

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

PRINTED: 11/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/14/2013
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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{F 000} INITIAL COMMENTS

An onsite revisit was conducted 11/13/13 through 11/14/13, and based on the revisit the facility was deemed to be in compliance as alleged on 09/18/13.

{F 000}

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

TITLE

(X6) DATE

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.

Acceptable Doc

09/18/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
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F 000	INITIAL COMMENTS AMENDED 09/24/13 A Recertification/Extended Survey was conducted 08/20/13 through 08/30/13. Immediate Jeopardy was identified on 08/23/13, and was determined to exist on 04/12/13 at 42 CFR 483.20 Resident Assessment, F-280; 42 CFR 483.25 Quality of Care, F-323; and, 42 CFR 483.75 Administration, F-490 and F-520. The facility was notified of the Immediate Jeopardy on 08/23/13. Substandard Quality of Care (SQC) was identified at 42 CFR 483.25, F-323. The facility failed to have an effective system in place to identify causal factors of falls in order to implement effective interventions to prevent accidents. The facility's Administration failed to have oversight to ensure the facility's Falls Policy was implemented and effective for prevention of accidents. In addition, the facility's Quality Assurance failed to ensure there was an effective monitoring system in place to evaluate the prevention of accidents. On 04/12/13 at 1:00 AM, Resident #1 was found on the floor behind his/her room door with a laceration to his/her forehead, swelling to the left eye, and complaints of severe head and neck pain. Resident #1 was sent to the Emergency Room for evaluation and admitted to the hospital with cervical fractures in his/her neck and returned to the facility on 04/15/13. Record review revealed the resident sustained another fall on 05/18/13; however, the facility failed to revise the resident's care plan to prevent further falls, even though the resident had a previous serious injury from a fall; had been assessed as a high risk for	F 000	The preparation and execution of this credible allegation of compliance 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. The facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. The facility further disputes that the circumstances constituted immediate jeopardy to any resident. This credible allegation of compliance is prepared and execute solely because it is required by federal and state law.		

RECEIVED
OCT 10 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Tiki Thomas
TITLE Administrator
(X8) DATE 10-9-13

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F 000	<p>Continued From page 1</p> <p>falls; and, had a history of frequent falls at the facility. Record review revealed on 11/05/12, at 6:25 AM Resident #1 was found on the floor under the bedside table with complaints of left shoulder pain and was diagnosed with a fracture of the left clavicle. Resident #1 also sustained three (3) falls in December 2012 on 12/04/12, 12/08/12, and on 12/10/12. Interview with the Administrator and record review revealed no documented evidence Resident #1's falls were thoroughly investigated to determine all causal factors, nor was the resident's Comprehensive Care Plan related to Falls revised in an attempt to prevent further falls. On 05/18/13, Resident #1 experienced another fall; however, continued review of the Comprehensive Care Plan revealed no documented evidence of revisions.</p> <p>Interview with the facility's Administrator revealed all falls were reviewed in the daily Continuous Quality Improvement (CQI) meeting conducted Monday through Friday. However, review of the Causation Factor Analysis forms for Resident #1's falls revealed no documented evidence contributing factors to Resident #1's falls were identified. Review of the Interdisciplinary Plan of Care (IPOC) team notes revealed no documented evidence immediate changes were implemented to the Comprehensive Care Plan as indicated per facility policy. Further interview with the Administrator also revealed there was no documented evidence of the Director of Nursing's (DON's) follow-up of Resident #1's falls per the facility's policy.</p> <p>The facility could provide no documented evidence falls were thoroughly tracked and trended, nor that the facility had identified, through the facility's Quality Assurance (QA)</p>	F 000		
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F 000	Continued From page 2 process, that procedures related to falls were not being implemented. Deficiencies cited were 42 CFR 483.20 Resident Assessment, F-280 at a Scope and Severity (S/S) of "K"; 42 CFR 483.25 Quality of Care, F-323 at a Scope and Severity (S/S) of "K"; and 42 CFR 483.75 Administration, F-490 and F-520 at a Scope and Severity (S/S) of "K". The facility provided an acceptable credible Allegation of Compliance (AoC) on 08/30/13 with the facility alleging removal of the Immediate Jeopardy on 08/30/13. The State Survey Agency verified, on 08/30/13, the Immediate Jeopardy was removed as alleged on 08/30/13, with remaining non-compliance at 42 CFR 483.20 Resident Assessment (F-280); 42 CFR 483.25 Quality of Care (F-323); and, 42 CFR 483.75 Administration (F-490 & F-520), at a S/S of a "E", while the facility develops, implements, and monitors a Plan of Correction to prevent recurrence of the deficient practice. Additional deficiencies were cited as a result of the Recertification Survey at 42 CFR 483.15 Quality of Life (F-253) at a S/S of an "E"; 42 CFR 483.35 Dietary Services (F-371) at a S/S of and "E"; 42 CFR 483.60 Pharmacy Services (F-431) at a S/S of a "D"; 42 CFR 483.65 Infection Control (F-441) at a S/S of an "E"; and 42 CFR 483.70 Physical Environment (F-463) at a S/S of an "E".	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253	F253 Criteria 1 -The ceiling tiles in the south dining room have been replaced. -The Wallpaper in room #316 has been	

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F 253	Continued From page 3 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure residents had comfortable and orderly interiors in one (1) room of twenty-six (26) rooms on the South Unit; and, in one (1) of two (2) dining rooms in the facility. Wall paper was torn off the wall in Room 316 and ceiling tiles were stained in the South Dining Room. The findings include: Review of the facility's policy, Wall (Interior) and Ceiling Maintenance, undated, revealed it was the policy of the facility to maintain the interior walls and ceilings of the building in good repair. The Maintenance and Housekeeping Departments monitored the interior walls and ceilings of the building by completing a monthly walk through of the building. Issues were prioritized and scheduled for repair as permitted. Observation of the facility, on 08/22/13 at 9:40 AM, in the South Dining Room revealed three (3) dark, brownish-colored stained ceiling tiles at one end of the South Dining Room. Observation of Room 316-B, on 08/22/13 at 10:00 AM, revealed a large area of torn wall paper, approximately eighteen (18) inches in diameter torn off the wall beside the resident's bed. The resident's bed was against the wall where the wall paper was torn. Interview, on 08/23/13 at 6:30 PM, with the	F 253	removed. Criteria 2 - An inspection of the entire Facility interior was completed by the Maintenance Director on 8-31-13 to determine that there are no other ceiling tiles or wallpaper, or other housekeeping/maintenance issues which require attention. Criteria 3 -The Maintenance and Housekeeping Staff have received in-service education on 9-16-13 by the Administrator on the routine inspection of facility common areas and resident rooms to identify and address issues which require cleaning and/or repair. Criteria 4: -The CQI indicator for the monitoring/identification of maintenance/housekeeping issues in facility common areas and resident rooms will be utilized monthly X 2 months and then quarterly under the supervision of the Administrator who will assign completion of the tool to housekeeping or maintenance staff. All completed tools are reviewed by the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.	9-17-13

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F 253	<p>Continued From page 4</p> <p>Maintenance Director revealed the wall paper had been missing on the wall for at least one (1) month. Further interview revealed the resident pcked at the wall paper everyday. Therefore, it continued to worsen. During the interview with the Maintenance Director, he stated repairing the wall in Room 316 had taken place during the July 2013 Interdisciplinary Plan of Care (IPOC) Meeting, but nothing had been done to date. The Maintenance Director revealed the facility was waiting to move the resident to another bed in the same room as soon as one of the residents moved out or could be transferred to another room. The Maintenance Director stated the ceiling tiles in the South Dining Room were replaced about one month ago, but the air conditioning was leaking condensation. The Maintenance Director stated the stained ceiling tiles and the torn wall paper were not homelike, but he had been on jury duty and had not had time to make the repairs.</p> <p>Interview with the Administrator, on 08/22/13 at 11:00 AM, revealed the Maintenance Director had been on jury duty and had been ill. The Administrator said it was just too hot to send the Maintenance Director up in the attic to repair the air conditionng condensation while it was so hot outside and they had gotten behind on repairs.</p>	F 253			
F 280 SS=K	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p>	F 280	<p>F280 Criteria 1 -The care plan and C.N.A care plan for residents #1, 4, 11, 12, and 13 have been reviewed/revise by the Interdisciplinary care plan team to reflect the fall management interventions indicated by the residents' fall risk assessments, the facility fall log review,</p>		

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F 280	<p>Continued From page 5</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to ensure the Comprehensive Care Plan was periodically reviewed and revised for seven (7) of fifteen (15) sampled residents (Residents #1, #4, #11, #12, #13, #16 and #17).</p> <p>On 04/12/13 at 1:00 AM, Resident #1 was found on the floor behind his/her room door with a laceration to his/her forehead, swelling to the left eye, and complaints of severe head and neck pain. Resident #1 was sent to the Emergency Room for evaluation and admitted to the hospital with cervical fractures in his/her neck. Record review revealed Resident #1 had a history of falls at the facility and had sustained a previous injury from a fall. On 11/05/12, at 6:25 AM Resident #1 was found on the floor under the bedside table with complaints of left shoulder pain and was diagnosed with a fracture of the left clavicle.</p>	F 280	<p>and Nurse Consultants suggestions for fall management interventions.</p> <p>The care plans for residents #16 and 17 have been reviewed/ revised by the Interdisciplinary care plan team to reflect the psychiatric treatment recommendations.</p> <p>Criteria 2 - All residents were reviewed to determine if they had experienced a fall in the last 90 days. The 19 residents who have exhibited a fall within the past 90 days have had a new Fall Log completed by the Interdisciplinary care plan team to assist with tracking/trending patterns and issues with their individual falls. Care plans were revised based on the review and causal factors identified for these residents. Using the Fall Log and Fall Assessment information, the team completed review/ revisions of the care plan and C.N.A. care plan for each resident exhibiting a fall in the last 60 days to determine that these reflect the fall management interventions indicated.</p> <p>- All residents were reviewed to identify those receiving specialized psychiatric services. Residents receiving psychiatric treatment recommendations have had review/revision by the Interdisciplinary care plan team to reflect the psychiatric treatment recommendations.</p> <p>Criteria 3 - Fall team staff, licensed nurses, Housekeepers and Laundry have received in-service education from the DON or Staff Development on the comprehensive investigation of all falls utilizing the Fall</p>		

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F 280	<p>Continued From page 6</p> <p>12/10/12. Interview with the Administrator and record review revealed no documented evidence Resident #1's falls were thoroughly investigated to determine all causal factors, nor was the resident's Comprehensive Care Plan related to Falls revised in an attempt to prevent further falls. (Refer to F323)</p> <p>Resident #4 experienced five (5) falls from 03/21/13 to 05/09/13 all attempting to get out of bed unassisted. The Comprehensive Care Plan was not revised to include interventions to prevent further falls.</p> <p>Resident #11 experienced seven (7) falls from 04/30/13 to 07/16/13 with no documented evidence of revisions to the care plan to include interventions to prevent further falls.</p> <p>Resident #12 experienced four (4) falls from 02/21/13 to 06/18/13 with no documented evidence the resident's care plan had been revised.</p> <p>Resident #13 experienced four (4) falls from 05/01/13 to 07/23/13 with no documented evidence of revisions to the care plan.</p> <p>In addition, Residents #16 and #17's record revealed no documented evidence the Comprehensive Care Plan was revised to include the Psychologist's Care Plan Information.</p> <p>The facility's failure to have an effective system in place to ensure residents' Comprehensive Care Plans were revised to prevent future falls, and failure to thoroughly implement and ensure the Care Plan Policy was effective in the prevention of falls placed Resident #1 and other residents at</p>	F 280	<p>interventions indicated by the Investigation and the need to implement alternative interventions when those first attempted are unsuccessful as provided on 8/26-29/2013.</p> <p>-The Interdisciplinary Care Plan team has received in-service education by the DON on the following: the use of the care plan check list to assist the team in identifying areas for development/revision of care plans inservice on 8-27-13; review/revision of care plans following resident Fall Investigations to determine that the Fall Team Interventions are addressed inservice on 8-27-13; and the review/revisions of care plans following psychiatric treatment visits to determine that recommendations are addressed inservice on 9-9-13.</p> <p>Criteria 4 - The CQI indicator for the monitoring of care plan documentation will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON, who will assign completion of the tool to nursing staff. All completed tools are reviewed by the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.</p>	9-18-13	

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F 280	<p>Continued From page 7</p> <p>Care Plan Policy was effective in the prevention of falls placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified at 42 CFR 483.20, Resident Assessment, F-280 at a Scope and Severity of "K". The Immediate Jeopardy was identified on 08/23/13 and determined to exist on 04/12/13.</p> <p>An acceptable Credible Allegation of Compliance, related to the Immediate Jeopardy, was received on 08/30/13. On 08/30/13, the Immediate Jeopardy was verified removed on 08/30/13 as alleged prior to exit. However, non-compliance continued to exist at 42 CFR 483.20 Resident Assessment at a Scope and Severity of an "E", as the facility had not completed the development and implementation of a Plan of Correction (PoC) to ensure the facility established and maintained an effective system to ensure residents' care plans were revised to ensure residents remained free from avoidable accidents.</p> <p>The findings include:</p> <p>Review of the facility's Care Plans Policy Statement, undated, revealed an individualized Comprehensive Care Plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs was to be developed for each resident. According to the policy, a Comprehensive Care Plan was based on a thorough assessment that included, but was not limited to the Minimum Data Set (MDS). The policy indicated an assessment of the residents was ongoing and care plans were revised as information about the resident and the resident's condition changed. The policy stated each</p>	F 280		
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F 280: Continued From page 8

resident's Comprehensive Care Plan was designed to: incorporate identified problems; incorporate risk factors associated with identified problems; build on the resident's strengths; reflect the resident's expressed wishes regarding care and treatment goals; reflect treatment goals, timetables and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventing or reducing declines in the resident's functional status and/or function levels; enhance the optimal functioning of the resident by focusing on a rehabilitative program.

