

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

PRINTED: 01/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/23/2014
NAME OF PROVIDER OR SUPPLIER LORETTO MOTHERHOUSE INFIRMARY			STREET ADDRESS, CITY, STATE, ZIP CODE 515 NERINX ROAD NERINX, KY 40049	
(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 standard survey (KY22604) was initiated on 12/22/14 and concluded on 12/23/14. The complaint was substantiated with deficient practiced identified at a scope and severity level of "D".	F 000		
F 282 SS=D	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 interview, record review, and a review of the facility's policy it was determined the facility failed to provide care in accordance with the resident's plan of care for one of three sampled residents (Resident #1). Staff assisted Resident #1 to a chair at the reception desk where staff was not familiar with the resident's need for assistance when ambulating. Resident #1 rose from the chair, ambulated unassisted to a bathroom near the reception desk, and sustained a fall that resulted in bruising to the resident's head. The findings include: A review of the facility's policy titled "Resident Assessment and Care Plan Policy and Procedure," with a revision date of 11/11/14, revealed a resident's care plan was developed in accordance with the Minimum Data Set (MDS) and the Care Area Assessment (CAA). Further	F 282	F282 Corrective action for resident #1 following fall on 12/16/14 included: 1. Resident's chair alarm changed to a model that it is always on and does not get turned off so that staff will be alerted when she is up unassisted in room. 2. Direct care staff educated on importance of following Resident Care Plan conducted by ADON. 3. Resident was assessed as an elopement risk after 12/16/14 incident and added to the Elopement Risk Resident Watch List. This list includes the resident picture and is available for staff in all departments, including the receptionist, so that staff is aware of who is at risk for unsafe wandering and how to respond. Caption under Resident #1 picture states "If off the unit unassisted please notify the supervisor immediately and escort or ask staff to escort back to unit or preferred location." 4. Disciplinary action taken against staff responsible for ensuring chair alarm was on and for resident's care, and against the	01/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michelle Essex* TITLE: *ADMINISTRATOR* (X6) DATE: *1/16/15*

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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F 282	<p>Continued From page 1</p> <p>review of the policy revealed staff was to review residents' care plans daily at the beginning of the shift and provide assistance with mobility in accordance with the care plan.</p> <p>A record review for Resident #1 revealed the facility admitted the resident on 10/22/14 with diagnoses that included Senile Dementia, Muscle Weakness, and Osteomyelitis. Further review of the record revealed the facility assessed the resident as being at risk for falls and developed a care plan on 10/22/14 that addressed the resident's fall risk. The facility revised Resident #1's care plan on 11/09/14, after the resident sustained a fall, to include the requirement that one staff member assist the resident with all transfers and ambulation.</p> <p>A review of nurse's notes revealed Resident #1 sustained a fall with injury on 12/16/14 at 11:45 AM while ambulating without assistance in a first floor bathroom. Further review revealed the resident was transferred to a hospital and returned to the facility with a diagnosis of a bruise to the right side of the head on 12/16/14 at 2:30 PM.</p> <p>An interview conducted with the facility Receptionist on 12/23/14 at 10:10 AM, revealed Resident #1 was observed sitting in a chair near the reception desk when the resident got up without the assistance of staff and ambulated to a bathroom approximately twelve steps from the reception desk. According to the Receptionist, she was not aware of the care needs of the resident and called the unit the resident resided on to inform staff the resident was walking back to the unit. Further interview revealed after the resident entered the bathroom, the Receptionist</p>	F 282	<p>DON for failure to follow the resident care plan by leaving the resident unattended which resulted in a fall.</p> <p>The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing a high fall risk resident each week at the QA Resident Incident Meeting to evaluate effectiveness of interventions in an attempt to prevent future falls. High fall risk residents will be identified by tracking previous falls and by Members of the QA Resident Incident Committee who will review fall incident reports at the morning rounding meeting along with resident status changes that may indicate an increase in fall risk.</p> <p>Measures put in place to ensure that the deficient practice will not recur include the SRNA care plan tool which list appropriate interventions for the resident and is reviewed at the beginning of the shift by SRNA staff. This SRNA care plan tool is kept in the room on the foot of the bed so that it is accessible by any staff person providing direct care. Weekly compliance rounds will be conducted by Nurse Supervisors to ensure interventions listed on the SRNA care plan are implemented. All Nursing Department staff were in-</p>		

