Supervisor by 5/6/15 to ensure that 1) residents are evaluated for pain daily at a minimum for presence of pain by inquiry or by observation for signs of pain, 2) Pain Evaluation is completed when a resident experiences a change in pain status, 3) the residents receive pain medication as ordered for verbal or observed signs of pain, and 4) that observations or reports of pain are to be reported to the nurse responsible for the resident. Re-education includes post-test to validate understanding with a required 80% to pass; to be graded by the Director of Nursing or Assistant Director of Nursing. RNs, LPNs, and CNAs not available during this time frame will be provided re-education upon return to work by the Director of Nursing, Assistant Director of nursing, Unit manager or Weekend Supervisor.</p>	
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F 309	<p>Continued From page 13</p> <p>Review of the facility's Risk Management System (RMS) Incident Report, with a completion date of 03/31/15 at 10:03 AM, revealed Resident #1 had experienced a fall during a transfer and was lowered to the floor on 03/18/15 at 7:30 PM. The Incident Report revealed at the time of the fall Resident #1 denied pain and was assisted to bed. Continued review revealed the corrective action section included the following information: Resident #1 was "placed in bed, per staff, assessment completed per nurse, no s/s of pain or discomfort, x-rays ordered at 5:00 AM stat (immediately), then canceled due to resident being sent to the ER at 8:15 AM". Further review of the corrective action section revealed the hospital called the facility to report Resident #1 had a left femur fracture.</p> <p>Review of Resident #1's Nurse's Note dated 03/18/15 at 9:30 PM, documented by Registered Nurse (RN) #1 revealed the Note was a "change in condition" Note which stated Resident #1 had experienced "a(n) accident/incident/fall" in the past seventy-two (72) hours, which was witnessed during a resident room transfer.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 04/01/15 at 2:58 PM, revealed after the fall on 03/18/15, Resident #1 expressed his/her back was hurting. Per interview, Resident #1 often expressed pain by stating, "my back", but mainly staff would observe his/her facial expression since the resident did not talk very much. Further interview revealed she did not see RN #1 give Resident #1 anything for pain after the fall, but she believed something should have been given.</p> <p>Interview with CNA #2, on 03/31/15 at 5:18 PM, revealed she recalled Resident #1 expressing</p>	F 309	<p>4. The Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, or Weekend Supervisor will review nursing progress notes and pain monitors daily across all shifts for two weeks, then three times a week for two weeks across all shifts, then as determined by the monthly Performance Improvement Committee to ensure that pain medications are administered in accordance with the findings of the daily pain evaluations, Pain Evaluation, and as reported by staff or observed non-verbal signs of pain with corrective action and re-education if indicated. Findings will be reported to the Director of Nursing.</p> <p>The Director of Nursing or Assistant Director of Nursing will submit a summary of the findings to the monthly Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.</p> <p>Completion Date by 5/6/15.</p>	5/6/15
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F 309	<p>Continued From page 14</p> <p>being in pain, and stated, "yes" his/her leg was hurting when asked if she was in pain. Continued interview with CNA #2 revealed she and CNA #1 told RN #1, Resident #1 expressed being in pain, and RN #1 moved both of the resident's legs around with the resident continuing to complain of pain. However, CNA #2 stated she wasn't sure if RN #1 gave Resident #1 anything for pain or not. Per CNA #2, she was told by CNA #1, Resident #1 appeared to be in a lot of pain when she went in to change the resident, but CNA #2 stated she did not see the resident the rest of that night.</p> <p>Interview with RN #1, on 04/01/15 at 6:42 PM, revealed after the fall on 03/18/15, Resident #1 expressed his/her back was hurting by stating, "my back, my back". She stated however, she did not give Resident #1 any type of pain medication because she did not know if the resident was truly expressing pain. She stated Resident #1 would be able to tell her if he/she wanted a pain medication by stating, "yes", when asked if he/she was hurting. Per interview, Resident #1 was nonverbal, and for a non-verbal resident staff would watch for a grimace or for some kind of facial expression. Continued interview revealed Resident #1 did not show any of these signs after the fall. She stated unless a resident asked her for a pain medication, she would not give the resident anything for pain. Further interview revealed taking vital signs could indicate if a resident was in pain, and she stated Resident #1's vital signs were taken after the fall but not taken throughout her shift on 03/18/15. However, record review revealed no documented evidence the resident's vitals were taken after his/her initial fall.</p> <p>Review of the 03/19/15 Nurse's Note timed 4:52</p>	F 309		
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F 309	<p>Continued From page 15</p> <p>AM, documented by Licensed Practical Nurse (LPN) #1, revealed Resident #1 was complaining of pain in the left hip and knee when moved, inward rotation of the leg was noted, the Physician was notified with orders received for mobile x-rays, and the mobile x-ray company was notified.</p> <p>Review of Nurse's Note dated 03/19/15 at 4:56 AM, revealed LPN #1 documented a "change in condition follow-up note" related to the "accident/incident/fall" Resident #1 had experienced in the past seventy-two (72) hours. Continued review of the Note revealed "status of condition: deteriorated" regarding Resident #1, as the resident was now complaining of pain to the left hip and knee, with an inward rotation of the leg noted, orders received for x-ray. However, record review revealed no documented evidence Resident #1 was administered his/her PRN pain medication.</p> <p>Interview with CNA #3, on 04/01/15 at 7:13 PM, revealed she reported to LPN #1 the resident's leg was swollen, and when LPN #1 moved Resident #1's leg, he/she kept saying, "it hurts, it hurts". CNA #3 stated Resident #1 grimaced when they changed him/her. Per interview, it was obvious Resident #1 was in pain that night after he/she experienced the fall.</p> <p>Interview with LPN #1, on 04/01/15 at 11:28 PM, revealed she assessed nonverbal residents for pain by looking at a resident's body movement, and observing the way a resident was acting. Per LPN #1, around 4:00 AM that morning, 03/19/15, she "checked" Resident #1's leg, and the resident was saying, "oh my leg, my leg", when the left leg was moved when she did range of motion (ROM)</p>	F 309		
