

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 000 INITIAL COMMENTS

AMENDED

An Abbreviated Survey to investigate KY#00019766 and KY#00019769 was initiated on 02/11/13 and concluded on 02/15/13. KY#00019769 was unsubstantiated without deficiency. KY#00019766 was substantiated. Deficient practice was identified at a Scope and Severity of a "G" with the facility having no opportunity to correct.

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

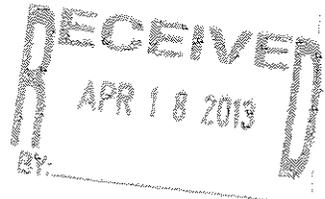
A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or

F 000

The amended completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law. The facility has submitted an Independent Informal Dispute Resolution for the following citations F282 and F323

The facility alleges compliance as of February 16, 2013.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

John J. Kelly Executive Director 3-12-13

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.

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 157 Continued From page 1
regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure the family was notified when there was an accident involving the resident which resulted in injury, for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed and care planned for two (2) person assist and the use of a gait belt during transfers. On 01/30/13, the resident was transferred with the assistance of one (1) person. On 01/31/13 at 7:49 AM, Resident #1 was found to have pain and the inability to move the right arm. The resident's family was not notified of the change in status until approximately 10:30 AM, while visiting the resident. The resident was diagnosed with a fracture of the right arm.

The findings include:

When the policy related to notifying residents' families when there was an accident or change in status was requested, the Director of Nursing stated the facility did not have a written policy to address notification of families.

Review of the clinical record revealed the facility admitted Resident #1 on 12/28/12 with diagnoses which included Hypertension, Congestive Heart Failure, Osteoarthritis and Gout. Review of the

F 157
F157 Notification of Changes
A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is - (A) An accident involving the resident which results in injury and has the potential for requiring physician interventions. Resident # 1 was assessed by nurse on 1/30/2013. Resident # 1 was assessed by the Physician Assistant on 1/31/13. Resident # 1 had x-rays ordered and obtained on 1/31/13. POA of resident # 1 was notified on 1/31/13. Resident # 1 was scheduled to see Orthopedic Doctor. Staff was notified on 1/31/13 that resident # 1 had a fracture. Therapy was notified on 1/31/13 of resident's fracture. A sling was ordered and obtained for resident # 1. Pain medications were reviewed and altered for resident # 1. Resident # 1 care plan was updated. All resident charts were checked for documentation reflecting if facilities notification policies were followed this check was done by the DON and ADON This check was completed on 2/15/2013. Resident #1 was discharged home on 2/15/2013 as scheduled with family after all therapy

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 2
admission Face Sheet revealed the resident's daughter was listed as the primary contact.

Review of the Nursing Progress Note, dated 01/31/13 at 7:49 AM, revealed Licensed Practical Nurse (LPN) #1 discovered Resident #1 to have pain in the right arm. Continued review revealed the resident stated, "I can't move my right arm at all". When the nurse attempted to assess the arm, the resident refused and stated, "It hurts too bad". LPN #1 documented the Physician was notified and orders were received. However, there was no documented evidence the family was notified.

Interview with Resident #1's daughter, on 02/12/13 at 2:55 PM, revealed she visited the resident on 01/31/13 at approximately 10:30 AM. She stated staff reported the resident's arm was hurt. Continued interview revealed the resident hurt his/her arm the previous evening during a transfer from the bed to the chair. She stated she was not called the previous evening or on the morning of 01/31/13 when the resident could not move his/her arm and was having pain.

Interview with LPN #2, on 02/14/13 at 3:40 PM, revealed she was caring for Resident #1 on the evening of 01/30/13. She stated during a transfer from the bed to the chair, she heard a "crack", like knuckles cracking, and the resident's arm hit the walker. Continued interview revealed she assessed the resident to have full range of motion of the right arm, and no pain. She further stated she notified the on-call Physician, but did not call the daughter because the resident had no complaint for the rest of the evening.

F 157 and clinical goals were met. The Notification of Change policy (Attachment #1) was updated on 2/15/2013 by the DON and reviewed with the medical director. This updated policy was given to the nurses during the February "Teaching Moment" given by the DON. This policy will also be covered in orientation of new nurses. The Director of Nursing and the Assistant Director of Nursing will audit all charts for 3 weeks and will address concerns immediately. The audits will be submitted to the facilities quality assurance committee monthly. The Quality Assurance Committee is made up of the facilities Medical Director, Pharmacist, DON, Administrator, Facilities Director, Assistant DON, Social Worker, Director of Dining Services, Director of Therapy, and MDS nurse. The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. The committee will review the audit and will determine if audits need to continue and for how long based on the findings of the audit. Plan of correction completed on 2/16/2013.

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)

F 157 Continued From page 3

Interview with LPN #1, on 02/13/13 at 3:25 PM, revealed she called the resident's Physician when Resident #1 was unable to move his/her arm and complained of pain, but did not notify the daughter when. She stated she was very busy and had to leave the facility emergently in the middle of her shift. She further stated she should have notified the resident's daughter.

Interview, 02/13/13 at 4:30 PM with the Physician Assistant working for the Resident #1's Physician, revealed he was called regarding the resident's arm and ordered an x-ray.

Review of the X-ray report, dated 01/31/13, revealed Resident #1 had a "non-displaced fracture through the distal humeral shaft". (a fracture of the upper arm near the elbow).

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=G

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the services provided were in accordance with the written plan of care, for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure the Care Plan was implemented

F 157

F 282

F282 Services by qualified person/per care card

Resident # 1 was assessed by nurse on 1/30/2013. Resident #1 was assessed by the Physician Assistant on 1/31/13. Resident # 1 had x-rays ordered and obtained on 1/31/13. POA of resident # 1 was notified on 1/31/13. Resident # 1 was scheduled to see Orthopedic Doctor. Staff was notified on 1/31/13 that resident # 1 had a fracture. Therapy was notified on 1/31/13 of resident's fracture. A sling was ordered for resident # 1. Pain medications were reviewed and

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)
F 282	<p>Continued From page 4</p> <p>for Resident #1, who was to have two (2) person assist and the use of a gait belt with transfers. On 01/30/13, the resident was transferred with the assistance of one (1) person, and sustained a fractured right arm. (Refer to F-323).</p> <p>The findings include:</p> <p>Review of the policy titled "Care Plans - Comprehensive", revised October 2010, revealed the comprehensive care plan was based on a thorough assessment that included the Minimum Data Set (MDS) assessment. Continued review revealed care plan interventions were developed based on the resident's problem areas identified on the MDS assessment.</p> <p>Review of the clinical record revealed the facility admitted Resident #1 on 12/28/12 with diagnoses which included Congestive Heart Failure, Hypertension, Osteoarthritis and Gout.</p> <p>Review of the Admission MDS Assessment, dated 01/03/13, revealed the facility assessed Resident #1 to require the extensive assistance of two (2) persons for bed mobility and transfers to or from bed, chair, wheelchair and standing position. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact.</p> <p>Review of the Care Area Assessment (CAA) Summary revealed Resident #1 triggered for falls which would be addressed in the care plan.</p> <p>Review of the Comprehensive Care Plan, dated 01/10/13, revealed the problem, Functional Deficit was identified with interventions initiated which included "resident requires extensive assist of two</p>	F 282	<p>altered for resident # 1. Resident # 1's care plan was updated. Resident #1 had a walker to use with transfers. Resident #1 completed therapy and discharged home as scheduled with family having all goals met on 2/15/2013.</p> <p>All resident charts were reviewed to monitor that resident care cards match the comprehensive care plans and that care is being given in a way that promotes safety and person centered care. Review was completed on 1/31/2013 a "Teaching Moment" was also done on 1/31/13 to re-educate staff on proper use of a gait belt. The Teaching Moment was presented by the DON. The facilities policy on Care Planning was reviewed (see attachment #2) and was updated on 2/15/2013. This policy was reviewed with the Medical Director. A teaching moment with done with the nurses on 2/15/13 (see attachment # 3). This information is also covered in orientation for new nurses. Chart audits were done on all resident charts by the DON and ADON to verify that facility policy on care planning and care card use is being followed. The Director of Nursing and the Assistant Director of Nursing will audit all charts for 3 weeks and will address concerns immediately; then all audits will be reviewed by the facility quality</p>