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F 282	Continued From page 2 heard a noise, and when she looked in the bathroom, the resident was lying on the floor. The Receptionist stated that Licensed Practical Nurse (LPN) #1 arrived from the unit, assessed the resident, and staff called an ambulance to take the resident to the hospital. An interview conducted with LPN #1 on 12/23/14 at 12:55 PM, revealed Resident #1 exited the unit on 12/16/14 and was walking in the hallway with the Director of Nursing, and the DON had taken the resident to the front desk while the LPN was making rounds with a physician. LPN #1 stated someone then called the unit and reported that the resident had fallen in the bathroom by the reception desk. The LPN stated she assessed the resident and the resident was transferred to the hospital due to a large bruise on the right side of the head. An interview conducted with the DON on 12/23/14 at 1:10 PM revealed on 12/16/14, the DON assisted Resident #1 with ambulating to the front desk because the resident did not want to return to his/her room. Further interview revealed the DON was aware the resident required assistance of one person with ambulation and assisted the resident to a chair by the reception desk on the first floor while the DON returned a medical record to the second floor. Additional interview revealed the DON did not arrange for the resident to be supervised and did not inform staff at the reception desk that the resident was not to be up without assistance. When the DON returned from the second floor, the resident had ambulated to the bathroom unassisted and sustained a fall.	F 282	serviced on Resident Care Plans, Fall Prevention/Interventions, and the importance of knowing the resident's needs by the ADON the week of 1/6/15. Another measure is the utilization of the Elopement Risk Resident Watch List to alert non-direct care staff of resident safety risks. The Quality Assurance Coordinator will oversee weekly Care Plan compliance rounds conducted by the QA Nurse, ADON, and DON in addition to the compliance checks completed by the Nurse Supervisor. The QA Coordinator will track compliance and monitor for trends. Areas needing immediate attention will be addressed by Nurse Supervisor.		
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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F 323 SS=D	<p>Continued From page 3</p> <p>HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility's policy it was determined the facility failed to ensure one of three sampled residents (Resident #1) received adequate supervision and assistance to prevent accidents. Resident #1, who the facility assessed as having moderately impaired cognition and requiring assistance with ambulation, was left in a chair at the reception desk where staff was not familiar with the resident's needs. Resident #1 got up from the chair, ambulated without assistance to a bathroom near the reception desk, and sustained a fall. Resident #1 sustained bruising to the resident's head as a result of the fall.</p> <p>The findings include:</p> <p>A review of the facility's fall policy titled "Resident Safety Clinical Protocol," with a revision date of 11/10/14, revealed if a resident was at risk for falls or injuries, the initial resident care plan would include appropriate approaches to prevent injury.</p> <p>A record review for Resident #1 revealed the facility admitted the resident on 10/22/14 with diagnoses that included Senile Dementia, Muscle</p>	F 323	<p>F323</p> <p>Corrective action for resident #1 following fall on 12/16/14 included:</p> <ol style="list-style-type: none"> 5. Resident's chair alarm changed to a model that it is always on and does not get turned off so that staff will be alerted when she is up unassisted in room. 6. Direct care staff educated on importance of following Resident Care Plan conducted by ADON. 7. Resident was assessed as an elopement risk after 12/16/14 incident and added to the Elopement Risk Resident Watch List. This list includes the resident picture and is available for staff in all departments, including the receptionist, so that staff is aware of who is at risk for unsafe wandering and how to respond. Caption under Resident #1 picture states "If off the unit unassisted please notify the supervisor immediately and escort or ask staff to escort back to unit or preferred location." 8. Disciplinary action taken against staff responsible for ensuring chair alarm was on and for resident's care, and against the DON for failure to follow the resident care plan by leaving the resident unattended which resulted in a fall. 	01/12/15	