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F 309	<p>Continued From page 16</p> <p>on his/her legs. She stated if she determined the resident was in pain she would check for PRN pain medication orders, and administer the PRN. Further interview revealed if the PRN was not effective she would notify the Physician for any additional orders or recommendations. Further interview revealed nonverbal residents should have their vital signs checked to assist in the pain assessment. LPN #1 revealed she could not recall if she had checked Resident #1's vital signs after the fall on 03/18/15.</p> <p>Further review of the Nurse's Notes revealed a "Late Entry" Note dated 03/19/15 at 8:00 AM, documented by RN #3. Review of the Note revealed RN #3 was called Resident #1's room where she observed the resident "lying in bed, quiet" with no "crying out in pain". Continued review of the Note revealed RN #3 noted Resident #1's left leg was "swollen at the thigh and knee and disfigured". RN #3 documented she told LPN #2 to send Resident #1 "out".</p> <p>Interview with RN #3, on 04/02/15 at 10:45 AM, revealed she was told by RN #2 Resident #1 expressed he/she was in pain by stating, "my hip, my hip". RN #3 stated she did not give Resident #1 anything for pain however, because the resident did not express to her he/she was in pain. Continued interview revealed she would have given Resident #1 something for pain had she heard the resident say he/she was in pain. However, she stated Resident #1 did not say anything when she went to the resident's room.</p> <p>Interview with RN #2, on 04/02/15 at 3:29 PM, revealed when she entered Resident #1's room at approximately 4:00 AM on 03/19/15, the resident stated, "don't touch, don't touch". She stated she</p>	F 309			

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F 309	<p>Continued From page 17</p> <p>believed Resident #1 was in pain at that time and she would have given the resident something for pain had she been the his/her nurse. Continued interview revealed with any resident's fall, the nurse should conduct a pain assessment of the resident.</p> <p>Review of LPN #2's Nurse's Note dated 03/19/15 at 8:15 AM, revealed Resident #1's left leg was rotated inward and swollen around knee and upper thigh area. LPN #2 noted Resident #1 was stating, "my hip, my hip, my hip". Per the Note, LPN #2 called the Physician and received an order to send Resident #1 to the ER for x-ray, ambulance personnel arrived and transported the resident out of the facility to the hospital ER. However, record review revealed no documented evidence Resident #1 was administered his/her PRN pain medication after LPN #2 heard the resident stating, "my hip, my hip, my hip".</p> <p>Interview with LPN #2, on 04/01/15 at 12:32 PM, revealed Resident #1 could not always express his/her needs, and it was important to recognize nonverbal cues for pain. LPN #2 stated when she checked on Resident #1, on 03/19/15 between 7:00 AM and 7:30 PM, the resident was touching his/her left hip repeating, "my hip, my hip, my hip". She reported she thought Resident #1's hip was fractured and contacted the resident's Physician. LPN #2 stated she knew Resident #1 was in pain by the way he/she was grabbing his/her hip, there was no question about it. Further interview revealed she did not give Resident #1 his/her PRN pain medications however, because she was more concerned with sending the resident out to the ER.</p> <p>Review of the hospital ER record revealed</p>	F 309		
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F 309	Continued From page 18  Resident #1 was diagnosed with a displaced left femur fracture. Review of the ER RN's Nurse's Note dated 03/19/15 at 8:58 AM, revealed Resident #1 had not been medicated with pain medications prior to the ER admission after the ER RN had reviewed the resident's MAR sent from the facility. Continued review of the ER RN's Note revealed Resident #1 was nonverbal and had Dementia "so was unable to express pain". Review revealed Resident #1's vital signs were stable; however, the resident's heart rate elevated when his/her left leg was "touched or messed with". Further review revealed Morphine four (4) mg was administered upon arrival to the ER.  Interview, on 04/01/15 at 10:30 AM, with the ER RN, who had cared for Resident #1 in the ER on 03/19/15, revealed when the resident arrived at the ER, he/she was observed to be nonverbal and pale. Per interview, Resident #1 grimaced in pain every time the ER staff would move him/her. Per the ER RN, Resident #1 was given Morphine for pain and started to relax. She stated when Resident #1 arrived at the ER, she noticed when going through the resident's MAR sent from the facility, that the resident had not received any of the PRN pain medications. The ER RN revealed with the type of femur fracture Resident #1 had, no one should have to ask the resident if he/she was in pain, they should have known. According to the ER RN, Resident #1 had PRN medications which should have been given to the resident. Further interview with the ER RN revealed there was a potential for psychological harm to Resident #1. She stated it would, "be horrible to a person's psychological well-being" to lay in pain after being picked up from a fall and just left until morning. It would be "torture". Further interview	F 309			

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NAME OF PROVIDER OR SUPPLIER  GRANT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097		
