

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

PRINTED: 12/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2014
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
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F 000	INITIAL COMMENTS An abbreviated standard survey (KY22491) was conducted on 11/19/14. The complaint was substantiated with deficient practice identified at "D" level.	F 000	Prestonsburg Health Care Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves its rights to contest the survey findings through Informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (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 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.	F 157		

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

Lynn Watts

TITLE

Administrative

(X5) DATE

12/1/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to immediately inform the resident's physician and responsible party for one of three sampled residents (Resident #2) of a fall that required physician intervention. Resident #2 sustained a fall from bed on 10/21/14 at 11:00 PM and required x-rays. The findings include: A review of the facility's fall policy dated April 2012, revealed if a fall occurred staff was required to notify the resident's attending physician and responsible party. A review of the medical record for Resident #2 revealed the resident was admitted by the facility on 09/23/14 with diagnoses that included Difficulty Walking and Alzheimer's Disease. An interview conducted with Resident #2's responsible party (RP) on 11/19/14 at 2:20 PM, revealed when the RP was visiting Resident #2 on 10/22/14, the resident's roommate notified the RP that Resident #2 had fallen out of bed on 10/21/14. When the RP questioned facility staff, staff was not aware the resident had sustained a fall on 10/21/14. An interview conducted with Registered Nurse (RN) #1 on 11/19/14 at 3:35 PM revealed on 10/22/14, Resident #2's RP asked her about a fall the resident had sustained. According to RN #1, she interviewed the resident's roommate and she suspected the resident had fallen from bed on	F 157	F 157 483.10 (b) (11) NOTIFY OF CHANGES Corrective action for resident(s) affected: On 11-19-14 DON did incident report on resident #2 and notified physician and responsible party. How the facility will act to protect residents in similar situation: On 11-19-14 thru 11-21-14 all charts were reviewed by DON and ADON to make sure all incidents were charted correctly. No concerns were identified. Measure to prevent reoccurrence: All incidents will be charted on the 24 hour report and the DON/designee will review chart(s) to make sure appropriate charting is done including notifying physician and responsible party. All incidents will be discussed in clinical meeting. Inservice all the nursing staff for complete fall policy and incident policy on 11-20-14 by DON/designee. Monitoring of Corrective Action: DON/Designee will audit 20% of charts for documentation of any accident/incident that needs to be investigated to ensure accident/incident was handled as per policy and procedure along with		

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F 157	Continued From page 2 10/21/14. Further interview with RN #1 revealed she contacted the resident's physician on 10/22/14, and orders were received for x-rays. A review of Resident #2's medical record revealed no evidence that the resident's physician or responsible party was notified on 10/21/14 that Resident #2 had sustained a fall. An interview conducted with the Director of Nursing (DON) on 11/19/14 at 6:00 PM, revealed Resident #2 sustained a fall from bed on 10/21/14. The Nurse assigned to the resident that day did not fill out an incident report and had not notified the resident's attending physician or responsible party that the resident had fallen as required by the facility's policy.	F 157	Completed thorough investigation that identifies root cause, weekly for 3 months, then monthly for 3 months. Results of the audit will be discussed in QAPI meeting to determine effectiveness and to determine if further education and/or interventions are needed. Completion date: 11-25-14		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	483.20(d)(3), 483.10(k)(2) Right to participate planning care-revise CP Corrective action for resident(s) affected: Resident #2 's care plan was updated by DON/MDSC to clinically correspond to the resident's care needs on 11-19-14. How the facility will act to protect residents in similar situation: All resident's care plans were reviewed between 11-19-14 thru 11-21-14 by the DON/ADON to compare the 24 hour report and incident report to the care plan to ensure each resident's care plan corresponded to their care needs. No concerns were identified.		

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F 280	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to review/revise the plan of care for one of three sampled residents. Resident #2 sustained a fall on 10/21/14 at 11:00 PM. The resident's plan of care was not revised with interventions to prevent/attempt to prevent other falls until 10/23/14. The findings include: A review of the facility's fall policy dated April 2012, revealed if a resident sustained a fall staff was required to review the plan of care following each fall and update the resident's plan of care with interventions indicated by an assessment of the resident. A review of Resident #2's medical record revealed the resident sustained a fall on 10/21/14 at 11:00 PM, and sustained no injury. An interview conducted with Licensed Practical Nurse (LPN) #1 on 11/19/14 at 5:35 PM, revealed LPN #1 assessed Resident #2 after the fall on 10/21/14 and observed a problem with the resident's positioning being too low at the head of the bed, but was busy training a new employee and forgot to review and revise the resident's plan of care or communicate the problem with positioning to the next shift. A review of Resident #2's plan of care revealed	F 280	Measures to prevent reoccurrence: Any changes on the 24 hour report and all incident reports will be reviewed and discussed in clinical meeting. Care plans will also be reviewed in this meeting to ensure that the care plan has been updated by the MDS nurse and corresponds to the resident's needs. Inservice by the DON/designee was done to all nursing staff on care plan policy on 11-20-14. Monitoring of Corrective action: The DON/ADON will audit 20% of resident's care plans weekly to ensure they are specific to each resident's needs weekly for 3 months, then biweekly for 3 months, then monthly for 3 months. Results of audit will be discussed in QAPI meeting to determine effectiveness and to determine if further education and /or interventions are needed. Completion date: 11-25-14		