1. Review of Resident #1's medical record revealed the facility admitted the resident on 02/21/06, with diagnoses that included a history of Ankle Fractures and Hip Fracture prior to admission, Diabetes, Alzheimer's, Osteoporosis, Dementia with Psychotic Features, Panic Disorder. Review of the Minimum Data Set (MDS) assessments completed on 09/27/12, 07/17/12 and 04/28/13 revealed the facility assessed the resident to be severely cognitively impaired and to require assistance with all Activities of Daily Living (ADLs). Review of the Fall Risk Assessments dated 12/13/12, 03/09/13, and 04/15/13 revealed the facility assessed Resident #1 to be a high risk for falls. Review of the Comprehensive Care Plan revealed the facility assessed Resident #1 to require a Falls Care Plan related to his/her history of falls and high risk for falls. Interventions included administer medications as ordered; assess for side effects to medication use and document if any noted; assist of one (1) with transfers; use a gait belt; call light within easy reach at all times; keep bed at lowest level at all times; labs as ordered; observe for change in mental status;

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F 280	<p>Continued From page 9</p> <p>nonskid shoes/socks when ambulating; observe for decrease or loss of functional status; provide clutter free pathways; respond promptly to call light; use of walker when ambulating; vital signs weekly and PRN (as necessary); remind resident to utilize call light; perimeter defined pressure reduction mattress to be to help prevent resident from rolling out of bed due to lays on edge of bed; use of wedge cushion to wheelchair to prevent sliding; restorative per plan of care; and scheduled toileting per plan of care. Review of the Nursing Assistant Care Plans for November 2012 through April 2013 revealed the resident to be on Extreme Fall Risk Precautions.</p> <p>Review of a fall investigation for Resident #1, dated 04/12/13 at 1:00 AM, revealed the resident sustained an unassisted fall and sustained a laceration to the head, and the left eye was bruised. Continued review of the Incident Log revealed Resident #1 was sent to the ER.</p> <p>Review of a Hospital Discharge Summary form revealed Resident #1 was diagnosed and treated for a cervical neck fracture. Continued review of the Summary revealed Resident #1 was discharged from the hospital on 04/15/13, with orders to wear a Miami J collar (neck collar) at all times. Review of the Comprehensive Care Plan revealed interventions of a sensor alarm and clip alarm were placed on Resident #1. Review of the Nurse's Note, dated 04/15/13 at 7:45 PM, revealed every fifteen (15) monitoring would be implemented. However, there was no documented evidence on the Comprehensive Plan of Care or on the Nursing Assistant Care Plan of the fifteen (15) minute monitoring of Resident #1 that was initiated, on 04/15/13 at 7:45 PM, when the resident returned to the facility</p>	F 280			

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F 280	<p>Continued From page 10 from the hospital.</p> <p>Record review revealed the resident sustained another fall on 05/18/13. Review of a fall investigation for Resident #1, dated 05/18/13 at 4:05 PM, revealed Resident #1 was found on the fall mat beside the bed and sustained no injury. Review of the Comprehensive Care Plan revealed the care plan was reviewed on 05/20/13. However, the facility failed to revise the resident's care plan to prevent further falls, even though the resident had a previous serious injury from a fall; had been assessed as a high risk for falls; and, had a history of frequent falls at the facility.</p> <p>Interview and record review revealed Resident #1 had a history of falls at the facility prior to the 04/12/13 fall in which the resident sustained a fractured neck. However, the facility failed to implement interventions in an attempt to prevent further falls.</p> <p>Review of a fall investigation for Resident #1, dated 11/05/12 at 6:25 AM, revealed Resident #1 was found on the floor under the bedside table and complained of left shoulder pain. The resident was diagnosed with an acute fracture of the distal clavicle (collar bone). Review of the Comprehensive Plan of Care for Resident #1 revealed the Falls Care Plan was reviewed on 11/05/12; however, the fall on 11/05/12 was not captured on the care plan. Continued review of the Comprehensive Nursing Care Plan revealed no documented evidence of additional interventions added to attempt to prevent additional falls. Review of the Nursing Assistant (NA) Care Plan revealed no documented evidence of changes or revisions put in place related to the fall.</p>	F 280		

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F 280	<p>Continued From page 11</p> <p>Review of a fall investigation for Resident #1, dated 12/04/12 at 10:30 PM, revealed the resident had transferred from his/her bed, and then fell trying to get out of his/her wheelchair. The fall investigation revealed the resident's blood sugar level was low; however, there was no evidence the facility attempted to determine the reason Resident #1's blood sugar was low. Review of the resident's care plan revealed it was not revised related to this fall.</p> <p>Review of a fall investigation for Resident #1, dated 12/07/12 at 4:30 PM, revealed Resident #1 was transferring from the bedside commode (BSC) to the wheelchair and sustained a fall. The IPOC Committee summarized that the resident would be checked for placement of the BSC and assessed for the need for personal alarms. However, review of the Comprehensive Care Plan revealed no documented evidence of revisions made to prevent additional falls and this fall was not reflected on the Care Plan.</p> <p>Review of a fall investigation for Resident #1, dated 12/10/12 at 11:00 PM, revealed Resident #1 sustained an unassisted fall with no injury. Review of the Comprehensive Care Plan revealed the care plan was reviewed on 12/10/12; however, there was no documented evidence of revisions made to prevent additional falls were identified.</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 8/22/13 at 5:50 PM, revealed she had been a Restorative Aid with the facility since February 2011 and was very familiar with caring for Resident #1. CNA #9 revealed Resident #1 would get up without putting on the call light and</p>	F 280		

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F 280	<p>Continued From page 12</p> <p>did not always understand how to use the call light and would get up independently. CNA #9 was uncertain if Resident #1 had falls mats or alarms in place before her falls when he/she fractured her collar bone in November 2012 and fractured her neck in April 2013.</p> <p>Interview with the Assistant Director of Nursing (ADON)/Minimum Data Set (MDS) Coordinator, on 08/22/13 at 2:00 PM, revealed she was responsible for updating Resident #1's plan of care with the interventions decided upon in the (IPOC) group meetings. The ADON was unsure why Resident #1's care plan had not been updated after the falls on 11/05/12, 12/04/12, 12/07/12, 12/10/12 and 05/18/13.</p> <p>Interview with the DON, on 08/23/13 at 2:05 PM, revealed the ADON/MDS Coordinator should have updated Resident #1's comprehensive care plan after every fall that the resident sustained from information received during the IPOC Team meetings. The DON admitted the IPOC Committee was not implementing interventions to be put in place to prevent future falls. The DON revealed she was not monitoring to see that the residents' Comprehensive Care Plans and Nurse Aid Care Plans were updated after the IPOC meetings and that she did not follow up to ensure interventions were implemented. The DON revealed she was responsible to ensure interventions were put in place on residents' Nursing and Nursing Assistant care plans. The DON revealed she had only been in the DON position since 04/29/13, was a DON in training, and was only responsible for what occurred after she took the position. The DON stated that she did not have a monitoring system in place to make certain the residents' care plans were</p>	F 280		
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updated/revised when a resident's conditions changes or when a resident had a fall.

2. Review of the medical record for Resident #4 revealed the resident was admitted by the facility on 01/22/13, with diagnoses which included Alzheimer's Dementia, Anxiety, and Depression. A review of the Minimum Data Set (MDS) assessments completed on 01/29/13, 06/30/13, and 07/25/13, all revealed the facility assessed the resident to be severely cognitively impaired. A review of fall risk assessments completed by the facility on 01/22/13, 03/15/13, and 06/30/13, all revealed the resident was assessed by the facility to be at high risk for falls to occur. A review of the comprehensive plan of care dated 02/11/13 for Resident #4, revealed interventions which had been put into place to prevent falls by administering medications as ordered by the physician, provide the assistance of two (2) persons with transfers, staff were to keep the call light within the resident's reach, staff were to check for incontinence on rounds and as needed, staff were to observe for a change in the resident's mental status and alert the physician as needed, staff were to orient the resident to his/her surroundings, staff were to respond promptly to the resident's call light, staff were to monitor vital signs every week and as needed, staff were to use a wheelchair with a gel cushion and bilateral leg rests, and a bedside commode would be used by the resident for ease with toileting.

Review of a fall investigation for Resident #4 dated 03/21/13 at 4:15 AM, revealed the resident fell again while attempting to use the bedside commode and sustained three (3) skin tears from the fall. A review of the Immediate Intervention Form dated 03/21/13, revealed education and

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instruction for the resident, and a walker had been added again as an intervention. A review of the incident log dated 03/21/13 at 4:15 AM, revealed education would be provided for the resident and since the resident had reached a plateau with therapy the resident would begin to receive restorative nursing services for safety had been added as interventions. However, review of the comprehensive plan of care for Resident #4 revealed the care plan had not been updated to reflect restorative nursing services.

Review of a fall investigation for Resident #4 dated 04/04/13 at 11:00 AM, revealed the resident fell attempting to use the bedside commode. A review of the Immediate Intervention Form dated 04/04/13, revealed ensure clothing does not contribute to falls, and non-skid socks had been added as an interventions. A review of the incident log dated 04/04/13 at 11:00 AM, revealed non-skid socks, and to encourage the resident to call for assistance were added as interventions. However, review of the comprehensive plan of care for Resident #4 revealed there was no evidence the facility revised the care plan to address the resident's attempt to toilet self.

Review of a fall investigation for Resident #4 dated 04/09/13 at 7:40 AM, revealed the resident fell attempting to use the bedside commode and sustained abrasions to the right upper back and a small "scratch" to the left upper back. A review of the Immediate Intervention Form dated 04/09/13 revealed ensure clothing does not contribute to falls, and access use of assistive devices had been added as interventions. A review of the incident log dated 04/09/13, revealed the resident would be educated about using the walker, and

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F 280	<p>Continued From page 15</p> <p>encourage to call for assistance were added as interventions. A review of the comprehensive plan of care for Resident #4 revealed the care plan had not been updated to educate the resident about using the walker or to encourage the resident to call for assistance after the resident sustained the fall.</p> <p>Review of a fall investigation for Resident #4 dated 04/09/13 at 11:00 AM, revealed the resident fell attempting to use the bedside commode and sustained laceration to the back of the head. A review of the Immediate Intervention Form dated 04/09/13 revealed ensure clothing does not contribute to falls, move bedside commode and walker closer to the bed had been added as an interventions. A review of the incident log dated 04/09/13 at 11:00 AM, revealed the resident would be placed on the toileting log which alerts staff to assist the resident with toileting, and the bedside commode would be moved had been added as Interventions. A review of the comprehensive plan of care for Resident #4 revealed no interventions regarding placing the resident on the toileting log, nor moving the bedside commode had been added as interventions to the care plan.</p> <p>Review of a fall investigation for Resident #4 dated 05/09/13 at 12:10 AM, revealed the resident fell attempting to get out of bed and sustained two (2) skin tears to the back and a skin tear reopened on the left arm. A review of the Immediate Intervention Form dated 05/09/13 revealed assess for functional status changes, and increased monitoring when the resident was in bed had been added as interventions. A review of the Incident log dated 05/09/13, at 12:10 AM, revealed float boots would be removed from the</p>	F 280		
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F 280	Continued From page 16 resident's feet was added as an intervention. A review of the comprehensive plan of care for Resident #4 revealed no intervention regarding the resident's float boots had been added as an intervention after the fall. An interview conducted with CNA #12 on 08/22/13, at 4:20 PM, and CNA #9 on 08/22/13, at 4:30 PM, both revealed Resident #4 had difficulty remembering things and required toileting every one to two (2) hours prior to the last couple of months. The CNA stated the resident had used a walker, but would attempt to get out of bed by himself/herself. The CNA's stated the resident could not recall to use the call light. Interview conducted with the Assistant Director of Nursing (ADON), on 08/22/13 at 1:40 PM, revealed she was also the MDS Coordinator and was responsible for coordinating the comprehensive plan of care. The ADON stated all falls are reviewed Monday through Friday at the morning meeting in which the interdisciplinary team meets. The ADON stated the interdisciplinary group meets and she was then responsible to update the plan of care with the interventions decided upon in the group. The ADON was unsure why the resident had fallen five (5) times before the resident was placed on a toileting program. The ADON stated she was unsure why Resident #4's care plan had not been updated after the resident had fallen on 03/21/13, at 4:15 AM, 04/09/13, at 7:40 AM, and 05/09/13, at 12:10 AM. The ADON stated a resident's care plan should always be updated after every fall. Interview conducted with the DON, on 08/22/13 at 2:05 PM, revealed the ADON was responsible for	F 280		
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F 280	<p>Continued From page 17</p> <p>updating the comprehensive plan of care. The DON stated all falls were required to have a care plan update and were reviewed in the morning interdisciplinary team meeting. The DON stated the falls were discussed and interventions were decided upon by the interdisciplinary team. The DON stated she did not review the completed care plans to ensure the interventions decided upon had been placed on the care plan. The DON stated Resident #4's care plan should have been updated to reflect the falls the resident sustained on 03/21/13, 04/04/13, 04/09/13, and 05/09/13.</p> <p>3. Review of the medical record for Resident #11, revealed the resident had been admitted by the facility on 02/23/09, with diagnoses which include Dementia, Encephalopathy, Non-organic Psychosis, Basal Ganglia Degeneration, and Carotid Artery Occlusion. A review of a significant change in condition MDS assessment for Resident #11, dated 03/21/13, and a quarterly MDS assessment, dated 08/08/13, revealed the facility had assessed the resident to be severely cognitively impaired on both assessments. A review of the Care Area Assessments (CAA) for the 03/21/13, revealed the resident was assessed as being at risk for falls.</p> <p>Review of a fall investigation for Resident #11 dated 04/30/13 at 3:48 PM, revealed the resident fell attempting to toilet him/herself after having had an enema. The fall investigation revealed the resident had not sustained an injury, an intervention had been added for the nurse to be reminded to stay with the resident until results were obtained after administering an enema to the resident. A review of the incident log dated 04/30/13, revealed the nurse would remain with</p>	F 280	

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the resident after administering an enema would be added as an intervention. A review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated with an intervention for the nurse to remain with the resident after administering an enema.