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)
F 282	<p>Continued From page 5</p> <p>with bed mobility, transfers and toileting....". Continued review of the Care Plan revealed Resident #1 was at risk for fractures due to Osteoporosis and Osteopenia (conditions associated with weak or brittle bones). Interventions for this risk included "use a gait belt with transfers".</p> <p>Review of the Resident Care Card, which were utilized by the Certified Nursing Assistants (CNAs) to guide the residents' care, revealed Resident #1 was to be transferred with the assist of two (2) persons and the use of a gait belt. Observation, on 02/13/13 at 11:25 AM, revealed the Resident Care Card was posted inside the resident's closet on the back of the closet door.</p> <p>Review of the Nursing Progress Notes, dated 01/31/13 at 12:47 AM, revealed Licensed Practical Nurse (LPN) #2 documented Resident #1 was transferred at 6:00 PM on 01/30/13 when a "crackle noise" was heard, and the resident stated, "you broke my arm". Continued review revealed the nurse reassured the resident, and assessed the arm to have full range of motion, no swelling, no redness, and no pain. Continued review revealed the "nurse aide and nurse transferred patient properly".</p> <p>However, review of a statement written by Certified Nursing Assistant (CNA) #1, dated 01/30/13, revealed she transferred Resident #1 from the chair to the bed, by herself and interview with Resident #1, on 02/12/13 at 2:55 PM, revealed he/she thought there was only one person in the room when the transfer occurred.</p> <p>Interview with CNA #1, on 02/13/13 at 3:25 PM,</p>	F 282	<p>assurance committee monthly. The Quality Assurance is made up of the facilities Medical Director, Pharmacist, DON, Administrator, Facilities Director, Assistant DON, Social Worker, Director of Dining Services, Director of Therapy, and MDS nurse. The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. The committee will review the audits monthly to determine if further audits need to be completed. Care planning</p>

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 6

revealed she used a gait belt and a walker to assist the resident with a transfer from the chair to the bed on 01/30/13. During follow up interview, on 02/14/13 at 4:40 PM, the CNA stated she was in the room by herself initially, but LPN #2 came into the room and observed the procedure. She further stated she was told Resident #1 was a one (1) person assist. She stated that's the way she always transferred Resident #1.

Interview with CNA #2, on 02/14/13, at 3:15 PM, revealed she was coming out of another resident's room on 01/30/13 when she heard CNA #1 call her name. She stated she went into the room of Resident #1 and the resident was sitting on the bed. She further stated she saw the resident's wheelchair by the bed, but she did not see a walker or gait belt. Continued interview revealed the resident was complaining of right arm pain and CNA #1 reported she was lifting the resident into the bed and heard the resident's arm crack. CNA #2 stated she did not know what CNA #1 meant when she said she lifted the resident into bed.

Interview with LPN #2, on 02/13/13 at 3:40 PM, revealed Resident #1 was a one (1) person assist at the time of the incident. She stated CNA #1 was using a gait belt and had the resident standing when LPN #2 entered the room. She further stated she observed the transfer. Continued interview revealed LPN #2 heard both arms crack, like cracking knuckles. She stated the resident's right arm did hit the walker. During follow up interview, on 02/14/13 at 5:00 PM, LPN #2 stated CNA #1 used a gait belt and a walker to transfer the resident. The LPN stated she was on

F 282

needs will continue to be reviewed at the weekly clinical meetings to ensure that care is meeting resident needs. The staff that was directly involved completed a return demonstration with the DON on 1-31-2013 demonstrating the ability to read, understand, and follow the resident care guide.

Plan of correction completed on 2/16/2013.

2/16/13
2/15/13

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
			(X5) COMPLETION DATE

F 282 Continued From page 7

F 282

one side of the bed and the CNA was on the other side.

Review of the Nursing Progress Note, dated 01/31/13 at 7:49 AM, revealed LPN #1 discovered Resident #1 to have pain in the right arm. Continued review revealed the resident stated, "I can't move my right arm at all". When the nurse attempted to assess the arm, the resident refused and stated, "It hurts too bad".

Interview with LPN #1, on 02/13/13 at 3:25 PM, revealed she saw Resident #1 at the beginning of the day shift on 01/31/13. She stated Resident #1 reported the arm was hurt when she was being transferred the night before. The LPN stated Resident #1 was a two (2) person assist for transfers.

During interview with the Director of Nursing (DON), on 02/15/13 at 3:15 PM, she stated Resident #1 required the assist of two (2) persons for transfers at the time of the incident, based on the comprehensive Care Plan and according to the Resident Care Card. Continued interview revealed the Resident Care Cards were posted in the resident rooms, so all staff could determine at a glance what was required for each resident's care. However, observation, on 02/13/13 at 11:25 AM revealed the Resident Care Card was not visible "at a glance" in the resident's room, but was posted inside the closet on the back of the closet door. Further interview with the DON revealed she did not know why CNA #1 and LPN #2 thought the resident only required one (1) person assist.

F 323 483.25(h) FREE OF ACCIDENT
SS=G HAZARDS/SUPERVISION/DEVICES

F 323

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 323	<p>Continued From page 8</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 observation, interview and record review, it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents, for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed to require the assistance of two (2) persons for transfers; however, the resident was transferred with the assistance of one (1) person and sustained a fracture to the right upper arm.</p> <p>The findings include: Interview with the Director of Nursing (DON), on 02/15/15 at 3:15 PM, revealed she considered it a standard of care that a gait belt be used for all transfers, although the facility did not have a written policy related to transfers and gait belts. Review of the clinical record revealed the facility admitted Resident #1 on 12/28/12 with diagnoses which included Congestive Heart Failure, Hypertension, Osteoarthritis and Gout. Review of Section G of the Admission Minimum</p>	F 323	<p>F323 Accidents 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. Resident # 1 was assessed by nurse on 1/30/2013. Resident #1 was assessed by the Physician Assistant on 1/31/13. Resident # 1 had x-rays ordered and obtained on 1/31/13. POA of resident # 1 was notified on 1/31/13. Resident # 1 was scheduled to see Orthopedic Doctor. Staff was notified on 1/31/13 that resident # 1 had a fracture. Therapy was notified on 1/31/13 of resident's fracture. A sling was ordered for resident # 1. Pain medications were reviewed and altered for resident # 1. Resident # 1 care plan was updated. Resident # 1 had a walker to use with transfers all resident charts were reviewed resident care cards were also audited to match the comprehensive care plans. A "Teaching Moment" was done on 1/31/13 to re-educate staff on proper use of a gait belt. This "Teaching Moment" was done by the DON. The review of the charts and care cards was completed on 1/31/2013 this review was completed by the DON and ADON. The facilities policy on Accidents was reviewed (Attachment #4) and was updated on 2/15/2013 by the DON. This policy was reviewed with the Medical Director.</p>

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)

F 323 Continued From page 9

Data Set (MDS) Assessment, dated 01/03/13, revealed the facility assessed Resident #1 to require extensive assistance of two persons for bed mobility and transfers to or from the bed, chair, wheelchair and standing position. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact.

