

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

PRINTED: 02/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185253	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2013
NAME OF PROVIDER OR SUPPLIER CARTER NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 250 MCDAVID BLVD GRAYSON, KY 41143	

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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY# 00019675 was initiated on 01/22/13 and was concluded on 01/23/13. KY# 00019675 was substantiated with deficiencies cited.

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

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure all resident's received adequate supervision and assistance devices to prevent accidents, for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure staff had check the functioning of the sensor alarm for Resident #1, who sustained a fall on 12/14/12 and it was determined the sensor alarm was not working.

The findings include:
Interview with the Director of Nursing (DON), on 01/23/13 at 6:00 PM, revealed the facility did not have a policy on checking sensor alarms to ensure they were functioning; however, it was their system to check the sensor alarms at the start of every shift for function and placement.

F 000 To the best of my knowledge and belief, as an agent of Carter Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.

F 323 Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.

It is the policy of Carter Nursing & Rehabilitation Center to ensure that the residents' environment remains as free of accidents as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Resident #1's sensor pad was replaced with a functioning replacement by the Charge Nurse after the fall on 12/14/12. The Charge Nurse also completed a new fall assessment on 12/14/12. The residents' care plan was reviewed by the Care Plan Coordinator on 12/17/12 and no changes were made. The resident was receiving both occupational and

2/15/13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Samuel R. Williams II Administrator
TITLE
DATE
2/25/2013

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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 and to also check for function and placement of the sensor alarm throughout the shift and when providing care for the residents who had sensor alarms. Record review revealed the facility admitted Resident #1 on 12/13/12 with diagnosis which included personal history of Falls, Subdural Hematoma from a previous fall, a facial Fracture from a previous Fall, and Convulsions. Review of the Admission Care Plan, dated 12/13/12, revealed the facility assessed Resident #1 as being at risk for falls and put into place interventions to prevent a fall, which included a sensor pad to Resident #1's bed at all times. Review of the Physician Order Sheet (POS), dated 12/13/12, revealed Resident #1 was to have a sensor pad at all times due to increased risk for falls. Review of the Fall Risk Assessment, dated 12/13/12, revealed Resident #1 had a score of twenty-six (26), residents who had a score of ten (10) or higher, were at a high risk for falls, and interventions should be put into place immediately. Review of the Department Notes for Nursing, dated 12/15/12 at 1:01 AM, revealed on 12/14/12 at 10:15 PM Resident #1 was found in the floor at the bathroom on his/her back. Further review revealed Resident #1 stated he/she had hit his/her head on the floor. Further review revealed Resident #1's sensor pad was in place but was not working. Further review of the Department Notes for Nursing revealed no documented evidence the sensor alarm was working and in place for 12/14/12 and 12/15/12. Review of the Incident Report, daled 12/14/12,	F 323	physical therapy at the time of the fall and both the Occupational and Physical Therapist provided safety awareness education to the resident on 12/17/12. Resident #1 was discharged from the facility on December 18, 2012, return not anticipated. Each resident of the facility who had an assistive device in use to prevent accidents was checked by administrative nursing staff on 1/23/13 for placement and function. This included, but not limited to; sensor pads, break away alarms, wheel chair devices and bed devices. Each assistive device assigned or ordered for a resident will be recorded on the TAR (treatment administration record) by the Charge Nurse and be checked every shift daily for placement, function and proper use by the treatment nurse. This will include following the manufactures recommendations for battery replacement on sensor pads and break away alarms. (These are the only assistive devices used for safety in the facility requiring batteries.) This was completed by February 14, 2013. A listing of all residents with assistive devices ordered or in use for safety will be maintained and available for all staff at each		

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F 323	<p>Continued From page 2</p> <p>revealed Resident #1 was attempting to walk to the bathroom and was found by staff laying on the floor. Further review revealed the answer to the question asking why the incident had occurred, it stated because the sensor pad was not sounding and had to be replaced.</p> <p>Interview with License Practical Nurse (LPN) #1, on 01/22/13 at 5 PM, revealed she was Resident #1's nurse the night he/she fell. She stated Resident #1 had a sensor pad when he/she fell; however, the sensor alarm was not working and had to be replaced. Further interview revealed she could not recall if she had checked the sensor alarm when she put the sensor pad on Resident #1's bed. She further stated the Certified Nursing Assistant (CNA) who was assigned to the resident should check the sensor pad for placement and function at the start of each shift and any time they were providing care; however, there was not a place to document the sensor pad was checked for placement and function, therefore she did not know for sure if the CNA who was assigned to Resident #1 the night he/she fell had checked the sensor pad for function. Further interview revealed she was not aware of what the lights on the box of the sensor pads meant. She stated if the light was green she assumed that meant the batteries were good and the sensor pad was functioning. She further stated she was not aware of the light being red or if the sensor pad had a different alarm sound if the batteries were low or dead.</p> <p>Interview with CNA #5, on 01/23/13 at 1:20 PM, revealed the CNA's did not have an individual CNA Care Plan for each resident. He stated there was a binder at the nurses' station that had</p>	F 323	<p>nurse's station beginning 2/1/13. This list will be created and updated weekly by the Director of Nursing or designee. The information for this list will be gathered from physician orders by the Director of Nursing.</p> <p>All staff received education regarding the safety of residents and the use of assistive devices by the facility Staff Development Coordinator by 2/14/13. This included residents with devices in use and/or ordered for resident safety; following manufacture recommendations for use and the replacement of batteries for sensor pads and break away alarms. Staff also received additional education regarding the importance of ensuring the resident environment remains free of accident hazards as is possible; and that each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>Daily for the next 30 days and weekly thereafter the RN Supervisor will check one third of all residents with assistive devices to assure they have proper placement, function and are in use. This will include following the manufacture recommendations for replacement of batteries if applicable. The results of these checks will be provided to the Director of Nursing who will check at least</p>		