Review of a fall investigation for Resident #11 dated 05/30/13 at 7:30 PM, revealed the resident fell while a staff person was attempting to transfer the resident from a wheelchair to the shower chair. The fall investigation revealed the resident had not sustained an injury, an intervention had been added for the resident to be transferred with the assistance of two (2) staff. A review of the incident log dated 05/30/13, two (2) staff persons would be required to transfer the resident was added as an intervention. A review of the comprehensive plan of care for Resident #11 revealed no intervention had been added for the resident to be transferred with the assistance of two (2) staff.

Review of a fall investigation for Resident #11 dated 05/31/13 at 7:15 AM, revealed the resident fell by sliding out of the bed. The fall investigation revealed the resident had not sustained an injury, and an intervention had been added for a physical therapy evaluation. A review of the incident log dated 05/31/13 revealed physical therapy orders had been received. A review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the intervention.

Review of a fall investigation for Resident #11 dated, 06/05/13 at 3:48 PM, revealed the resident fell attempting to get out the bed unassisted. The fall investigation revealed the resident had not

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F 280	<p>Continued From page 19</p> <p>sustained an injury, and an intervention had been added for the resident to be placed up at the nursing station. A review of the incident log dated 06/05/13 revealed an order was obtained for Valium related to the resident not sleeping. A review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the intervention.</p> <p>Review of a fall investigation for Resident #11 dated 06/06/13 at 12:45 AM, fell from the bed to the floor and had not sustained an injury. The fall investigation also revealed physical therapy had assessed the resident and bed position, and had changed the bed position to ninety (90) degrees as an intervention. A review of the incident log dated 06/06/13 revealed physical therapy would assess the resident's bed and bed height, the bed was locked out, and tape was placed on the wall indicating where the bed should be placed was added as an intervention. A review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the changes identified as interventions to be used.</p> <p>Review of a fall investigation for Resident #11 dated 07/07/13 at 4:50 AM, revealed the resident fell from the bed to the floor and had not sustained an injury. The fall investigation also revealed "interventions currently being used for the resident were effective and no changes were made." A review of the incident log dated 07/07/13 revealed "the current interventions being used by the facility were effective." A review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall had occurred, nor did it address why if the interventions were effective the resident</p>	F 280		

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was continuing to fall.

Review of a fall investigation for Resident #11 dated 07/16/13 at 12:10 PM, fell from the bed to the floor and had not sustained an injury. The fall investigation also revealed "interventions currently being used for the resident were effective and no changes were made." A review of the incident log dated 07/16/13, revealed "the current interventions being used by the facility were effective." A review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall had occurred, nor did it address why if the interventions were effective the resident was continuing to fall.

An interview conducted with the ADON on 08/23/13, at 4:35 PM, revealed she was responsible to update Resident #11's plan of care with the interventions decided upon in the interdisciplinary group. The ADON was unsure why Resident #11's care plan had not been updated after the falls and stated it should have been. The ADON stated a resident's care plan should always be updated after every fall.

An interview conducted with the DON on 08/23/13, at 4:30 PM, revealed all falls were required to have a care plan update. The DON stated Resident #11's comprehensive plan of care should have been updated after every fall the resident sustained.

4. Review of the medical record for Resident #13 revealed the resident had been admitted by the facility on 01/03/07 with diagnoses which include Alzheimer's Dementia. A review of quarterly MDS assessment dated 06/19/13 revealed the resident

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 280	<p>Continued From page 21</p> <p>had been assessed by the facility to have moderately impaired cognition.</p> <p>Review of a fall investigation for Resident #13 dated 05/01/13 at 12:20 PM, revealed the resident fell from the chair to the floor and had not sustained an injury. The fall investigation also revealed an intervention would be put into place to assess the resident's chair and to remind the resident to call for assistance if needed. A review of the Immediate Intervention Form dated 05/01/13 revealed interventions to assess the use of assistive devices, and for a walker. A review of the incident log dated 05/01/13, revealed interventions for a chair assessment, and to remind the resident to call for assistance would be put into place. A review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the interventions fall.</p> <p>Review of a fall investigation for Resident #13 dated 05/07/13 at 01:30 PM, revealed the resident fell from the bed to the floor and had not sustained an injury. The fall investigation also revealed an intervention would be put into place for the resident to receive restorative nursing services. A review of the Immediate Intervention Form dated 05/07/13 revealed interventions to assess and to ensure current interventions were being used and were functioning, and to provide education/instruction to the resident. A review of the incident log dated 05/07/13 revealed interventions for the resident to receive restorative nursing services. A review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the interventions.</p>	F 280		
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F 280	Continued From page 22 Review of a fall investigation for Resident #13 dated 05/30/13 at 5:20 PM, revealed the resident fell from the bed to the bedside commode and had not sustained an injury. The fall investigation also revealed an intervention would be put into place to follow up with the family member of Resident #13 regarding the placement of the bedside commode. A review of the Immediate Intervention Form dated 05/30/13 revealed interventions would be put into place to move the bedside commode to the end of the resident's bed. A review of the incident log dated 05/30/13 revealed interventions to move the bedside commode to the end of the resident's bed would be put into place. A review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the interventions. Review of a fall investigation for Resident #13 dated 07/23/13, at 9:30 AM, revealed the resident fell from the bedside commode to the floor and had complained of right side pain, right hip pain, and left knee pain. The fall investigation revealed an intervention would be put into place to assess the resident's chair and to remind the resident to call for assistance if needed. A review of the Immediate Intervention Form dated 07/23/13, revealed interventions to make environmental modifications. A review of the incident log dated 07/23/13, revealed interventions for environmental modifications, and the resident would use a walker for ambulation. A review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect these interventions. Interview conducted with the ADON on 08/23/13 at 4:35 PM, revealed she was responsible to	F 280		
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F 280	<p>Continued From page 23</p> <p>update Resident #13's plan of care with the interventions decided upon in the interdisciplinary group. The ADON was unsure why Resident #13's care plan had not been updated after the falls and stated it should have been.</p> <p>Interview conducted with the DON on 08/23/13, at 4:30 PM, the ADON should have updated Resident #13's comprehensive plan of care after every fall the resident sustained.</p> <p>5. Resident #12 was admitted to the facility on 04/22/12 with diagnoses to include Diabetes Type II, difficulty in walking, muscle weakness, Hypertension, Hypothyroidism, Hyperlipidemia, Coronary Artery disease, Urinary Stress Incontinence, Depressive disorder, Accidental Fall, Osteoarthritis, history of Right total Knee Replacement, and Anxiety.</p> <p>Record review revealed on 02/21/13 at 5:55 PM, Resident #12 was found on the floor of his/her room and was assessed to have had no injury. An IPOC meeting was held on 02/25/13 and review of the IPOC Worksheet revealed under the summary section: Resident was found sitting on the floor on his/her buttocks in front of the bedside commode (BSC). Further review of the IPOC Worksheet revealed the resident stated he/she had gotten up from the BSC and was going to bed. He/She complained of right knee pain and stated it always hurt. It further revealed urine was noted under resident; he/she had a history of Incontinence, was followed by a urologist, wore pull-up briefs, and received Oxybutynin daily. Continued review of the IPOC Worksheet revealed a recommendation was made for a Physical Therapy (PT)/Occupational Therapy (OT) screening and to place a mat on</p>	F 280	

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F 280	<p>Continued From page 24</p> <p>the floor. However, review of the Resident 12's Comprehensive Care Plan revealed no documented evidence of revisions made after this fall to prevent further falls.</p> <p>On 04/25/13 at 4:10 PM, Resident #12 was found in the floor following a non-injury fall. The resident related that she was putting clothes in her closet and fell. It was recommended to Resident #12 to call for assistance. However, there was no revision made to Resident #12's care plan after this fall.</p> <p>On 05/30/13 at 11:00 AM, Resident #12 slid out of tub chair into the tub, with no injury. Review of the resident's plan of care revealed no changes in interventions to prevent further falls.</p> <p>On 06/18/13 at 3:00 AM, the resident was observed sitting on the floor beside her bed. Resident stated the floor was slick and urine was noted on the floor and the resident was wearing house shoes with a slick bottom. However, there was no documented evidences of revisions made to the care plan at that time.</p> <p>An interview with the MDS coordinator on 08/28/13 at 12 noon revealed that on 04/25/13, measures were taken to encourage the resident to call for assistance; however, the care plan was not up-dated to encourage to call for assistance. The Nursing Care Plan should have been up-dated.</p> <p>An interview with the Director of Nursing on 08/28/13 at 11:15 AM revealed that Resident #12 had always been independent with toileting and transfer. The resident's Care Plan was not changed or revised on 02/21/13, 04/25/13,</p>	F 280	

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05/30/13, and 06/18/13. The IPOC said to encourage resident to call for assistance and it should have been on the resident's Care Plan.

6. Review of the clinical record for Resident #16, revealed the facility admitted the resident with diagnoses of Adult Failure To Thrive, Depression, Debility and Congestive Heart Failure. The facility completed an admission Minimum Data Set (MDS) assessment on 07/30/13 which revealed the resident was cognitively intact and required limited assistance with Activities of Daily Living.

Review of the clinical record revealed Resident #16 was seen by a psychologist on 08/16/13 and was determined to be withdrawn, anxious and depressed. The psychologist wrote a care plan for the resident's withdrawn behaviors which included face to face invitations to social events. The care plan for anxiety included face to face invitations to social events, using a soothing voice, and removing irritants from the environment. The care plan for depression included supportive listening and redirection to positive topics.

Review of the comprehensive care plan, written 07/31/13, for Resident #16, revealed the psychologist's care plan interventions were not included in the comprehensive care plan. The facility was not able to locate any documentation to show the facility integrated the psychologist care plan into the comprehensive care plan.

Interview with Resident #16, on 08/30/13 at 1:10 PM, revealed the resident received medications for depression and anxious to return home when possible. The resident stated the stress of being

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F 280	<p>Continued From page 26</p> <p>in a nursing home again added to the depression.</p> <p>7. Review of the clinical record for Resident #17, revealed the facility admitted the resident with diagnoses of Depression, Left Hemiplegia secondary to a Cerebral Vascular Accident, and Hypertension. The facility completed an admission MDS assessment on the resident on 08/15/13 which revealed the resident was cognitively intact and required limited to extensive assistance with daily living tasks.</p> <p>Review of the psychological evaluation completed on 08/16/13, revealed Resident #17 was teary-eyed, depressed, and anxious. A psychological care plan was developed by the psychologist and included supportive listening and positive redirection for depression. Staff were to provide the resident with face to face invitations to social events, use soothing voice and touch and remove irritants from the environment.</p> <p>Review of the comprehensive care plan for Resident #17, revealed no documentation was located to show the facility integrated the psychologist care plan into the comprehensive care plan.</p> <p>Interview with Resident #17, on 08/30/13 at 9:30 AM, revealed the resident was new to the nursing home and was anxious to return home. The resident stated the current situation of being in a nursing home was causing anxiety and worry regarding the future.</p> <p>Interview with the MDS Coordinator, on 08/29/13 at 1:40 PM, revealed she was responsible for revising the care plans based on changes in</p>	F 280	

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physician orders and the resident's condition. She stated the psychological evaluation and resultant care plan had never been added to the comprehensive care plan in the past. She stated it was something new, however, the written notes and care plan were important to the care of the resident and should be added to the comprehensive care plan.