Review of the Comprehensive Care Plan, dated 01/10/13, revealed the problem Functional Deficit was identified with interventions initiated which included "resident requires extensive assist of two with bed mobility, transfers and toileting....". Continued review of the Care Plan revealed Resident #1 was at risk for fractures due to Osteoporosis and Osteopenia (conditions associated with weak or brittle bones). Interventions for this risk included "use a gait belt with transfers".

Review of the Resident Care Card, posted inside the resident's closet on the back of the closet door, revealed Resident #1 was to be transferred with the assist of two (2) persons and the use of a gait belt.

Review of the Nursing Progress Note, dated 01/31/13 at 12:47 AM, revealed Licensed Practical Nurse (LPN) #2 documented Resident #1 was transferred at 6:00 PM on 01/30/13 when a "crackle noise" was heard, and the resident stated, "you broke my arm". Continued review revealed the nurse reassured the resident, and assessed the arm to have full range of motion, no swelling, no redness, and no pain. Continued review revealed the nurse documented the "nurse aide and nurse transferred patient properly".

F 323

This information is also covered in orientation for new nurses. Nurses and nurse aides were reeducated on the importance of following care cards by the DON (Attachment #3). Chart audits were done on all resident charts by the DON and ADON to verify that facility policy on care planning and care card use is being followed this audit was completed on 1/31/2013. The Director of Nursing and the Assistant Director of Nursing will audit all charts for 3 weeks and will address concerns immediately; then all audits will be reviewed by the facility quality assurance committee monthly. The Quality Assurance is made up of the facilities Medical Director, Pharmacist, DON, Administrator, Facilities Director, Assistant DON, Social Worker, Director of Dining Services, Director of Therapy, and MDS nurse. The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. The committee will review the audits

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)

F 323 : Continued From page 10

F 323,

Review of the Nursing Progress Note, dated 01/31/13 at 7:49 AM, revealed Licensed Practical Nurse (LPN) #1 discovered Resident #1 to have pain in the right arm. Continued review revealed the resident stated, "I can't move my right arm at all". When the nurse attempted to assess the arm, the resident refused and stated, "It hurts too bad".

Interview with Resident #1, on 02/12/13 at 2:55 PM, revealed he/she thought there was only one person in the room when the transfer occurred. The resident did not know the staff member's name. The resident stated, "I heard the bone crack". Continued interview revealed the resident reported he/she "almost passed out it hurt so bad". The resident stated all kinds of people came in and the resident told them, "Just leave me alone, get out and stay out". (At this point in the interview, Resident #1 stated "I'm tired of talking about it" and turned his/her head away from the surveyor.)

Review of the Physical Therapy (PT) Daily Note, dated 01/31/13 at 4:46 PM, revealed Resident #1 reported being in a great amount of pain in the right shoulder. Continued review revealed the PT Assistant was told by a nursing aide the resident had been transferred the previous evening by staff pulling under his/her arms, which resulted in a popping sound.

Interview with the Physical Therapy Assistant (PTA), on 02/13/13 at 11:40 AM, revealed Resident #1 was a "maximum assist of two" prior to the incident. She stated she saw Resident #1 on 01/31/13 and he/she was extremely guarded

monthly to determine if further audits need to be completed. Care planning needs will continue to be reviewed at the weekly clinical meetings to ensure that care is meeting resident needs. The staff that was directly involved completed a return demonstration with the DON on 1-31-2013 demonstrating the ability to read, understand, and follow the resident care guide.

Plan of correction completed on 2/16/2013.

2/16/13
Z-15-13

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 323	<p>Continued From page 11</p> <p>and in a lot of pain. She verified her written statement, noted above, that it was reported to her an aide had transferred the resident by lifting under the resident's arms, and had heard a popping sound. The PTA could not identify the aide who transferred the resident, or the aide who gave the account to the PTA. Continued interview revealed therapy staff had given an in-service on transfers approximately one week before the incident, but she did not know how many staff had attended.</p> <p>Interview with the Occupational Therapy Assistant (OTA), on 02/13/13 at 11:00 AM, revealed she had seen Resident #1 in the afternoon of 01/31/13. She stated the resident complained of pain in the right arm and did not want to move it. She stated the resident was very protective of the right arm, which was swollen approximately twice its normal size. Continued interview revealed the resident reported to the OTA the resident's arm was injured the night before when "the girl" was putting the resident to bed. The resident told the girl she was not doing it the way therapy did it (put the resident to bed) but the girl didn't listen. The OTA stated Resident #1 required two (2) people for transfers.</p> <p>Interview with CNA #3, on 02/13/13 at 3:00 PM, revealed Resident #1 required the assistance of two (2) staff for transfers. She stated she took care of the resident on 01/31/13 on the day shift. CNA #3 reported Resident #1 complained of her right arm hurting and stated staff picked her up wrong the evening before. Resident #1 did not know the staff member's name.</p> <p>Review of a statement written by Certified</p>	F 323	

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)

F 323 , Continued From page 12

F 323

Nursing Assistant (CNA) #1, dated 01/30/13 during the Initial Investigation of the incident, revealed she transferred Resident #1 from the chair to the bed, by herself. Review of a subsequent (undated) written statement by CNA #1, she reported LPN #2 came into the room and performed an assessment after the resident was in bed.

Interview with CNA #1, on 02/13/13 at 3:25 PM, revealed she used a gait belt and a walker to assist the resident with a transfer from the chair to the bed on 01/30/13. She stated LPN #2 was in the room during the transfer. Continued interview revealed CNA #1 had the walker in front of the resident and the resident pivoted around from the chair to the bed. She reported as the resident moved to sit on the bed, his/her right elbow hit the handle of the walker and made a popping sound, "like a joint popping". She stated it was "very scary". On further interview, CNA #1 stated she had been trained on proper transfers during CNA training and at another facility but had not received any training at this facility. Per interview, she started working at the facility in January, 2013. During follow-up interview, on 02/14/13 at 4:40 PM, CNA #1 stated she was in the room by herself initially, but LPN #2 came into the room and observed the procedure. She further stated she had been told Resident #1 was a one (1) person assist. She stated that was the way she always transferred Resident #1.

Interview with CNA #2, on 02/14/13, at 3:15 PM, revealed she was coming out of another resident's room on 01/30/13 when she heard CNA #1 call her name. She stated she went into the room of Resident #1 and the resident was

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 323 Continued From page 13

F 323

sitting on the bed. She further stated she saw the resident's wheelchair by the bed, but she did not see a walker or gait belt. Continued interview revealed the resident was complaining of right arm pain and CNA #1 reported she was lifting the resident into the bed and heard the resident's arm crack. CNA #2 stated she did not know what CNA #1 meant when she said she lifted the resident into bed. On further interview, CNA #2 stated she stayed with the resident while CNA #1 went to get LPN #2. CNA #2 described Resident #1 as being fairly calm, was holding his/her right arm next to the body, and supported the right hand across the abdomen with the left hand. CNA #2 stated she had been trained on transfers at another facility, but had not received training since coming to work at this facility. Per interview she had been at the facility since December 2012.

