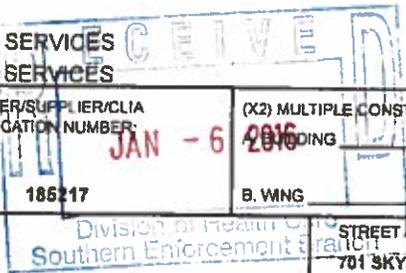


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/04/2016  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/15/2015
NAME OF PROVIDER OR SUPPLIER  METCALFE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  An abbreviated survey (KY24110) was conducted on 12/15/15. The complaint was unsubstantiated; however, related deficient practice was identified at "D" level.	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined that the facility failed to maintain an environment free of accident/fall hazards related to geriatric recliners not being routinely maintained for one (1) of three (3) sampled residents (Resident #1). Review of Resident #1's record revealed he/she sustained an unwitnessed fall from his/her geriatric recliner on 10/24/15 that resulted in injuries (an abrasion to the forehead, an abrasion to the right hand, and a hematoma to the forehead).  The findings include:  Review of facility policy titled "Resident Safe Environment," undated, revealed wheelchairs were to be evaluated for condition and proper functioning. However, the facility policy did not address geriatric recliners.	F 323	1. The geri-chair for resident #1 was replaced on 10/24/15 by the charge nurse. 2. All resident geri-chairs were inspected by maintenance staff on 10/26/15 and 11/17/15 to determine that they were all in good repair and functioning properly. There were no issues identified. 3. In-service education was provided for maintenance staff on 12/17/15 by the Administrator on the need to perform preventative maintenance inspections on all resident geri-chairs on a quarterly basis, utilizing the checklist developed for this purpose. 4. The QAPI indicator for the monitoring of resident equipment preventative maintenance will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance. This indicator will audit the completion of preventative maintenance on geri-chairs and other resident adaptive equipment.	12/17/15

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

TITLE

(X6) DATE

*Doug Neighbourn* Admin

1/6/16

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

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F 323	<p>Continued From page 1</p> <p>Review of Resident #1's record revealed the facility admitted Resident #1 on 05/19/15 with diagnoses including Senile Dementia with Behavioral Disturbances, Anxiety, Depression, and Osteoarthritis. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) assessment dated 10/30/15 revealed Resident #1 had been assessed to have a Brief Interview for Mental Status (BIMS) score of 01 which indicated Resident #1 was severely cognitively impaired. Review of Resident #1's comprehensive care plan, undated, revealed an intervention that Resident #1 could sit in a geri-chair (geriatric recliner) when out of bed for comfort, safety, and positioning. Review of Resident #1 Physician's Orders for December 2015 revealed Resident #1 could sit in a geri-chair when out of bed for comfort, safety, and positioning. Continued review of Resident #1's record revealed Resident #1 had been transferred out to the hospital on 10/24/15 as a result of a fall that he/she sustained on 10/24/15. Review of the History and Physical (H&amp;P) from the hospital dated 10/24/15 revealed Resident #1 sustained an abrasion to the forehead, an abrasion to the right hand, and a hematoma to the forehead as a result of the fall.</p> <p>Review of the facility fall investigation dated 10/24/15 revealed staff heard a loud noise coming from Resident #1's room as well as Resident #1 screaming. Resident #1 was found by staff sitting on the floor in front of his/her geri-chair on his/her bottom with his/her glasses broken and lying next to him/her. Continued review of the facility investigation revealed the root cause of the fall to be a possible geriatric recliner malfunction.</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 12/15/15 at 2:17 PM revealed she had been working on 10/24/15 when Resident #1 fell. Continued interview with SRNA #1 revealed she had taken Resident #1 to his/her room in the geriatric recliner and had made sure that the geriatric recliner was locked in the reclined position before she left the room. SRNA #1 stated she heard the chair lock into place and SRNA #2 had been the one that actually locked the chair into the reclined position. Further interview with SRNA #1 revealed she had not noticed anything different or unusual about the geriatric recliner that Resident #1 was in on 10/24/15.</p> <p>Interview with SRNA #2 on 12/15/15 at 2:25 PM revealed she had been working on 10/24/15 when Resident #1 had fallen from his/her geriatric recliner. Continued interview with SRNA #2 revealed she had locked Resident #1's geriatric recliner into place in the reclined position and had not noticed anything unusual about the geriatric recliner when she had locked it into place.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 12/15/15 at 3.39 PM revealed she had worked on 10/24/15 and was giving the day shift nurse report when she heard noise coming from Resident #1's room. Continued interview with LPN #1 revealed when she went into Resident #1's room Resident #1 was sitting in front of the geriatric recliner. Further interview with LPN #1 revealed the locking bar on the chair was not working properly and she was not able to determine how Resident #1 had fallen out of the front of the chair.</p> <p>Interview with the facility Environmental Services</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>Supervisor (ESS) on 12/15/15 at 4:07 PM revealed the facility did not have a program in place to ensure that the mechanisms on the geriatric recliners were functioning properly. Continued interview with the ESS revealed the ESS stated that she conducted daily rounds to observe for any maintenance issues within the facility to include geriatric recliners and had not identified any issues or concerns with any geriatric recliners. Further interview with the ESS revealed she was not able to determine for sure that Resident #1's geriatric recliner had malfunctioned on 10/24/15 or when Resident #1's geriatric recliner had last been serviced.</p> <p>Interview with the facility Director of Nursing (DON) on 12/15/15 at 6:22 PM revealed she had been involved in conducting the fall investigation for Resident #1 and had not been able to determine the exact cause of Resident #1's fall on 10/24/15. Continued interview with the DON revealed she was not aware of facility geriatric recliners being checked on a routine basis and was not sure if any routine maintenance had been performed on Resident #1's geriatric recliner prior to the fall on 10/24/15. The DON stated that she conducted daily rounds at the facility to include observing resident equipment and had not identified any concerns with any geriatric recliners.</p> <p>Interview with the facility Administrator on 12/15/15 at 6:46 PM revealed that she had not been aware of any maintenance issues with any geriatric recliners in the facility by the ESS prior to Resident #1 falling from his/her chair. Further interview with the Administrator revealed that all of the geriatric chairs in the facility were checked for proper functioning right after Resident #1 fell</p>	F 323			