Interview with the Director of Nursing, on 08/30/13 at 11:05 AM, revealed she was not sure why the psychologist's care plans were not added to the comprehensive care plans for Residents #16 and #17. She stated there was no rationale to this and in the future, mood care plans would be developed.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 08/30/13 that alleged removal of the Immediate Jeopardy (IJ) on 08/30/13, based on the following:

1. Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed.
2. Nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team to assist with tracking and trending patterns and issues with their individual falls. Out of those residents reviewed, ten (10) care plans were revised based on the review and causal factors identified for the residents. Using the Fall Log and Fall Assessment Information, the Interdisciplinary Management team completed the review and revision of the care plan and CNA Care Plan for the residents who had fallen in the past sixty (60) days, to determine these reflect

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F 280	Continued From page 28 the fall management interventions indicated by the residents' fall risk assessments, facility Fall Log and Nurse Consultant suggestions for fall management interventions. These items were completed 08/27/13. 3. A new Fall Scene Investigation form was implemented to assist the facility in identifying and addressing causative factors of residents' falls. The form was to be completed by the Fall Team staff with each resident fall, to assist in determining the appropriate immediate interventions for the identified causative factor. The Fall Team members would include the Charge Nurse, the CNA, Housekeeper, and/or Laundry personnel for the resident who had fallen. The Charge Nurse was to complete and sign the Fall Team Investigation Report upon completion of the form. All resident falls were to be reviewed by the Interdisciplinary Management team Monday through Friday with residents' Comprehensive Care Plan and CNA Care Plan updated as needed. The Weekend Registered Nurse (RN) Supervisor was to review all incidents including falls within twenty-four (24) hours when the Interdisciplinary Management team was not present, to determine that all indicated interventions were in place and to ensure additional interventions were added if indicated. 4. A new event follow up form was to be completed after all Incident/Fall investigations to assist the Interdisciplinary Management team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form would note if the interventions were successful, and if any modifications or new/additional interventions were indicated.	F 280			

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5. The Fall Team staff, licensed nurses, Housekeepers, and Laundry personnel were inserviced by the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the investigation, and the need to implement alternative interventions when those first attempted were unsuccessful. These inservices were conducted 08/26-29/13. Facility staff who were unable to attend these inservices by 08/30/13 (due to vacations, medical leave, etc.) were to complete the inservice prior to being allowed to work their next shift. These staff would not be placed on the work schedule until completion of the inservice.

6. A meeting of the facility's Continuous Quality Improvement (CQI) committee which included the Medical Director was held on 08/30/13 to review the Allegation of Compliance, the new forms and procedures.

7. The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures was to be utilized monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON.

8. The Nurse Consultant was to review fall investigations, and the associated interventions with each quarterly visit.

9. The CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter under the supervision of the Administrator.

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F 280	<p>Continued From page 30</p> <p>On 08/30/13, the State Survey Agency verified the immediacy of the Immediate Jeopardy was removed and the facility implemented corrective actions as alleged in the AoC, effective 08/30/13 based on the following:</p> <ol style="list-style-type: none"> 1. Review of the Interdisciplinary Management meeting notes dated 08/27/13 revealed Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed. 2. Additional review revealed nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team. Review revealed ten (10) residents' care plans were revised based on the Interdisciplinary Management team's review. 3. Review of the facility's new "Falls Procedure" revealed the Charge Nurse was to complete a Fall Scene Investigation form to assist the facility in identifying and addressing causative factors of residents' falls. Review revealed the Fall Scene Investigation was included in the "Fall Procedure" packet. Continued review of the "Fall Procedure" revealed the staff member either witnessing or discovering a resident's fall was to notify the Charge Nurse who would page the Fall Team to the location of the fall. The Charge Nurse would assess the resident for injuries and the Fall Team would assess the environment and resident for causative factors of the fall. The Charge Nurse was to complete the Incident Report, Fall Scene Investigation Report form, and implement any needed interventions and adjust the care plan accordingly. The Charge Nurse was to notify the 	F 280		

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F 280	<p>Continued From page 31</p> <p>Director of Nursing (DON), Administrator, Physician, and Responsible Party of the fall. The resident was to be assessed every shift for seventy-two (72) hours.</p> <p>4. Further review revealed the Incident Report and Interventions were to be evaluated for effectiveness within twenty-four (24) hours by the Interdisciplinary Management team or the Registered Nurse (RN) Supervisor and any additional interventions were to be implemented. The Fall Team members would include on day shift the Charge Nurse, the Certified Nursing Assistant (CNA), and Housekeeper; on evening shift the Fall Team was to include the Charge Nurse, CNA, and Laundry personnel; on night shift the Fall Team was to include the Charge Nurse and CNA. Review revealed a new Event Report-Witness Statement Form was to be completed if an employee witnessed a fall.</p> <p>5. Review of inservice sheets revealed the following number of facility employees had been inserviced on the new Fall Procedures and forms: three (3) of the facility's four (4) RN's; sixteen (16) of the facility's seventeen (17) Licensed Practical Nurses (LPNs); twenty-one (21) of the facility's thirty-three (33) CNAs; five (5) of the facility's seven (7) Housekeepers; and two (2) of the facility's two (2) Laundry personnel were inserviced on the new fall procedures 08/27-29/13.</p> <p>Interviews were conducted on 08/30/13 with the following staff to verify the facility had educated them on the new Fall Procedures and to ensure their knowledge of the facility's new procedure and documents:</p>	F 280		
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F 280	Continued From page 32 Assistant Director of Nursing (ADON/Minimum Data Set (MDS) Coordinator at 2:55 PM; Weekend RN Supervisor #1, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM, and Weekend RN Supervisor #3, who worked the 10:00 PM to 6:00 AM shift, at 1:41 PM; LPN #3, who worked the 6:00 AM to 2:00 PM shift, at 1:19 PM; LPN #4, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM; LPN #2, who worked the 6:00 AM to 2:00 PM shift, at 2:15 PM; LPN #1, who worked the 10:00 PM to 6:00 AM shift, at 2:15 PM; LPN #11, who worked the 2:00 PM to 10:00 PM shift, at 2:38 PM; LPN #8, who worked the 2:00 PM to 10:00 PM shift, at 2:40 PM; LPN #5, who worked the 6:00 PM to 6:00 AM shift, at 2:42 PM; LPN #10, who worked the 2:00 PM to 10:00 PM shift, at 2:46 PM; CNA #9, who worked the 6:00 AM to 2:00 PM shift, at 1:10 PM; CNA #6, who worked the 6:00 AM to 2:00 PM shift, at 1:30 PM; CNA #8, who worked the 6:00 AM to 2:00 PM shift, at 1:45 PM; CNA #7, who worked the 6:00 AM to 2:00 PM shift, at 1:55 PM; CNA #4, who worked the 6:00 AM to 2:00 PM shift, at 2:00 PM; CNA #5, who worked the 6:00 AM to 2:00 PM shift, at 2:10 PM; CNA #3, who worked the 2:00 PM to 10:00 PM shift, at 2:20 PM; CNA #10, who worked the 2:00 PM to 10:00 PM shift, at 2:45 PM; CNA #18, who worked the 10:00 PM to 6:00 AM shift, at 3:06 PM; CNA #12, who worked the 2:00 PM to 10:00 PM shift, at 3:10 PM, and CNA #11, who worked the 2:00 PM to 10:00 PM shift, at 3:25 PM Housekeeper #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:38 PM; and Laundry Personnel #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:51 PM. All	F 280			

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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F 280 Continued From page 33
of the above staff were knowledgeable of the facility's new Falls Procedures, and Falls Team members and duties. All nursing staff interviewed were knowledgeable of the Fall Scene Investigation Report form and when to complete it. All staff verified they had received inservice education regarding these matters by the facility.

F 280

Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed most of the facility's staff had received inservice education on the new Fall Procedure/Policy, the Fall Scene Investigation Report form, the revision to the Incident Report form. According to the Administrator, any staff who had not received the inservice education would not be allowed to work until they had received it and would not be put on the schedule to work until they had received the education.

6. Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed the Medical Director had been informed of the Immediate Jeopardy findings and had been updated on the facility's Allegation of Compliance on 08/30/13 during the CQI Committee meeting. She stated the CQI Committee members had discussed the new forms and procedures the facility had implemented. The Administrator indicated the facility would use the CQI indicator for the monitoring of compliance with the facility fall management policies and procedures monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON. She stated the CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter. The Administrator stated a Nurse Consultant would visit quarterly and review fall investigations, and

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F 280	<p>Continued From page 34 the associated interventions.</p> <p>Interview, on 08/30/13 at 12:33 PM, with the Medical Director revealed the facility's CQI Committee, which he was a member of, had met that morning and discussed the facility's AoC plan and what interventions had been put in place to correct the Immediate Jeopardy.</p> <p>7. Interview, on 08/30/13 at 3:10 PM, with the Director of Nursing (DON) revealed all falls for the past sixty (60) days had been reviewed and the care plans revised as necessary. The DON stated the Assistant Director of Nursing (ADON) would be responsible for updating Comprehensive Care Plans and CNA Care Plans during the Monday through Friday interdisciplinary Management team meeting. She stated the Falls Policy had been revised and new Falls Teams had been implemented for each shift. The DON stated staff had been educated on the new policy, new forms, and Falls Teams duties. According to the DON, the CQI Committee had met that morning and the Medical Director had signed off on the facility's new policy, and new forms implemented by the facility.</p> <p>8. Interview, on 08/30/13 at 3:10 PM, with the facility's Nurse Consultant revealed she or another Nurse Consultant would be making quarterly visits to the facility to monitor. She stated residents' Comprehensive Care Plans and CNA Care Plans are now being brought to the Monday through Friday Interdisciplinary Management Team meeting and updated as interventions are discussed.</p> <p>9. The Nurse Consultant stated during the Interdisciplinary Management Team meeting a</p>	F 280		

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F 280 Continued From page 35
date would be set to review the revisions recommended by the team to ensure the new interventions were effective or see if additional interventions needed to be added. She indicated a Nurse Consultant would be coming to the facility on a quarterly basis to review falls and follow up performed, review the monthly CQI monitoring performed to ensure the AoC plan was followed.

The facility remained out of compliance at a lower Scope and Severity of a "E", a pattern deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).

F 323 483.25(h) FREE OF ACCIDENT
SS=K 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 observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure residents received adequate supervision and assistive devices to prevent falls for five (5) of fifteen (15) sampled residents (Residents #1, #4, #11, #12, and #13). The facility failed to have an effective system in place to thoroughly identify the root cause of falls in

F 280

F 323 F323

Criteria 1 - The Care Plan and C.N.A care plans for residents #1, 4, 11, 12, and 13 have been reviewed/ revised by the Interdisciplinary care plan team to reflect the fall management interventions indicated by the residents' fall risk assessments, the facility fall log review, and Nurse Consultants suggestions for fall management interventions on 8-24 and 8-27-13.

-The water temperatures in resident bathrooms between 603/605, 604/606 and the 600 Shower Room, are being maintained within the regulatory required parameters, as determined by the daily checks X 2 weeks, and then weekly thereafter as performed by the Maintenance Director and/or Administrator in Training.

Criteria 2 - -All residents were reviewed

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F 323	Continued From page 36 order to identify interventions to prevent further accidents for these residents. On 04/12/13, Resident #1 fell and sustained a cervical neck fracture. Record review revealed Resident #1 had a history of falls. On 11/05/12, the resident fell and sustained a fractured clavicle; fell three (3) times in December 2012; and, sustained a fall in May 2013. Record review and interview revealed the facility failed to identify the root cause of the falls and there were no changes in interventions implemented to prevent further falls for Resident #1 per facility policy and procedures. Resident #4 sustained a fall on 03/14/13, with no injury sustained by the resident. On 03/21/13, Resident #4 sustained a fall which resulted in three (3) skin tears. Resident #4 sustained a fall on 04/04/13, and sustained no injury. Resident #4 experienced two (2) falls on 04/09/13 which resulted in abrasions to the right upper back and a small "scratch" to the left upper back and a laceration to the back of the head. Additionally on 04/11/13, Resident #4 fell three (3) times and sustained a small laceration to the back of his/her head and a scrape to his/her left back. Resident #4 sustained a fall on 04/26/13, and had no injury. Resident #4 also experienced a fall on 05/09/13, which resulted in Resident #4 sustaining two (2) skin tears to the back and a skin tear reopened on the left arm. Residents #11, #12, and #13 also experienced falls between November 2012 and July 23, 2013 with no injury. The facility failed to identify the root cause of the falls and there were no changes in interventions implemented to prevent further falls for these residents per facility policy and procedures.	F 323	to determine if they had experienced a fall in the last 90 days. The 19 residents who have exhibited a fall within the past 90 days have had a new Fall Log completed by the Interdisciplinary care plan team to assist with tracking/trending patterns and issues with their individual falls. Care plans were revised based on the review and causal factors identified for these residents completed on 8-27-13. Using the Fall Log and Fall Assessment information, the team completed review/revisions of the care plan and C.N.A care plan for each resident exhibiting a fall in the last 90 days to determine that these reflect the fall management interventions indicated. - Water temperatures in resident rooms are being maintained within the regulatory required parameters as determined by daily checks X 2 weeks (initiated on 9-2-13), and then weekly thereafter as performed by the Maintenance Director and/or Administrator in Training. Criteria 3 - The facility has implemented a new Fall Scene Investigation form (initiated on 8/30/13) provided by the OIG at a Fall Management seminar, to help the facility to identify and address causative factors of resident falls. This form will be completed by Fall Team staff with each resident fall, to assist in determining the appropriate immediate interventions for the identified causative factors. The form will then be reviewed		

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F 323	<p>Continued From page 37</p> <p>In addition, the facility failed to ensure the facility's hot water system was maintained at a temperature to ensure water temperatures in resident care areas did not exceed State regulatory requirements based on 902 KAR 20:310-16(5)(g) and per facility policy, on one (1) of two (2) resident units. The facility also failed to monitor water temperatures in residents' individual rooms on two (2) of two (2) resident units.</p> <p>The facility's failure to ensure each resident received adequate supervision and assistive devices to prevent falls, failure to have an effective system in place to identify causal factors of falls in order to put effective interventions in place to prevent avoidable accidents, and failure to thoroughly implement the facility's Falls Policy to ensure the policy was effective in the prevention of avoidable accidents placed Resident #1 and the other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 08/23/13 and determined to exist on 04/12/13.</p> <p>Immediate Jeopardy was identified at Quality of Care, F-323 at a Scope and Severity of a "K".</p> <p>An acceptable Credible Allegation of Compliance, related to the Immediate Jeopardy, was received on 08/30/13. On 08/30/13, the Immediate Jeopardy was verified removed on 08/30/13 as alleged prior to exit. However, non-compliance continued to exist at Quality of Care, F-323 at a Scope and Severity of a "E", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained effective systems to ensure residents remain free</p>	F 323	<p>the next day by the Interdisciplinary team Monday - Friday, and the weekend RN supervisor on the weekends, to determine that all indicated interventions are in place, and if any additional interventions are indicated.</p> <p>-A new event follow up form (initiated on 8-30-13) will be completed after all incident investigations to assist the interdisciplinary team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form will note if the intervention(s) is successful, and if any modifications or new/additional interventions are indicated.</p> <p>-Fall team staff (licensed nurses, housekeeping/laundry staff) and all licensed nurses have received in-service education from the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the Investigation and the need to implement alternative interventions when those first attempted are unsuccessful on 8/26-30/13.</p> <p>-Facility staff who were not able to receive the in-service education by the completion of 8/30/13 (due to vacations, medical leave etc.), were required to complete the in-service prior to starting their next scheduled shift. This was achieved by staff who had not completed the inservice education were not scheduled after 8/30/13 until completion on the information.</p>	

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F 323 Continued From page 38
from avoidable accidents, the facility effectively implements their policy.