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a list of resident's who had sensor pads. Further interview revealed he would check each resident at the beginning of his shift, and this included checking the sensor alarm to ensure it was functioning and in place. He further stated the CNA's did not do walking rounds or have a list they would keep with them to list every resident who had a sensor alarm. He further stated the sensor alarms had a box and if the light was green this meant the batteries were working; however, if the light was red and there was an intermittent beep sounding, this meant the batteries were low and would need to be changed.

Interview with LPN #2, on 01/23/14 at 4:00 PM, revealed she worked the desk and would take off orders; however, the treatment nurse was the one who would check for placement and function of the sensor alarms every shift and document this on the Treatment Administration Record (TAR). Further interview revealed, after review of Resident #1's TAR, she stated she thought the sensor alarm would be listed on the TAR and the placement and function would have been documented every shift; however, she had not observed this on Resident #1's TAR. Further interview revealed she knew the sensor alarm had a box and there was a green light; however, she was not aware the light would change colors and if the light color did change she did not know what this would mean.

Interview with CNA # 5, on 01/23/13 at 4:10 PM, revealed he was the CNA assigned to Resident #1 the night he/she fell. He stated Resident #1 had been attempting to get out of bed earlier in the shift; however, he had not heard the alarm

F 323 five residents randomly per week for the same time period, 30 days. The audit tool will also be utilized to visually review the resident environment to ensure the environment remains as free of accident hazards as possible; and that residents receive adequate supervision in addition to assistive devices as listed above.

Results of these audits will be forwarded to the facility's weekly Focus Meeting (a sub-committee of the Continuous Quality Assurance Committee) for further review and discussion to assure compliance. Members of the Focus committee include the Administrator, Director of Nursing, Assistant Director of Nursing, RN Supervisor, MDS/Care Plan Coordinator, Dietary Manager, Social Worker, Activity Director and Clinical Records Coordinator.

Additionally, the results of the audits will be forwarded to the facility's monthly CQI (Continuous Quality Improvement) meeting for further monitoring and continued compliance. Members of the CQI Committee include the Administrator, Director of Nursing, Assistant Director of Nursing, RN Supervisor, MDS/Care Plan Coordinator, Dietary Manager, Social Worker, Activity Director, Clinical Records Coordinator, Environmental Manager, Staffing Coordinator, Business Office Manager, and Medical Director.

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sound since he had provided care for Resident #1 the last time before he/she was found on the floor in his/her bathroom. Further interview revealed the sensor pad alarm was not sounding when Resident #1 was found on the floor in his/her bathroom. He further stated the sensor pad had a box it was connected to and the wires had been very easy to disconnect causing the sensor alarm not to sound. He further stated he was not aware of a different color light on the box to the sensor pad which would indicate the wires had been disconnected, and he was also not aware of a different beep the sensor box would make if the batteries were getting low and needed to be replaced. Further interview revealed if the light was green on the sensor pad box, the sensor alarm was working; however, if the light was red he would assume the batteries were dead and would need to be replaced. He further stated there was not a place for the staff to document the placement and function of the sensor pads.

Interview with the CNA #6, on 01/23/13 at 5:15 PM, revealed she was the CNA who placed the sensor pad on Resident #1's bed the day he/she was admitted to the facility. She stated she could not remember for sure if she had checked the sensor pad for function before she placed the sensor pad on Resident #1's bed; however, she thought she had because she always checked function of the sensor pads before she placed them on a resident's bed. Further interview revealed she was aware the green light meant the sensor pad was functioning and if the batteries were getting low the light would change to red and the box would have made a very faint beep to alert staff the batteries needed to be changed. She stated once the batteries were

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 dead the light on the box would go out.
 Interview with the DON, on 01/23/13 at 5:30 PM, revealed when Resident #1 fell his/her sensor alarm was not working. She further stated she did not know if the sensor pad was not working because the batteries were dead or the wires had been disconnected; however, the pad was thrown away and a new sensor pad was placed. She further stated staff would check for function and placement of the sensor pad at the start of the shift and every time they would provide care for the resident. Further interview revealed she did not know what the light colors on the sensor pad box meant, or if there was a different sound that would have alerted staff the batteries were getting low or were dead. Further interview revealed there was not a certain day the batteries for the sensor pads were changed and there was not a place on the TAR for staff to document they had checked the placement and function of the sensor pads.

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