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F 323	Continued From page 4 on 10/24/15 and the geriatric recliners had not been checked again since then. Continued interview with the Administrator revealed she made rounds daily to ensure resident equipment was in proper working order and had not identified any issues with geriatric recliners.	F 323		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined that the facility failed to have an effective preventative maintenance program in place to ensure patient care equipment (geriatric reclining chairs) was maintained in safe operating condition for one (1) of three (3) sampled residents (Resident #1). Review of Resident #1's record revealed he/she had sustained an unwitnessed fall from his/her geriatric recliner on 10/24/15 that resulted in injuries. Interviews and review of the facility fall investigation revealed the facility determined the geriatric recliner malfunctioned causing the fall. Review of the facility policy related to preventative maintenance revealed the facility preventative maintenance program included inspecting all equipment on a scheduled basis to include wheelchairs and all other equipment used by residents. However, the facility had no record that any routine preventative maintenance had been conducted on geriatric recliners.	F 456	1. The geri-chair for resident #1 was replaced on 10/24/15 by the charge nurse. 2. All resident geri-chairs were inspected by maintenance staff on 10/26/15 and 11/17/15 to determine that they were all in good repair and functioning properly. There were no issues identified. 3. A preventative maintenance inspection checklist has been developed for quarterly use on resident geri-chairs. Inservice education was provided for maintenance staff on 12/17/15 by the Administrator on the need to perform preventative maintenance inspections on all resident geri-chairs on a quarterly basis, utilizing the checklist developed for this purpose. 4. The QAPI indicator for the monitoring of resident equipment preventative maintenance will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Director of Maintenance. This indicator will audit the completion of preventative maintenance on geri-chairs and other resident adaptive equipment.	12/17/15

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F 456	<p>Continued From page 5</p> <p>The findings include:</p> <p>Review of facility policy titled "Preventative Maintenance Program," undated, revealed the facility was required to maintain all resident care equipment in a safe operating condition. Continued review of the facility policy revealed preventative maintenance meant to inspect all equipment on a scheduled basis, to make necessary repairs, and to service and document the maintenance. Further review of the facility policy revealed preventative maintenance should include physical therapy equipment, water fountains, hair dryers, wheelchairs, and all equipment used by residents. Further review of the facility policy revealed the policy included a copy of the facility preventative maintenance checklist which did not include an area to document preventative maintenance for resident geriatric recliners.</p> <p>Review of Resident #1's record revealed the facility admitted Resident #1 on 05/19/15 with diagnoses including Senile Dementia with Behavioral Disturbances, Anxiety, Depression, and Osteoarthritis. Review of Resident #1's most recent Quarterly Minimum Data Set (MDS) assessment dated 10/30/15 revealed Resident #1 had been assessed to have a Brief Interview for Mental Status (BIMS) score of 01 which indicated Resident #1 to be severely cognitively impaired. Review of Resident #1's comprehensive care plan, undated, revealed an intervention that Resident #1 could sit in a geri-chair (geriatric recliner) when out of bed for comfort, safety, and positioning. Review of Resident #1 Physician's Orders for December 2015 revealed Resident #1 could sit in a geri-chair when out of bed for</p>	F 456			