The findings include:

Review of the facility's policy regarding Falls, undated, revealed the facility was to provide care and an environment that would allow every resident to be free from falls or injury to the best of the facility's ability. The facility was to ensure each resident received adequate supervision and assistive devices to prevent accidents. If a resident experienced a fall, an Incident Report was to be completed and a causative factor analysis conducted to aid in identifying contributing factors. According to the policy, the Incident Report was to be reviewed by the Interdisciplinary Plan of Care (IPOC) team following any incident. The facility was to implement immediate changes in the care plan, if assessment indicated the need. The Director of Nursing (DON) or designee was to follow up on the investigation, utilizing the IPOC team and therapy department for input.

The facility used a three part fall investigation process the facility referred to as the Incident Report form, a Causative Factor Analysis Form, and a Fall Management-Immediate Interventions form. In addition to the fall investigation forms, the facility also used an Incident Log Form on which the Interdisciplinary Plan of Care (IPOC) Committee documented information on each resident's individual fall. The facility also utilized a form titled IPOC (Interdisciplinary Plan of Care) Worksheet which was used by the IPOC Committee to summarize follow up of falls and incidents.

F 323 -The Maintenance Director, Administrator in Training have received inservice education from the Administrator on the weekly checking and logging of water temperatures chosen at random throughout the facility, which includes resident rooms.

Criteria 4 - The Interdisciplinary Management team will review the Fall Team investigations and immediate interventions put in place for all falls daily during the week, with review completed by the weekend RN Supervisor on the weekends, to determine that all recommended interventions are in place and effective.

-A CQI Meeting with the Medical Director and CQI team was held on 8/30/13 to review the facility Plan of Correction, and the new forms and procedures.

-The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures will be utilized monthly X 2 months and then quarterly as per the established CQI calendar by the under the supervision of the DON who will assign completion of the tool to nursing staff for reviewing of residents with falls. All completed tools are reviewed by the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.

-The water temperature logs will be reviewed by the IDT CQI team monthly in the facility CQI meetings to determine that

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F 323	<p>Continued From page 39</p> <p>1. Review of the Incident Log dated, 04/12/13 at 1:00 AM, revealed Resident #1 was found lying on the floor behind the door in his/her room with a laceration to the head, and a bruise to the left eye. Continued review of the Incident Log revealed the resident was sent to the Emergency Room (ER). Record review revealed no documented evidence of an Interdisciplinary Plan of Care (IPOC) Worksheet.</p> <p>Review of a Fall Investigation for Resident #1 for a fall sustained on 04/12/13 revealed no documented evidence of the completion of the Incident Report form or the Falls Management-Immediate Interventions Form. Continued review of the Fall Investigation forms revealed a Causative Factor Analysis Report for 04/12/13 at 1:00 AM, which provided no documented evidence of the cause of the injury. Continued review of the Causative Factor Analysis Report form revealed under the "alarms attached" section the Nurse had checked N/A (not applicable); and under the "what exactly was the resident doing prior to the event" section the nurse noted "sitting in bed". Further review of the Fall Investigation revealed it did not address the root cause of the resident's fall.</p> <p>Record review revealed no documented evidence in the Nurse's Notes, regarding the details of Resident #1's fall on 04/12/13. Review of a Nurse's Note dated 04/12/13 at 1:20 AM, revealed Resident #1 was transferred to the ER was complaining of pain and was transferred to the ER.</p> <p>Review of a Hospital Discharge Summary form revealed Resident #1 was diagnosed with cervical neck fracture and admitted to the hospital on</p>	F 323	<p>they are being maintained within required parameters with development of an Action Plan for any issues identified.</p> <p>9-17-13</p>

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F 323	<p>Continued From page 40</p> <p>04/12/13. Continued review of the Discharge Summary revealed Resident #1 was discharged from the hospital on 04/15/13 with orders to wear a Miami J collar (neck collar) at all times.</p> <p>Review of the Nurse's Note, dated 04/15/13 revealed Resident #1 was now to have a sensor alarm and clip alarm and was to have every fifteen (15) minute monitoring of the resident was initiated. However, record review revealed no evidence the 15 minute checks were completed.</p> <p>Review of the Comprehensive Care Plan revealed on 04/17/13 it was reviewed and revisions were put in place. Resident #1 was to have assistance of two (2) verses the one (1) person assistance he/she required prior to the fall. Resident #1 was to have a low bed with a fall mat on the floor; and pressure and personal alarm at all times.</p> <p>Record review revealed Resident #1 sustained another fall on 05/18/13 at 4:05 PM. Review of the facility's three (3) part Fall Investigation forms revealed an Incident Report, dated 05/18/13 at 4:05 PM. Review of the Causative Factor Analysis Form, identified sensor and clip alarms were in place; however, there was no documented evidence the root cause of the fall was identified. Continued review of the Falls Investigation forms revealed no documented evidence of the Falls Management-Immediate Interventions Form. Further review of the Fall Investigation revealed no new interventions were addressed in order to prevent recurrence of falls.</p> <p>Review of the Incident Log, dated 05/18/13 at 4:05 PM, revealed Resident #1 was found on the</p>	F 323			

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F 323	Continued From page 41 mat beside the bed. Continued review of the Log revealed Resident #1 sustained no injury and the alarms were sounding. Record review revealed no documented evidence of an IPOC Worksheet to indicate the IPOC Committee had investigated the fall, addressed if interventions in place were effective, and whether new interventions were required. Review of Resident #1's medical record revealed the facility admitted the resident on 02/21/06, with diagnoses which included a history of Ankle Fractures and Hip Fracture prior to admission, Diabetes, Alzheimer's, Osteoporosis, Dementia with Psychotic Features. Review of the Annual Minimum Data Set (MDS) assessment, dated 07/17/12, the Quarterly MDS assessment dated 09/27/12, revealed the facility assessed the resident to be severely cognitively impaired. Review of the Fall Assessments dated 12/13/12, and 03/09/13 revealed the facility assessed Resident #1 to be a high risk for falls. Review of the Comprehensive Care Plan dated 08/03/12, revealed Resident #1 was at risk for falls related to a history of falls, a diagnosis of Alzheimer's Disease, and use of anti-depressant and anti-anxiety medications. Review of the Nursing Assistant Care Plans for 11/2012 revealed Resident #1 was on Extreme Fall Risk Precautions. Review of the Significant Change MDS assessment, dated 04/28/13, revealed the facility assessed the resident to be severely cognitively impaired the facility assessed Resident #1 to require limited assistance of one (1) staff person for transfers. Further review revealed the facility assessed Resident #1 to require extensive assistance of two (2) staff for transfers. Review of	F 323			

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F 323	<p>Continued From page 42</p> <p>the Fall Assessments dated 04/15/13 revealed the facility continued to assess Resident #1 as a high risk for falls.</p> <p>Record review revealed Resident #1 had a history of falls at the facility and had sustained a previous injury from a fall prior to 04/12/13.</p> <p>Review of the facility's three (3) part Fall Investigation forms revealed an Incident Report dated 11/05/12 at 6:25 AM in which it noted Resident #1 was complaining of left shoulder pain; under the "injuries noted" section there was no documented evidence of an injury. Continued review of the Incident Report revealed the Director of Nursing (DON) or her designee documented it appeared Resident #1 rolled out of bed. Review of the Fall Management-immediate intervention form dated, 11/05/12, revealed Resident #1 was assessed for injury, assisted to bed, the Physician was notified, and the resident was noted to have had left shoulder x-rays. Further review of the form revealed no documented evidence of new interventions to be added to prevent further falls. Review of the Causative Factor Analysis form dated, 11/05/12 revealed Resident #1 had been wearing non-skid slippers; and under the "alarm attached" section N/A (not applicable) was checked. However, further review of the Causation Factor Analysis form revealed no documented evidence it addressed the root cause of the resident's fall.</p> <p>Review of the the Interdisciplinary Plan of Care (IPOC) Work Sheet dated 11/06/12 revealed Resident #1 had a perimeter defined mattress (pdm) in place; his/her legs "were rolled up" with the blanket and had to be untangled to get Resident #1 up off the floor. Continued review of</p>	F 323)			

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the IPOC Work Sheet form revealed Resident #1 was noted to lay or sit on the side of his/her bed and lean over to "get into" his/her bedside table or overbed table. Further review revealed Resident #1 was placed on Physical Therapy's (PT's) caseload. Review of the Incident Log, dated 11/05/12, revealed Resident #1 was to be placed on PT caseload.

Review of the Nurse's Note, dated 11/05/12 at 9:25 AM, revealed an x-ray of the left shoulder was completed. Continued review of the Nurse's Notes revealed no documented evidence of the results of the shoulder x-ray. Review of a Nurse's Note, dated 11/05/12 at 10:00 AM, revealed the resident was complaining of shoulder pain.

Review of a Nurse's Note, dated 11/05/12 at 1:40 PM, revealed Resident #1 was "yelling" out in pain; had left shoulder edema (swelling); the left shoulder was noted to be uneven; the left hand had edema and the resident could not move the fingers.

Record review revealed a Physician Telephone Order dated 11/05/12 at 4:15 PM, to transfer Resident #1 to the Emergency Room (ER), post fall, for increased pain of the left shoulder.

Review of the hospital's shoulder x-ray, completed on 11/05/12 at 5:53 PM, revealed an acute fracture of the distal clavicle (collar bone).

Review of Resident 1's Comprehensive Care Plan revealed a care plan for Falls which was noted to have been reviewed on 11/05/12; however, there was no documented evidence of implementation of interventions to prevent recurrence of falls.

Interview, on 08/23/13 at 3:15 PM, with the

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F 323	<p>Continued From page 44</p> <p>Administrator revealed on 11/05/12 Resident #1 had been toileted at 6:00 AM, so toileting was not a factor in the fall. She stated the IPOC Committee would have looked at Resident #1's blood sugars as these were "very unstable". The Administrator stated Resident #1 had placed a pillow under the perimeter defined mattress which made the mattress "wibbiy wobbly" and he/she "just rolled right out" of the bed. The Administrator indicated Dycem (a non-slip mat which grips items in place, preventing any movement) was placed under Resident #1's mattress. However, she was unable to provide documented evidence this was performed. Continued interview with the Administrator revealed Resident #1 had a history of sitting up on the edge of the bed where he/she checked his/her purse and jewelry box. She stated the IPOC Committee did not identify a need for "anything else" other than the PT referral.</p> <p>Review of the facility's three (3) part fall investigation forms revealed an Incident Report, dated 12/04/12 at 9:45 AM. Review of this Incident Report revealed Resident #1 had experienced an unassisted fall with no injury. Further review of the Incident Report revealed the Director of Nursing (DON) noted Resident #1's fingerstick blood sugar (fsbs) was decreased to 75 mg (milligrams)/dl (deciliter); the resident was given a protein to increase the fsbs and assisted up to the wheelchair. Review of the Causative Factor Analysis revealed Resident #1's blood sugar level was low; however did not reflect the reason the blood sugar was low. Review of the Immediate Intervention Form, dated 12/04/12, revealed the facility would evaluate a change in Resident #1's insulin. Record review revealed no documented evidence the facility evaluated</p>	F 323		

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Resident #1's insulin for a possible change.

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Review of the Incident Log indicated Resident #1 had transferred from the bed and fell trying to get into his/her wheelchair. Further review of the Incident Log intervention section revealed Resident #1's fingerstick blood sugar (fsbs) was 75 mg (milligrams)/dl (deciliter); however, there was no documented evidence a change in insulin was to be performed. Review of the IPOC Worksheet dated 12/08/12, revealed no documented evidence the IPOC Committee assessed Resident #1 for a change in his/her insulin related to the low fsbs.

