

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

PRINTED: 04/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2015
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELEY RD. LOUISVILLE, KY 40216	
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F 000	INITIAL COMMENTS A Recertification and Abbreviated Survey was initiated on 03/17/15 and concluded on 03/19/15 to investigate KY22978 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of a "G". The Division of Health Care unsubstantiated the allegation with no deficiencies cited.	F 000	F 000 This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because Summerfield Health and Rehabilitation Center agrees with the citations noted on the pages of this Statement of Deficiencies.	
F 280 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 280	F 280 #1. Resident #4's falls care plan was reviewed and revised on March 26, 2015, by the QA Coordinator, the Blue Unit Manager, and Social Services assistant. After reviewing the care plan and fall history, new interventions were implemented which were based on reassessment of needs and identified risk factors. The effectiveness of these interventions at preventing additional falls will be evaluated through the facility's falls management program. #2. The facility DON, Unit Managers, Assistant Unit Managers, or QA Coordinator identified residents who have been assessed as being at risk for falls. For these residents, the DON, Unit Managers, Assistant Unit Managers or QA Coordinator will review the fall risk screens and fall history in an effort to identify root causes, patterns, or other contributing factors. Care plans of these residents will be reviewed to confirm they include interventions for prevention. This will be completed by April 13, 2015.	04/22/2015

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

TITLE

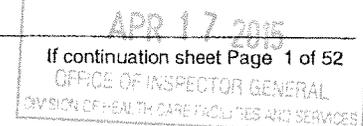
(X6) DATE

KewFoot

X Administrator

X 4-17-15

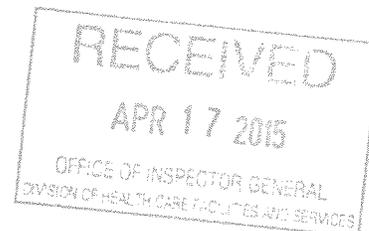
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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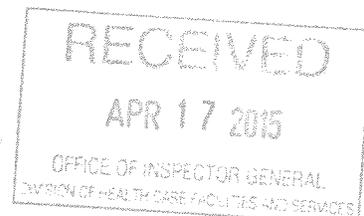
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F 280	<p>Continued From page 1</p> <p>review of the Resident Assessment Instrument (RAI) Manual, Incident Reports, Fall Investigations, and facility policy, it was determined the facility failed to revise the care plan with interventions to prevent further falls for one (1) of twenty-five (25) sampled residents (Resident #4). Resident #4 sustained a fall on 12/31/14 resulting in a bruised lump on the forehead, bruising of the left upper arm and a skin tear on the left forearm that required a transfer to the hospital emergency room for evaluation and treatment. Resident #4 fell again on 02/25/15 when the resident sustained bruising of both eyes and a fractured nose that required an emergency room evaluation. The facility failed to revise the care plan after each fall with interventions to prevent additional falls.</p> <p>The findings include:</p> <p>Interview with the Administrator, on 03/19/15 at 2:20 PM, revealed the facility used the RAI Manual, Version 3.0, dated October/November 2012, as the facility's policy for revision of care plans.</p> <p>Review of the RAI Manual, Version 3.0, dated October/November 2012, page 4-8, revealed the care plan should be revised on an ongoing basis to reflect changes in the resident and the care the resident received.</p> <p>Review of the facility's policy regarding Falls Management, dated 01/01/10, revealed the purpose of the policy was to establish a program to identify residents with risk factors that might place them at risk for falls, and to manage those residents who experience a fall to minimize the risk of a fall from reoccurring or minimize the risk</p>	F 280	<p>F 280 Continued from page 1</p> <p>#3. On March 30, 2015, the corporate RN consultant provided education to the DON, ADON, QA Coordinator, and Administrator. The training topic was care plan revisions and strategies for developing interventions in response to incidents and accidents. This education also included a review of the Falls Management program and how it can be used to document the facility's efforts to investigate the cause of falls and efforts to evaluate the effectiveness of care plan interventions.</p> <p>The Director of Nursing, ADON, or QA Coordinator will complete in-service education for licensed staff by April 21, 2015. The training will address identifying residents at risk for falls and the process for reviewing and revising the care plan with interventions for prevention. The training will stress that the licensed staff have the authority and responsibility to participate in the plan of care development and the implementation of therapeutic interventions. The training will emphasize identifying causal factors to incidents and immediately putting care plan revisions in place to address them. A score of 85% on a post test will indicate training material comprehension. This training will be included as part of the new hire orientation process.</p>		



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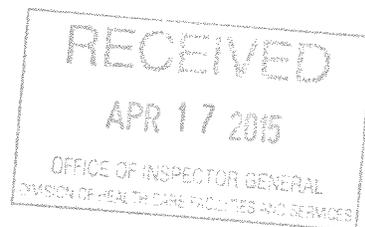
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F 280	Continued From page 2 of injury related to a fall. Review of the current plan of care and if necessary revision of the interventions to reduce the likelihood that the fall would reoccur and/or minimize the risk of injury related to a fall. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 10/12/12 with diagnoses of Alzheimer's Disease with Dementia, Bipolar Disorder, Depression, Anxiety and Behaviors. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #4 and completed by the facility on 01/04/15, revealed the facility assessed the resident with the Brief Interview for Mental Status as a score of eight (8) which meant the resident had a moderate cognitive impairment and interviewable. The facility assessed the resident to require limited assistance of one for transfers, ambulation and dressing, and extensive assistance with hygiene and bathing. The facility determined the resident was frequently incontinent of bowel and bladder and received psychoactive medications. Review of the Comprehensive Care Plan for Resident #4, dated 01/04/15, revealed the resident was at risk for falls related to impaired mobility and the use of a psychoactive medication. Interventions included: self transfers and assist as needed; provide incontinent care as indicated; complete falls assessment per facility protocol; attempt to keep room/hall free from clutter, keep call light and personal items within reach; encourage use of rolling walker for ambulation; encourage resident to participate in range of motion and ambulation; may be up in recliner/lift chair; ensure the resident wears tennis	F 280	F 280 Continued from page 2 #4. Incident/accident reports and care plans of the residents involved are being reviewed during the morning nursing administration meeting. The purpose of the reviews is to ensure care plan revisions have been put in place following the incident. Incidents will be logged as part of the QA process to assist nursing leadership in tracking each resident's incident history and identifying trends related to these incidents. A QA subcommittee will convene monthly for the next 6 months to review the log and determine if compliance or need for additional system modification is needed. The QA Coordinator will present the subcommittee's findings, along with data from the incident log, no less than quarterly to the QA committee so that compliance or need for additional system modification can be determined.	



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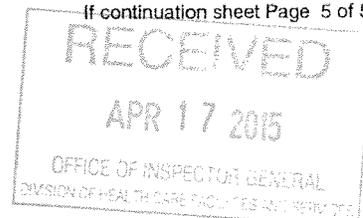
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F 280	<p>Continued From page 3</p> <p>shoes at all times; medications as ordered; medication adjustments as ordered; observe for signs of adverse reactions related to psychoactive medications; attempt a gradual drug reduction unless otherwise indicated; re-educate the resident to use walker at all times for ambulation; physical therapy referral related to a fall on 12/31/14; and, sensor alarm to bed and chair added on 01/29/15. There was no evidence the care plan for Resident #4 was reviewed or revised to ensure one staff member provided assistance to the resident when transferring and ambulating</p> <p>Review of the Incident Report and the Fall Investigation for 12/31/14, revealed the staff turned off the sensor alarm on the bed and left the room as the resident planned to get out of bed. Resident #4 removed his/her tennis shoes, got out of bed, and walked to the hallway without the use of the assistive device of a walker. The resident slipped and fell in the hallway at 4:15 PM. The resident had a bruise and a lump on the forehead, a raised bruise on the left upper arm and a skin tear on the left forearm. The cause of the fall was attributed to the resident transferring out of bed without assistance. The Fall Investigation did not contain evidence that referenced the staff allowed Resident #4 to get out of bed alone when the MDS assessment revealed the resident needed the limited assistance of one to transfer and ambulate. There was no evidence the facility reviewed or revised the care plan after the fall to ensure the resident was assisted by staff to ambulate.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 03/18/15 at 10:41 AM, revealed the resident had a fall after the sensor alarm was</p>	F 280	



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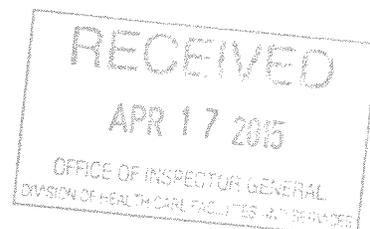
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F 280	<p>Continued From page 4</p> <p>turned off by staff. She indicated the resident planned to get out of bed so the alarm was turned off prior to the staff leaving the room. She stated the resident often ambulated without staff assistance, but did need the walker.</p> <p>Review of the Incident Report and the Fall Investigation for 02/25/15, revealed Resident #4 was assisted out of bed by staff. The resident was ambulated by staff for several feet when the staff left the resident's side and returned to obtain the resident's walker sitting by the bedside. Before the staff could get back to the resident, the resident was at the doorway and fell face first onto the floor. The cause of the fall was attributed to the resident ambulating without assistance. There was no evidence the facility reviewed or revised the care plan after the fall to ensure staff assisted the resident to ambulate.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 03/18/15 at 10:41 AM, revealed she stated she had cared for Resident #4. She stated the facility policy was to check all residents every two (2) hours in order to provide care for incontinence, turning, and fluids. She stated Resident #4 had frequent falls and wandered around the facility without a walker or staff assistance frequently. She stated the resident had the right to be independent even if injured during a fall. She further stated the resident had sensor alarms on the chair and bed and she checked on the resident about every two (2) hours.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/19/15 at 9:15 AM, revealed all incidents/accidents were documented by the nurse then reviewed by the Interdisciplinary Team</p>	F 280			



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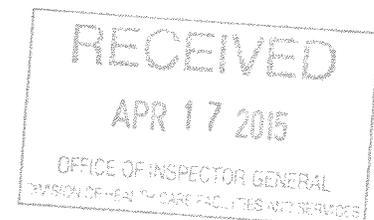
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F 280	<p>Continued From page 5</p> <p>in Morning Meeting. She stated the care plans were revised during the meeting and reviewed by the team to ensure the revision was appropriate for the problem. She stated the revisions were communicated to the staff. She stated she did not remember Resident #4's care plan being revised to ensure the resident was walked with the limited assistance of one person. She stated the resident walked alone and sometimes used a walker. She indicated the resident's care plan had not been revised to prevent further falls since the fall on 02/25/15.</p> <p>Interview with CNA #7, on 03/19/15 at 12:30 PM, revealed Resident #4 received care from her frequently. She stated she checked residents every two (2) hours for cleanliness and turning. She stated Resident #4 liked to be independent and walked all around the unit. She indicated the resident did not use the walker consistently and staff would attempt to redirect the resident if she wandered too far from the unit. She stated the staff would try to redirect the resident and sometimes the resident was not able to be redirected. She stated she was not aware the resident required the assistance of one with ambulation. She stated she had the Nurse Aide Care Plan for instructions; however, she saw the resident often walking alone.</p> <p>Interview with LPN #7, on 03/19/15 at 12:43 PM, revealed nursing staff supervised residents every two (2) hours and there was no policy she knew of to require supervision more frequently. She stated there were times the resident would not use the walker and became agitated when encouraged to do so. She indicated it was better to leave the resident alone and go back later. She stated the nurses were responsible for</p>	F 280			