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F 309	<p>Continued From page 19</p> <p>revealed the time Resident #1 had to wait for relief from his/her pain was "unacceptable".</p> <p>Review of Resident #1's March 2015 Medication Administration Record (MAR) revealed no documented evidence Resident #1 Acetaminophen or Hydrocodone/Acetaminophen were administered on 03/18/15 or 03/19/15. Continued review revealed for the monitoring Resident #1 for pain order stated to ask Resident #1 "are you free of pain or hurting". Per the monitoring for pain order, it was noted "if no, indicate response through chart code: PI every shift", with no code noted if the answer was "yes". However, review of the pain monitoring order revealed nurses had documented a "Y" for each shift from 03/06/15 through 03/18/15, even though review of the MAR "chart codes/follow-up codes" revealed no evidence of a code for a "Y".</p> <p>Further interview with RN #2, on 04/02/15 at 3:29 PM, revealed in reviewing Resident #1's MAR, RN #2 stated since the resident reported or gave a sign he/she was "in pain", the MAR should have been marked with a "PI" (Pain Indication) and the expressed pain documented in the "progress notes". Continued interview revealed the "Y" in the MAR indicated, a "yes", to note Resident #1 was free from pain when staff had asked "Are you free from pain?". However, RN #2 was unable to explain why there was a "Y" documented on second and third shift on 03/18/15, if Resident #1 had expressed being in pain. Further interview revealed if "the resident would be in continuous pain, it would be devastating to the resident".</p> <p>Further interview with RN #1, on 04/01/15 at 6:42 PM revealed even though Resident #1 had an order to monitor the resident every shift for pain,</p>	F 309			

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F 309	<p>Continued From page 20</p> <p>RN #1 expressed she had never filled out the MAR related to monitoring the resident for pain. She revealed she was not familiar with what the "Y's" on the form meant, and stated she did not know she was supposed to monitor Resident #1 for pain by asking the resident every shift, "Are you free of pain or hurting?" as indicated on the MAR. Per RN #1, she did not often ask Resident #1 if he/she was in pain, unless the resident appeared to be restless. According to RN #1, she would document a resident's pain in a "progress note" and would not document unless a resident expressed he/she was in pain. She stated if someone were left in pain without relief that would be, "pretty bad".</p> <p>Interview with CNA#5, on 04/02/15 at 7:58 AM, revealed Resident #1 did not communicate and staff would have to ask the resident if he/she was in pain. Per interview, staff would observe Resident #1's "body language" to determine if the resident was in pain. CNA #5 stated Resident #1 was not able to ask for pain medication and could not state, "I am in pain".</p> <p>Interview with the Social Worker (SW), on 04/02/15 at 2:42 PM, revealed Resident #1 was nonverbal and often repeated words. She reported she had seen Resident #1 express pain in the past by "grimacing", and when this occurred she got a nurse to assist the resident.</p> <p>Interview with the MDS Coordinator and the Clinical Reimbursement Coordinator (CRC), on 04/02/15 at 2:07 PM, revealed when a resident experienced a fall, it would be documented in the "change of condition" computer file. They reported the "pain assessment" would be part of one (1) of the assessments completed after a</p>	F 309		
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F 309	<p>Continued From page 21</p> <p>resident's fall. Continued interview revealed staff should be completing Resident #1's MAR correctly, to include asking the resident, "Are you free from pain or hurting?" as indicated. Per interview, if Resident #1 had a PRN pain medication, then the pain medication should have been given based on the resident's pain.</p> <p>Interview with the Assistant Director of Nursing (ADON), acting for the Director of Nursing (DON), on 04/02/15 at 4:02 PM, revealed it was her expectation staff on each shift, should have be asking Resident #1, "Are you in Pain or Hurting" and indicate this assessment on the MAR. The ADON stated that if Resident #1 reported he/she was in pain the MAR should have been marked with a "PI", this documented in the progress notes and a PRN pain medication should have been given. Continued interview revealed the "Y" in the MAR indicated, a "yes", to note Resident #1 was free from pain when staff had asked "Are you free from pain?". Further interview revealed the ADON expected staff would have provided Resident #1 his/her PRN pain medications when he/she expressed being in pain.</p> <p>Interview with the facility's Medical Director, on 04/01/15 at 4:52 PM, revealed it was his expectation the facility staff would provide residents with PRN pain medications if the resident was hurting.</p> <p>Interview with the Administrator, on 04/02/15 at 4:45 PM, revealed it was his expectation staff would have administered Resident #1 his/her PRN pain medications when he/she expressed being in pain.</p>	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=G	<p>Continued From page 22</p> <p><b>HAZARDS/SUPERVISION/DEVICES</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one (1) of five (5) sampled residents (Resident #1).</p> <p>Interview and record review revealed the facility had assessed Resident #1 to need extensive physical assist of two (2) staff for transfers. On 03/18/15 Resident #1 experienced a fall, sometime between 7:00 PM and 8:00 PM, when Certified Nursing Assistant (CNA) #1, unassisted, lowered the resident to the floor after the resident's leg gave out during a transfer from the wheelchair to the bed. The resident was assessed to have no injury and was assisted back to bed. On 03/19/15 at 8:15 AM, Resident #1's left leg was observed to have an inward rotation and complaints of pain. The Physician was notified and orders received to send Resident #1 to the hospital emergency room (ER), where the resident was diagnosed with a left femur fracture and was hospitalized. (Refer to F323)</p>	F 323		

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F 323	<p>Continued From page 23 The findings include:</p> <p>Review of the facility's policy titled, "Accidents/Incidents", revised 05/15/14, revealed the facility would use the "Risk Management System (RMS)" to report, review and investigate all accidents/incidents which occurred, or allegedly occurred, on the facility's property and involved, or allegedly involved, for residents receiving services. The Policy revealed an accident was defined as any unexpected or unintentional incident which would result in injury or illness to a resident. Review of the Policy revealed a licensed nurse would utilize the RMS to report accidents/incidents and assist with completion of a timely investigation to determine the root cause. Per the Policy, the nurse would examine a resident involved in a accident/incident, and would notify the Physician or mid-level provider of the accident/incident, report the physical findings and extent of injuries, and obtain orders as indicated. The Policy revealed if a resident's injury was of an emergent nature, the resident would be transported to the hospital. Continued review revealed the incident/accident was to be documented in the resident's medical record to include all pertinent information, date, time, place, notifications, and initial and ongoing assessments. The Policy noted the incident/accident would be documented on the facility's "24 Hour Report", and the Director of Nursing (DON) or designee would close the event within five (5) days. Further review revealed the Administrator or designee would coordinate all the facility's investigations.