Interview with LPN #2, on 02/13/13 at 3:40 PM, revealed Resident #1 was a one (1) person assist at the time of the incident. She stated CNA #1 was using a gait belt and had the resident standing when LPN #2 entered the room. She further stated she observed the transfer. Continued interview revealed she heard "cracks" like cracking knuckles when CNA #1 pulled on the gait belt. During follow up interview, on 02/14/13 at 5:00 PM, LPN #2 stated Resident #1 was in the bed and was uncomfortable and wanted to get up. On reflection, the LPN stated "I forget", and stated the resident was either in the chair and wanted to go to bed, or was in the bed and wanted to get in the chair. The LPN stated she was on one side of the bed and the CNA was on the other side, and began to recount how CNA #1 was putting the resident to bed. She reported

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE			

F 323 Continued From page 14

Resident #1's arm hit the walker and she heard both arms "crack". Further interview with LPN #2, and review of the incident report completed on 01/30/13, revealed the LPN notified the on-call Physician. She stated since the resident denied pain, and the nurse found no abnormalities on her assessment of the resident's arm, the Physician stated to just monitor the resident.

Interview with LPN #1, on 02/13/13 at 3:25 PM, revealed she saw Resident #1 at the beginning of the day shift on 01/31/13. She stated the resident was holding his/her right arm close to his/her side and complaining of pain. The resident was wearing long sleeves and would not allow the nurse to assess the arm; the nurse could not say if there was any swelling or bruising. Continued interview with LPN #1 revealed Resident #1 reported the arm was hurt when she was being transferred the night before. The LPN stated Resident #1 was a two (2) person assist for transfers. She further stated she notified the Physician and received an order to obtain an X-ray of the right arm and shoulder.

Interview, 02/13/13 at 4:30 PM with the Physician Assistant working for the Resident #1's Physician, revealed he was called regarding the resident's arm and complaints of pain, and felt like the fracture did occur during the transfer.

During Interview with the Director of Nursing (DON), on 02/15/13 at 10:35 AM, she stated Resident #1 required the assist of two (2) persons for transfers at the time of the incident, based on the MDS Assessment and the comprehensive Care Plan, and as indicated on the Resident Care Card. Continued interview revealed the Resident

F 323

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)

F 323 Continued From page 15

F 323

Care Cards were posted in the residents' rooms, so all staff could determine at a glance what was required for each resident's care. However, observation, on 02/13/13 at 11:25 AM, revealed the Resident Care Card was not visible "at a glance" in the resident's room, but was posted inside the closet on the back of the closet door. Continued interview revealed the DON did not know why CNA #1 and LPN #2 thought the resident only required one (1) person assist. On further interview, the DON stated the in-service on transfers, provided by the therapy department, should have been mandatory for all nurses and CNAs. She stated it would normally be the Human Resources staff person who would ensure all staff had attended. However, she reported, they did not have anyone in the Human Resources position at the time of the in-service, and the DON was unaware that anyone had verified whether or not all staff attended the in-service. Review of the sign-in sheets revealed CNA #1 and CNA #2 had not attended the in-service.

Interview with the Administrator, on 02/15/13 at 12:00 PM, revealed he felt LPN #2 was a good nurse and he trusted her. He stated he and LPN #2 had followed up with the resident's daughter after the incident, and the conversation included discussion of the use of gait belts for transfers. He further stated the facility had done audits in the past related to proper transfer techniques, but had not identified the need to continue them. He further stated the transfer in-service was mandatory, but he did not know if all staff had attended.

During subsequent interview with the DON, on

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

PRINTED: 03/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MADONNA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 16
02/15/15 at 3:15 PM, she stated she considered it a standard of care that a gait belt be used for all transfers, although the facility did not have a written policy related to transfers and gait belts. She further stated she had investigated the incident and interviewed all staff involved. Continued interview revealed the DON recognized inconsistencies between the resident and staff accountings of the incident involving Resident #1. She also acknowledged inconsistencies between staff descriptions of the event and had re-interviewed staff involved. She further stated it was impossible to know exactly what occurred. She agreed it appeared the resident had been transferred by CNA #1 alone, and it was not clear when LPN #2 entered the room or if she gave any hands-on assistance or simply observed.

F 323



MADONNA MANOR

A FRANCISCAN LIVING COMMUNITY

Notification of Change Policy and Procedure

F157 Notification of Change

POLICY: It is the policy of Madonna Manor to notify the attending physician (and/or Medical Director) in a timely manner, of changes or concerns in resident condition. It is the policy of Madonna Manor to notify the resident and his/her family in a timely manner, of changes or concerns in resident condition. The policy of Madonna Manor is to ensure that the residents receive quality care and services.

PROCEDURE:

- The nurse on duty is to notify the attending physician (or P.A., ARNP) and POA when there is a concern with the resident
- The nurse on duty is to notify the physician (or P.A., ARNP) and responsible party of any significant change in health, mental, or psychosocial status changes in the residents
- The nurse on duty is to notify the physician (or P.A., ARNP) and responsible party when the resident has an accident, which results in injury and could require physician interventions
- If the nurse on duty is unable to reach the attending physician, then the nurse is to notify the Medical Director with any concerns
- The only way that the facility does not notify the responsible party of significant changes is when the resident is alert and oriented and declines to have family notified
- The nurse on duty is to alert the resident of changes

Comprehensive Care Planning Policy and Procedure



MADONNA MANOR

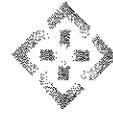
A FRANCISCAN LIVING COMMUNITY

Policy

It is the policy of Madonna Manor to develop an individualized comprehensive care plan for each individual resident. The care plans will be measurable objectives, in order to meet the resident's medical, physical, nursing, mental and psychological needs.

Procedure

- The care planning team, resident, and his/her family develop and maintain the residents comprehensive care plan
- The comprehensive care plan identifies the highest level of functioning that the resident may be expected to attain
- The comprehensive care plan is based on a thorough assessment that includes (but is not limited to) the MDS
- The care plan is used to:
 - incorporate identified problems
 - Incorporate risk factors
 - Build on resident strengths
 - Reflect treatment goals
 - Identify treatments and services needed
 - To aid in preventing (or reducing) declines in resident status
 - To enhance optimal functioning of the resident
 - To reflect currently recognized standards of practice for problem areas and conditions
- The resident care cards are an extension of the care card
- The resident care cards are a guide to resident care
- The care cards are updated weekly as needed with changes
- The comprehensive care plans are updated at least quarterly with the MDS assessment
- Acute care plans are initiated based on the nurses judgment



MADONNA MANOR
A FRANCISCAN LIVING COMMUNITY

Accidents and Incidents Policy and Procedures

F323 Accidents

Policy

It is the policy of Madonna Manor that the residents environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. It is the policy of Madonna Manor that all incidents involving residents shall be investigated as needed and reported to the administrator and Director of Nursing.

Procedure

- The nurse will assess the resident immediately
- The nurse will initiate interventions immediately if needed
- The nurse will notify the physician in a timely manner
- The nurse will notify the family within a timely manner
- The nurse will document:
 - the date and time of the accident or incident
 - the nature of the incident or accident
 - where the incident occurred
 - the names of witnesses and any accounts that they may have of the incident
 - the time that the physician and family were notified
 - nursing assessment obtained
 - any corrective actions taken
- The nursing supervisor or Director of Nursing will be notified within 24 hours of occurrence
- The accident or incident will be reviewed in clinical meeting weekly and by the QA committee

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

N 000 INITIAL COMMENTS

AMENDED

A Complaint Survey to investigate KY#00019766 and KY#00019769 was initiated on 02/11/13 and concluded on 02/15/13. KY#00019769 was unsubstantiated with no deficient practice identified. KY#00019766 was substantiated and deficiencies were cited.