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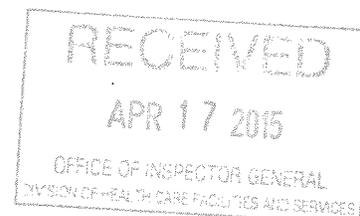
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F 280	<p>Continued From page 6</p> <p>supervising the nurse aides; however, the resident often ambulated without staff assistance and staff were used to seeing it. She stated the resident's balance was poor and the resident could fall while walking without assistance. She stated the care plan should be changed to ensure the resident was assisted by one person while ambulating to prevent further falls and possible injuries.</p> <p>Interview with the Blue Unit Manager, on 03/19/15 at 12:57 PM, revealed she reviewed all incident reports and fall investigations for completeness. She stated there were no special interventions to supervise residents based on history of falls or behaviors that placed the resident at high risk of falls. She indicated that all staff checked residents every two (2) hours and had received training on fall prevention and investigation. She stated care plans were updated daily if there were changes in the resident's care. She stated she was unable to explain how Resident #4's care plan was missed after the falls.</p> <p>Interview with the Director of Nursing, on 03/19/15 at 2:09 PM, revealed the incident reports and fall investigations were reviewed daily by the nursing management and interventions were added to the care plan to prevent further falls. She stated the Morning Meeting was held Monday through Friday and care plans were revised as needed during the meeting. She stated she was not able to recall Resident #4's falls or review of the care plan. She stated the resident had sustained falls and injuries and needed the assistance of staff to ambulate. She stated the care plan should reflect the resident's actual need for assistance.</p>	F 280			



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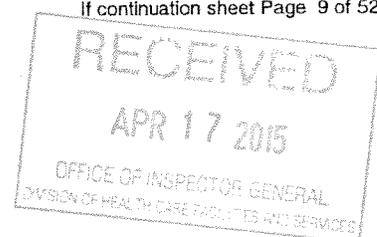
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F 282 F 282 SS=G	Continued From page 7 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure staff followed the care plans for three (3) of twenty-five (25) sampled residents. (Residents #6, #9 and #19). The nursing staff failed to follow the care plan for Resident #6 when Certified Nursing Assistant (CNA) #11 failed to utilize a Maxi lift (mechanical lift) and use two (2) person assist while transferring Resident #6 from the wheelchair to the bed resulting in a fall. Resident #6 sustained a fracture to the Proximal Diaphysis of the right Fibula that resulted in a transfer to hospital emergency room for evaluation. In addition, the nursing staff failed to follow the care plan for Resident #9 for placement of edema gloves, Geri sleeves and utilizing arm troughs resulting in edema and bruising. The nursing staff failed to follow the care plan for Resident #19 when the splint for contractures was not placed in the resident's hand. The findings include: Interview with the Administrator, on 03/19/15 at 2:20 PM, revealed the facility utilized the Minimum Data Set (MDS) Manual, Version 3.0, Section 4, 4-6, Page 4-11, which stated the Interdisciplinary Team identified specific,	F 282 F 282	F 282 #1. On April 9, 2015, the interdisciplinary team completed reviews and revisions of the care plans for residents #6, 9, and 19 to confirm they accurately reflect the residents' care needs. The IDT also reviewed the nurse aide assignment sheets and TARS for these residents to verify they accurately reflected the physician orders and care plan. A member of the IDT verified that lifts, geri sleeves, edema gloves, arm troughs, and carrot splint were available for use as planned. After this deficient practice was identified, the Unit Manager verbally discussed the importance of following the care directions on the aide assignment sheets. The C.N.A. involved with resident #6's incident no longer provides services at this facility. On April 16th and 17th, the facility care plan coordinator will make direct observations of residents #6, 9, and 19 and compare them with the nurse aide assignment sheets to confirm the care being delivered at the time of the observations followed the plans. #2. The Nurse Unit Managers will complete a 100% audit of the care plans and nurse aide assignment sheets to verify the directions for resident transfer are accurate and clearly communicated.	04/22 2015



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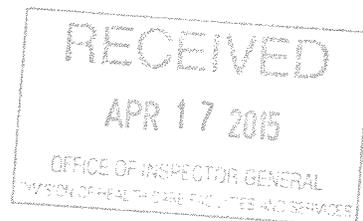
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F 282	<p>Continued From page 8</p> <p>individualized steps or approaches that would be taken to help the resident achieve his or her goals. These approaches serve as instructions for resident care and provide for the continuity of care by all staff. Precise and concise instructions help staff understand and implement interventions.</p> <p>1. Review of Resident #6's clinical record, revealed the facility admitted the resident on 04/11/14, with diagnoses of Disc Degeneration, Spinal Stenosis, Muscle Weakness, Debility, Lack of Coordination, Joint Pain and Osteoarthritis.</p> <p>Review of Resident #6's MDS Significant Change Assessment, dated 12/09/14, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) score of three (3), which meant the resident was not interviewable. The facility determined Resident #6's ambulation status was an eight (8) of eight (8) which indicated the activity was not performed by the resident and did not occur during the entire observation period for that assessment.</p> <p>Review of Resident #6's Nursing Care Plan, dated 07/23/14, revealed the staff was to assist the resident with two (2) persons for all transfers and use a Maxi lift, as indicted.</p> <p>Review of Resident #6's CNA Sheet, dated 10/01/14, revealed the staff was to use a Maxi lift with two (2) persons assist.</p> <p>Review of Resident #6's Nursing Notes, dated 10/02/14 at 10:16 PM, revealed Licensed Practical Nurse (LPN) #12, documented she was alerted by CNA #11 that Resident #6 had reported</p>	F 282	<p>F 282 Continued from page 8</p> <p>A list of resident orders related to adaptive equipment, which includes geri sleeves, edema gloves, arm troughs, and splints, was obtained through the medical records department of the facility pharmacy. This list was used to identify residents with such equipment ordered. The Unit Managers will audit 100% of these resident records to verify the order is captured on the care plans, nurse aide care plans and TARS when applicable. On April 16th and 17th, the DON, ADON, QA Coordinator, Unit Managers, Assistant Unit Managers, MDS nurses, Wound Care Coordinator, or Staff Development nurse will make direct care observations of all residents. These observations will be compared to the nurse aide assignment sheets to confirm the care being delivered follows the plans.</p> <p>#3. The Director of Nursing, ADON, or QA Coordinator will provide in-service education for the Certified Nursing Assistant staff. The training will reinforce the importance of following the resident care plans. It will instruct the CNAs on how and where to obtain the aide assignment sheets and that it is their responsibility to do so every shift. The training will also address the specific care issues of resident transfers, applying splints and using positioning aides and protective devices.</p>	



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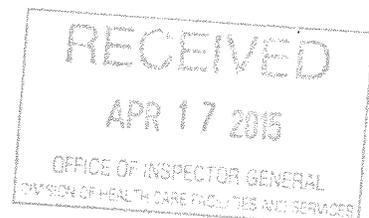
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F 282	<p>Continued From page 9</p> <p>right knee pain after Resident #6 was placed onto the bed. CNA #11 stated a pop sound was heard while transferring the resident by pivot from the wheelchair to the bed. Further review of the Nursing Note revealed LPN #12 documented she then completed an assessment of Resident #6 and the resident reported pain at that time.</p> <p>Interview with CNA #11, (who was an agency staff pulled from another unit) on 03/19/15 at 12:34 PM, revealed she received training from the facility and knew the CNA Care Sheets could be found at the Nurses' Station. However, CNA #11 stated she did not obtain a CNA Care Sheet when she came onto the Green Unit. She stated she remembered Resident #6 requested to go to bed multiple times so she asked CNA #12 to assist her with Resident #6's care. Further interview revealed CNA #12 told her that Resident #6 could be pivoted to the bed. CNA #1 stated she was not aware Resident #6 was not interviewable, (as she did not have a CNA Care Sheet) so she asked Resident #6 if he/she could stand and pivot and the resident answered "yes". CNA #11 stated as she got Resident #6 up from his/her wheelchair, she noticed Resident #6 could not turn his/her leg and when she went to turn the resident onto the bed she heard a pop sound. CNA #11 stated if she had looked at the CNA care sheet, Resident #6 would not have sustained an injury, because she would have used a Maxi lift on the resident with assistance.</p> <p>Interview with LPN #12, on 03/18/15 at 4:17 PM, revealed she remembered working with agency staff the night of the incident. LPN #12 stated when the CNA agency staff come onto the Unit they obtain their CNA Care Sheets and tour the unit with a staff member. LPN #12 stated she</p>	F 282	<p>F 282 Continued from page 9</p> <p>A score of 85% on a post training test will be used to confirm comprehension of the training material. This will be completed by April 21, 2015. This training will be done as part of the new C.N.A. orientation and annually. The Unit Managers, Assistant Unit Managers, or shift supervisors will ensure the aide assignment sheets are available every shift.</p> <p>#4 To verify the nurse aide staff are following the care directions on the aide assignment sheets, the DON, ADON, QA Coordinator, or Staff Development will observe 10 resident transfers and 10 general care occurrences. During these observations, the CNAs will be asked to produce their assignment sheets. The audits will be done weekly for one month, every other week for one month, and then monthly for 12 months. Identified deficient practice will be corrected immediately. The Director of Nursing will submit a quarterly audit report summary to the QA Committee so that compliance or need for additional systemic modification may be determined.</p>		



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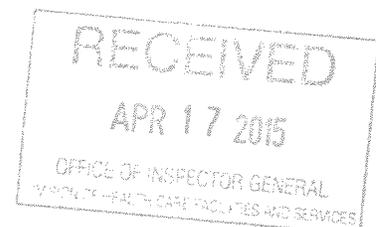
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F 282	<p>Continued From page 10</p> <p>remembered at or around dinner time CNA #11 stated she had transferred Resident #6 without a lift, but she did not give an explanation as to why she did this.</p> <p>LPN #12 stated she assessed Resident #6's limb and there was no visible injury though the resident complained of pain. The LPN stated the care plans were in place so staff would know how to take care of the residents. LPN #12 stated she would expect the CNAs to inform her if they needed help with residents.</p> <p>Review of Resident #6's x-ray to the right knee, dated 10/05/14, revealed there was a minimally displaced fracture of the Proximal (situated nearer to the center of the body) Diaphysis (shaft of the long bone) of the right Fibula (calf bone in the leg located on the outer side of the tibia, the small bone).</p> <p>Observation of Resident #6, on 03/17/15 at 11:50 AM and 1:31 PM, revealed Resident #6 was lying on the bed. Observation of Resident #6, at 2:27 PM and 4:00 PM, revealed Resident #6 was sitting up in his/her wheelchair with his/her legs elevated.</p> <p>Interview with Resident #6, on 03/17/15 at 2:27 PM, revealed he/she remembered sustaining an injury to the right lower leg when a nurse fell on the leg a few months ago.</p> <p>Interview with the Unit Manager, on 03/19/15 at 1:38 PM, revealed she looked at the CNA Care Sheets everyday and updated the CNA care sheets when orders were changed. The Unit Manager stated she tried to monitor the staff to ensure they were following the care plans and her</p>	F 282		



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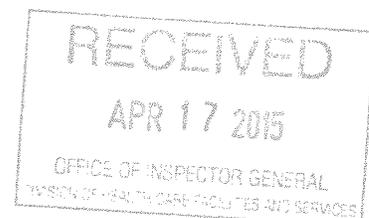
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F 282	<p>Continued From page 11</p> <p>expectation was for the staff to follow the care plans. She stated if CNA #11 had utilized a Maxi lift as care planned, it would have prevented the fracture from occurring to Resident #6.</p> <p>Interview with the MDS Coordinator, on 03/19/15 at 5:02 PM, revealed care plans were in place to ensure each resident was cared for and given care on an individual need. The MDS Coordinator stated she expected the staff to follow the care plans.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 03/19/15 at 2:34 PM, revealed she felt if CNA #11 had used the Maxi lift with two (2) assist, the injury in which Resident #6 had sustained could have been avoided.</p> <p>Interview with the Director of Nursing (DON), on 03/19/15 at 4:23 PM, revealed the Unit Managers were responsible to ensure the CNA Care Sheets were updated. The DON stated the incident occurred because CNA #11 did not follow the CNA care sheet.</p> <p>2. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 10/14/11 with diagnoses of Acute Respiratory Failure, Dysphagia Pharyngeal, Chronic Kidney Disease, Diastolic Heart Failure, Atrial Fibrillation, Joint Disease, Esophageal Reflux, Type 2 Diabetes, Hypothyroidism, Cerebrovascular Accident (CVA), and Muscle Disorders.</p> <p>Review of Resident #9's quarterly MDS assessment, completed on 02/07/15, revealed the facility assessed the resident as requiring extensive assistance from staff to toilet, transfer</p>	F 282		