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F 456	<p>Continued From page 6</p> <p>comfort, safety, and positioning. Continued review of Resident #1's record revealed Resident #1 had been transferred to the hospital on 10/24/15 as a result of a fall that he/she had sustained on the same date. Review of the History and Physical (H&amp;P) from the hospital dated 10/24/15 revealed Resident #1 had sustained an abrasion to the forehead, an abrasion to the right hand, and a hematoma to the forehead as a result of the fall.</p> <p>Review of the facility fall investigation dated 10/24/15 revealed staff heard a loud noise coming from Resident #1's room as well as Resident #1 screaming. Resident #1 was found by staff sitting on the floor in front of his/her geri-chair on his/her bottom with his/her glasses broken and lying next to him/her. Continued review of the facility investigation revealed the root cause of the fall to be a possible geriatric recliner malfunction.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1 on 12/15/15 at 2:17 PM revealed she had been working on 10/24/15 when Resident #1 fell. Continued interview with SRNA #1 revealed she heard the geriatric recliner lock into place in the reclined position. Further interview with SRNA #1 revealed she had not noticed anything different or unusual about the geriatric recliner that Resident #1 was in on 10/24/15. SRNA #1 stated that she was unsure how often geriatric recliners were checked by Maintenance for proper functioning.</p> <p>Interview with SRNA #2 on 12/15/15 at 2:25 PM revealed she had been working on 10/24/15 when Resident #1 had fallen from his/her geriatric recliner. Continued interview with SRNA #2</p>	F 456			

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F 456	<p>Continued From page 7</p> <p>revealed she had locked Resident #1's geri-chair into place in the reclined position and had not noticed anything unusual about the geriatric recliner when she had locked it into place. Further interview with SRNA #2 revealed she had not been aware of any facility geriatric recliners not being maintained or not being in a safe working order.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 12/15/15 at 3:39 PM revealed she worked on 10/24/15. LPN #1 stated that when she observed Resident #1's geriatric recliner after the resident's fall, the locking bar on the chair was not working properly, and she was not able to determine how Resident #1 had fallen out of the front of the chair. LPN #1 stated that Resident #1's geriatric recliner had been locking properly prior to Resident #1 falling on 10/24/15.</p> <p>Interview with the facility Environmental Services Supervisor (ESS) on 12/15/15 at 4:07 PM revealed she had no way of knowing when Resident #1's geriatric recliner had last been serviced. Continued interview with the ESS revealed the facility did not have a program in place to ensure that the mechanisms on the geriatric recliners were functioning properly. The ESS stated that she conducted daily rounds to observe for any maintenance issues within the facility to include geriatric recliners and had not identified any issues or concerns with any geriatric recliners. Further interview with the ESS revealed she was not able to determine for sure that Resident #1's geriatric recliner had malfunctioned on 10/24/15.</p> <p>Interview with the facility Director of Nursing (DON) on 12/15/15 at 6:22 PM revealed she had</p>	F 456			

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F 456	<p>Continued From page 8</p> <p>been involved in conducting the fall investigation for Resident #1 and she was not aware of facility geriatric recliners being checked on a routine basis and was not sure if any routine maintenance had been performed on Resident #1's geriatric recliner prior to the fall on 10/24/15. The DON stated that she conducted daily rounds at the facility including observing resident equipment and had not identified any concerns with any geriatric recliners.</p> <p>Interview with the facility Administrator on 12/15/15 at 6:46 PM revealed that she had not been made aware of any maintenance issues with any geriatric recliners in the facility by the ESS prior to Resident #1 falling from his/her chair. Further interview with the Administrator revealed that all of the geriatric chairs in the facility were checked for proper functioning right after Resident #1 fell on 10/24/15 and the geriatric recliners had not been checked again since then. Continued interview with the Administrator revealed she made rounds daily to ensure resident equipment was in proper working order and had not identified any issues with geriatric recliners.</p>	F 456			