</p> <p>Review of the facility's, "Fall Response Protocol" Policy, revised May 2013, revealed staff would evaluate and monitor a resident for seventy-two</p>	F 323	<p>F 323</p> <p>1. Resident #1's care plan was updated to reflect current transfer status, including required number of staff assistance, on 4/6/15 by Director of Nursing.</p> <p>Certified Nursing Assistant (CNA) #1, CNA#2, CNA#3, and Licensed (LPN)#1, and #2, and Registered Nurse (RN) #1, #2, and #3 will be re-educated by Director of Nursing or Assistant Director of Nursing, by 5/6/15 to ensure that 1) the correct number of staff required for safe transfer are utilized, 2) the comprehensive care plan must include the transfer status, including staff assistance required, and 3) and that Change in Condition progress note is initiated with each fall to include evaluation and monitoring of the resident for 72 hours after each fall with a posttest given to validate understanding with a required 80% to pass; to be graded by the Director of Nursing or Assistant Director of Nursing.</p> <p>2. All residents have the potential to be affected. A review of the residents' care plans was completed by the Director of Nursing, Assistant Director of Nursing, and /or Unit Manager to reflect residents' current transfer status, including assistance required, by 4/9/15 with corrective action and re-education if indicated.</p>	
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F 323	<p>Continued From page 24</p> <p>(72) hours after a fall. Per the Policy, after a resident's fall staff would evaluate the resident's level of consciousness, vital signs, airway, breathing, circulation, and summon help. Continued review revealed staff would also document and investigate the circumstances per a "change of condition note", Incident Report, Fall Investigation Form and RMS, if applicable.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 12/11/09, and readmitted on 03/27/15, with diagnoses which included Personal History of Falls, History of Hip Fracture, Generalized Pain, Alzheimer's Disease, Aftercare for Healing Traumatic Fracture of the Upper Leg, Osteoporosis, Anxiety and Depressive Disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/12/15, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status score of three (3), which indicated the resident was severely cognitively impaired. Continued review of the MDS Assessment revealed the facility assessed Resident #1 to require extensive physical assist of two (2) staff for transfers and bed mobility. Further review revealed the facility assessed Resident #1's balance during transitions when moving from a seated to standing position and for surface-to-surface transfers, such as transferring from the bed to the wheelchair, as "not steady, only able to stabilize with staff assistance".</p> <p>Review of Resident #1's Comprehensive Care Plan, revised 03/05/15, revealed the facility had care planned the resident for being at risk for falls; however, review of the interventions revealed no documented evidence of how much</p>	F 323	<p>3. All RNs, LPNs, and CNAs will be re-educated to ensure that 1) the correct number of staff required for safe transfer is utilized, 2) the comprehensive care plan must include the transfer status, including staff assistance required, and 3) that Change in Condition progress note is initiated with each fall to include evaluation and monitoring of the resident for 72 hours, including vital signs, after each fall with a posttest given to validate understanding by the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Weekend Supervisor by 5/6/15 with a required 80% to pass; to be graded by the Director of Nursing or Assistant Director of Nursing. RNs, LPNs, and CNAs not available during this time frame will be provided re-education upon return to work by the Director of Nursing, Assistant Director of Nursing, Unit Manager and/or Weekend Supervisor a post-test will be given to determine understanding.</p>	

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F 323	<p>Continued From page 25</p> <p>assistance he/she required with transfers. Continued review revealed the facility care planned Resident #1 for requiring assistance with Activities of Daily Living (ADLs) care due to history of falls, cognitive impairment, Parkinson's Disease, Anxiety and decreased mobility. Review of the ADL care plan revealed Resident #1 required assistance with most ADLs including the ability to transfer. The ADL care plan goal stated Resident #1's ADL care needs would be anticipated and met in order to maintain the highest practicable level of functioning and physical well-being. Review of the ADL care plan interventions revealed for staff to assist with the resident's ADLs as needed and adjust the level of care according to the individual needs.</p> <p>Review of the MDS Kardex, the CNAs care plan, dated March 2015, revealed Resident #1 was an extensive assist of two (2) staff with bed mobility and transfers.</p> <p>Review of the facility's RMS incident Report, with a completion date of 03/31/15 at 10:03 AM, revealed Resident #1 experienced a fall on 03/18/15 at 7:30 PM. Review of the "injury" section of the Incident Report revealed "while being transferred from wheelchair to bed", Resident #1's legs gave out and staff lowered the resident to the floor. The Incident Report noted after the fall Resident #1 was able to move all extremities, denied any pain, was assisted to bed per two (2) staff, and the Physician and family notified. Review revealed the witnesses included CNA #1 and CNA #2.