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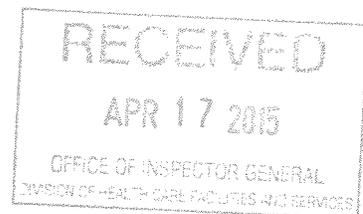
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F 282	<p>Continued From page 12</p> <p>to wheelchair, for locomotion within the facility, and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) exam in which the facility scored the resident as a fifteen (15), indicating the resident was interviewable.</p> <p>Review of Resident #9's care plan, updated 02/07/15, revealed the staff was to elevate both the resident's arms in a trough attached to the wheel chair daily for positioning. The nursing staff was to place a full arm length edema glove on each of the resident's arms and Geri-sleeves on each of the resident's arms as the physician ordered.</p> <p>Review of the CNA Care Plan, not dated, revealed the CNAs were to place Geri-sleeves on both of the resident's arms and that the resident wore them at all times. The CNAs were also to place edema gloves on the resident daily to prevent swelling. The CNA's could remove the edema gloves at night. The CNA Care Plan stated CNAs were to place a trough on each of the resident's wheelchair arms daily for arm positioning.</p> <p>Review of the Physician's Orders for Resident #9, dated 03/02/15, revealed the nursing staff was to place Geri-sleeves on both of the resident's upper extremities at all times. The nursing staff was to apply a full arm length edema glove daily to both of the resident's arms and could remove the edema gloves at night and for personal care. The staff was to apply an elevating arm trough to Resident #9's wheelchair daily for positioning and to prevent edema.</p> <p>Review of the Treatment Administration Record (TAR) for Resident #9, dated March 2015,</p>	F 282		



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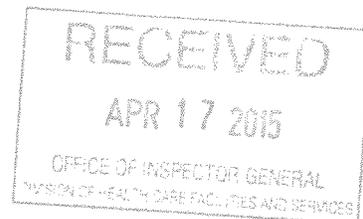
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F 282	<p>Continued From page 13</p> <p>revealed the nurse documented the resident refused to wear Geri-sleeves, edema gloves, and refused to use the arm troughs on one (1) of the last nineteen (19) days.</p> <p>Review of the Nurses Skin Audit for Resident #9, dated March 2015, revealed the resident suffered edema to his/her bilateral upper extremities at the time of the last skin check completed on 03/19/15. The skin check also revealed the resident had purple bruising to both arms.</p> <p>Observation of Resident #9, on 03/17/15 at 1:15 PM, revealed the resident did not have Geri-sleeves or edema gloves on. The resident did not have both arms placed on troughs to rest his/her arms. At 2:00 PM, the resident did not have edema gloves or Geri-sleeves on either arm, and did not have both arms placed on the troughs on the wheelchair at that time. At 4:00 PM, the resident was sitting in his/her room in a wheelchair. The resident was not wearing edema gloves or Geri-sleeves. There was no arm troughs on the wheel chair.</p> <p>Observation of Resident #9, on 03/18/15 at 8:00 AM, revealed the resident was lying in his/her bed watching television. The resident was wearing a short sleeve shirt with no edema gloves or Geri-sleeves. At 12:00 PM, the resident was up in his/her wheelchair. The resident was wearing a short sleeve shirt and did not have Geri-sleeves or edema gloves on the resident's arms. There were no arm troughs on the resident's wheelchair.</p> <p>Interview with Resident #9, on 03/19/15 at 9:50 AM, revealed the resident was wearing the Geri-sleeves and resting his/her arms in the arm</p>	F 282		



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F 282	Continued From page 14 troughs attached to his/her wheelchair. Resident #9 stated he/she felt comfortable with the arm troughs. The resident stated he/she used to wear the Geri-sleeves all of the time when sitting in the wheelchair, but did not wear them often anymore. Resident #9 stated he/she wore the devices when staff offered them, but if the staff did not offer, he/she did not remind them. Interview with CNA #8, on 03/19/15 at 10:10 AM, revealed the CNAs read the CNA Card, also known as the CNA Care Plan, to find out what care to give each resident. The CNA stated she looked at the CNA Card daily at the start of her shift. The CNA also stated the nurses told the CNAs about any changes with any resident. CNA #8 stated, according to the CNA Care Plan, Resident #9 wore Geri-sleeves and had his/her arms resting on arm troughs attached to the resident's wheelchair. CNA #8 stated Resident #9 sometimes refused to wear the devices. When this happened, the CNA informed the nurse of the resident's choices. Interview with the Occupational Therapist (OT), on 03/19/15 at 11:00 AM, revealed OT started working with Resident #9 on 07/08/14. OT ordered the edema gloves for the resident at that time to decrease swelling in the resident's arms. OT stated the resident's arms were more prone to injury due to the edema and the edema gloves may not have provided enough protection against possible skin tears. Nursing staff used the Geri-sleeves with the edema gloves to protect the resident's arms from injury and edema. OT further stated the Therapy Department fitted and placed arm troughs on each of the wheelchair arms for Resident #9. OT stated if the resident did not use the edema gloves, Geri-sleeves, and	F 282		



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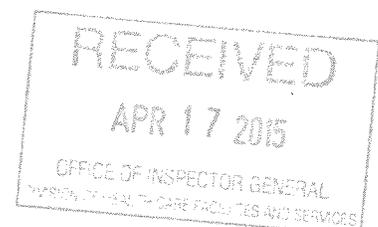
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F 282	<p>Continued From page 15</p> <p>arm troughs, the resident would be at risk for increased skin tears and bruising due to the edema.</p> <p>Interview with the Assistant Unit Manager of the Green Unit, on 03/19/15 at 12:40 PM, revealed the CNAs used the CNA Care Plans to find out what equipment, devices, and care to give to each resident. CNAs obtained a copy of the CNA care plan each shift from a folder at the Nurse's station after the CNAs received their assignments for the shift. CNAs also asked the nurses on the hall for information on how to give care to the residents. If a CNA had any questions about care, they asked the Assistant Unit Coordinator or the Unit Manager. The Assistant Unit Coordinator revealed the CNAs were to place the edema gloves and Geri-sleeves on Resident #9. CNAs were also to attach the arm troughs to the wheelchair arms for Resident #9. The Assistant Unit Coordinator stated the resident sometimes refused to wear this equipment; however, there were no nursing notes stating the resident refused this equipment on 03/17/15 or 03/18/15. The Assistant Unit Coordinator reviewed the TAR as well and stated nursing had no documentation that indicated the resident refused the devices.</p> <p>Interview with the Unit Manager of the Green Unit, on 03/19/15 at 1:35 PM, revealed she oversaw the nursing staff on the Green Unit. She stated she monitored the nursing staff by making rounds on the hallway. The Unit Manager admitted that she did not check all of the devices on each resident to ensure the residents each had all of their care equipment in place. The Unit Coordinator stated per the Care Plan, the nursing staff placed edema gloves on the arms of Resident #9 to reduce edema. The CNAs were to</p>	F 282		
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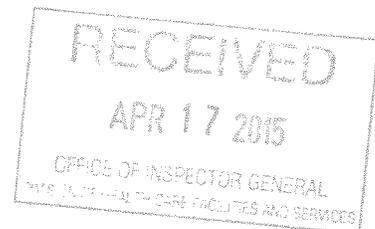
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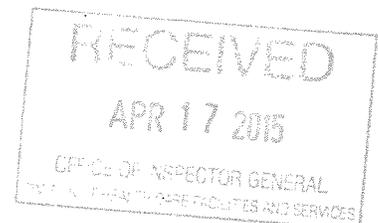
F 282	<p>Continued From page 16</p> <p>place Geri-sleeves on the resident to prevent skin tears, and CNAs placed arm troughs on Resident #9's wheelchair. The Unit Manager stated the resident had a history of refusing the equipment. If the resident refused the equipment, then the CNA would inform the nurse and the nurse would write a nursing note. The Unit Coordinator stated she provided education to the nursing staff about documenting, but did not check every nursing note or documentation to ensure the nurses documented refusals of care. The Unit Manager stated Resident #9 was at increased risk of pitting edema and skin tears without his/her devices in place.</p> <p>3. Observation of Resident #19, on 03/18/15 at 3:30 PM, revealed the resident was laying on the bed with his/her eyes closed and covered. The resident did not have the carrot splint in the left hand.</p> <p>Observation of Resident #19, on 03/19/15 at 9:00 AM, revealed the resident was sitting up in a Geri-chair and had a carrot splint in his/her left hand.</p> <p>Review of the clinical record for Resident #19 revealed the facility admitted the resident on 02/24/14 with diagnoses of End Stage Alzheimer's Disease, Hypertension, History of Falls, Gait Disturbance, Respiratory Failure, and Arthritis. The resident used a Geri-chair when up out of the bed.</p> <p>Review of Resident #19's quarterly MDS assessment, completed on 12/31/14, revealed the facility assessed the resident as needing extensive assistance from staff to toilet, walk, and bathe. The facility conducted a Brief Interview for</p>	F 282		
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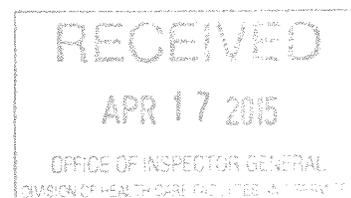
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F 282	<p>Continued From page 17</p> <p>Mental Status (BIMS) exam during the assessment and scored the resident with a ninety-nine (99) indicating the resident was unable to complete the BIMS exam and was not interviewable.</p> <p>Review of an untitled document located in the clinical record, dated 06/11/14, revealed staff reported contractures were causing Resident #19's hand to close more and more each day and that the palm protector was no longer working. The form stated OT addressed this issue and applied a carrot splint to the resident's hand.</p> <p>Review of the Physicians Orders for Resident #19, dated 03/04/15, revealed the nursing staff was to place a carrot splint in Resident #19's left hand. The staff would place the splint in the resident's left hand every morning and would only remove the splint during range of motion (ROM) and cleansing of hand twice per day.</p> <p>Review of Resident #19's Care Plan for left hand contractures, dated 12/31/14, revealed nursing staff was to place the hand splint on Resident #19 as ordered on 03/04/15. The care plan further stated staff was to use a green carrot splint on the resident's left palm for skin hygiene.</p> <p>Review of the Restorative Referral form, dated 03/18/14, for Resident #19 revealed the resident was at risk for progressive range of motion (ROM) loss, increased contractures, and skin breakdown in the resident's left hand. The Referral form stated the restorative goal was to prevent skin breakdown in the resident's left hand.</p> <p>Review of the CNA care plan, not dated, revealed</p>	F 282		



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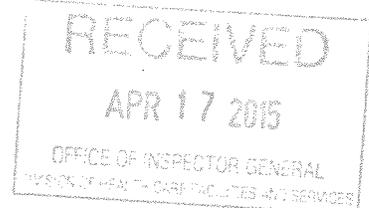
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F 282	<p>Continued From page 18</p> <p>the CNA was to place the splint on the resident's left hand every morning.</p> <p>Interview with the OT, on 03/19/15 at 10:00 AM, revealed Resident #19 was referred to therapy because he/she had contractures in his/her hands. OT started the resident with palm protectors. Restorative therapy and the palm protectors became too painful for the resident because the resident's hand was clamped too tightly with contractures. At that time, OT assessed and initiated the carrot splint. The OT stated the resident would develop skin breakdown without the carrot splint. OT also stated staff would have a difficult time treating any skin breakdown on the inside of the closed hand. OT stated Resident #19 was supposed to wear the carrot splint at all times. He stated that if the resident did not wear the splint for three (3) to four (4) hours, the resident was at risk for not being able to open the hand enough to put the splint back in.</p> <p>Interview with CNA #8, on 03/19/15 at 2:35 PM, revealed the care plan stated the CNA should place the splint on Resident #19 in the morning. CNA #8 admitted the care plan did not state when the resident should wear the splint. CNA #8 stated she interpreted the care plan to indicate the CNA should remove the carrot splint in the evening and at night.</p> <p>Interview with CNA #9, on 03/19/15 at 2:45 PM, revealed the CNA kept the carrot splint on Resident #19 during second shift, and then removed the splint at night. The CNA stated the carrot splint was also removed for hand hygiene during second shift and the CNA would leave the splint off of the resident for one (1) to one and a</p>	F 282			