N 017: 902 KAR 20:300-3(2)(i)1.a. Section 3. Resident Rights

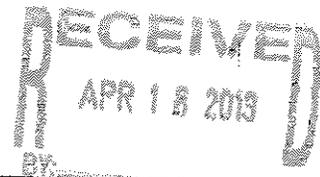
- (2) Notice of rights and services.
(i) Notification of changes.
1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is:
a. An accident involving the resident which results in injury;

This requirement is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the family was notified when there was an accident involving the resident which resulted in injury, for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed and care planned for two (2) person assist and the use of a gait belt during transfers. On 01/30/13, the resident was transferred with the assistance of one (1) person. On 01/31/13 at 7:49 AM, Resident #1 was found to have pain and the inability to move the right arm. The resident's family was not notified of the change in status until approximately 10:30 AM, while visiting the resident. The resident was diagnosed with a fracture of the right arm.

N 000

N 017

The amended completion and submission of this plan of correction does not constitute an admission that the facility agrees with the cited deficiencies as stated in the 2567. The facility is completing the plan of correction because it is required by state and federal law. The facility alleges compliance as of February 16, 2013.



[Handwritten Signature]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Executive Director

(X6) DATE

3-12-13

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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 PRECEDED BY REFERENCE TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 017	Continued From page 1 The findings include: When the policy related to notifying residents' families when there was an accident or change in status was requested, the Director of Nursing stated the facility did not have a written policy to address notification of families. Review of the clinical record revealed the facility admitted Resident #1 on 12/28/12 with diagnoses which included Hypertension, Congestive Heart Failure, Osteoarthritis and Gout. Review of the admission Face Sheet revealed the resident's daughter was listed as the primary contact. Review of the Nursing Progress Note, dated 01/31/13 at 7:49 AM, revealed Licensed Practical Nurse (LPN) #1 discovered Resident #1 to have pain in the right arm. Continued review revealed the resident stated, "I can't move my right arm at all". When the nurse attempted to assess the arm, the resident refused and stated, "It hurts too bad". LPN #1 documented the Physician was notified and orders were received. However, there was no documented evidence the family was notified. Interview with Resident #1's daughter, on 02/12/13 at 2:55 PM, revealed she visited the resident on 01/31/13 at approximately 10:30 AM. She stated staff reported the resident's arm was hurt. Continued interview revealed the resident hurt his/her arm the previous evening during a transfer from the bed to the chair. She stated she was not called the previous evening or on the morning of 01/31/13 when the resident could not move his/her arm and was having pain. Interview with LPN #2, on 02/14/13 at 3:40 PM,	N 017	N 017 Resident Rights A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is - (A) An accident involving the resident which results in injury and has the potential for requiring physician interventions. Resident # 1 was assessed by nurse on 1/30/2013. Resident # 1 was assessed by the Physician Assistant on 1/31/13. Resident # 1 had x-rays ordered and obtained on 1/31/13. POA of resident # 1 was notified on 1/31/13. Resident # 1 was scheduled to see Orthopedic Doctor. Staff was notified on 1/31/13 that resident # 1 had a fracture. Therapy was notified on 1/31/13 of resident's fracture. A sling was ordered and obtained for resident # 1. Pain medications were reviewed and altered for resident # 1. Resident # 1 care plan was updated. All resident charts were checked for documentation reflecting if facilities notification policies were followed this check was done by the DON and ADON This check was completed on 2/15/2013. Resident #1 was discharged home on 2/15/2013 as scheduled with family after all therapy and clinical goals were met. The Notification of Change policy (Attachment #1) was updated on 2/15/2013 by the DON and reviewed	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 017	Continued From page 2 revealed she was caring for Resident #1 on the evening of 01/30/13. She stated during a transfer from the bed to the chair, she heard a "crack", like knuckles cracking, and the resident's arm hit the walker. Continued interview revealed she assessed the resident to have full range of motion of the right arm, and no pain. She further stated she notified the on-call Physician, but did not call the daughter because the resident had no complaint for the rest of the evening. Interview with LPN #1, on 02/13/13 at 3:25 PM, revealed she called the resident's Physician when Resident #1 was unable to move his/her arm and complained of pain, but did not notify the daughter when. She stated she was very busy and had to leave the facility emergently in the middle of her shift. She further stated she should have notified the resident's daughter. Interview, 02/13/13 at 4:30 PM with the Physician Assistant working for the Resident #1's Physician, revealed he was called regarding the resident's arm and ordered an x-ray. Review of the X-ray report, dated 01/31/13, revealed Resident #1 had a "non-displaced fracture through the distal humeral shaft". (a fracture of the upper arm near the elbow).	N 017	with the medical director. This updated policy was given to the nurses during the February "Teaching Moment" given by the DON. This policy will also be covered in orientation of new nurses. The Director of Nursing and the Assistant Director of Nursing will audit all charts for 3 weeks and will address concerns immediately. The audits will be submitted to the facilities quality assurance committee monthly. The Quality Assurance Committee is made up of the facilities Medical Director, Pharmacist, DON, Administrator, Facilities Director, Assistant DON, Social Worker, Director of Dining Services, Director of Therapy, and MDS nurse. The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. The committee will review the audit and will determine if audits need to continue and for how long based on the findings of the audit. Plan of correction completed on 2/16/2013.	
N 194	902 KAR 20:300-7(4)(c)2. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 2. Be provided by qualified persons in accordance with each resident's written plan of care.	N 194		2/14