</p> <p>Further review of the Incident Report revealed under the "summary of investigation" section Resident #1 was "lowered to floor per CNA</p>	F 323	<p>4. Director of Nursing, Assistant Director of Nursing, Unit Manager, 3-11 Supervisor, 11-7 Supervisor, and/or Weekend Supervisor will conduct five transfer observation audits across all shifts three times per week, then three transfer observation audits across all shifts for four weeks to ensure that residents are transferred with the required assistance; will review nursing progress notes daily across all shifts for two weeks, then three times a week across all shifts for two weeks to ensure that residents are assessed and evaluated for 72 hours following a fall, including vital signs; and review the care plans of residents weekly that are at risk, or have experienced falls, for one month to ensure transfer status with required staff assist is present with corrective action and re-education if indicated, then by the monthly with Performance Improvement Committee. Findings will be reported to the Director of Nursing.</p> <p>The Director of Nursing or Assistant Director of Nursing will submit a summary of findings to the Performance Improvement Committee consisting of Administrator, Director of Nursing, Activity Director, Housekeeping Director, Health Information Manager Coordinator, MDS Coordinator, Social Services, Food Service Manager, Business Office Manager, and Maintenance Director for further review and recommendation for three months.</p> <p>Completion Date by 5/6/15.</p>	5/6/15

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F 323	<p>Continued From page 26</p> <p>around 8:00 PM while being transferred to bed" with staff reporting the resident's "knees gave out". Continued review of the "summary of investigation" section revealed an assessment was performed of Resident #1 by the nurse after the fall, with the resident denying pain, able to move all extremities within "normal limits", and was assisted back to bed per three (3) staff members. Further review of the Incident Report revealed Resident #1 was sent to the hospital ER where the resident was diagnosed with a left femur fracture.</p> <p>Review of the facility's investigation statements, dated 03/19/15 at 4:10 PM, revealed CNA #1 reported she went into Resident #1's room on 03/18/15, to put the resident to bed. She wrote Resident #1 stood to get into bed, slumped down and stood back up and then slumped again. Per CNA #1's written statement, Resident #1 fell on his/her left side and his/her legs were laying "funny". She revealed Registered Nurse (RN) #1 asked Resident #1 if he/she was in pain and the resident said, his/her "back". Review of the written statement revealed RN #1 asked Licensed Practical Nurse (LPN) #1 to assess Resident #1 as well, and they both determined the resident was fine. CNA #1 noted Resident #1 did not complain of pain anymore that night, but CNA #1 observed the resident's leg did not appear to move correctly when he/she turned. Further review of CNA #1's written statement revealed she told RN #1 about Resident #1's leg, and the RN checked the resident around 11:00 PM, and the resident was fine.</p> <p>Interview with CNA #1, on 04/01/15 at 2:58 PM, revealed she worked with Resident #1 every day, and the resident was care planned to be a two (2)</p>	F 323			

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F 323	<p>Continued From page 27</p> <p>person assist, but could bear weight. Per interview, it helped to have two (2) people to assist when transferring Resident #1, and the resident's "care card" indicated he/she was a two (2) person assist. Continued interview with CNA #1 revealed on the night of 03/18/15, at approximately 8:00 PM, she was assisting Resident #1 back to his/her room, where she assisted the resident to transfer from his/her wheelchair to the bed. She stated Resident #1 appeared to be a little weak when standing up, and the resident stood and pivoted to the left, while CNA #1 pivoted to the right. Per interview, CNA #1 was standing in front of Resident #1 during the transfer, and the resident moved down and stood up again holding onto the CNA's arms. CNA #1 reported she asked Resident #1 if he/she was okay; however, the resident did not respond, and then slumped over and put all of his/her weight onto CNA #1 and leaned forward. Continued interview revealed CNA #1 eased Resident #1 to the floor to sit on his/her bottom. She stated she was on the other side of Resident #1 and believed she had a good hold on the resident when he/she went down onto the floor, which happened pretty quickly. Per CNA #1, Resident #1 landed on his/her bottom, and his/her left leg was turned inward facing his/her right knee. She reported the placement of the resident's leg "didn't look normal, it looked abnormal". CNA #1 stated she asked Resident #1 if the leg hurt, and the resident stated "no, my back, my back, my back". The CNA revealed this was how Resident #1 expressed pain, and she had someone get RN #1. She stated RN #1 and CNA #2 came to Resident #1's room, and the RN assessed the resident before they moved him/her off the floor onto the bed. Interview revealed CNA #1 heard Resident #1 continue to say, "my back";</p>	F 323		
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however, after RN #1 assessed the resident, she said it was okay to move the resident to the bed. CNA #1 reported she and CNA #2 proceeded to put Resident #1 to bed, she did not see any bruising on the resident's leg, but was bothered by the way the resident's leg was turned. Per the CNA, RN #1 asked Resident #1 if he/she was okay and the resident continued to say, "my back". Interview revealed LPN #1 also came into Resident #1's room and assessed the resident with RN #1, and the resident was able to move his/her leg pretty well at that point. Further interview with CNA #1 revealed at 10:30 PM, she was doing her final rounds and Resident #1 needed to be changed, so she rolled the resident and his/her left leg moved along with her "lifelessly". She stated Resident #1's left leg was not bruised or had any swelling, but the leg did not have any resistance or no force at all when the resident was moved. Further interview with CNA #1 revealed when she moved the resident, there was also a slight popping which she told RN #1 about. In addition, she stated she told RN #1 Resident #1's knee was turned inward and it was facing toward the right knee, and the RN checked the resident by shaking his/her left foot. According to CNA #1, RN #1 asked Resident #1 if he/she was in pain, and the resident said, "no, no, no". CNA #1 further revealed she should have asked for assistance when transferring Resident #1 from the wheelchair to the bed, as the care plan indicated the resident was a two (2) person assist. Additionally, CNA #1 added, "if there was another CNA to assist, I'm sure the resident would not have fallen or hurt" himself/herself.