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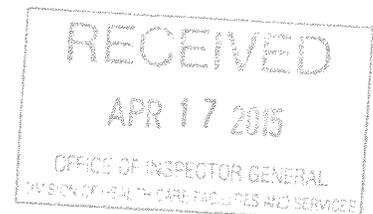
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F 282	<p>Continued From page 19</p> <p>half (1 ½) hours before putting the splint back on the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 03/19/15 at 3:00 PM, revealed she looked at each resident at least every two (2) hours and visually ensured residents had the required equipment and that they had their needs met. LPN #8 stated the CNA's on her hall reported to her and that the CNA's would let the LPN know if any of the residents refused to use any adaptive equipment. LPN #8 stated she was in Resident #19's room, but did not notice if the resident had the carrot splint on at that time. The LPN stated the CNA might have taken the splint off when they put the resident to bed, or the resident may have dropped the splint.</p> <p>Interview with the Assistant Unit Manager of the Green Unit, on 03/19/15 at 12:40 PM, revealed the CNA care plan was reviewed by her and determined it was confusing and not clear on how the CNAs provided care to Resident #19 as it pertained to the carrot splint. The Assistant Unit Coordinator further stated the facility was not clear about how to apply the carrot splint for Resident #19 in the Nursing Care Plan. The Nursing Care Plan stated to apply the splint per the physician's order. However, the physician's order and TAR were clear as to application of the splint.</p> <p>Interview with the Unit Manager of the Green unit, on 03/19/15 at 1:35 PM, revealed the CNA Care Plan for Resident #19 was confusing. She stated the resident had a carrot brace for his/her hand due to contractures and used the brace to circulate air and keep the hand open. The Unit Manager stated without the brace, the resident's</p>	F 282		



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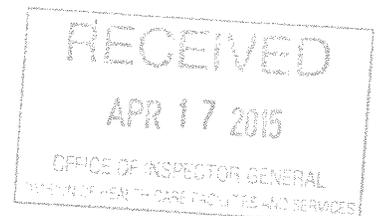
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F 282	<p>Continued From page 20</p> <p>hand could get tighter and would be more difficult to clean.</p> <p>Interview with the Director of Nursing (DON), on 03/19/15 at 4:15 PM, revealed the DON oversees the Unit Managers. The DON stated the Unit Managers ensured the CNA assignment sheets were clear, understandable, and updated. The DON stated she looked at the CNA care plans and had last looked at them about two (2) weeks ago. The DON stated it was important for CNAs to follow the resident care plans and physician orders because it was that particular resident's plan of care. The DON stated she monitored CNAs and nurses by making rounds on the units and monitored the residents on a daily basis. The DON stated she looked at care devices and at the residents to see what they looked like. The DON stated the Unit Managers and Nurses made rounds on the units as well to ensure residents had all of their care devices in place.</p> <p>Post survey interview via telephone with the Green Unit Assistant Manager, on 04/01/15 at 8:45 AM, revealed the facility did not have a formal system in place to ensure staff providing care followed the care plan. However, she stated she made rounds through out the day talking to residents and staff. She further stated care plan changes were communicated to the nurses and CNA verbally and anyone could make a change to the care plan. She stated she was not sure of a specific policy regarding following care plans and would have to ask about the policy; however, she knew they had specific protocols to follow such as for falls.</p> <p>Post survey interview via telephone with the</p>	F 282		



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F 282	Continued From page 21 Green Unit Manager, on 04/01/15 at 9:10 AM, revealed she spent most of her time at the nurses station. She further stated she made rounds two (2) to three (3) times a shift, talking with families, looking at the environment to ensure residents had needed equipment. The Unit Manager stated she did not know if there was a specific policy regarding following the care plan as the care plan was based on the assessed needs of the resident and it was a nursing standard of care. The Unit Manager further stated she communicated with staff through unit meetings to discuss resident specific changes and reinforced the care plan interventions with the nurses. She further stated the CNAs received report specific to each resident when they began their shift and would get a copy of the CNA sheet to assist with the care. Post survey interview via telephone with the ADON, on 04/01/15 at 10:10 AM, revealed the facility's system to ensure staff followed the care plans involved updating CNA care sheets specific to the resident, provide the CNA with a report before starting work, and utilizing a 24 hour report sheet that would be reviewed in the morning meeting each day. The ADON further stated her role in supervision of care was a paper compliance issue; however, she did check that devices were used correctly. She further stated the CNA was required to have the resident care sheet on them at all times as part of their uniform, the staff was told this during orientation, and she would go out and ask staff if they had it on them. She stated this was not in policy, it was her requirement.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F 309 See page 23	



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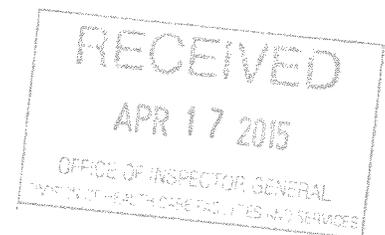
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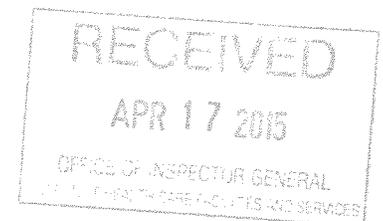
F 309	Continued From page 22 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to follow the physician orders for two (2) of twenty-five (25) sampled residents, Resident #9 and Resident #19. The staff failed to apply edema gloves and Geri-sleeves to Resident #9's arms and bilateral troughs to Resident #9's wheelchair for edema management. The staff failed to apply a carrot splint to Resident #19's left hand for contracture management. The findings include: The facility did not provide a policy for following physician's order. 1. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 10/14/11 with diagnoses of Acute Respiratory Failure, Dysphagia Pharyngeal, Chronic Kidney Disease, Diastolic Heart Failure, Atrial Fibrillation, Joint Disease, Esophageal Reflux, Type 2 Diabetes, Hypothyroidism, Cerebrovascular Accident (CVA), and Muscle Disorders. Review of Resident #9's quarterly Minimum Data	F 309	F 309 Continued from page 22 #1. On April 9, 2015, the IDT completed reviews of the care plans and physicians orders for residents #9 and 19. The order for #19's hand splint was clarified by the MDS Coordinator on April 3, 2015. The IDT also reviewed and revised as needed, the nurse aide assignment sheets for these residents to verify they clearly and accurately identify the residents' care needs. The IDT verified that lifts, geri sleeves, edema gloves, arm troughs, and carrot splint were available for use as planned. #2. All physician orders have been reviewed by the nurses responsible for the monthly rollover of orders, MARs and TARS,. A list of resident orders related to adaptive equipment, which includes geri sleeves, edema gloves, arm troughs, and splints, was obtained through the medical records department of the facility pharmacy. This list was used to identify residents with such equipment ordered. The Unit Managers will conduct a 100% audit to verify the order is captured on the care plans, nurse aide care plans, and TARS. As part of the audit, the Unit Managers will confirm that the ordered protective devices, positioning aides, and splints are available for use. This will be completed by April 17, 2015.	04/22/2015
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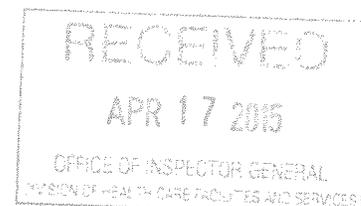
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F 309	<p>Continued From page 23</p> <p>Set (MDS) assessment, completed on 02/07/15, revealed the facility assessed the resident as needing extensive assistance from staff to toilet, transfer to wheelchair, for locomotion within the facility, and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) and scored the resident at a fifteen (15), indicating the resident was cognitively intact and interviewable.</p> <p>Review of the Physician's Orders for Resident #9, dated 03/02/15, revealed an order for Geri-sleeves on both upper extremities at all times and full arm length edema gloves daily to both of the resident's arms. The edema gloves could be removed at night and for personal care. The staff was to apply an elevating arm trough to Resident #9's wheelchair daily for positioning and to prevent edema.</p> <p>Observation of Resident #9, on 03/17/15 at 1:15 PM, revealed the resident did not have the Geri-sleeves or edema gloves on either arm. The arm troughs were not on the resident's wheelchair arm rests. At 2:00 PM, the edema gloves or Geri-sleeves were not on the resident, nor were the arm troughs on the resident's wheelchair. At 4:00 PM, the resident was sitting in his/her room in a wheelchair. The edema gloves and Geri-sleeves were not on the resident. The arm troughs were not on the wheel chair.</p> <p>Observation of Resident #9, on 03/18/15 at 8:00 AM, revealed the resident was lying on his/her bed watching television. The resident was wearing a short sleeve shirt with no edema gloves or Geri-sleeves on his/her arms. At 12:00 PM, the resident was up in his/her wheelchair. The resident was wearing a short sleeve shirt and the Geri-sleeves or edema gloves were not on</p>	F 309	<p>F 309 Continued from page 23</p> <p>#3. The Director of Nursing, ADON, or QA Coordinator will complete n-service education for licensed staff by April 21, 2015. The training will cover the facility processes in place to ensure physician orders are followed and the licensed staff's role in this process. The training will also include review of the job description for licensed staff to clarify their role in the supervision of unlicensed staff.</p> <p>The Director of Nursing, ADON or QA Coordinator will provide in-service education to the Certified Nursing Assistant staff. The training will reinforce the importance of following the resident care plans. It will instruct the CNAs on how and where to obtain the aide assignment sheets and that it is their responsibility to do so every shift. The training will also address the specific care issues of resident transfers, applying splints and using positioning aides and protective devices. A score of 85% on a post training test will be used to confirm the comprehension of the training material. This will be completed by April 21, 2015. This training will be done as part of the new C.N.A. orientation and annually. The Unit Managers, Assistant Unit Managers, or shift supervisors will ensure the aide assignment sheets are available every shift.</p>	



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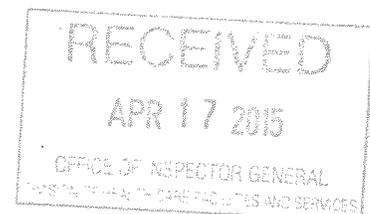
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F 309	Continued From page 24 the resident's arms. The arm troughs were not on the resident's wheelchair. Review of the Nurses Skin Audit for Resident #9, dated March 2015, revealed the resident suffered edema to his/her bilateral upper extremities at the time of the last skin check completed on 03/19/15. The skin check also revealed the resident had purple bruising to both arms. Review of the TAR for Resident #9, dated March 2015, revealed the nurse documented the resident refused to wear Geri-sleeves, edema gloves, and refused to use the arm troughs on one (1) of the last nineteen (19) days that did not include the dates 03/17/15 or 03/18/15. Interview with Resident #9, on 03/19/15 at 9:50 AM, revealed he/she used to wear the Geri-sleeves all of the time when sitting in the wheelchair, but did not wear them often anymore. Resident #9 stated he/she wore the devices when staff offered them, but if the staff did not offer, he/she did not remind them. Interview with Certified Nursing Assistant (CNA) #8, on 03/19/15 at 10:10 AM, revealed according to the CNA Care Plan, Resident #9 wore Geri-sleeves and had his/her arms resting on arm troughs attached to the resident's wheelchair. CNA #8 stated Resident #9 sometimes refused to wear the devices. When this happened, the CNA informed the nurse of the resident's choices. Interview with the Occupational Therapist (OT), on 03/19/15 at 11:00 AM, revealed Occupational Therapy started working with Resident #9 on 07/08/14. OT ordered the edema gloves for the resident at that time to decrease swelling in the	F 309	F 309 Continued from page 24 #4. To verify the nurse aide staff are following the care directions on the aide assignment sheets, the Unit Manager or Assistant Unit Manager will observe 10 residents per week who have an order for protective devices, positioning aides, and splints. The audits will be done weekly for one month, then bi-monthly for one month then monthly for 12 months. The audits will be submitted to the Director of Nursing to confirm audit completion. The Director of Nursing will submit a quarterly audit report summary to the QA Committee so that compliance or need for additional systemic modification may be determined.	