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100288	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 194	Continued From page 3 This requirement is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the services provided were in accordance with the written plan of care, for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure the Care Plan was implemented for Resident #1, who was to have two (2) person assist and the use of a gait belt with transfers. On 01/30/13, the resident was transferred with the assistance of one (1) person, and sustained a fractured right arm. (Refer to F-323). The findings include: Review of the policy titled "Care Plans - Comprehensive", revised October 2010, revealed the comprehensive care plan was based on a thorough assessment that included the Minimum Data Set (MDS) assessment. Continued review revealed care plan interventions were developed based on the resident's problem areas identified on the MDS assessment. Review of the clinical record revealed the facility admitted Resident #1 on 12/28/12 with diagnoses which included Congestive Heart Failure, Hypertension, Osteoarthritis and Gout. Review of the Admission MDS Assessment, dated 01/03/13, revealed the facility assessed Resident #1 to require the extensive assistance of two (2) persons for bed mobility and transfers to or from bed, chair, wheelchair and standing position. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact. Review of the Care Area Assessment (CAA) Summary revealed Resident #1 triggered for falls	N 194	N 194 Resident Assessments Resident # 1 was assessed by nurse on 1/30/2013. Resident #1 was assessed by the Physician Assistant on 1/31/13. Resident # 1 had x-rays ordered and obtained on 1/31/13. POA of resident # 1 was notified on 1/31/13. Resident # 1 was scheduled to see Orthopedic Doctor. Staff was notified on 1/31/13 that resident # 1 had a fracture. Therapy was notified on 1/31/13 of resident's fracture. A sling was ordered for resident # 1. Pain medications were reviewed and altered for resident # 1. Resident # 1's care plan was updated. Resident #1 had a	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 194	Continued From page 4 which would be addressed in the care plan. Review of the Comprehensive Care Plan, dated 01/10/13, revealed the problem, Functional Deficit was identified with interventions initiated which included "resident requires extensive assist of two with bed mobility, transfers and toileting...". Continued review of the Care Plan revealed Resident #1 was at risk for fractures due to Osteoporosis and Osteopenia (conditions associated with weak or brittle bones). Interventions for this risk included "use a gait belt with transfers". Review of the Resident Care Card, which were utilized by the Certified Nursing Assistants (CNAs) to guide the residents' care, revealed Resident #1 was to be transferred with the assist of two (2) persons and the use of a gait belt. Observation, on 02/13/13 at 11:25 AM, revealed the Resident Care Card was posted inside the resident's closet on the back of the closet door. Review of the Nursing Progress Notes, dated 01/31/13 at 12:47 AM, revealed Licensed Practical Nurse (LPN) #2 documented Resident #1 was transferred at 6:00 PM on 01/30/13 when a "crackle noise" was heard, and the resident stated, "you broke my arm". Continued review revealed the nurse reassured the resident, and assessed the arm to have full range of motion, no swelling, no redness, and no pain. Continued review revealed the "nurse aide and nurse transferred patient properly". However, review of a statement written by Certified Nursing Assistant (CNA) #1, dated 01/30/13, revealed she transferred Resident #1 from the chair to the bed, by herself and interview with Resident #1, on 02/12/13 at 2:55 PM,	N 194	walker to use with transfers. Resident #1 completed therapy and discharged home as scheduled with family having all goals met on 2/15/2013. All resident charts were reviewed to monitor that resident care cards match the comprehensive care plans and that care is being given in a way that promotes safety and person centered care. Review was completed on 1/31/2013 a "Teaching Moment" was also done on 1/31/13 to re-educate staff on proper use of a gait belt. The Teaching Moment was presented by the DON. The facilities policy on Care Planning was reviewed (see attachment #2) and was updated on 2/15/2013. This policy was reviewed with the Medical Director. A teaching moment with done with the nurses on 2/15/13 (see attachment # 3). This information is also covered in orientation for new nurses.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 194	Continued From page 5 revealed he/she thought there was only one person in the room when the transfer occurred. Interview with CNA #1, on 02/13/13 at 3:25 PM, revealed she used a gait belt and a walker to assist the resident with a transfer from the chair to the bed on 01/30/13. During follow up interview, on 02/14/13 at 4:40 PM, the CNA stated she was in the room by herself initially, but LPN #2 came into the room and observed the procedure. She further stated she was told Resident #1 was a one (1) person assist. She stated that's the way she always transferred Resident #1. Interview with CNA #2, on 02/14/13, at 3:15 PM, revealed she was coming out of another resident's room on 01/30/13 when she heard CNA #1 call her name. She stated she went into the room of Resident #1 and the resident was sitting on the bed. She further stated she saw the resident's wheelchair by the bed, but she did not see a walker or gait belt. Continued interview revealed the resident was complaining of right arm pain and CNA #1 reported she was lifting the resident into the bed and heard the resident's arm crack. CNA #2 stated she did not know what CNA #1 meant when she said she lifted the resident into bed. Interview with LPN #2, on 02/13/13 at 3:40 PM, revealed Resident #1 was a one (1) person assist at the time of the incident. She stated CNA #1 was using a gait belt and had the resident standing when LPN #2 entered the room. She further stated she observed the transfer. Continued interview revealed LPN #2 heard both arms crack, like cracking knuckles. She stated the resident's right arm did hit the walker. During follow up interview, on 02/14/13 at 5:00 PM, LPN	N 194	Chart audits were done on all resident charts by the DON and ADON to verify that facility policy on care planning and care card use is being followed. The Director of Nursing and the Assistant Director of Nursing will audit all charts for 3 weeks and will address concerns immediately; then all audits will be reviewed by the facility quality assurance committee monthly. The Quality Assurance is made up of the facilities Medical Director, Pharmacist, DON, Administrator, Facilities Director, Assistant DON, Social Worker, Director of Dining Services, Director of Therapy, and MDS nurse. The QA committee reviews accidents each time they meet, identifies the need for audits and programmatic changes as necessary. The committee will review the audits monthly to determine if further audits	

2-15-13
2/16/13

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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) COMPLETE DATE
N 194	<p>Continued From page 6</p> <p>#2 stated CNA #1 used a gait belt and a walker to transfer the resident. The LPN stated she was on one side of the bed and the CNA was on the other side.</p> <p>Review of the Nursing Progress Note, dated 01/31/13 at 7:49 AM, revealed LPN #1 discovered Resident #1 to have pain in the right arm. Continued review revealed the resident stated, "I can't move my right arm at all". When the nurse attempted to assess the arm, the resident refused and stated, "It hurts too bad".</p> <p>Interview with LPN #1, on 02/13/13 at 3:25 PM, revealed she saw Resident #1 at the beginning of the day shift on 01/31/13. She stated Resident #1 reported the arm was hurt when she was being transferred the night before. The LPN stated Resident #1 was a two (2) person assist for transfers.</p> <p>During interview with the Director of Nursing (DON), on 02/15/13 at 3:15 PM, she stated Resident #1 required the assist of two (2) persons for transfers at the time of the incident, based on the comprehensive Care Plan and according to the Resident Care Card. Continued interview revealed the Resident Care Cards were posted in the resident rooms, so all staff could determine at a glance what was required for each resident's care. However, observation, on 02/13/13 at 11:25 AM revealed the Resident Care Card was not visible "at a glance" in the resident's room, but was posted inside the closet on the back of the closet door. Further interview with the DON revealed she did not know why CNA #1 and LPN #2 thought the resident only required one (1) person assist.</p>	N 194	<p>need to be completed. Care planning needs will continue to be reviewed at the weekly clinical meetings to ensure that care is meeting resident needs. The staff that was directly involved completed a return demonstration with the DON on 1-31-2013 demonstrating the ability to read, understand, and follow the resident care guide.</p> <p>Plan of correction completed on 2/16/2013.</p>

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 220	Continued From page 7	N 220		
N 220	902 KAR 20:300-8(7)(b) Section 8. Quality of Care (7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents. This requirement is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents, for one (1) of three (3) sampled residents (Resident #1). Resident #1 was assessed to require the assistance of two (2) persons for transfers; however, the resident was transferred with the assistance of one (1) person and sustained a fracture to the right upper arm. The findings include: Interview with the Director of Nursing (DON), on 02/15/13 at 3:15 PM, revealed she considered it a standard of care that a gait belt be used for all transfers, although the facility did not have a written policy related to transfers and gait belts. Review of the clinical record revealed the facility admitted Resident #1 on 12/28/12 with diagnoses which included Congestive Heart Failure, Hypertension, Osteoarthritis and Gout. Review of Section G of the Admission Minimum Data Set (MDS) Assessment, dated 01/03/13, revealed the facility assessed Resident #1 to require extensive assistance of two persons for	N 220 N 220	N 220 Quality Care Resident # 1 was assessed by nurse on 1/30/2013. Resident #1 was assessed by the Physician Assistant on 1/31/13. Resident # 1 had x-rays ordered and obtained on 1/31/13. POA of resident # 1 was notified on 1/31/13. Resident # 1 was scheduled to see Orthopedic Doctor. Staff was notified on 1/31/13 that resident # 1 had a fracture. Therapy was notified on 1/31/13 of resident's fracture. A sling was ordered for resident # 1. Pain medications were reviewed and altered for resident # 1. Resident # 1 care plan was updated. Resident # 1 had a walker to use with transfers all resident charts were reviewed resident care cards were also audited to match the comprehensive care plans. A "Teaching Moment" was done on 1/31/13 to re-educate staff on proper use of a gait belt. This "Teaching Moment" was done by the DON. The review of the charts and care cards was completed on 1/31/2013 this review was completed by the DON and ADON. The facilities policy on Accidents was reviewed (Attachment #4) and was updated on 2/15/2013 by the DON. This policy was reviewed with the Medical Director. This information is also covered in orientation for new nurses. Nurses and nurse aides were reeducated on the importance of following care cards by	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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)

N 220 Continued From page 8

bed mobility and transfers to or from the bed, chair, wheelchair and standing position. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was cognitively intact.