Review of Resident #1's Comprehensive Care Plan revealed no documented evidence it was revised to include evaluating Resident #1's insulin for a possible change. Further review revealed the Falls Care Plan was reviewed on 12/06/12; however, there was no documented evidence of implementation of additional interventions to prevent further falls from occurring.

Interview, on 08/23/13 at 3:15 PM, with the Administrator revealed all three (3) parts of the Fall Investigation forms were completed. She stated the Falls Management-Immediate Intervention form indicated to evaluate Resident #1's insulin for a change related to his/her low fsbs. The Administrator indicated the cause of this fall was the resident's low fsbs. According to the Administrator, Resident #1 had been eating a pimento cheese sandwich prior to the fall. She stated staff performed an Immediate intervention of giving Resident #1 a carbohydrate and protein. The Administrator stated staff contacted the Physician and "kept an eye" on Resident #1. She stated, after reviewing the Director of Nursing's

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F 323	Continued From page 46 (DON's) documentation on the Incident Log, there was no indication the DON performed any further follow-up to ensure Resident #1's insulin was evaluated for a possible change. The Administrator stated the IPOC Committee reviewed Resident #1's Comprehensive Care Plan for interventions already in place and made no changes. Review of the facility's three (3) part Investigation report for Resident #1 revealed an Incident Report, dated 12/07/12 at 4:30 PM. Review of the Incident Report form revealed Resident #1's fsbs was 262 mg/dl; however there was no indication of what the resident was doing at the time of the fall. Review of the the Fall Management-Immediate Interventions form, dated 12/07/12, revealed interventions to be put in place were, to keep frequently used items in reach, increase monitoring of the resident, and place Resident #1's bedside commode (BSC) closer to the bed. Review of the Causative Factor Analysis form revealed Resident #1 was assessed for injuries, assisted up, a fsbs was "retaken" and the Physician was notified. Review of the Incident Log, dated 12/08/12 at 4:30 PM, revealed Resident #1 was transferring self from the bedside commode (BSC) to the wheelchair. Further review of the Incident Log revealed under the "interventions" section staff were to check for placement of the BSC and were to re-assess Resident #1 for the use of alarms. Review of the summary on the IPOC Worksheet, dated 12/10/12, revealed the fall as occurring on 12/08/12 versus 12/07/12. Review of the IPOC Worksheet revealed no documented evidence of the cause of the fall on the worksheet. Further review revealed the IPOC Committee indicated	F 323			

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staff were to check Resident #1's BSC for placement and the resident was to be re-assessed for the use of alarms. Review of Resident #1's Comprehensive Care Plan revealed no documented evidence it was revised to include the immediate interventions indicated on the Fall Management-Immediate Intervention form or of the IPOC Committee's recommendations.

Review of the Nurse's Notes revealed the fall occurred, on 12/08/12 at 4:30 PM, even though the Fall Investigation forms indicated the fall occurred on 12/07/12. The Nurse's Notes indicated no injuries were sustained and Resident #1 was found sitting on his/her bare behind on the floor beside the BSC.

Review of a Personal Alarm/Safety Assessment Form, dated 12/10/12 revealed Resident #1 could not comprehend danger and had a history of falls. Further review revealed the facility determined Resident #1 would have no alarms at that time related to the resident having a history of disconnecting alarms.

Review of the fall investigation for Resident #1, dated 12/10/12 at 11:00 PM, revealed Resident #1 sustained an unassisted fall with no injury. Review of the Incident Report form dated 12/10/12 revealed Resident #1 the DON or designee had documented the resident had experienced "some changes"; the Physician had been at the facility at 6:30 AM and ordered Resident #1 "sent to ER". Further review of the Incident Report form revealed Resident #1 was admitted to the hospital with no documented evidence of reason for admission. Review of the Causative Factor Analysis form revealed

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F 323	<p>Continued From page 48</p> <p>Resident #1 was assessed for injuries; however, there was no documented evidence a root cause was identified for the fall. Review of the Fall Management-Immediate Interventions form, undated revealed interventions included a bedside commode, perimeter defined mattress, and the resident's bed against the wall.</p> <p>Review of the Incident Log revealed the resident was noted with some changes and the Physician was there at 6:30 AM and sent Resident #1 to Emergency Room (ER) which resulted in admission to the hospital. The falls investigation did not investigate the root cause of the fall or put interventions in place to prevent future falls.</p> <p>An interview, on 08/22/13 at 4:00 PM, with Resident #1's family member, (FM) revealed Resident #1 needed assistance with transfers, was unable to use the call light unless cued, was unstable on his/her feet, and would get up independently. The staff had reported to the FM that Resident #1 would get up independently and look through drawers for picture albums and jewelry. The FM stated there were no alarms in place and no falls mats in place before the fall in April 2013 when the Resident broke her neck. The FM commented the family had asked the facility to move the Resident closer to the Nurse's Station so that he/she could be monitored more closely. The FM was told there were no rooms available closer to the nurses desk.</p> <p>Interview, on 08/22/13 at 5:50 PM, with Certified Nursing Assistant (CNA) #9 revealed she had been a Restorative Aide with the facility since February 2011 and was very familiar with caring for Resident #1. CNA #9 revealed Resident #1 was in Restorative Care in April 2013 and still</p>	F 323		

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F 323	<p>Continued From page 49</p> <p>was. CNA #9 revealed it was not safe for the Resident to walk in his/her room independently or transfer self. CNA #9 revealed Resident #1 would get up without putting on the call light. CNA #9 revealed the Resident did not always understand how to use the call light and would get up independently. CNA #9 was uncertain if Resident #1 had falls mats or alarms in place before her falls when he/she fractured her collar bone in November 2011 and fractured her neck in April 2013.</p> <p>Interview with the DON, on 08/23/13 at 2:05 PM, revealed the ADON/MDS Coordinator should have updated Resident #1's comprehensive care plan after every fall the resident sustained from information received during the IPOC Team meetings. The DON stated the IPOC Committee had not been determining the root cause of the falls and was not implementing interventions to be put in place to prevent future falls. The DON revealed she was responsible to see that the root cause of an incident was determined and that interventions were put in place on residents' care plans. The DON revealed she had only been in the DON position since 04/29/13, was a DON in training, and was only responsible for what occurred after she took the position.</p> <p>2. A review of the medical record for Resident #4 revealed the resident was admitted by the facility on 01/22/13, with diagnoses which included Depression, Alzheimer's Dementia, and Anxiety. A review of the Minimum Data Set (MDS) assessments completed on 01/29/13, 06/30/13, and 07/25/13 all revealed the facility assessed the resident to be severely cognitively impaired. A review of fall risk assessments completed by the facility on 01/22/13, 03/15/13, and 06/30/13, all</p>	F 323	

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F 323	<p>Continued From page 50</p> <p>revealed the resident had been assessed by the facility to be at high risk for falls.</p> <p>Review of a fall investigation for Resident #4 dated 03/14/13 at 3:40 PM, revealed Resident #4 had fallen while attempting to use the bedside commode. Review of the nurses notes for Resident #4 dated 03/14/13 at 3:40 AM, revealed the resident had not sustained any injury. Review of the Immediate Intervention Form dated 03/14/13, revealed non-skid strips on the floor, and a walker to be placed in the resident's room by therapy had been added as interventions. Review of the incident log dated 03/14/13 at 3:30 PM, therapy to leave a walker to assist with transfers was added as an intervention. Review of the comprehensive plan of care for Resident #4 revealed a walker to aid with transfers was added as an Intervention. However, the fall investigation did not address the root cause of the resident's fall.</p> <p>Review of a fall investigation for Resident #4 dated 03/21/13 at 4:15 AM, revealed the Resident #4 fell while attempting to use the bedside commode, and according to nurses notes for Resident #4 dated 03/21/13 at 5:20 AM, the resident sustained three (3) skin tears from the fall. No measurements of the skin tears were documented in the nurses notes or the fall investigation. Review of the Immediate Intervention Form dated 03/21/13 revealed education and instruction for the resident and a walker had been added as interventions. Review of the incident log dated 03/21/13 at 4:15 AM, revealed education would be provided for the resident and since the resident had reached a plateau with therapy the resident would begin to receive restorative nursing services for safety had</p>	F 323	

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F 323	Continued From page 51 been added as interventions. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #4 revealed the care plan had not been updated to reflect any change in interventions related to the fall. Review of a fall investigation for Resident #4 dated 04/04/13 at 11:00 AM, revealed the Resident #4 fell while attempting to use the bedside commode, and according to nurses notes for Resident #4 dated 04/04/13 at 11:00 AM, the resident sustained no injury from the fall. Review of the Immediate Intervention Form dated 04/04/13 revealed ensure clothing does not contribute to falls, and non-skid socks had been added as an interventions. Review of the incident log dated 04/04/13 at 11:00 AM, revealed non-skid socks, and to encourage the resident to call for assistance were added as interventions. Review of the comprehensive plan of care for Resident #4 revealed the interventions had been added as interventions. However, the fall investigation did not address the root cause of the resident's fall. Review of a fall investigation for Resident #4 dated 04/09/13, at 7:40 AM, revealed Resident #4 fell attempting to use the bedside commode. Review of the nurses notes for Resident #4 dated 04/09/13 at 7:40 AM, revealed the resident sustained abrasions to the right upper back and a small "scratch" to the left upper back. No measurements were documented in the nurses notes or the fall investigation. Review of the Immediate Intervention Form dated 04/09/13, revealed ensure clothing does not contribute to falls, and access use of assistive devices had been added as interventions. Review of the	F 323			

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F 323	<p>Continued From page 52</p> <p>incident log dated 04/09/13, revealed the resident would be educated about using the walker, and encourage to call for assistance were added as interventions. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #4 revealed the care plan had not been updated to reflect the fall.</p> <p>Review of a fall investigation for Resident #4 dated 04/09/13, at 11:00 AM, revealed Resident #4 fell attempting to use the bedside commode and according to nurses notes for Resident #4 dated 04/09/13, at 11:00 AM, the resident sustained laceration to the back of the head. No measurements were documented in the nurses notes or the fall investigation. Review of the immediate Intervention Form dated 04/09/13, revealed ensure clothing does not contribute to falls, move bedside commode and walker closer to the bed, had been added as an Interventions. Review of the incident log dated 04/09/13 at 11:00 AM, revealed the resident would be placed on the toileting log, and the bedside commode would be moved, had been added as interventions. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #4 revealed no interventions had been added to the care plan to reflect the fall.</p> <p>Review of a fall investigation for Resident #4 dated 04/11/13 at 3:15 AM, revealed Resident #4 fell attempting to use the bedside commode and according to nurses notes for Resident #4 dated 04/11/13, at 3:15 AM, the resident sustained a small laceration to the back of the head. No measurements were documented in the nurses notes or the fall investigation. Review of the</p>	F 323		
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F 323	<p>Continued From page 53</p> <p>Immediate Intervention Form dated 04/11/13, revealed remove clutter and obstacles, keep frequently used items in reach, increased monitoring, ensure clothing does not contribute to falls, and access use of assistive devices had been added as interventions. Review of the incident log dated 04/11/13, at 3:15 AM, revealed call light within the resident's reach, and physical therapy orders were obtained were added as interventions. However, the fall investigation did not address the root cause of the resident's fall. A review of the comprehensive plan of care for Resident #4 revealed a urinal to be placed within the resident's reach had been added as an intervention.</p> <p>Review of a fall investigation for Resident #4 dated 04/11/13, at 11:15 AM, revealed Resident #4 fell attempting to use the bedside commode and review of the nurses notes for Resident #4 revealed the resident sustained a reddened area on the left hip. Review of the Immediate Intervention Form dated 04/11/13, revealed placing the oxygen concentrator at the head of the resident's bed had been added as an intervention. Review of the incident log dated 04/11/13, also revealed the oxygen concentrator would be placed at the head of the resident's bed, had been added as an intervention. Review of the comprehensive plan of care for Resident #4 revealed an intervention dated 04/12/13 for the oxygen concentrator to be placed at the head of the resident's bed to decrease the risk of the resident becoming tangled in the oxygen tubing had been added as an intervention. However, the fall investigation did not address the root cause of the resident's fall.</p> <p>Review of a fall investigation for Resident #4</p>	F 323	

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F 323 Continued From page 54

dated 04/11/12 at 11:00 PM, revealed Resident #4 fell attempting to use the bedside commode and according to nurses notes for Resident #4 dated 04/11/13 at 11:00 PM, the resident sustained a scrape to the left back. No measurements were documented in the nurses notes or the fall investigation. Review of the Immediate Intervention Form dated 04/11/13, revealed a urinal, and moving the resident's bed against the wall had been added as interventions. Review of the incident log revealed the urinal to be placed at the resident's bedside, remove the bedside commode from the resident's room, and to encourage the resident to use the urinal were added as interventions. Review of the comprehensive plan of care for Resident #4 revealed the interventions had been placed on the care plan. However, the fall investigation did not address the root cause of the resident's fall.

Review of a fall investigation for Resident #4 dated 04/26/13 at 12:30 AM, revealed Resident #4 fell by sliding out of the bed and sustained no injury. Review of the Immediate Intervention Form dated 04/26/13, revealed moving the resident's bed against the wall, and adding a drawsheet to the resident's bed had been added as interventions. Review of the incident log dated 04/26/13 at 12:30 AM, revealed adding a drawsheet to the resident's bed had been added as an intervention. A review of the comprehensive plan of care for Resident #4 revealed on 04/30/13, the facility added a drawsheet to the resident's care plan as an intervention. However, the fall investigation did not address the root cause of the resident's fall.