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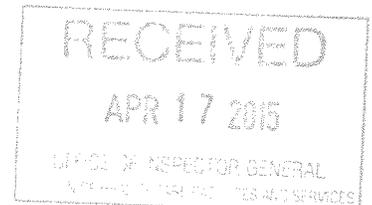
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F 309	<p>Continued From page 25</p> <p>resident's arms caused by the edema. OT stated the resident's arms were more prone to injury due to the edema and the edema gloves may not have provided enough protection against possible skin tears. Nursing staff used the Geri-sleeves with the edema gloves to protect the resident's arms from injury and edema. OT further stated the Therapy Department fitted and placed an arm trough on each of the wheelchair arms for Resident #9. OT stated if the resident did not use the edema gloves, Geri-sleeves, and arm troughs, the resident would be at risk for increased skin tears and bruising due to the edema.</p> <p>Interview with the Assistant Unit Coordinator of the Green Unit, on 03/19/15 at 12:40 PM, revealed the CNAs were to place the edema gloves and Geri-sleeves on Resident #9. CNAs were also to attach the arm troughs to the wheelchair arms of Resident #9. The Assistant Unit Coordinator revealed the resident sometimes refused to wear this equipment; however, there were no nursing notes stating the resident refused this equipment on 03/17/15 or 03/18/15. The Assistant Unit Coordinator reviewed the TAR as well and stated nursing had not documented the resident refused the devices.</p> <p>Interview with the Unit Manager of the Green Unit, on 03/19/15 at 1:35 PM, revealed she monitored the nursing staff by making rounds on the hallway. The Unit Manager admitted that she did not check all of the devices on each resident to ensure the residents each had all of their care equipment in place. The Unit Coordinator stated per the Care Plan, the nursing staff placed edema gloves on the arms of Resident #9 to reduce edema in his/her arms. The CNAs also placed</p>	F 309			



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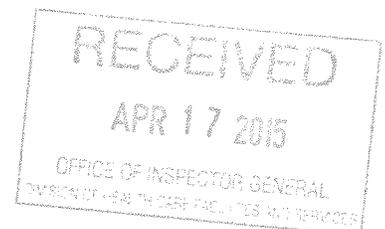
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F 309	<p>Continued From page 26</p> <p>Geri-sleeves on the resident to prevent skin tears. CNAs placed arm troughs on Resident #9's wheelchair arms. The Unit Manager stated that the resident had a history of refusing the equipment. If the resident refused the equipment, then the CNA would inform the nurse and the nurse would write a nursing note. The Unit Manager stated Resident #9 was at increased risk of pitting edema and skin tears without his/her devices in place.</p> <p>Interview with the Director of Nursing (DON), on 03/19/15 at 4:15 PM, revealed the DON oversees the Unit Managers. She stated she monitored the CNAs and nurses by making rounds on the units and monitoring residents on a daily basis. The DON stated she looked at care devices and at the residents to see what they looked like. The DON stated the Unit Managers and Nurses make rounds on the units as well to ensure residents have all of their care devices in place.</p> <p>2. Observation of Resident #19, on 03/18/15 at 3:30 PM, revealed the nursing staff had placed the resident in his/her bed. The resident was laying with his/her eyes closed and covers over him/her. The resident did not have the carrot splint on his/her left hand.</p> <p>Observation of Resident #19, on 03/19/15 at 9:00 AM, revealed the resident was sitting up in a Geri-chair. The resident had a carrot splint in his/her left hand.</p> <p>Review of the clinical record for Resident #19 revealed the facility admitted the resident on 02/24/14 with diagnoses of End Stage Alzheimer's Disease, Hypertension, History of Falls, Gait Disturbance, Respiratory Failure, and</p>	F 309		



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F 309	Continued From page 27 Arthritis. The resident used a Geri-chair when up out of the bed. Review of the Physician Orders for Resident #19, dated 03/04/15, revealed an order for a carrot splint to be placed in the left hand every morning and the staff could remove the splint during range of motion and cleansing of the hand twice per day. Interview with the Occupational Therapist (OT), on 03/19/15 at 10:00 AM, revealed Resident #19 was referred to therapy because he/she had contractures in his/her hands. OT started the resident with palm protectors. Restorative therapy and the palm protectors became too painful for the resident because the resident's hand was clamped too tightly with contractures. At that time, OT assessed and initiated the carrot splint. The OT stated the resident would develop skin breakdown without the carrot splint. OT also stated staff would have a difficult time treating any skin breakdown on the inside of the closed hand. OT stated that Resident #19 was supposed to wear the carrot splint at all times. He stated that if the resident did not wear the splint for three (3) to four (4) hours, the resident was at risk of not being able to open the hand enough to put the splint back in. Review of Resident #19's quarterly Minimum Data Set (MDS) assessment, completed on 12/31/14, revealed the facility assessed the resident as needing extensive assistance from staff to toilet, walk, and bathing. The facility conducted a Brief Interview for Mental Status (BIMS) exam during the assessment and scored the resident as a ninety-nine (99) indicating the resident was unable to complete the BIMS exam	F 309		



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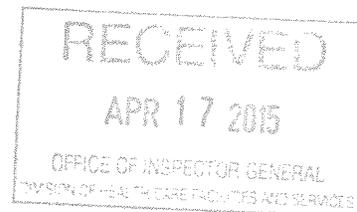
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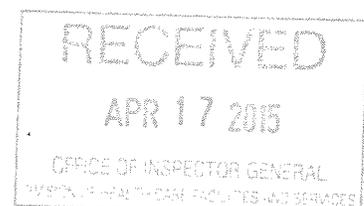
F 309	<p>Continued From page 28 and not interviewable.</p> <p>Review of Resident #19's Care Plan for left hand contractures, dated 12/31/14, revealed nursing staff was to place the hand splint on Resident #19 as ordered. The care plan further stated staff was to use a green carrot splint on the resident's left palm for skin hygiene.</p> <p>Review of the Restorative Referral form, dated 03/18/14, for Resident #19 revealed the resident was at risk for progressive range of motion (ROM) loss, increased contractures, and skin breakdown in the resident's left hand. The Referral form stated the restorative goal was to prevent skin breakdown in the resident's left hand.</p> <p>Review of an untitled document, dated 06/11/14, revealed staff reported contractures causing Resident #19's hand to close more and more each day and that the palm protector was no longer working. The form stated OT addressed the issue and applied a carrot splint to the resident's hand.</p> <p>Review of the CNA care plan, not dated, revealed the CNA was to place the splint in the resident's left hand every morning.</p> <p>Interview with Certified Nursing Assistant (CNA) #8, on 03/19/15 at 10:10 AM, revealed she looked at the CNA Card daily when she came on shift. The CNA also stated the nurses tell the CNA's about any changes with any resident.</p> <p>Interview with CNA #8, on 03/19/15 at 2:35 PM, revealed the care plan stated the CNA should place the splint on Resident #19 in the morning.</p>	F 309		
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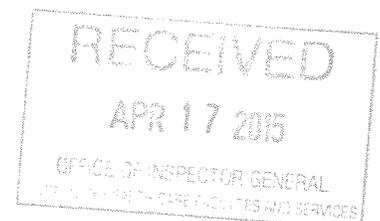
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F 309	<p>Continued From page 29</p> <p>CNA #8 admitted the care plan did not state when the resident could not wear the splint. CNA #8 stated she interpreted the care plan to indicate the CNA should remove the carrot splint in the evening and at night.</p> <p>Interview with CNA #9, on 03/19/15 at 2:45 PM, revealed the CNA kept the carrot splint on Resident #19 during second shift, and then removed the splint at night. The CNA stated the carrot splint was also removed for hand hygiene during second shift and the CNA would leave the splint off of the resident for one (1) to one and a half (1 ½) hours before putting the splint back on the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 03/19/15 at 3:00 PM, revealed the LPN looks at each resident at least every two (2) hours and visually ensures residents have the required equipment and that they have their needs met. LPN #8 stated the CNA's on her hall report to her and that the CNA's would let the LPN know if any of the residents refused to use any adaptive equipment. LPN #8 stated she was in Resident #19's room, but did not notice if the resident had his/her carrot hand splint on at that time. The LPN stated the CNA might have taken the splint off when they put the resident to bed, or the resident may have dropped the splint.</p> <p>Interview with the Assistant Unit Coordinator of the Green Unit, on 03/19/15 at 12:40 PM, revealed the care plan was confusing and not clear on how the CNAs provided care to Resident #19 as it pertained his/her carrot splint. The Assistant Unit Coordinator further stated the facility was not clear about how to apply the carrot splint for Resident #19 in the Nursing Care Plan.</p>	F 309		



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F 309	<p>Continued From page 30</p> <p>The Nursing Care Plan stated to apply the splint per the physician's order. The Assistant Unit Coordinator reviewed the physician's order and TAR and stated the facility was clear about the application of the carrot splint in the physician's orders and TAR.</p> <p>Interview with the Unit Manager of the Green Unit, on 03/19/15 at 1:35 PM, revealed she monitored the nursing staff by making rounds on the hallway. The Unit Manager stated she did not check all of the devices on each resident to ensure the residents each had all of their care equipment in place. The Unit Manager stated the CNA Care Plan for resident #19 was confusing. She stated the resident had a carrot brace for his/her hand due to contractures and use the brace to circulate air and keep the hand open. The Unit Manager stated without the brace, the resident's hand could get tighter and would be more difficult to clean.</p> <p>Interview with the Director of Nursing (DON), on 03/19/15 at 4:15 PM, revealed the DON oversees the Unit Managers. The DON stated the Unit Managers ensured the CNA assignment sheets were clear, understandable, and updated. The DON stated she looked at the CNA care plans and had last looked at them about two (2) weeks ago. The DON stated it is important for CNAs to follow the physician orders. The DON stated she monitored CNAs and nurses by making rounds on the units and monitoring residents on a daily basis. The DON stated she looked at care devices and at the residents to see what they look like. The DON stated the Unit Managers and Nurses make rounds on the units as well to ensure residents have all of their care devices in place.</p>	F 309		



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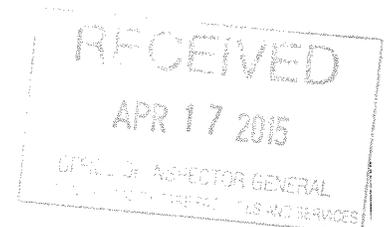
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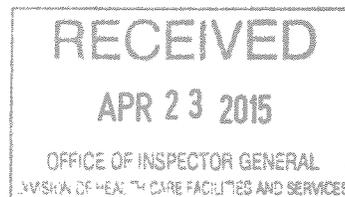
F 309	Continued From page 31 Post survey interview via telephone with the Green Unit Assistant Manager, on 04/01/15 at 8:45 AM, revealed the facility did not have a formal system in place to ensure staff providing care followed physician orders. However, she stated physician orders would be added to the care plan, medication and treatment records and these would be communicated to the nurses verbally and to the CNAs if it was specific to them. She stated she was not sure of a specific policy regarding following physician orders and would have to ask about the policy; however, she knew they had specific protocols to follow such as for falls. The Assistant Unit Manager further stated, she recieved training to her supervisory role on hire during orientation and again when she became the Assistant Unit Manger. Post survey interview via telephone with the Green Unit Manager, on 04/01/15 at 9:10 AM, revealed she spent most of her time at the nurses station and would assist with taking orders. She stated she would verbally tell the nurse of any physician orders if it was a major change. If not she would just put the physician order on the medication or treatment record and place on the CNA sheet. She further stated she made rounds two (2) to three (3) times a shift. The Unit Manager stated she did not know if there was a specific policy regarding following physician orders, it was a nursing standard of practice to note the order, place the order on the medication or treatment record, making sure they had the right resident, right drug, right dose at the right time. The Unit Manager stated she had previous experience as a supervisor and was assisting the position prior to taking it over; however, had not	F 309		
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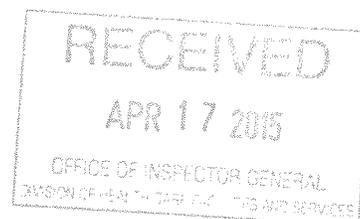
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F 309	Continued From page 32 received any training from the facility. Post survey interview via telephone with the Assistant Director of Nurses (ADON), on 04/01/15 at 10:10 AM, revealed the facility's system to ensure staff followed physician orders involved updating CNA care sheets specific to the resident, provide the CNA with a report before starting work, utilizing a 24 hours report sheet that would be reviewed in the morning meeting each day. In addition, all telephone orders were reviewed during the morning meeting and assured they were placed on the medication record, treatment record and CNA care sheet if specific to the care of the resident. The ADON further stated she would make spot checks of CNA care sheets to make sure they were up to date because this was the tool the CNA used to take care of the residents. She stated as part of her role in supervision of care, entailed a check that devices were used correctly. She further would re-educate staff according to the findings of her audits. The ADON stated her hands on assurance of following physician orders was through the Safety and Infection Control audits. She stated she would have nursing meetings if specific issues were identified.	F 309			
F 323 SS=G	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.	F 323	F 323 #1. Resident #4's falls care plan was revised on March 26, 2015, by the QA Coordinator, Blue Unit Manager, and Social Services assistant. After reviewing the care plan and fall history, new interventions were implemented which were based on reassessment of needs and identified risk factors. The effectiveness of these interventions will be evaluated through the facility's falls management program.	2/2/15 04/21/2015	