Review of the Comprehensive Care Plan, dated 01/10/13, revealed the problem Functional Deficit was identified with interventions initiated which included "resident requires extensive assist of two with bed mobility, transfers and toileting...". Continued review of the Care Plan revealed Resident #1 was at risk for fractures due to Osteoporosis and Osteopenia (conditions associated with weak or brittle bones). Interventions for this risk included "use a gait belt with transfers".

Review of the Resident Care Card, posted inside the resident's closet on the back of the closet door, revealed Resident #1 was to be transferred with the assist of two (2) persons and the use of a gait belt.

Review of the Nursing Progress Note, dated 01/31/13 at 12:47 AM, revealed Licensed Practical Nurse (LPN) #2 documented Resident #1 was transferred at 6:00 PM on 01/30/13 when a "crackle noise" was heard, and the resident stated, "you broke my arm". Continued review revealed the nurse reassured the resident, and assessed the arm to have full range of motion, no swelling, no redness, and no pain. Continued review revealed the nurse documented the "nurse aide and nurse transferred patient properly".

Review of the Nursing Progress Note, dated 01/31/13 at 7:49 AM, revealed Licensed Practical Nurse (LPN) #1 discovered Resident #1 to have pain in the right arm. Continued review revealed

N 220

the DON (Attachment #3). Chart audits were done on all resident charts by the DON and ADON to verify that facility policy on care planning and care card use is being followed this audit was completed on 1/31/2013. The Director of Nursing and the Assistant Director of Nursing will audit all charts for 3 weeks and will address concerns immediately; then all audits will be reviewed by the facility quality assurance committee monthly. The Quality Assurance is made up of the facilities Medical Director, Pharmacist, DON, Administrator, Facilities Director, Assistant DON, Social Worker, Director of Dining Services, Director of Therapy, and MDS nurse. The QA committee reviews accidents each time they meet, identifies the need for audits and

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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) COMPLETE DATE
N 220	<p>Continued From page 9</p> <p>the resident stated, "I can't move my right arm at all". When the nurse attempted to assess the arm, the resident refused and stated, "It hurts too bad".</p> <p>Interview with Resident #1, on 02/12/13 at 2:55 PM, revealed he/she thought there was only one person in the room when the transfer occurred. The resident did not know the staff member's name. The resident stated, "I heard the bone crack". Continued interview revealed the resident reported he/she "almost passed out it hurt so bad". The resident stated all kinds of people came in and the resident told them, "just leave me alone, get out and stay out". (At this point in the interview, Resident #1 stated "I'm tired of talking about it" and turned his/her head away from the surveyor.)</p> <p>Review of the Physical Therapy (PT) Daily Note, dated 01/31/13 at 4:46 PM, revealed Resident #1 reported being in a great amount of pain in the right shoulder. Continued review revealed the PT Assistant was told by a nursing aide the resident had been transferred the previous evening by staff pulling under his/her arms, which resulted in a popping sound.</p> <p>Interview with the Physical Therapy Assistant (PTA), on 02/13/13 at 11:40 AM, revealed Resident #1 was a "maximum assist of two" prior to the incident. She stated she saw Resident #1 on 01/31/13 and he/she was extremely guarded and in a lot of pain. She verified her written statement, noted above, that it was reported to her an aide had transferred the resident by lifting under the resident's arms, and had heard a popping sound. The PTA could not identify the aide who transferred the resident, or the aide who gave the account to the PTA. Continued</p>	N 220	<p>programmatic changes as necessary. The committee will review the audits monthly to determine if further audits need to be completed. Care planning needs will continue to be reviewed at the weekly clinical meetings to ensure that care is meeting resident needs. The staff that was directly involved completed a return demonstration with the DON on 1-31-2013 demonstrating the ability to read, understand, and follow the resident care guide.</p> <p>Plan of correction completed on 2/16/2013.</p>

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	
(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) COMPLETE DATE
N 220	<p>Continued From page 10</p> <p>Interview revealed therapy staff had given an in-service on transfers approximately one week before the incident, but she did not know how many staff had attended.</p> <p>Interview with the Occupational Therapy Assistant (OTA), on 02/13/13 at 11:00 AM, revealed she had seen Resident #1 in the afternoon of 01/31/13. She stated the resident complained of pain in the right arm and did not want to move it. She stated the resident was very protective of the right arm, which was swollen approximately twice its normal size. Continued interview revealed the resident reported to the OTA the resident's arm was injured the night before when "the girl" was putting the resident to bed. The resident told the girl she was not doing it the way therapy did it (put the resident to bed) but the girl didn't listen. The OTA stated Resident #1 required two (2) people for transfers.</p> <p>Interview with CNA #3, on 02/13/13 at 3:00 PM, revealed Resident #1 required the assistance of two (2) staff for transfers. She stated she took care of the resident on 01/31/13 on the day shift. CNA #3 reported Resident #1 complained of her right arm hurting and stated staff picked her up wrong the evening before. Resident #1 did not know the staff member's name.</p> <p>Review of a statement written by Certified Nursing Assistant (CNA) #1, dated 01/30/13 during the initial investigation of the incident, revealed she transferred Resident #1 from the chair to the bed, by herself. Review of a subsequent (undated) written statement by CNA #1, she reported LPN #2 came into the room and performed an assessment after the resident was in bed.</p>	N 220	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE	
N 220	Continued From page 11 Interview with CNA #1, on 02/13/13 at 3:25 PM, revealed she used a gait belt and a walker to assist the resident with a transfer from the chair to the bed on 01/30/13. She stated LPN #2 was in the room during the transfer. Continued interview revealed CNA #1 had the walker in front of the resident and the resident pivoted around from the chair to the bed. She reported as the resident moved to sit on the bed, his/her right elbow hit the handle of the walker and made a popping sound, "like a joint popping". She stated it was "very scary". On further interview, CNA #1 stated she had been trained on proper transfers during CNA training and at another facility but had not received any training at this facility. Per interview, she started working at the facility in January, 2013. During follow-up interview, on 02/14/13 at 4:40 PM, CNA #1 stated she was in the room by herself initially, but LPN #2 came into the room and observed the procedure. She further stated she had been told Resident #1 was a one (1) person assist. She stated that was the way she always transferred Resident #1. Interview with CNA #2, on 02/14/13, at 3:15 PM, revealed she was coming out of another resident's room on 01/30/13 when she heard CNA #1 call her name. She stated she went into the room of Resident #1 and the resident was sitting on the bed. She further stated she saw the resident's wheelchair by the bed, but she did not see a walker or gait belt. Continued interview revealed the resident was complaining of right arm pain and CNA #1 reported she was lifting the resident into the bed and heard the resident's arm crack. CNA #2 stated she did not know what CNA #1 meant when she said she lifted the resident into bed. On further interview, CNA #2 stated she stayed with the resident while CNA #1 went to get LPN #2. CNA #2 described Resident	N 220			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 220	Continued From page 12 #1 as being fairly calm, was holding his/her right arm next to the body, and supported the right hand across the abdomen with the left hand. CNA #2 stated she had been trained on transfers at another facility, but had not received training since coming to work at this facility. Per interview she had been at the facility since December 2012. Interview with LPN #2, on 02/13/13 at 3:40 PM, revealed Resident #1 was a one (1) person assist at the time of the incident. She stated CNA #1 was using a gait belt and had the resident standing when LPN #2 entered the room. She further stated she observed the transfer. Continued interview revealed she heard "cracks" like cracking knuckles when CNA #1 pulled on the gait belt. During follow up interview, on 02/14/13 at 5:00 PM, LPN #2 stated Resident #1 was in the bed and was uncomfortable and wanted to get up. On reflection, the LPN stated "I forget", and stated the resident was either in the chair and wanted to go to bed, or was in the bed and wanted to get in the chair. The LPN stated she was on one side of the bed and the CNA was on the other side, and began to recount how CNA #1 was putting the resident to bed. She reported Resident #1's arm hit the walker and she heard both arms "crack". Further interview with LPN #2, and review of the incident report completed on 01/30/13, revealed the LPN notified the on-call Physician. She stated since the resident denied pain, and the nurse found no abnormalities on her assessment of the resident's arm, the Physician stated to just monitor the resident. Interview with LPN #1, on 02/13/13 at 3:25 PM, revealed she saw Resident #1 at the beginning of the day shift on 01/31/13. She stated the resident was holding his/her right arm close to his/her side	N 220		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 220	<p>Continued From page 13</p> <p>and complaining of pain. The resident was wearing long sleeves and would not allow the nurse to assess the arm; the nurse could not say if there was any swelling or bruising. Continued interview with LPN #1 revealed Resident #1 reported the arm was hurt when she was being transferred the night before. The LPN stated Resident #1 was a two (2) person assist for transfers. She further stated she notified the Physician and received an order to obtain an X-ray of the right arm and shoulder.</p> <p>Interview, 02/13/13 at 4:30 PM with the Physician Assistant working for the Resident #1's Physician, revealed he was called regarding the resident's arm and complaints of pain, and felt like the fracture did occur during the transfer.</p> <p>During interview with the Director of Nursing (DON), on 02/15/13 at 10:35 AM, she stated Resident #1 required the assist of two (2) persons for transfers at the time of the incident, based on the MDS Assessment and the comprehensive Care Plan, and as indicated on the Resident Care Card. Continued interview revealed the Resident Care Cards were posted in the residents' rooms, so all staff could determine at a glance what was required for each resident's care. However, observation, on 02/13/13 at 11:25 AM, revealed the Resident Care Card was not visible "at a glance" in the resident's room, but was posted inside the closet on the back of the closet door. Continued interview revealed the DON did not know why CNA #1 and LPN #2 thought the resident only required one (1) person assist. On further interview, the DON stated the in-service on transfers, provided by the therapy department, should have been mandatory for all nurses and CNAs. She stated it would normally be the Human Resources staff person who would</p>	N 220		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100268	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017	