Review of CNA #2's statement, dated 03/27/15 at 4:15 PM, revealed during a transfer from the "chair to bed" on 03/18/15, Resident #1 was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/02/2015
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NAME OF PROVIDER OR SUPPLIER  GRANT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 KIMBERLY LANE WILLIAMSTOWN, KY 41097
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(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
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F 323	<p>Continued From page 29</p> <p>lowered to the floor. CNA #2 noted she went to get RN #1 and the vitals machine. Review of the written statement revealed Resident #1 was seated on his/her bottom with his/her back against the bed. CNA #2 documented when Resident #1 was placed in the bed, his/her knees popped with movement. Per the written statement, RN #1 and LPN #1 assessed Resident #1, and reported the resident was fine. CNA #2 noted she did not return to Resident #1's room anymore that night.</p> <p>Interview with CNA #2, on 03/31/15 at 5:18 PM, revealed she did not normally care for Resident #1, normally CNA #1 was assigned to work the resident's hall. She reported on the night of the incident, 03/18/15, she was returning from break between 7:30 PM and 8:30 PM, and the bathroom's emergency light was on and CNA #1 was asking for RN #1. She stated she observed Resident #1 sitting on the floor with his/her back leaned up against the bed. Per interview, she and CNA #1 asked Resident #1 if he/she was hurting and the resident said, "yes", his/her leg was hurting. CNA #2 reported RN #1 assessed Resident #1's leg and she and CNA #1 both told the RN the resident complained of his/her leg hurting. She stated RN #1 moved both of Resident #1's legs around, and CNA #2 was pretty sure the resident continued to express being in pain. Per CNA #2, LPN #1 also came into Resident #1's room and assessed the resident by moving his/her legs as well, and asked the resident if he/she was okay, but the resident did not respond. CNA #2 reported Resident #1's vitals were taken and the resident's vital signs were normal. CNA #2 revealed she believed Resident #1 was care planned to be a two (2) person assist, and staff was aware the</p>	F 323		
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F 323	<p>Continued From page 30</p> <p>resident was two (2) person assist. According to CNA #2, CNA #1 told her Resident #1 would often assist her with transfers and could bear weight and she was trying to transfer Resident #1 on her own because the resident normally helped her. Additionally, CNA #2 stated she would not try to transfer a resident on her own because "it's just too risky".</p> <p>Review of CNA #3's written statement, dated 03/27/15 at 2:55 PM, revealed she went into Resident #1's room at 1:00 AM on 03/19/15, and the resident did not appear to be in any pain and he/she was not complaining of pain when being turned in bed. CNA #3 noted when she went back into Resident #1's room at 4:00 AM to check on the resident, he/she did not want her to touch his/her left leg. Review revealed Resident #1's left leg appeared to be turned inward. Continued review of CNA#3's written statement revealed she asked LPN #1 to look at Resident #1's leg and an x-ray was ordered for the resident.</p> <p>Interview with CNA #3, on 04/01/15 at 7:13 PM, revealed she worked the second and third shifts on the night Resident #1 fell. She stated CNA #1 did not tell her many details of Resident #1's fall, only that the resident had fallen, but seemed to be okay. Per interview, this was about 11:00 PM, and she was working on a different unit at the time. According to CNA #3, she did not see Resident #1 until around 1:00 AM to 1:30 AM. She reported Resident #1 did not seem to be in any pain at that time, and the resident was dry and didn't need changing. Continued interview with CNA #3 revealed she checked on Resident #1 again at 4:00 AM, and when she walked in the room, the resident's left leg was turned in so she immediately got RN #2. Per CNA #3, she thought</p>	F 323		

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F 323	<p>Continued From page 31</p> <p>Resident #1's leg was swollen, and knew there was something wrong when she saw the resident's leg. She stated Resident #1 did not say anything until RN #2 started to move his/her left leg when the resident said "it hurts". CNA #3 reported RN #2 had LPN #1 come and assess Resident #1 also, and when LPN #1 tried to move the resident's leg, the resident kept saying, "it hurts, it hurts". Further interview revealed LPN #1 then called the doctor who ordered an x-ray. She revealed RN #2 assisted her with changing Resident #1, and the resident grimaced while they were changing him/her.</p> <p>Review of LPN #1's investigation statement, dated 03/19/15 with no time documented, revealed she was called to Resident #1's room and the resident was observed in his/her bed without any sign of pain. The statement revealed she reported she was told by the staff present Resident #1 was being transferred to bed by two (2) CNAs, and the resident's leg had went out from under him/her so, they lowered the resident to the floor. Per the statement, as Resident #1 was assisted to bed and had no sign of any pain or discomfort she left the room. LPN #1's statement revealed she was called back to Resident #1's room around 4:40 AM, to check the resident regarding reported pain, and the LPN documented a slight inward rotation of the left foot and the knee looked displaced. Continued review of the statement revealed when LPN #1 was assessing Resident #1, the resident did not complain of pain when his/her leg was moved. The statement noted LPN #1 reported staff told her Resident #1 complained of pain when they were turning the resident and reported the resident did not complain of pain during the night. Further review of the statement revealed LPN #1</p>	F 323		
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F 323	<p>Continued From page 32</p> <p>received an order to obtain an x-ray of Resident #1's knee and hip.</p> <p>Interview with LPN #1, on 04/01/15 at 11:28 PM, revealed on the day of the incident, 03/18/15, she was working as a nursing assistant on the floor on second shift, at the time the incident occurred. LPN #1 reported she was called to the resident's room by RN #1 who asked her "to check something for her". She stated when she entered Resident #1's room, the resident was already in bed and CNA#1 and CNA#2 were in the room with the resident. Continued interview revealed LPN #1 was not sure she was told Resident #1 had experienced a fall but she was told the resident's knees buckled. Per interview, she talked to Resident #1, but the resident did not say anything, and she did not ask the resident if he/she was in pain because the resident was already in bed. The LPN revealed she was not even sure why she was called to Resident #1's room that night, as RN #1 was the resident's nurse and handled "everything else.</p> <p>Review of RN #1's investigation statement, dated 03/19/15 at 12:30 PM, and on 03/27/15 at 3:00 PM, revealed Resident #1 was sitting on the floor beside his/her bed when she entered the room on 03/18/15. The statement revealed RN #1 was told by CNA #1, she had lowered Resident #1 to the floor, and LPN #1 and LPN #3 also came into the resident's room to check on the resident. She documented the resident did not complain of pain at the time, and had no noted deformities and was able to move everything. Per the RN #1's later statement, Resident #1 was transferred from the wheelchair to his/her bed, on 03/18/15 at 8:00 PM, by two (2) staff, and was eased to the floor by the staff landing on his/her buttocks. The</p>	F 323	

