

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

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/15/2013
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NAME OF PROVIDER OR SUPPLIER GLENVIEW HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 GLENVIEW DR. GLASGOW, KY 42141
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F 000	INITIAL COMMENTS	F 000	The submission of this plan of correction does not constitute an admission by the facility of the cited deficiencies or any violation of a regulation. Also, we reserve the right to take further action, including any and all means necessary, to resolve any dispute about the accuracy of this information.	
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure review, it was determined the facility failed to ensure the results of the comprehensive care plan reflected the resident's needs, according to	F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 1) On 03/15/2013, the Assistant Director of Nursing updated resident #1's care plan and CNA care plan to reflect the resident's needs. Resident #1 was assessed to require the total assistance of two staff members with bed mobility. On 03/15/2013 the Staff Development Nurse in-serviced all nursing staff concerning the turning and repositioning needs for resident #1 or any other resident requiring the assistance of two staff members for bed mobility. Radiological reports for resident #1 state: a) 01/13/2013 - An oblique or spiral fracture of the proximal humeral shaft. b) 01/29/2013 - An oblique fracture of the proximal shaft of the humerus. Orthopedic report states: a) 01/15/2013 - An oblique fracture of the proximal humerus. 2) By 03/19/2013 the Director of Nursing and the Assistant Director of Nursing had performed a chart review of every resident in (continued on page 2)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 03/29/2013
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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 Minimum Data Set (MDS) assessment, for one (1) resident (#1), in the selected sample of three (3) residents. Resident #1 was assessed to require the total assistance of two staff members with bed mobility, according to the MDS; however, neither the comprehensive care plan nor the Certified Nurse Aide (CNA) care plan, addressed the amount of assistance or staff required for bed mobility. Resident #1 sustained a right upper arm fracture during AM care.</p> <p>Findings include:</p> <p>A review of the "Care Planning Policy", dated 03/04/11, revealed the Resident Assessment Instrument (RAI) process shall be adhered to by the interdisciplinary team to develop an accurate and individualized plan of care, reflective of resident needs to ensure quality of care."</p> <p>A record review revealed Resident #1 was admitted to the facility on 03/10/09, with diagnoses to include a History of Osteoporosis and Right Arm, Left Hip, Two Ribs and Low Back Fractures; Chronic Heart Failure; and Alzheimer's Dementia.</p> <p>A review of the Annual MDS assessment, dated 09/09/12 and last revised 12/22/12, revealed the facility assessed Resident #1 as severely cognitively impaired and required extensive assistance of two staff for bed mobility, transfers and total assistance of two staff for bathing.</p> <p>A review of the Comprehensive Care Plan for Self Care Deficit, dated 12/10/10, revealed two staff should provide assistance with transfers; however, the care plan did not address bed</p>	F 279	<p>(continued from page 1)</p> <p>the facility. All resident care plans and CNA care plans were assessed and updated to correctly reflect the needs of each resident for bed mobility.</p> <p>The admitting nurse will assess all newly admitted residents on bed mobility at the time of admission.</p> <p>3) The staff nurse will place interim care plans on resident's chart as needed. The staff nurse will also update the CNA care plan at that time.</p> <p>The MDS Coordinator / designee will perform weekly reviews for any new orders to ensure the care plan has been updated to the individual resident needs.</p> <p>The Assistant Director of Nursing / designee will perform weekly reviews for any new orders to ensure the CNA care plans have been updated according to the individual resident needs.</p> <p>On 03/26/2013 the facility updated the Care Planning Policy and Procedure.</p> <p>By 04/01/2013 all licensed nursing staff and care plan team members will be in-serviced according to updated policy.</p> <p>4) The Director of Nursing will monitor all updated care plans and CNA care plans monthly to ensure that all are updated in a timely manner.</p> <p>The Director of Nursing will report findings to the QA committee monthly for a period of 12 months.</p>	04/01/2013	

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F 279	<p>Continued From page 2</p> <p>mobility or assessed amount of assistance or staff needed with bed mobility.</p> <p>An interview with CNA #1, on 03/14/13 at 2:03 PM, revealed on 01/13/13 at approximately 4:00 AM, Resident #1 was "curled up in a ball," per usual lying on his/her left side with the right arm/hand between the knees. The CNA attempted to provide care by himself and to turn the resident over on the back and the resident remained curled up. The CNA turned the resident back over to the left side and attempted to move the arm out from between his/her legs, when the CNA heard a "pop," stopped and went to get the charge nurse (Licensed Practical Nurse (LPN) #1). The CNA stated Resident #1 was not assessed to need the assistance of two staff members with bed mobility and he had always been able to change the resident, by himself without difficulty. The CNA revealed the resident had a history of "tensing-up" anytime staff assisted with ADLs, but the staff were "usually able to talk to the resident and he/she would loosen up, somewhat." The CNA was unaware of the resident's history of fractures and Osteopenia.</p> <p>An interview with LPN #1, on 03/15/13 at 1:00 PM, revealed the CNA came and alerted the LPN to come and assess the resident. The CNA stated he was attempting to change the resident's brief, when he heard a "pop." When the LPN came into the room, the resident was moaning and the LPN looked at the right arm and stated there was no bruising and no redness and could not see any visible deformity. When the LPN raised the resident's right arm, "it moved in a funny way" and the LPN had another LPN from the long hall, to come an assess. LPN #1 called</p>	F 279		

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F 279	<p>Continued From page 3</p> <p>the physician and had the resident sent to the ER for evaluation. The LPN stated the resident was not assessed as needing the assistance of two staff with bed mobility and this was not on the Comprehensive Care Plan or the CNA Care Plan.</p> <p>A review of the Quarterly MDS assessment, dated 02/17/13, revealed the facility assessed Resident #1 as severely cognitively impaired and required a total assist of two staff with bed mobility, transfers and bathing. Further review of the Comprehensive Care Plan, dated 12/10/10 revealed the care plan still did not address bed mobility or the assessed amount of assistance and staff needed for bed mobility.</p> <p>An interview with the MDS Coordinator, on 03/15/13 at 2:50 PM, revealed she was responsible for generating the comprehensive care plan and had assessed the resident to require the extensive assist of two staff with bed mobility prior to the fracture on 01/13/13. She revealed when she assessed the resident after the fracture she determined the resident required total assistance of two staff with bed mobility. She stated the care plan should have addressed the amount of assistance and staff needed for bed mobility.</p> <p>An interview with the Director of Nursing (DON), on 03/15/13 at 3:12 PM, revealed the comprehensive care plan should have addressed turning and repositioning and the amount of assistance and staff required.</p> <p>A review of the Radiology reports, for 01/13-29/13, revealed the resident had a spiral fracture of the right upper arm, Osteopenic Bone</p>	F 279		

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F 279	<p>Continued From page 4</p> <p>Mineralization, and in addition a lesion, cyst, or "possible metastatic disease" in the upper right arm and stated a pathologic fracture was "not excluded."</p> <p>An interview with the physician, on 03/15/13 at 3:00 PM, revealed he stated "there has been a lot of bad press on spiral fractures and the mechanism of how this occurs. The fact is, it can happen with a relatively benign event. Any force or torque on the resident's bones could have caused this" and "the resident has the potential for this to reoccur."</p> <p>An observation of Resident #1, on 03/15/13 at 11:00 AM, revealed the resident was resting quietly in the bed, on the left side with knees bent. The right upper arm was secured to the resident's torso with a gray colored immobilizer, with Velcro straps to the right wrist and right upper arm.</p>	F 279		