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

N 220 : Continued From page 14

ensure all staff had attended. However, she reported, they did not have anyone in the Human Resources position at the time of the in-service, and the DON was unaware that anyone had verified whether or not all staff attended the in-service. Review of the sign-in sheets revealed CNA #1 and CNA #2 had not attended the in-service.

Interview with the Administrator, on 02/15/13 at 12:00 PM, revealed he felt LPN #2 was a good nurse and he trusted her. He stated he and LPN #2 had followed up with the resident's daughter after the incident, and the conversation included discussion of the use of gait belts for transfers. He further stated the facility had done audits in the past related to proper transfer techniques, but had not identified the need to continue them. He further stated the transfer in-service was mandatory, but he did not know if all staff had attended.

During subsequent interview with the DON, on 02/15/15 at 3:15 PM, she stated she considered it a standard of care that a gait belt be used for all transfers, although the facility did not have a written policy related to transfers and gait belts. She further stated she had investigated the incident and interviewed all staff involved. Continued interview revealed the DON recognized inconsistencies between the resident and staff accountings of the incident involving Resident #1. She also acknowledged inconsistencies between staff descriptions of the event and had re-interviewed staff involved. She further stated it was impossible to know exactly what occurred. She agreed it appeared the resident had been transferred by CNA #1 alone, and it was not clear when LPN #2 entered the room or if she gave any hands-on assistance or

N 220

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100258	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 02/15/2013
NAME OF PROVIDER OR SUPPLIER MADONNA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 2344 AMSTERDAM ROAD VILLA HILLS, KY 41017		
(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) COMPLETE DATE
N 220	Continued From page 15 simply observed.	N 220		

2-16-13
2-15-13



MADONNA MANOR

A FRANCISCAN LIVING COMMUNITY

Notification of Change Policy and Procedure

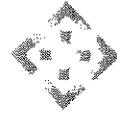
F157 Notification of Change

POLICY: It is the policy of Madonna Manor to notify the attending physician (and/or Medical Director) in a timely manner, of changes or concerns in resident condition. It is the policy of Madonna Manor to notify the resident and his/her family in a timely manner, of changes or concerns in resident condition. The policy of Madonna Manor is to ensure that the residents receive quality care and services.

PROCEDURE:

- The nurse on duty is to notify the attending physician (or P.A., ARNP) and POA when there is a concern with the resident
- The nurse on duty is to notify the physician (or P.A., ARNP) and responsible party of any significant change in health, mental, or psychosocial status changes in the residents
- The nurse on duty is to notify the physician (or P.A., ARNP) and responsible party when the resident has an accident, which results in injury and could require physician interventions
- If the nurse on duty is unable to reach the attending physician, then the nurse is to notify the Medical Director with any concerns
- The only way that the facility does not notify the responsible party of significant changes is when the resident is alert and oriented and declines to have family notified
- The nurse on duty is to alert the resident of changes

Comprehensive Care Planning Policy and Procedure



MADONNA MANOR

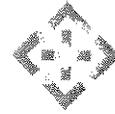
A FRANCISCAN LIVING COMMUNITY

Policy

It is the policy of Madonna Manor to develop an individualized comprehensive care plan for each individual resident. The care plans will be measurable objectives, in order to meet the resident's medical, physical, nursing, mental and psychological needs.

Procedure

- The care planning team, resident, and his/her family develop and maintain the residents comprehensive care plan
- The comprehensive care plan identifies the highest level of functioning that the resident may be expected to attain
- The comprehensive care plan is based on a thorough assessment that includes (but is not limited to) the MDS
- The care plan is used to:
 - incorporate identified problems
 - Incorporate risk factors
 - Build on resident strengths
 - Reflect treatment goals
 - Identify treatments and services needed
 - To aid in preventing (or reducing) declines in resident status
 - To enhance optimal functioning of the resident
 - To reflect currently recognized standards of practice for problem areas and conditions
- The resident care cards are an extension of the care card
- The resident care cards are a guide to resident care
- The care cards are updated weekly as needed with changes
- The comprehensive care plans are updated at least quarterly with the MDS assessment
- Acute care plans are initiated based on the nurses judgment



MADONNA MANOR

A FRANCISCAN LIVING COMMUNITY

Accidents and Incidents Policy and Procedures

F323 Accidents

Policy

It is the policy of Madonna Manor that the residents environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. It is the policy of Madonna Manor that all incidents involving residents shall be investigated as needed and reported to the administrator and Director of Nursing.

Procedure

- The nurse will assess the resident immediately
- The nurse will initiate interventions immediately if needed
- The nurse will notify the physician in a timely manner
- The nurse will notify the family within a timely manner
- The nurse will document:
 - the date and time of the accident or incident
 - the nature of the incident or accident
 - where the incident occurred
 - the names of witnesses and any accounts that they may have of the incident
 - the time that the physician and family were notified
 - nursing assessment obtained
 - any corrective actions taken
- The nursing supervisor or Director of Nursing will be notified within 24 hours of occurrence
- The accident or incident will be reviewed in clinical meeting weekly and by the QA committee