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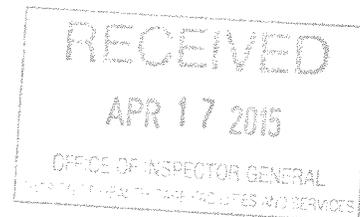
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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 #1. Resident #4's falls care plan was revised on March 26, 2015, by the QA Coordinator, Blue Unit Manager, and Social Services assistant. After reviewing the care plan and fall history, new interventions were implemented which were based on reassessment of needs and identified risk factors. The effectiveness of these interventions will be evaluated through the facility's falls management program.	04/21/2015



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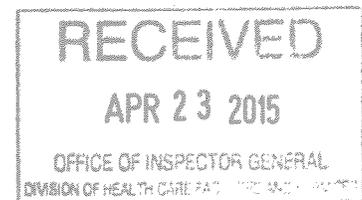
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F 323	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review and review of incident/accident reports and facility investigation, it was determined the facility failed to ensure residents received supervision to prevent accidents and utilized appropriate assistive devices to prevent injuries, for two (2) of twenty-five (25) sampled residents, (Resident #4 and #6). Certified Nursing Assistant (CNA) #11 transferred Resident #6 on 10/05/14 without the assessed assistive device and two person assist that resulted in a fracture of the Proximal Diaphysis of the right Fibula and required an evaluation at the hospital emergency room. In addition, Resident #4 sustained two falls, one on 12/31/14 resulting in a bruised lump on the forehead, bruising of the left upper arm and a skin tear on the left forearm and a transfer to the hospital emergency room for evaluation and treatment. A second fall on 02/25/15 ocured when the resident sustained bruising of both eyes and a fractured nose that required an emergency room evaluation. The findings include: Review of the Falls Management Policy, effective 01/01/10, revealed the facility would establish a program to identify residents with risk factors that may place them at risk for falls, and to manage those residents who experience a fall to minimize the risk of the fall reoccurring or minimize the risk of injury related to the fall. It was the policy of the facility to screen all residents to identify possible	F 323	F 323 Continued from page 33 On April 2, 2015, the interdisciplinary team completed review of the care plan for resident #6 and confirmed it accurately reflected the resident's care needs. The IDT also reviewed #6's nurse aide assignment sheets to verify the directions for resident transfer are accurate and clearly communicated. #2. The facility DON, Unit Managers, Assistant Unit Managers, or QA Coordinator identified residents who have been assessed as being at risk for falls. For these residents, the DON, QA Coordinator, Unit Managers, or Assistant Unit Managers will review the falls risk screens and falls history in an effort to identify root causes, patterns, or other contributing factors. This group will review the care plans of these residents to confirm they include interventions for prevention. The Nurse Unit Managers will complete a 100% audit of the care plans and nurse aide assignment sheets to verify the directions for resident transfer are accurate and clearly communicated. This will be completed by April 15, 2015.	



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F 323	<p>Continued From page 34</p> <p>risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risks and monitor those interventions and modify when necessary. It was also the policy of the facility to investigate any resident falls to determine appropriate interventions to put in place to reduce the likelihood that a fall would reoccur and/or to minimize the risk of injury related to a fall. A fall was defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, was considered a fall. The facility was to manage the resident who experienced a fall by completing an incident report for Quality Assurance Reporting, document the incident in the nursing notes to include: date, time, place, what occurred, treatment required and notification of family and physician, and to complete a post fall investigation tool (this would be completed at the time of the fall) for Quality Assurance Reporting.</p> <p>1. Review of Resident #6's record, revealed the facility admitted the resident on 04/11/14, with diagnoses of Disc Degeneration, Spinal Stenosis, Muscle Weakness, Debility, Lack of Coordination, Joint Pain and Osteoarthritis.</p> <p>Review of Resident #6's Minimum Data Set (MDS), Significant Change Assessment, dated 12/09/14, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) and scored the resident at a three (3), which meant the resident was not interviewable. Resident #6's ambulation status was an eight (8) of eight (8), which meant the activity was not</p>	F 323	<p>F 323 Continued from page 34</p> <p>#3. On March 30, 2015, the corporate RN consultant provided education to the DON, ADON, QA Coordinator, and Administrator. The training topic was care plan revisions and strategies for developing interventions in response to incident and accidents. This education also included a review of the Falls Management program and how it can be used to document the facility's efforts to investigate the cause of falls and efforts to evaluate the effectiveness of care plan interventions.</p> <p>The Director of Nursing, ADON, or QA Coordinator will complete in-service education for licensed staff by April 21, 2015. The training will address identifying residents at risk for falls and the process for reviewing and revising the care plan with interventions for prevention. The training will stress that the licensed staff have the authority and responsibility to participate in the plan of care development and the implementation of therapeutic interventions. The training will emphasize identifying causal factors to incidents and immediately putting care plan revisions in place to address them. The training will also include a review of the job description for licensed staff to clarify their role in the supervision of unlicensed staff. A score of 85% on a post test will indicate training material comprehension. This training will be included as part of the new hire orientation process.</p>	



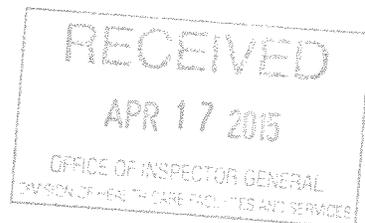
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2015
NAME OF PROVIDER OR SUPPLIER SUMMERFIELD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216	

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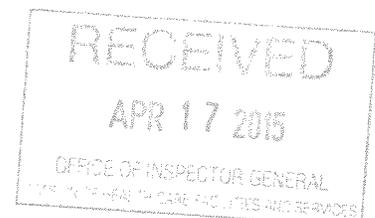
F 323	Continued From page 34 risk factors that may place a resident at risk for falls, to evaluate those risks, implement interventions to reduce those risks and monitor those interventions and modify when necessary. It was also the policy of the facility to investigate any resident falls to determine appropriate interventions to put in place to reduce the likelihood that a fall would reoccur and/or to minimize the risk of injury related to a fall. A fall was defined as unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, was considered a fall. The facility was to manage the resident who experienced a fall by completing an incident report for Quality Assurance Reporting, document the incident in the nursing notes to include: date, time, place, what occurred, treatment required and notification of family and physician, and to complete a post fall investigation tool (this would be completed at the time of the fall) for Quality Assurance Reporting. 1. Review of Resident #6's record, revealed the facility admitted the resident on 04/11/14, with diagnoses of Disc Degeneration, Spinal Stenosis, Muscle Weakness, Debility, Lack of Coordination, Joint Pain and Osteoarthritis. Review of Resident #6's Minimum Data Set (MDS), Significant Change Assessment, dated 12/09/14, revealed the facility assessed Resident #6 with a Brief Interview for Mental Status (BIMS) and scored the resident at a three (3), which meant the resident was not interviewable. Resident #6's ambulation status was an eight (8) of eight (8), which meant the activity was not	F 323	F 323 Continued from page 34 #3. On March 30, 2015, the corporate RN consultant provided education to the DON, ADON, QA Coordinator, and Administrator. The training topic was care plan revisions and strategies for developing interventions in response to incident and accidents. This education also included a review of the Falls Management program and how it can be used to document the facility's efforts to investigate the cause of falls and efforts to evaluate the effectiveness of care plan interventions. The Director of Nursing, ADON, or QA Coordinator will complete in-service education for licensed staff by April 21, 2015. The training will address identifying residents at risk for falls and the process for reviewing and revising the care plan with interventions for prevention. The training will stress that the licensed staff have the authority and responsibility to participate in the plan of care development and the implementation of therapeutic interventions. The training will emphasize identifying causal factors to incidents and immediately putting care plan revisions in place to address them. The training will also include a review of the job description for licensed staff to clarify their role in the supervision of unlicensed staff. A score of 85% on a post test will indicate training material comprehension. This training will be included as part of the new hire orientation process.	
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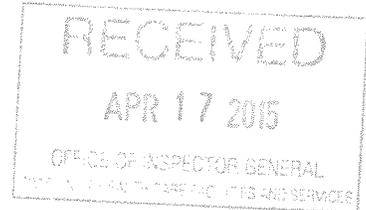
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F 323	Continued From page 35 performed by the resident and did not occur during the entire observation period for this assessment. Dressing was assessed as extensive assist of one person. Transferring was assessed as extensive assistance of two persons. Bathing was assessed as dependant on staff for completion. The facility further assessed the resident as always incontinent of bowel and bladder. Review of Resident #6's Physical Therapy Notes, dated 04/14/14, revealed Resident #6 presented with significant pain and stiffness to the left knee that impacted Resident #6's range of motion and left extremity use. Resident #6 had poor range of motion to the right knee due to a Total Knee Arthroplasty. Resident #6 had gross bilateral lower extremity weakness, debility due to primarily in bed or wheelchair. Resident #6 was non ambulatory, utilized a Maxi lift for transfers due to lack of progress with transfers. Resident #6 had impaired posture in bed and needed wheelchair set up for proper positioning, posture, and comfort when out of bed. Review of Physical Therapy Notes, dated 04/30/15, revealed Resident #6's transfer status would be total dependence with a Maxi lift. Review of Resident #6's Nursing Care Plan, dated 07/23/14, revealed the staff was to assist with all transfer using assist of two (2) persons and a Maxi lift as indicted. Review of Resident #6's Certified Nursing Assistant (C.N.A) sheet, dated 10/01/14, revealed the staff was to use a Maxi lift with two (2) person assist. Review of Resident #6's Nursing Notes, dated	F 323	F 323 Continued from page 35 The Director of Nursing, ADON, or QA Coordinator will provide in-service education to the Certified Nursing Assistant staff. The training will reinforce the importance of following the resident care plans. It will instruct the CNAs on how and where to obtain the aide assignment sheets and that it is their responsibility to do so every shift. The training will also address the specific care issues of resident transfers, applying splints and using positioning aides and protective devices. A score of 85% on a post training test will be used to confirm comprehension of the training material. This will be completed by April 21, 2015. This training will be done as part of the new C.N.A. orientation and annually. The Unit Managers or Assistant Unit Managers will ensure the aide assignment sheets are available every shift. #4. Incident/accident reports and care plans of the residents involved are being reviewed during the morning nursing administration meeting. The purpose of the reviews is to ensure care plan revisions have been put in place following the incident. Incidents will be logged as part of the QA process to assist nursing leadership in tracking each resident's incident history and identifying trends related to these incidents.	