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F 323	<p>Continued From page 33</p> <p>statement revealed RN #1 assessed Resident #1, the resident had no complaints of pain and was assisted to bed by two (2) staff who elevated both of the resident's legs on a pillow. RN #1 documented she asked Resident #1 at 8:20 PM that night if he/she was hurting and the resident complained of his/her back hurting. Per the statement, at 10:00 PM and through the rest of the evening RN #1 continued to observe Resident #1 for discomfort, without any changes. Further review of the statements revealed at 11:00 PM on 03/18/15, a CNA (not mentioned by name) made rounds changed Resident #1's brief and reported while turning the resident, there was no resistance. RN #1 documented she had the evening manager and night manager assess Resident #1 before she left work at the facility, and when she spoke to them they had found no apparent problems.</p> <p>Interview with RN #1, on 04/01/15 at 6:42 PM, revealed CNA #2 called her to Resident #1's room on 03/18/15, reporting the resident had fallen. Per interview, when she entered Resident #1's room, the resident was seated on the floor and was calling out "my back, my back". She stated she was told by CNA #1 and CNA #2 Resident #1's legs gave out during a transfer and the resident was eased to the floor. RN #1 reported she assessed Resident #1 took vital signs, then CNA #1 and CNA #2 assisted the resident onto the bed. According to RN #1, she took Resident #1's vital signs and the resident was monitored for seventy-two (72) hours. However, record review revealed no documented evidence this monitoring was completed. Continued interview revealed she asked LPN #1 to assess Resident #1 also, and LPN #1 thought the resident was "fine" as well. RN #1 stated she</p>	F 323		
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F 323	<p>Continued From page 34</p> <p>continued to take vital signs on Resident #1 that night. However record review revealed no documented evidence Resident #1's vital signs were taken except the set obtained after the resident's initial fall. Continued interview with RN #1 later that night, CNA #1 asked her to look at Resident #1's left leg because she thought the leg was lying differently. Per interview, she told CNA #1 the resident's leg "always" looked that way due to his/her Arthritis. RN #1 stated she contacted the resident's Physician to inform him of Resident #1's fall; however, did not inform him the resident had an injury as her assessment had revealed no injury. She stated she completed the RMS Incident Form, but the current one was incorrect as her findings suggested the resident was without injury and no fracture was indicated. Further interview with RN #1 revealed she was not aware Resident #1 was transferred by an assist of one (1) that night, but sometimes the resident could be a one (1) person assist because he/she could bear weight. She stated however, she believed Resident #1 was care planned to be a two (2) person assist, but was not certain of that.</p> <p>Continued interview with LPN #1, on 04/01/15 at 11:28 PM, revealed switched from a nursing assistant role to Supervisor on third shift the night of the incident. She stated she was called to Resident #1's room around 4:00 AM that morning, 03/19/15 by RN #2, who told her the resident was complaining of his/her leg. Per LPN #1, she "checked" Resident #1's leg, and noticed the knee, "not so much the foot" was turned and "looked deformed". LPN #1 stated she thought it was Arthritis, but the resident was saying, "oh my leg, my leg", when the left leg was moved when she did range of motion (ROM) on his/her legs.</p>	F 323		
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F 323	Continued From page 35 According to LPN #1, RN #2 and CNA #3 told her Resident #1 complained of pain every time they turned him/her. LPN #1 revealed at around 1:00 AM, she called Resident #1's Physician and "got an order for an x-ray". However, she stated when she returned to Resident #1's room the resident was asleep, so she arranged to have the x-ray "first thing in the morning". Further interview with LPN #1 revealed if she had known Resident #1 had fallen "earlier", she would have checked the resident out a little more, and inquired how the fall occurred, how far had the resident fallen, and how he/she landed after the fall. LPN #1 stated if she had known it was a fall, vital signs would have been checked four (4) times every half hour, then four (4) times every hour, then every four (4) hours for twenty-four (24) hours.  Review of RN #2's statement, dated 03/19/15 at 4:15 PM, revealed Resident #1 was lowered to the floor by CNA #1. The statement revealed CNA #1 went and got the resident's nurse, RN #1, and the night shift Supervisor, LPN #1, to assess Resident #1 at around 7:00 PM to 7:30 PM on 03/18/15. RN #1 noted she heard RN #1 report "they" assessed Resident #1, and helped put the resident to bed. Per the statement, RN #2 did not hear anything else that night until CNA #3 got her out of another resident's room to come assess Resident #1. According to the statement, RN #2 entered Resident #1's room around 4:00 AM to 4:30 AM, and observed the resident's left leg was inverted and he/she was complaining of pain. Further review of the statement revealed RN #2 noted Resident #1 could not say what was hurting, the resident just kept saying, "don't touch" when the leg was moved. The statement revealed RN #2 got LPN #1 to come assess Resident #1 as well, and LPN #1 then obtained	F 323		