Review of a fall investigation for Resident #4 dated 05/09/13, at 12:10 AM, revealed Resident

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F 323	Continued From page 55 #4 fell attempting to get out of bed and according to nurses notes dated 05/09/13 at 12:10 AM, the resident sustained two (2) skin tears to the back and a skin tear reopened on the left arm. No measurements were documented in the nurses notes or the fall investigation. Review of the Immediate Intervention Form dated 05/09/13, revealed assess for functional status changes, and increased monitoring when the resident was in bed, had been added as interventions. Review of the Incident log dated 05/09/13 at 12:10 AM, revealed float boots would be removed from the resident's feet was added as an intervention. However, the fall investigation did not address the root cause of the resident's fall. A review of the comprehensive plan of care for Resident #4 revealed no intervention had been added related to the fall. Interview conducted with the Assistant Director of Nursing (ADON) on 08/22/13 at 1:40 PM, revealed she was also the MDS Coordinator and responsible for coordinating the comprehensive plan of care. The ADON revealed all falls were reviewed Monday through Friday during the morning meeting with the interdisciplinary team. The ADON stated when the interdisciplinary group meets, she was then responsible to update the plan of care with the interventions decided upon in the group. The ADON was unsure why the resident had fallen five (5) times before the resident was placed on a toileting program. The ADON stated she was unsure why Resident #4's care plan had not been updated after the resident had fallen on 03/21/13, at 4:15 AM, 04/09/13, at 7:40 AM, and 05/09/13, at 12:10 AM. The ADON stated a resident's care plan should always be updated after every fall.	F 323		
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F 323	<p>Continued From page 56</p> <p>Interview conducted with the DON on 08/22/13 at 2:05 PM, revealed the ADON was responsible for updating the comprehensive plan of care. The DON stated all falls were required to have a care plan updated and were reviewed in the morning interdisciplinary team meeting. The DON stated the falls were discussed and interventions were decided upon by the interdisciplinary team. The DON stated she had not reviewed the completed care plans to ensure the interventions decided upon had been placed on the care plan. The DON stated Resident #4's care plan should have been updated to reflect the falls the resident sustained on 03/21/13, at 4:15 AM, 04/09/13, at 7:40 AM, 05/09/13, at 12:10 AM. The DON further stated the facility should have looked at putting a toileting program in place for Resident #4 prior to the Resident sustaining five (5) falls attempting to use the bedside commode.</p> <p>3. Review of the medical record for Resident #11, revealed the resident had been admitted by the facility on 02/23/09, with diagnoses which include Dementia, Encephalopathy, Non-organic Psychosis, Basal Ganglia Degeneration, and Carotid Artery Occlusion. Review of a significant change in condition MDS assessment for Resident #11 dated 03/21/13, and a quarterly MDS assessment dated 06/06/13, revealed the facility had assessed the resident to be severely cognitively impaired on both assessments. Review of the Care Area Assessments (CAA) for the 03/21/13, revealed the resident was assessed as being at risk for falls.</p> <p>Review of a fall investigation for Resident #11 dated 04/30/13 at 3:48 PM, revealed Resident #11 fell attempting to toilet him/herself after having had an enema. The falls investigation</p>	F 323	

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F 323	Continued From page 57 revealed the resident had not sustained an injury, an intervention had been added for the nurse to be be reminded to stay with the resident until results were obtained after administering an enema to the resident. Review of the Incident log dated 04/30/13, revealed the nurse would remain with the resident after administering an enema was added as an intervention. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall. Review of a fall investigation for Resident #11 dated 05/30/13 at 7:30 PM, revealed Resident #11 fell while a staff person was attempting to transfer the resident from a wheelchair to the shower chair. The fall investigation revealed the resident had not sustained an injury, an intervention had been added for the resident to be transferred with the assistance of two (2) staff. Review of the incident log dated 05/30/13, two (2) staff persons would be required to transfer the resident was added as an intervention. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall. Review of a fall investigation for Resident #11 dated 05/31/13, at 7:15 AM, revealed Resident #11 fell by sliding out of the bed. The fall investigation revealed the resident had not sustained an injury, and an intervention had been added for a physical therapy evaluation. Review of the incident log dated 05/31/13, revealed physical therapy orders had been received. However, the fall investigation did not address the	F 323			

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F 323	<p>Continued From page 58</p> <p>root cause of the resident's fall. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall.</p> <p>Review of a fall investigation for Resident #11 dated, 06/05/13 at 3:48 PM, revealed Resident #11 fell attempting to get out the bed unassisted. The fall investigation revealed the resident had not sustained an injury, and an intervention had been added for the resident to be placed up at the nursing station. Review of the incident log dated 06/05/13, revealed an order was obtained for Valium related to the resident not sleeping. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall.</p> <p>Review of a fall investigation for Resident #11 dated 06/06/13 at 12:45 AM, revealed Resident #11 fell from the bed to the floor and had not sustained an injury. The falls investigation also revealed physical therapy had assessed the resident and bed position and had changed the bed position to ninety (90) degrees as an Intervention. Review of the incident log dated 06/06/13, revealed physical therapy would assess the resident's bed and bed height, the bed was locked out, and tape was placed on the wall indicating where the bed should be placed was added as an intervention. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the changes identified as interventions to be used.</p>	F 323		

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Review of a fall investigation for Resident #11 dated 07/07/13 at 4:50 AM, revealed Resident #11 fell from the bed to the floor and had not sustained an injury. The falls investigation also revealed interventions currently being used for the resident were effective and no changes were made. Review of the incident log dated 07/07/13, revealed the current interventions being used by the facility were effective. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall. However, the fall investigation did not address the root cause of the resident's fall.

Review of a fall investigation for Resident #11 dated 07/16/13 at 12:10 PM, revealed Resident #11 had fallen from the bed to the floor and had not sustained an injury. The falls investigation also revealed interventions currently being used for the resident were effective and no changes were made. A review of the incident log dated 07/16/13, revealed the current interventions being used by the facility were effective. Review of the comprehensive plan of care for Resident #11 revealed the care plan had not been updated to reflect the fall. However, the fall investigation did not address the root cause of the resident's fall.

Interview conducted with the ADON on 08/23/13, at 4:35 PM, revealed she was responsible to update Resident #11's plan of care with the interventions decided upon in the interdisciplinary group. The ADON was unsure why Resident #11's care plan had not been updated after the falls and stated it should have been. The ADON stated a resident's care plan should always be updated after every fall.

Interview conducted with the DON on 08/23/13, at

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F 323	<p>Continued From page 60</p> <p>4:30 PM, revealed all falls were required to have a care plan update. The DON stated Resident #11's comprehensive plan of care should have been updated after every fall the resident sustained. The DON also revealed she signed the fall investigations after they were completed, and agreed there was not a root cause identified.</p> <p>4. Review of the medical record for Resident #13, revealed the resident had been admitted by the facility on 01/03/07, with diagnoses which include Alzheimer's Dementia. A review of quarterly MDS assessment dated 08/19/13, revealed the resident had been assessed by the facility to have moderately impaired cognition.</p> <p>Review of a falls investigation for Resident #13 dated 05/01/13 at 12:20 PM, revealed Resident #13 fell from the chair to the floor and had not sustained an injury. The fall investigation also revealed an intervention would be put into place to assess the resident's chair and to remind the resident to call for assistance if needed. Review of the Immediate Intervention Form dated 05/01/13, revealed interventions to assess the use of assistive devices, and for a walker. Review of the incident log dated 05/01/13, revealed interventions for a chair assessment, and to remind the resident to call for assistance would be put into place. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the fall.</p> <p>Review of a fall investigation for Resident #13 dated 05/07/13 at 01:30 PM, revealed Resident #13 fell from the bed to the floor and had not sustained an injury. The fall investigation also</p>	F 323			

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F 323	Continued From page 61 revealed an intervention would be put into place for the resident to receive restorative nursing services. Review of the Immediate Intervention Form dated 05/07/13, revealed interventions to assess and to ensure current interventions were being used and were functioning, and to provide education/instruction to the resident. Review of the incident log dated 05/07/13, revealed interventions for the resident to receive restorative nursing services. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the fall. Review of a fall investigation for Resident #13 dated 05/30/13 at 5:20 PM, revealed Resident #13 fell from the bed to the bedside commode and had not sustained an injury. The fall investigation also revealed an intervention would be put into place to follow up with the family member of Resident #13 regarding the placement of the bedside commode. A review of the Immediate Intervention Form dated 05/30/13, revealed interventions would be put into place to move the bedside commode to the end of the resident's bed. Review of the incident log dated 05/30/13, revealed interventions to move the bedside commode to the end of the resident's bed would be put into place. However, the fall investigation did not address the root cause of the resident's fall. Review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the fall. Review of a fall investigation for Resident #13 dated 07/23/13 at 9:30 AM, revealed Resident #13 fell from the bedside commode to the floor and had complained of right side pain, right hip	F 323			

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F 323	Continued From page 62 pain, and left knee pain. The nurses notes dated 07/23/13, at 9:30 AM, revealed the physician was notified with physician's orders obtained for a chest Xray. The falls investigation also revealed an intervention would be put into place to assess the resident's chair and to remind the resident to call for assistance if needed. Review of the Immediate Intervention Form dated 07/23/13, revealed interventions to make environmental modifications. Review of the incident log dated 07/23/13, revealed interventions for environmental modifications, and the resident would use a walker for ambulation. Review of the comprehensive plan of care for Resident #13 revealed the care plan had not been updated to reflect the fall. However, the fall investigation did not address the root cause of the resident's fall. An interview conducted with the ADON on 08/23/13, at 4:35 PM, revealed she was responsible to update Resident #13's plan of care with the interventions decided upon in the interdisciplinary group. The ADON was unsure why Resident #13's care plan had not been updated after the falls and stated it should have been. An interview conducted with the DON on 08/23/13, at 4:30 PM, the ADON should have updated Resident #13's comprehensive plan of care after every fall the resident sustained. The DON stated a root cause had not been identified for Resident #13's falls. 5. Record review revealed Resident #12 was admitted to the facility on 04/22/12 with diagnoses to include Diabetes Type II, difficulty in walking, muscle weakness, Hypertension, Hypothyroidism, Hyperlipidemia, Coronary Artery disease, Urinary	F 323			

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F 323	<p>Continued From page 63</p> <p>Stress Incontinence, Depressive disorder, Accidental Fall, Osteoarthritis, Hx of Right total Knee Replacement, and Anxiety.</p> <p>Record review revealed on 02/21/13 at 5:55 PM, Resident #12 was found in the floor of his/her room and was assessed to have no injury. An IPOC meeting was held on 02/25/13 and a summary of the fall revealed: Resident found sitting in floor on buttocks in front of bedside commode (BSC), states she had got up off BSC and was going to bed. She c/o of right knee hurting and states it always hurts. Urine was noted under resident; she has a history of incontinence, followed by urologist, wears pull-ups, and receives Oxybutynin daily. A recommendation was made for a PT/OT screen and to place a mat on floor. Review of the care plan revealed there was no revision made to Resident #12's care plan at this time. However, there was no evidence the facility had determined the root cause for the resident's fall.</p> <p>On 04/25/13 at 4:10 PM, Resident #12 was found in the floor following a non-injury fall. The resident stated he/she was putting clothes in his/her closet and fell. The immediate interventions were to assess for injury, help resident out of the floor to bed, and offer Tylenol that PM. There was no revision made to Resident #12's care plan at that time. It was recommended to Resident #12 to call for assistance.</p> <p>On 05/30/13 at 11:00 AM, Resident #12 slid out of tub chair into the tub. The immediate interventions where to assess the resident for any injury, assist the resident into a standing position and dressed. The resident was assessed to not</p>	F 323		

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F 323	<p>Continued From page 64</p> <p>have received an injury; no revision was made to Resident #12's care plan at this time. There was no evidence the facility had determined the root cause for the resident's fall.</p> <p>On 06/18/13 at 3:00 AM, resident was observed sitting on the floor beside her bed. Resident stated the floor was slick. Urine was noted on the floor and the resident was wearing house shoes with a slick bottom. No injuries were assessed. The Resident was assisted to bed and her call light was placed within reach. No revision was made to the care plan at this time and there was no evidence the facility had determined the root cause for the resident's fall.</p> <p>An interview with the MDS coordinator on 08/28/13 at 12 noon revealed that on 04/25/13, measures were taken to encourage the resident to call for assistance; however the care plan was not up-dated to encourage to call for assistance. The Nursing Care Plan should have been up-dated.</p> <p>An interview with the Director of Nursing on 08/28/13 at 11:15 AM revealed that Resident #12 has always been independent with toileting and transfer. The Nursing Care Plan was not changed or revised on 02/16/13, 04/25/13, 05/30/13, and 06/18/13. The IPOC said to encourage resident to call for assistance and it should have been on the Nursing Care Plan.</p> <p>Interview, on 08/23/13 at 3:15 PM, with the Administrator revealed if a resident experienced a fall an Incident Report and a Causative Factor Analysis form were completed. The Interdisciplinary Plan of Care (IPOC) team would review the fall the next day, unless it happened</p>	F 323	