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F 280	Continued From page 4 no evidence the resident's plan of care was revised until 10/23/14, when the facility initiated the use of a fall mat on the floor beside the resident's bed and the resident's bed in the lowest position. An interview conducted with the Director of Nursing (DON) on 11/19/14 at 6:00 PM, revealed the fall mat and bed in the lowest position interventions were implemented for Resident#2 on 10/22/14; however, the resident's care plan was not updated to include the interventions until the morning meeting on 10/23/14. Further interview revealed the DON was not aware that LPN #1 had identified any concerns regarding the resident's positioning.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one of three sampled residents (Resident #2) received adequate supervision and assistance devices to prevent accidents. On 10/21/14 at 11:00 PM, Resident #2 was found on the floor by facility staff. There was no evidence that the facility initiated an investigation of the fall or	F 323	F323 483.25(h) Free of accident hazards/supervision/devices Corrective action for resident(s) affected: On 11-19-14 the DON did an incident report on resident #2 that included a thorough investigation that identified the root cause. How the facility will act to protect resident's in similar situation: All items that were put on the 24 hour report and all incident reports for month of November was reviewed by the DON/ADON to make sure that a thorough investigation that included the root cause were identified on 11-19-14 thru 11-21-14. No areas were identified.	

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F 323	<p>Continued From page 5</p> <p>implemented interventions to prevent further falls until Resident #2's family questioned facility staff about the resident's fall the next day, 10/22/14.</p> <p>The findings include:</p> <p>A review of the facility's fall policy dated April 2012, revealed if a fall occurred staff was required to complete an incident/accident occurrence form, determine the root cause of the fall if possible, update the resident's plan of care, and enter the resident's name on the 24-hour report for follow-up assessments and charting.</p> <p>A review of the medical record for Resident #2 revealed the resident was admitted by the facility on 09/23/14 with diagnoses that included Difficulty Walking and Alzheimer's Disease. A review of a nurse's note dated 10/21/14 at 11:00 PM revealed Resident #2 had sustained a fall but denied pain, was moving all extremities, and no changes were noted to the resident's level of consciousness. There was no evidence the root cause of the fall was assessed or that the resident's care plan was revised after the fall.</p> <p>An interview conducted with Resident #2's responsible party (RP) on 11/19/14 at 2:20 PM, revealed Resident #2's roommate told the RP on 10/22/14 that Resident #2 had fallen out of bed. The RP questioned facility staff about the fall, but staff was not aware the resident had sustained a fall on 10/21/14.</p> <p>An interview conducted on 11/19/14 at 4:25 PM, with State Registered Nurse Aide (SRNA) #1 revealed when the SRNA was making rounds on 10/21/14 at approximately 11:00 PM, Resident #2 was lying on the floor. According to SRNA #1,</p>	F 323	<p>Measures to prevent reoccurrence:</p> <p>All items on the 24 hour report and all incident reports will be discussed in clinical meeting by DON/ADON to make sure a thorough investigation with a root cause are identified. Inservice to all nursing staff was done on 11-20-14 by DON/ADON on fall and incident policy.</p> <p>Monitoring of corrective action:</p> <p>DON/Designee will audit 20% of incidents on the 24 hour report for appropriate charting of a thorough investigation with a root cause weekly for 3 months, then monthly for 3 months. Results of the audit will be discussed in QAPI meeting to determine effectiveness and to determine if further education and/or interventions are needed.</p> <p>Completion Date:</p> <p>11-25-14</p>	

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F 323	<p>Continued From page 6</p> <p>she notified the nurse assigned to Resident #2 that the resident had fallen from bed.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 11/19/14 at 5:35 PM, revealed she was notified that Resident #2 was on the floor. She stated she went to the resident's room and assessed the resident and found no injuries to the resident. The LPN stated she documented that the resident had fallen in the nurse's notes in the resident's chart. According to LPN #1, she was training another nurse, had gotten busy, and forgot to complete an incident report, notify the resident's physician and responsible party, and update the resident's plan of care.</p> <p>An interview conducted with the facility Administrator on 11/19/14 at 6:10 PM, revealed when a resident sustained a fall the nurse was supposed to assess the resident for injuries, notify the resident's physician and responsible party, review the plan of care, put an intervention in place to prevent further falls, complete an incident report and fall investigation, and the resident was to be monitored each shift for three days for additional concerns regarding the fall. Further interview revealed the fall and the interventions were reviewed in the morning meeting for appropriate interventions.</p>	F 323			