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F 323	<p>Continued From page 36 orders to get an x-ray.</p> <p>Interview with RN #2, on 04/02/15 at 3:29 PM, revealed she was working as a CNA during the night shift when the incident occurred. RN #2 revealed she recalled hearing CNA #1 stating she lowered Resident #1 to the floor, and RN #1 and LPN #1 talked about the resident's fall during third shift report. Per interview, she did not hear anything else about Resident #1 until about 4:00 AM, on 03/19/15, when CNA #3 called her into the resident's room. She reported when she entered Resident #1's room, the resident's leg looked inverted, and she then went to get LPN #1, who was the acting Supervisor to assess the resident also. Per RN #2, LPN #1 advised her and CNA #3 not to touch Resident #1 until she obtained an x-ray. RN #2 reported she recalled Resident #1 saying, "don't touch, don't touch". Continued interview revealed RN #2 interpreted that as an indication Resident #1 was in pain, and due to the condition of the resident's leg, she would have made the judgement call to call an ambulance. She stated Resident #1's Physician was notified and LPN #1 was advised to get an x-ray for the resident. RN #2 revealed she asked LPN #1 if she needed any assistance and LPN #1 reported she was fine. Per RN #2, LPN #1 "was the nurse for the whole building that night". RN #2 stated Resident #1 was a two (2) person assist and therefore the resident should never be transferred by one (1) person as it was not safe.</p> <p>Interview with LPN #2, on 04/01/15 at 12:32 PM, revealed she normally worked first shift, and when she reported to work the morning of 03/19/15 at around 7:00 AM, she was told in shift report, Resident #1 had fallen and complained of pain in the middle of the night and a mobile x-ray</p>	F 323	

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F 323	Continued From page 37 had been ordered. LPN #2 stated she went to see Resident #1 after the morning report and the resident was awake and lying on his/her bed. Per interview, Resident #1 was holding his/her left leg and repeating, "my hip, my hip, my hip". LPN #2 revealed she assessed Resident #1's left hip and noticed the thigh area was swollen, and the leg was rotated inward. According to LPN #2, she asked Resident #1 if he/she was hurting and the resident stated, "my hip". Continued interview revealed LPN #2 immediately thought Resident #1 had a fractured hip and alerted RN #3, the Unit Manager. LPN #2 reported she was instructed to call the resident's Physician, which she did and informed the Physician of Resident #1's fall and he/she was complaining of pain. She stated she also told the Physician Resident #1's leg was rotated inward and it appeared to be fractured. LPN #2 revealed in looking at Resident #1's leg, it could not have been mistaken as Arthritis. Per LPN #2, "I just knew it wasn't right". Further interview with LPN #2 revealed when a resident experienced a witnessed fall, vital signs would be taken on the resident before moving the resident, no other vital signs would be taken after that. However, the facility's policy stated staff would evaluate and monitor a resident for seventy-two (72) hours after a fall. LPN #2 stated Resident #1 should not have been assisted with only one (1) staff person, for the resident's safety, as well as, staff.  Interview with RN #3, on 04/02/15 at 10:45 AM, revealed she arrived to work on 03/19/15 at 8:00 AM, and LPN #2 reported to her Resident #1 was in pain, stating, "my hip, my hip". Per interview, she asked LPN #2 if x-rays were ordered and was told an order was received around 5:00 AM. She stated after assessing Resident #1's leg, she	F 323		
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F 323	<p>Continued From page 38</p> <p>thought the knee might have been dislocated, and asked LPN #2 to notify the Physician to have the resident sent to the hospital. RN #3 revealed it was the facility's policy in the event of a fall which was witnessed, the assessment of the resident would "stop" with the initial vital signs. However, the facility's policy stated staff would evaluate and monitor a resident for seventy-two (72) hours after a fall. Continued interview revealed Resident #1 should never have been transferred by one (1) person for the resident's and staff's safety.</p> <p>Interview, on 04/01/15 at 10:30 AM, with the hospital ER RN revealed when Resident #1 arrived at the ER he/she was non-verbal and pale. Continued interview revealed Resident #1 "grimaced" in pain every time he/she was moved. Per the ER RN, Resident #1 had an "s-shaped" left femur fracture which was "rock hard". She stated the fracture appeared to be an "older fracture" which had been "sitting for a while, at least a couple of hours". Further interview revealed if the fracture had been "fresh", the muscle would still spasm. According to the ER RN, "you would not have needed to be in the medical profession" to have know Resident #1 had fractured his/her leg, as there was an "obvious deformity".</p> <p>Interview with the Assistant Director of Nursing (ADON), acting for the Director of Nursing (DON), on 04/02/15 at 4:02 PM, revealed on 03/18/15, she was notified of Resident #1's fall, but was not notified of the resident's change of condition at 4:00 AM. She stated she should have been notified, as she was the on call person, and the facility's process was for staff to phone the on call person. Per interview, in the event of a fall, a</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER  <b>GRANT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 KIMBERLY LANE WILLIAMSTOWN, KY 41097</b>
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(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
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F 323	<p>Continued From page 39</p> <p>resident would be assessed from head to toe, staff would check for ROM, and ensure there were no deformities anywhere. The ADON revealed if the fall was a unwitnessed, then neurological (neuro) checks would have been completed; however, if the fall was witnessed and the resident hadn't hit his/her head this would not be done. However, the facility's policy stated staff would evaluate and monitor a resident for seventy-two (72) hours after a fall and the policy did not differentiate between a witnessed fall or an unwitnessed fall. Continued interview as Resident #1's fall was witnessed, vital signs should have been taken on every shift; however, the ADON reported there was no documented evidence this was done. She stated when Resident #1 complained of pain, it was her expectation staff would have found out where the pain was coming from. Further interview revealed since there were two (2) aides in Resident #1's room after the fall, it was assumed the resident was assisted by staff of two (2); however, later discovered the resident had been assisted by only one (1). The ADON revealed the resident should not have been assisted by only one (1) staff member.</p> <p>Interview with the Administrator, on 04/02/15 at 4:45 PM, revealed there was an investigation regarding the incident involving Resident #1, and he was under the impression the resident was transferred from the wheelchair to the bed by two (2) staff. He stated he did not know Resident #1's care plan was not followed for two (2) staff to assist because he did not have that information. Per interview, he would have expected his staff to follow the facility's policy regarding incident/accidents and the fall protocol, in which the resident's vital signs would have been</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185265	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 04/02/2015
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F 323	Continued From page 40 assessed.	F 323		
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