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F 323	<p>Continued From page 36</p> <p>10/02/14 at 10:16 PM, revealed Licensed Practical Nurse (LPN) #12, documented she was alerted by CNA #11, that Resident #6 was reporting right knee pain after Resident #6 was placed onto the bed. CNA #11, stated a pop sound was heard while transferring the resident by pivot from wheelchair to the bed. LPN #12 documented she then completed an assessment of Resident #6 and Resident #6 reported pain at that time. Further review of the Nursing Notes, revealed the Doctor was called with new orders for an X-Ray of the right knee and ice pack applied for twenty (20) minutes every two (2) hours as needed. The family was notified of the incident and the new orders. The family member voiced understanding.</p> <p>Review of Resident #6's X-Ray, to the right knee, on 10/02/14, revealed there were no fractures or dislocation.</p> <p>Review of the Incident Report completed by LPN #12, on 10/02/14 at 9:00 PM, revealed the incident occurred in Resident #6's room and Resident #6 complained of right knee pain. The nursing assessment was completed at 9:10 PM and Resident #6 was given Tylenol 325 mg. A transfer to the hospital did not occur. The Doctor was notified on 10/02/14 at 9:15 PM and the family was notified on 10/02/14 at 9:20 PM. The Post Fall Investigation Tool was not completed. The Post Injury Investigation Tool, revealed Resident #6 had sustained an injury by CNA #11. CNA #11 alerted LPN #12 of a possible knee injury on transfer of resident while being put to bed. The investigation revealed no further investigation was required and their was a reasonable explanation for how the injury occurred because of the unsafe transfer. LPN</p>	F 323	<p>F 323 Continued from page 36</p> <p>A QA subcommittee will convene monthly for the next 6 months to review the log and determine if compliance or need for additional system modification is needed. The QA Coordinator will present the subcommittee's findings, along with data from the incident log, no less than quarterly to the QA committee so that compliance or need for additional modification can be determined.</p> <p>To verify the nurse aide staff are following the care directions on the aide assignment sheets, the DON, ADON, QA Coordinator, or Staff Development will observe 10 resident transfers and 10 general care occurrences. During these observations, the CNAs will be asked to produce their assignment sheets. The audits will be done weekly for one month, every other week for one month, and then monthly for 12 months. Identified deficient practice will be corrected immediately. The Director of Nursing will submit a quarterly audit report summary to the QA Committee so that compliance or need for additional systemic modification may be determined.</p>		



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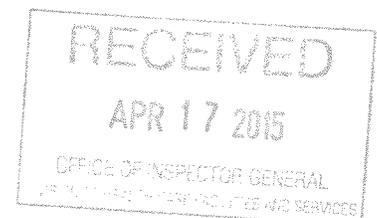
F 323	<p>Continued From page 37</p> <p>#12 documented she reported to the Director of Nursing (DON), the Agency Supervisor and educated CNA #11.</p> <p>Review of Resident #6's Nursing Notes, dated 10/03/15 at 2:15 PM, revealed the Doctor was informed the results of the X-Ray of the knee was negative and orders for pain medication was received.</p> <p>Review of Resident #6's X-Ray, to the right knee, on 10/05/14, revealed there was a minimally displaced fracture of the Proximal (situated nearer to the center of the body) Diaphysis (shaft of the long bone) of the right Fibula (calf bone in the leg located on the lateral side of the tibia, the small bone).</p> <p>Review of the Nurses Notes, dated 10/06/14 at 7:35 PM, revealed the Doctor was called related to Resident #6 had no relief from right knee pain with Tramadol (pain medication). New orders were obtained for Norco 5/325 mg every six (6) hours as needed for pain. A repeat X-Ray of the right knee was to be obtained immediately. The right knee X-Ray results showed a fracture and the family was notified. Resident #6 was sent to the hospital for evaluation and treatment.</p> <p>Interview with Resident #6, on 03/17/15 at 2:27 PM, revealed Resident #6 remembered sustaining an injury to the right lower leg when a nurse fell on the leg a few months ago.</p> <p>Review of CNA #11's statement, dated 10/02/14, revealed she transferred Resident #6 from the wheelchair to the bed and heard Resident #6's leg break. Resident #6 requested to see the nurse and so CNA #11 went and got the second</p>	F 323		
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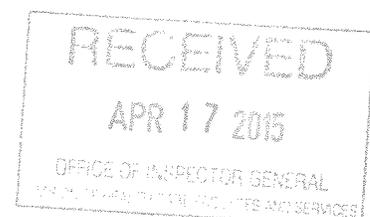
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F 323	Continued From page 38 shift supervisor and she informed CNA #11 that Resident #6 was a two (2) person assist and a Maxi lift. CNA #11 documented she took full responsibility for not consulting with the CNA Care Sheet to see how Resident #6 was to be transferred. Interview with CNA #11 (who worked for an agency), on 03/19/15 at 12:34 PM, revealed when she came into the facility on 10/02/14 she initially started on the Blue Unit. CNA #11 stated she obtained a CNA care sheet and began to pass ice on the hall. CNA #11 stated she was then pulled to the Green Unit by CNA #12 who informed CNA #11 of what residents needed assistance getting up and transferring, but she did not obtain a CNA care sheet. CNA #11 stated she remembered Resident #6 requested to go to bed multiple times and CNA #11 kept looking for CNA #12 to assist her with Resident #6's care. CNA #11 stated CNA #12 informed her Resident #6 could be pivoted to the bed. CNA #11 stated she asked Resident #6 if he/she could stand and pivot and Resident #6 responded with a yes answer. CNA #11 stated as she got Resident #6 up from his/her wheelchair, she noticed Resident #6 could not turn his/her leg and when she went to turn Resident #6 onto the bed she heard a pop sound. CNA #11 stated she informed Resident #6 she was sorry and would go get the nurse. LPN #12 assessed the resident and Resident #6 complained of pain. LPN #12 asked CNA #11 where was her CNA care sheet and CNA #11 answered she did not have one. CNA #11 stated she should have had her CNA care sheet and she felt bad because she had not caused harm to a resident before. CNA #11 stated she was not aware Resident #6 was not interviewable. CNA #11 stated if she had looked at the CNA care sheet, Resident #6 would not	F 323			



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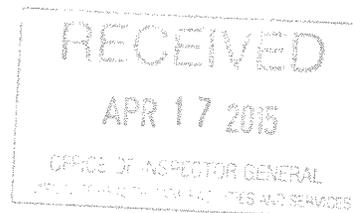
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F 323	<p>Continued From page 39</p> <p>have sustained an injury, because she would have used a Maxi lift on the resident with assistance. CNA #11 stated she received training from the facility and knew to find the CNA care sheet at the nurses station.</p> <p>Interview with LPN #12, on 03/18/15 at 4:17 PM, revealed she remembered working with agency staff the night of the incident. LPN #12 stated when the CNA agency staff come onto the unit they obtain their CNA care sheets and tour the unit with a staff member. LPN #12 stated she remembered on or around dinner CNA #11 stated she transferred Resident #6 without a lift and did not give an explanation as to why she did this. LPN #12 stated she had CNA #11 write a statement. LPN #12 stated the Maxi lifts were functioning so their was no excuses as to why CNA #11 could not use the lift. LPN #12 stated Resident #6 was already in the bed when she was alerted to the incident. LPN #12 stated she assessed the Resident and his/her limb with no visible injury. LPN #12 called the Doctor whom ordered an X-Ray, pain management and ice.</p> <p>Interview with the Unit Manager on the Green Unit, on 03/19/15 at 1:38 PM, revealed she did not remember receiving a phone call on the night of the incident. The Unit Manager stated she remembered reviewing the incident report a couple of days later when there were complaints by Resident #6 of still having pain to the right leg. The Unit Manager stated the Nurse on the unit informed her of the swelling and increase pain Resident #6 was having, so the nurse obtained a new X-Ray and found the fracture and sent Resident #6 out to the Hospital. The Unit Manager stated she reviewed the incident reports in the morning meetings with the DON, but did</p>	F 323			



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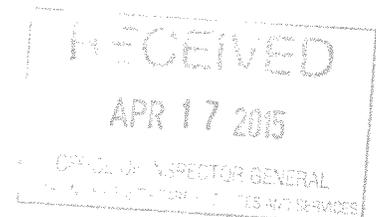
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F 323	Continued From page 40 not remember reviewing Resident #6's incident report. The Unit Manager stated she was not sure if the incident reports were reviewed in the fall meeting, since this occurrence was not a fall. The Unit Manager stated Resident #6 had always been total care. Resident #6 was pretty fragile and sometimes he/she did not like to get out of the bed. The Unit Manager stated if CNA #11 had utilized a Maxi lift it could have prevented the fracture from occurring; however, Resident #6 had a diagnosis of osteoarthritis which made him/her very susceptible to fractures. Interview with the Assistant Director of Nursing (ADON), on 03/19/15 at 2:34 PM, revealed the incident reports were reviewed in the morning meetings. The incidents were reviewed with the Unit Managers separately from the fall meeting. The ADON stated she sometimes attended the incident meetings and sometimes she did not. The ADON stated she had not talked to any of the staff involved in the incident with Resident #6 and it was not the facility's practice to document interviews. The ADON stated she looked over the incident report to ensure the report was documented thoroughly and try to find the root cause of an incident. The ADON stated she could not find a full investigation of the incident nor come up with an evaluation or analysis of the incident. The ADON stated the information she had was the verbal "stuff" that she had heard about the incident. The ADON stated CNA #11 was educated about the care plan because it was an isolated incident. The ADON stated she remembered walking around to ensure staff had their care plan, though the rounds were not documented. There was no auditing tool. The ADON stated she did not do an investigation to rule out neglect because she felt the CNA care	F 323			



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F 323	<p>Continued From page 41</p> <p>sheet was the root cause and if CNA #11 would have used the Maxi lift with two (2) assist, the injury in which Resident #6 had sustained may have been avoided.</p> <p>Interview with the DON, on 03/19/15 at 10:09 AM, revealed she could not recall receiving a phone call the day of the incident. The DON stated she called the Agency in which CNA #11 worked and informed them what had happened and discussed CNA #11 not coming back to the facility because the CNA did not acknowledge or follow the care plan. The DON stated the only bit of evidence she had to ensure she had investigated the incident was the statement that she had received from CNA #11. The DON stated she did not obtain a statement from LPN #12. The DON stated no education was provided on following the care plan and the incident was not considered a fall, though it was a major injury. There was no formal investigation.</p> <p>Continued interview with the DON, on 03/19/15 at 4:23 PM, revealed Resident #6's incident would have been an acute issue and she felt the incident occurred because of a lack of not having a CNA care sheet to follow. The DON stated she expected the staff to follow the care plan. The DON stated if the CNA would have followed her assignment sheet there may have been a different outcome for Resident #6.</p> <p>Interview with the Administrator, on 03/19/15 at 2:54 PM, revealed he did not attend the incident meetings, but was aware of the incidents as they occurred. The Administrator stated he knew what CNA #11 had done and that Resident #6 was assessed. The Administrator stated from his end he knew the CNA had taken responsibility for the</p>	F 323		



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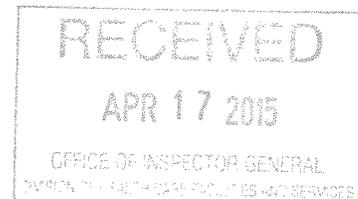
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F 323	<p>Continued From page 42</p> <p>incident. The Administrator stated the incident did not trigger an abuse investigation and he believed the CNA was not neglectful. The Administrator stated neglect was something that was done on purpose and had a negative result. The Administrator stated he did make sure Resident #6 was taken care of and that CNA #11 no longer worked in the building. The Administrator stated he could not say yes or no to the fact that if CNA #11 had utilized a Maxi lift with Resident #6, it could have prevented an injury to Resident #6.</p> <p>Further interview with the DON, on 03/19/15 at 4:23 PM, revealed she had a small "pow wow" with the Unit Managers to see if anything had occurred like falls and accidents. The Fall Committee met weekly and then there was a daily meeting where she would talk about any acute issues.</p> <p>Continued interview with the Unit Manager on the Green Unit, on 03/19/15 at 1:38 PM, revealed they assisted the residents because it was the safest thing to do for the residents. The Unit Manager stated as part of her responsibilities, she was to review the incident report to ensure the family and Doctor were notified. The Unit Manager stated the Quality Assurance Director was also responsible for review of the incident</p> <p>Further interview with the Administrator, on 03/19/15 at 2:54 PM, revealed the facility did not have a call log or a way to document the notification of the Administrator and DON. The Administrator stated all incidents and accidents were tracked and trended and he trusted his staff to complete the investigations. The Administrator stated he just knew that the DON was doing Quality Assurance audits though he did not</p>	F 323		
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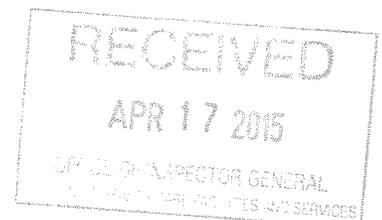