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F 323	<p>Continued From page 4</p> <p>Weakness, and Osteomyelitis. Further review of the record revealed the facility assessed the resident to be at risk for falls and developed a care plan dated 10/22/14 with interventions to address the resident's fall risk. Further review revealed the resident's care plan was revised on 11/09/14, when the resident sustained a fall, to include an intervention for one staff person to assist the resident with all transfers and ambulation.</p> <p>Further review of Resident #1's medical record revealed a nurse's note dated 12/16/14 at 11:45 AM. The note stated the resident sustained a fall with injury while ambulating without assistance in a first floor bathroom. The resident was transferred to a hospital for evaluation/treatment and returned to the facility on 12/16/14 at 2:30 PM with a diagnosis of a bruise on the right side of the resident's head.</p> <p>On 12/23/14 at 10:10 AM, an interview with the facility Receptionist revealed the Receptionist observed Resident #1 sitting in a chair near the reception desk. She stated the resident stood up without the assistance of staff and ambulated to a bathroom approximately twelve steps from the reception desk. According to the Receptionist, she was not aware of the resident's care needs and called the unit where Resident #1 resided to inform staff that the resident was walking back to the unit. Further interview revealed after the resident entered the bathroom the Receptionist heard a noise, and when she looked into the bathroom the resident was lying on the floor. The Receptionist stated that Licensed Practical Nurse (LPN) #1 arrived from the unit, assessed the resident, and staff called an ambulance to take the resident to the hospital.</p>	F 323	<p>The facility will identify other residents having the potential to be affected by the same deficient practice by reviewing a high fall risk resident each week at the QA Resident Incident Meeting to evaluate effectiveness of interventions in an attempt to prevent future falls. High fall risk residents will be identified by tracking previous falls and by Members of the QA Resident Incident Committee who will review fall incident reports at the morning rounding meeting along with resident status changes that may indicate an increase in fall risk.</p> <p>Measures put in place to ensure that the deficient practice will not recur include the SRNA care plan tool which list appropriate interventions for the resident and is reviewed at the beginning of the shift by SRNA staff. This SRNA care plan tool is kept in the room on the foot of the bed so that it is accessible by any staff person providing direct care. Weekly compliance rounds will be conducted by Nurse Supervisors to ensure interventions listed on the SRNA care plan are implemented. All Nursing Department staff were in-serviced on Resident Care Plans, Fall Prevention/Interventions, and the importance of knowing the resident's needs by the ADON the week of 1/6/15. Another measure is the</p>		

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F 323	Continued From page 5 An interview conducted with LPN #1 on 12/23/14 at 12:55 PM, revealed Resident #1 was walking in the hallway with the Director of Nursing's (DON) assistance. She further stated the DON had taken the resident to the front desk while the LPN was making rounds with a physician. LPN #1 stated someone then called the unit and reported that Resident #1 had fallen in the bathroom by the reception desk. The LPN stated she assessed the resident and the resident was transferred to the hospital due to bruising to the resident's face. An interview with the DON on 12/23/14 at 1:10 PM revealed on 12/16/14, the DON assisted Resident #1 with ambulating to a chair at the front desk because the resident did not want to return to his/her room. The DON was aware the resident required assistance of one person with ambulation; however, the DON left the resident to go to another floor of the facility without arranging for the resident to be supervised and without informing staff at the reception desk that the resident was not to be up without assistance. When the DON returned from the second floor, the resident had ambulated to the bathroom unassisted and sustained a fall.	F 323	utilization of the Elopement Risk Resident Watch List to alert non-direct care staff of resident safety risks. The Quality Assurance Coordinator will oversee weekly Care Plan compliance rounds conducted by the QA Nurse, ADON, and DON in addition to the compliance checks completed by the Nurse Supervisor. The QA Coordinator will track compliance and monitor for trends. Areas needing immediate attention will be addressed by Nurse Supervisor.		