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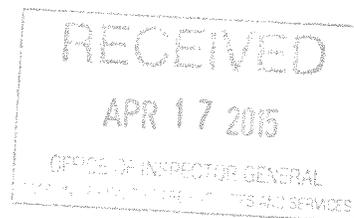
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F 323	<p>Continued From page 43</p> <p>review any documentation. The Administrator stated the staff was to complete the investigation and complete the investigation tool. There was some fact gathering and if something triggered such as neglect the Administrator stated he would have formalized a process and would have required an investigation. The Administrator stated he was tracking and trending falls and there was a committee. The Administrator stated they logged the falls as a way to track them.</p> <p>2. Review of the clinical record for Resident #4, revealed the facility admitted the resident on 10/20/12 with diagnoses of Dementia, Bipolar Disorder, Psychotic/Delusional, Anxiety, Depression, and Fibromyalgia.</p> <p>Review of the Falls Risk Assessment, on 10/14/14, revealed the facility assessed Resident #4 as a high risk for falls.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment for Resident #4 and completed by the facility on 01/04/15, revealed the facility assessed the resident with a Brief Interview for Mental Status and scored the resident with an eight (8) meaning moderate cognitive impairment and interviewable. The facility further assessed the resident as requiring limited assistance of one with transfers, ambulation and dressing, and extensive assistance with hygiene and bathing. The facility further assessed the resident as frequently incontinent of bowel and bladder and receiving psychoactive medications.</p> <p>Review of the Comprehensive Care Plan for Resident #4, revealed the facility had identified the resident as being a fall risk since 10/23/13.</p> <p>The facility did not add the fall of 12/31/14 to the</p>	F 323		



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F 323	<p>Continued From page 44</p> <p>care plan or the referral that was made for a physical therapy screen on 01/02/15. There was no evidence the facility evaluated the care plan for effectiveness or add interventions to prevent or minimize further injury from another fall. On 01/29/15, the facility added sensor alarms to bed and chair.</p> <p>Review of the Comprehensive Care Plan for Resident #4, dated 01/04/15, revealed the facility determined the resident had a risk of falls related to impaired mobility and use of psychoactive medications. Interventions included: self transfers and assist as needed; provide incontinent care as indicated; complete falls assessment per facility protocol; attempt to keep room/hall free from clutter, keep call light and personal items within reach; encourage use of rolling walker for ambulation; encourage resident to participate in range of motion and ambulation; may be up in recliner/lift chair; ensure resident wears tennis shoes at all times; medications as ordered; medication adjustments as ordered; observe for signs of adverse reactions noted from psychoactive medications; attempt gradual drug reduction unless otherwise indicated; re-educate resident to use walker at all times for ambulation; physical therapy referral related to a fall on 12/31/14; and, sensor alarm to bed and chair on 01/29/15.</p> <p>Review of the Fall Investigation for Resident #4, revealed the resident fell, on 12/31/14 at 4:15 PM. The report documented the resident removed both shoes, got out of bed and fell. The bed sensor alarm was turned off by staff prior to the fall since the resident expressed the wish to get out of bed. The staff then left the resident's</p>	F 323			



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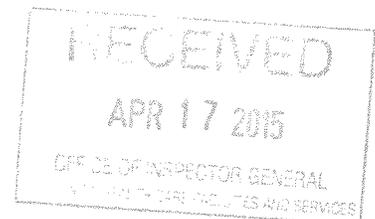
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F 323	<p>Continued From page 45</p> <p>room. There were no witnesses according to the report. The resident sustained a bruised lump on the forehead, a raised bruise on the right upper arm and a skin tear on the right forearm. The facility sent the resident to the emergency room later where a Urinary Tract Infection was diagnosed. The investigation determined Resident #4's fall and injuries were a result of the resident making a transfer without seeking assistance from staff. There was no evidence the facility identified environmental hazards or determined the resident's need for supervision in order to reduce the risk of an accident. There was no evidence of interviews with staff to determine how the resident fell. The Fall Investigation did not contain evidence that referenced the staff allowed Resident #4 to get out of bed alone.</p> <p>Interview with CNA #5, on 03/18/15 at 10:41 AM, revealed the resident did have a fall after the sensor alarm was turned off by staff in the room. She indicated the resident planned to get out of bed so the alarm was turned off. She revealed the resident often ambulated without staff assistance but did need the walker.</p> <p>Review of the Fall Investigation for Resident #4, revealed the resident fell, on 02/25/15 at 4:45 AM. The nursing staff found the resident awake and assisted the resident out of bed. The staff accompanied the resident toward the doorway then turned around to go back and retrieve the resident's walker. Before the staff reached the resident, the resident fell face first to the floor. The facility sent the resident to the emergency room where the resident was diagnosed with a Urinary Tract Infection and bruising around both eyes and the left cheek and a fractured nose.</p>	F 323		
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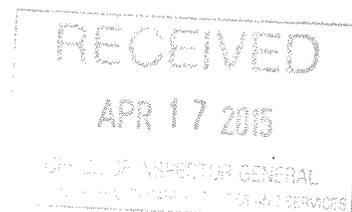
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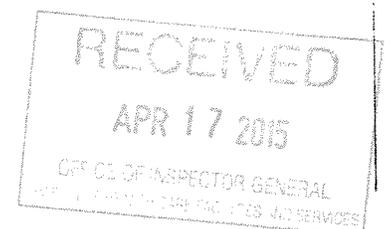
F 323	<p>Continued From page 46</p> <p>There was no evidence the facility reassessed environmental hazards or determined the resident's need for supervision. There was no evidence of interviews with staff who witnessed or provided care prior to the fall. There was no evidence the facility recognized the CNA left the resident's side while the resident was walking and the resident fell. On 02/25/15, the resident fell and sustained injuries. The was no evidence the facility evaluated the care plan for effectiveness or add interventions to prevent further falls and injuries. In addition, there was no evidence the facility implemented increased supervision for the resident to prevent further falls and injuries.</p> <p>Observation of Resident #4, on 03/17/15 at 11:17 AM, 11:32 AM, 1:56 PM, 2:21 PM and on 03/18/15 at 7:51 AM, 8:25 AM and 9:23 AM, revealed the resident was up and walking about in the room and hallway without assistance of staff or a walker. The resident was dressed and had on socks and tennis shoes. The resident's balance was poor and gait was unsteady. The resident was able to talk; however, most answers were unclear and difficult to understand. The resident's left cheek was a yellowish color down to the mouth and both eyes were purple with black areas.</p> <p>Review of the Facility In-Service Training, revealed training was provided on falls, investigation and care plans for the interdisciplinary care plan team on 10/30/14. Nursing staff received training on falls on 11/04/15. The facility did not provide specific information on the training content although this information was requested.</p> <p>Interview with CNA #5, on 03/18/15 at 10:41 AM,</p>	F 323		
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F 323	Continued From page 47 revealed she had received training on falls and prevention of falls by the facility. She stated she provided care for Resident #4 and checked all residents every two (2) hours for incontinence and to see if they needed fluids or turned. She stated the resident did have a fall after the sensor alarm was turned off by staff in the room. She indicated the resident planned to get out of bed so the alarm was turned off. She revealed the resident often ambulated without staff assistance but did need the walker. She indicated Resident #4 had frequent falls and wandered around the facility with a walker or with no assistive device frequently. She stated the resident had the right to be independent even if injured in falls. She stated the resident had sensor alarms on the chair and bed and she checked on the resident about every two (2) hours. She stated Resident #4 did not have any specific interventions for supervision. Interview with CNA #7, on 03/19/15 at 12:30 PM, revealed Resident #4 received care from her frequently. She stated all residents were checked every two (2) hours for cleanliness and turning. She stated the resident liked to be independent and walked all around the unit. She indicated the resident did not use the walker consistently and staff would attempt to redirect the resident. She stated the resident could be redirected; however, sometimes the resident was not able to be redirected. She stated she was not aware the resident required the assistance of one when ambulating. She stated she did have the Nurse Aide Care Plan for instructions; however, she saw the resident walking alone often. She stated there were no specific instructions for Resident #4 to be supervised on any schedule or specific time.	F 323		



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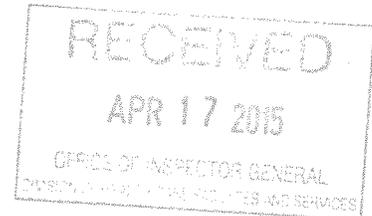
F 323	Continued From page 48 Interview with LPN #7, on 03/19/15 at 12:43 PM, revealed nursing staff supervised residents every two (2) hours and there were no assessments she was aware of that required supervision more frequently. She stated Resident #4 did wander and was at risk for elopement. She stated there were times the resident would not use the walker and became agitated when coached to do so. She indicated it was better to leave the resident alone and go back later. She stated the nurses were responsible for supervising the nurse aides; however, the resident often ambulated without staff assistance and staff were used to seeing that. She stated she had received training on falls and determining the root cause of a fall. Interview with the Blue Unit Manager, on 03/19/15 at 12:57 PM, revealed she reviewed all incident reports and fall investigations for completeness. She stated there were no special interventions to supervise residents based on history of falls or behaviors that placed the resident at high risk of falls. She indicated that all staff had received training on fall prevention and investigation. Interview with the Director of Nursing, on 03/19/15 at 2:09 PM, revealed all staff had been trained on prevention of falls and investigation of falls. She stated the incident reports and fall investigations were reviewed daily by the nursing management and interventions were added to the care plan to prevent further falls. She stated she did not know what interventions were added as a result of fall investigations and she did not see any interventions to provide added supervision to prevent further falls. She stated there were no written minutes of the daily meetings to discuss falls or of the weekly Fall Committee meetings.	F 323		
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F 323	<p>Continued From page 49</p> <p>She stated falls were not added to the care plans by direction of her corporate management.</p> <p>Further interview with the DON, on 03/19/15 at 4:23 PM, revealed she had a small "pow wow" with the Unit Managers to see if anything had occurred like falls and accidents. The Fall Committee met weekly and then there was a daily meeting where she would talk about any acute issues.</p> <p>Continued interview with the Unit Manager on the Green Unit, on 03/19/15 at 1:38 PM, revealed they assisted the residents because it was the safest thing to do for the residents. The Unit Manager stated as part of her responsibilities, she was to review the incident report to ensure the family and Doctor were notified. The Unit Manager stated the Quality Assurance Director was also responsible for review of the incident</p> <p>Further interview with the Administrator, on 03/19/15 at 2:54 PM, revealed the facility did not have a call log or a way to document the notification of the Administrator and DON. The Administrator stated all incidents and accidents were tracked and trended and he trusted his staff to complete the investigations. The Administrator stated he just knew that the DON was doing Quality Assurance audits though he did not review any documentation. The Administrator stated the staff was to complete the investigation and complete the investigation tool. There was some fact gathering and if something triggered such as neglect the Administrator stated he would have formalized a process and would have required an investigation. The Administrator stated he was tracking and trending falls and there was a committee. The Administrator stated</p>	F 323		



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F 323	Continued From page 50	F 323		
F 497	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497		
SS=E	<p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure yearly in-service training of twelve (12) hours for Certified Nursing Assistants (CNA's) competency for three (3) of six (6) records reviewed.</p> <p>The findings include:</p> <p>Review of six (6) random in-service records revealed three (3) CNA's had less than the required twelve (12) hours. CNA #1 hired 08/05/13 had 10.75 hours, CNA #4 hired 06/04/07 had 10.25 hours, and CNA #5 hired 09/18/96 had 5.25 hours.</p> <p>Interview with the Assistant Director of Nursing,</p>	F 497	<p>#1. The 3 nurse aides identified with this deficiency now have the required 12 hours of in-service education. This was verified by the Director of Nursing as being completed on April 10, 2015.</p> <p>#2. The Director of Nursing completed a review of the nurse aide training records to identify any other CNAs who did not have the required training hours. The CNAs identified will have the required hours by April 19, 2015. This will be verified by the Director of Nursing.</p> <p>#3. On April 10, 2015, the Director of Nursing provided training for the ADON on this regulatory requirement. The ADONs process for tracking C.N.A. hours was reviewed and revised. To make it easier to verify the required in-service hours are being completed within their anniversary year, each aide's training record is now sorted by month of hire rather than alphabetically.</p>	04/20/2015