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F 323	Continued From page 65 on a weekend, in which case it would be reviewed on the following Monday. Per interview, the Administrator was unable to provide documented evidence thorough fall investigations were conducted for Residents #1's, #4's, #11's, #12's and #13's falls. There was no evidence causal factors had been identified to ensure implementation of interventions to prevent recurrence of falls, per the facility's policy. 6. Review of the facility's policy regarding Water Temperatures, undated, revealed water temperature checks were to be performed at least weekly at different locations throughout the building to ensure resident safety and to ensure the hot water system was functioning properly. The Maintenance Supervisor or designee were to conduct water temperature checks randomly throughout the building and record them on the proper forms. According to the policy, the temperatures in resident areas should range between 100 degrees to 110 degrees Fahrenheit for resident safety. Observation, of the water temperatures in the resident care areas on 08/20/13 at 12:15 PM, revealed random water temperature checks on the North Unit in Rooms 603, 604, 605, 606 and the 600 Shower Room to be 114 degrees Fahrenheit. Observation of the water temperatures in the resident care areas on 08/20/13 at 6:10 PM on the North Unit revealed water temperatures were 108 degrees (F) Fahrenheit as follows: in Rooms 603, 604, 605, 606 and the 600 Shower Room was 108 degrees (F). Interview with the Maintenance Director on	F 323			

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F 323	Continued From page 66 08/20/13 at 6:20 PM, revealed he adjusted the hot water heater to bring the temperatures down to 110 degrees (F) or lower on the 600 Hall, North Unit. He stated he checked the water temperatures every week to maintain water temperature between 100-110 degrees (F). Review of the water temperature logs maintained by the Maintenance Director revealed water temperatures were obtained throughout the facility in a random manner by Maintenance. The Maintenance Director was not monitoring water temperatures in residents' rooms. Water temperature were only being monitored in Shower Rooms and Community Bathrooms. There was no documentation in the log book for the water temperatures in any areas of the facility since 06/17/13. Interview with the Maintenance Director, on 08/23/13 at 6:30 PM revealed he never has taken water temperature checks in residents' rooms. The Maintenance Director revealed he thought it was not necessary to check temperatures in residents' rooms if he checked the community lavatories and shower rooms on each unit. The Maintenance Director was uncertain why there were no entries in the temperature log since 06/17/13. He commented he thought the Social Service Director (SSD) was keeping up with the log book. The Maintenance Director said maybe I did not give her the temperatures, I write them on sticky notes and then she records them in the log. I will find them. The Maintenance Director returned a few minutes later with several sticky notes with temperatures for the shower rooms and lavatories for July 2013 to present with temperature ranging from 100-110 degrees (F).	F 323		

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F 323 Continued From page 67

Interview with the Administrator in Training on 8/23/13 at 6:35 PM, revealed he was unaware water temperatures should be checked in residents' rooms.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 08/30/13 that alleged removal of the Immediate Jeopardy (IJ) on 08/30/13, based on the following:

1. Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed.
2. Nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team to assist with tracking and trending patterns and issues with their individual falls. Out of those residents reviewed, ten (10) care plans were revised based on the review and causal factors identified for the residents. Using the Fall Log and Fall Assessment information, the Interdisciplinary Management team completed the review and revision of the care plan and CNA Care Plan for the residents who had fallen in the past sixty (60) days, to determine these reflect the fall management interventions indicated by the residents' fall risk assessments, facility Fall Log and Nurse Consultant suggestions for fall management interventions. These items were completed 08/27/13.
3. A new Fall Scene Investigation form was implemented to assist the facility in identifying and addressing causative factors of residents' falls. The form was to be completed by the Fall Team staff with each resident fall, to assist in determining the appropriate immediate

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F 323	Continued From page 68 interventions for the identified causative factor. The Fall Team members would include the Charge Nurse, the CNA, Housekeeper, and/or Laundry personnel for the resident who had fallen. The Charge Nurse was to complete and sign the Fall Team Investigation Report upon completion of the form. All resident falls were to be reviewed by the Interdisciplinary Management team Monday through Friday with residents' Comprehensive Care Plan and CNA Care Plan updated as needed. The Weekend Registered Nurse (RN) Supervisor was to review all incidents including falls within twenty-four (24) hours when the Interdisciplinary Management team was not present, to determine that all indicated interventions were in place and to ensure additional interventions were added if indicated. 4. A new event follow up form was to be completed after all Incident/Fall investigations to assist the Interdisciplinary Management team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form would note if the interventions were successful, and if any modifications or new/additional interventions were indicated. 5. The Fall Team staff, licensed nurses, Housekeepers, and Laundry personnel were inserviced by the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the investigation, and the need to implement alternative interventions when those first attempted were unsuccessful. These inservices were conducted 08/26-29/13. Facility staff who were unable to attend these inservices	F 323		

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F 323 Continued From page 69
by 08/30/13 (due to vacations, medical leave, etc.) were to complete the inservice prior to being allowed to work their next shift. These staff would not be placed on the work schedule until completion of the inservice.

6. A meeting of the facility's Continuous Quality Improvement (CQI) committee which included the Medical Director was held on 08/30/13 to review the Allegation of Compliance, the new forms and procedures.

7. The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures was to be utilized monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON.

8. The Nurse Consultant was to review fall investigations, and the associated interventions with each quarterly visit.

9. The CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter under the supervision of the Administrator.

On 08/30/13, the State Survey Agency verified the immediacy of the Immediate Jeopardy was removed and the facility implemented corrective actions as alleged in the AoC, effective 08/30/13 based on the following:

1. Review of the Interdisciplinary Management meeting notes dated 08/27/13 revealed Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed.

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F 323	Continued From page 70 2. Additional review revealed nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team. Review revealed ten (10) residents' care plans were revised based on the Interdisciplinary Management team's review. 3. Review of the facility's new "Falls Procedure" revealed the Charge Nurse was to complete a Fall Scene Investigation form to assist the facility in identifying and addressing causative factors of residents' falls. Review revealed the Fall Scene Investigation was included in the "Fall Procedure" packet. Continued review of the "Fall Procedure" revealed the staff member either witnessing or discovering a resident's fall was to notify the Charge Nurse who would page the Fall Team to the location of the fall. The Charge Nurse would assess the resident for injuries and the Fall Team would assess the environment and resident for causative factors of the fall. The Charge Nurse was to complete the Incident Report, Fall Scene Investigation Report form, and implement any needed interventions and adjust the care plan accordingly. The Charge Nurse was to notify the Director of Nursing (DON), Administrator, Physician, and Responsible Party of the fall. The resident was to be assessed every shift for seventy-two (72) hours. 4. Further review revealed the Incident Report and interventions were to be evaluated for effectiveness within twenty-four (24) hours by the Interdisciplinary Management team or the Registered Nurse (RN) Supervisor and any additional interventions were to be implemented. The Fall Team members would include on day	F 323			

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F 323	<p>Continued From page 71</p> <p>shift the Charge Nurse, the Certified Nursing Assistant (CNA), and Housekeeper; on evening shift the Fall Team was to include the Charge Nurse, CNA, and Laundry personnel; on night shift the Fall Team was to include the Charge Nurse and CNA. Review revealed a new Event Report-Witness Statement Form was to be completed if an employee witnessed a fall.</p> <p>5. Review of inservice sheets revealed the following number of facility employees had been inserviced on the new Fall Procedures and forms: three (3) of the facility's four (4) RN's; sixteen (16) of the facility's seventeen (17) Licensed Practical Nurses (LPNs); twenty-one (21) of the facility's thirty-three (33) CNAs; five (5) of the facility's seven (7) Housekeepers; and two (2) of the facility's two (2) Laundry personnel were inserviced on the new fall procedures 08/27-29/13.</p> <p>Interviews were conducted on 08/30/13 with the following staff to verify the facility had educated them on the new Fall Procedures and to ensure their knowledge of the facility's new procedure and documents:</p> <p>Assistant Director of Nursing (ADON/Minimum Data Set (MDS) Coordinator at 2:55 PM; Weekend RN Supervisor #1, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM, and Weekend RN Supervisor #3, who worked the 10:00 PM to 6:00 AM shift, at 1:41 PM;</p> <p>LPN #3, who worked the 6:00 AM to 2:00 PM shift, at 1:19 PM; LPN #4, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM; LPN #2, who worked the 6:00 AM to 2:00 PM shift, at 2:15 PM; LPN #1, who worked the 10:00 PM to 6:00 AM</p>	F 323		

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F 323	<p>Continued From page 72</p> <p>shift, at 2:15 PM; LPN #11, who worked the 2:00 PM to 10:00 PM shift, at 2:38 PM; LPN #8, who worked the 2:00 PM to 10:00 PM shift, at 2:40 PM; LPN #5, who worked the 6:00 PM to 6:00 AM shift, at 2:42 PM; LPN #10, who worked the 2:00 PM to 10:00 PM shift, at 2:46 PM;</p> <p>CNA #9, who worked the 6:00 AM to 2:00 PM shift, at 1:10 PM; CNA #6, who worked the 6:00 AM to 2:00 PM shift, at 1:30 PM; CNA #8, who worked the 6:00 AM to 2:00 PM shift, at 1:45 PM; CNA #7, who worked the 6:00 AM to 2:00 PM shift, at 1:55 PM; CNA #4, who worked the 6:00 AM to 2:00 PM shift, at 2:00 PM; CNA #5, who worked the 6:00 AM to 2:00 PM shift, at 2:10 PM; CNA #3, who worked the 2:00 PM to 10:00 PM shift, at 2:20 PM; CNA #10, who worked the 2:00 PM to 10:00 PM shift, at 2:45 PM; CNA #18, who worked the 10:00 PM to 6:00 AM shift, at 3:06 PM; CNA #12, who worked the 2:00 PM to 10:00 PM shift, at 3:10 PM, and CNA #11, who worked the 2:00 PM to 10:00 PM shift, at 3:25 PM</p> <p>Housekeeper #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:38 PM; and Laundry Personnel #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:51 PM. All of the above staff were knowledgeable of the facility's new Falls Procedures, and Falls Team members and duties. All nursing staff interviewed were knowledgeable of the Fall Scene Investigation Report form and when to complete it. All staff verified they had received inservice education regarding these matters by the facility.</p> <p>Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed most of the facility's staff had received inservice education on the new Fall Procedure/Policy, the Fall Scene Investigation</p>	F 323		
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F 323	<p>Continued From page 73</p> <p>Report form, the revision to the Incident Report form. According to the Administrator, any staff who had not received the inservice education would not be allowed to work until they had received it and would not be put on the schedule to work until they had received the education.</p> <p>6. Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed the Medical Director had been informed of the Immediate Jeopardy findings and had been updated on the facility's Allegation of Compliance on 08/30/13 during the CQI Committee meeting. She stated the CQI Committee members had discussed the new forms and procedures the facility had implemented. The Administrator indicated the facility would use the CQI indicator for the monitoring of compliance with the facility fall management policies and procedures monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON. She stated the CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter. The Administrator stated a Nurse Consultant would visit quarterly and review fall investigations, and the associated interventions.</p> <p>Interview, on 08/30/13 at 12:33 PM, with the Medical Director revealed the facility's CQI Committee, which he was a member of, had met that morning and discussed the facility's AoC plan and what interventions had been put in place to correct the Immediate Jeopardy.</p> <p>7. Interview, on 08/30/13 at 3:10 PM, with the Director of Nursing (DON) revealed all falls for the past sixty (60) days had been reviewed and</p>	F 323		

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F 323	<p>Continued From page 74</p> <p>the care plans revised as necessary. The DON stated the Assistant Director of Nursing (ADON) would be responsible for updating Comprehensive Care Plans and CNA Care Plans during the Monday through Friday Interdisciplinary Management team meeting. She stated the Falls Policy had been revised and new Falls Teams had been implemented for each shift. The DON stated staff had been educated on the new policy, new forms, and Falls Teams duties. According to the DON, the CQI Committee had met that morning and the Medical Director had signed off on the facility's new policy, and new forms implemented by the facility.</p> <p>8. Interview, on 08/30/13 at 3:10 PM, with the facility's Nurse Consultant revealed she or another Nurse Consultant would be making quarterly visits to the facility to monitor. She stated residents' Comprehensive Care Plans and CNA Care Plans are now being brought to the Monday through Friday Interdisciplinary Management Team meeting and updated as interventions are discussed.</p> <p>9. The Nurse Consultant stated during the Interdisciplinary Management Team meeting a date would be set to review the revisions recommended by the team to ensure the new interventions were effective or see if additional interventions needed to be added. She indicated a Nurse Consultant would be coming to the facility on a quarterly basis to review falls and follow up performed, review the monthly CQI monitoring performed to ensure the AoC plan was followed.</p> <p>The facility remained out of compliance at a lower Scope and Severity of a "D", an isolated</p>	F 323	

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F 323 Continued From page 75
deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).

F 371 483.35(i) FOOD PROCURE,
SS=E STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and facility policy review, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation during the initial tour of the kitchen on 08/20/13, at 9:40 AM revealed kitchen floors with black marks, the exhaust fan between the steamer table and the food preparation table had gray debris on it, the steamer table with food particles floating in the water, spice containers and the shelf they were being stored on with a gray greasy film on them, a broken egg stored in the cooler in a box with other eggs, a shelf between the stove and the dishwasher had dried red food substance on it. In addition, on 08/20/13, beginning at 10:50 AM, observation of the steamer table revealed the dietary staff placed food serving pans in the steam table with the food particles floating in it, a box of oatmeal was opened and uncovered

F 323

F 371

F371
Criteria 1 - The floor in the dietary department was cleaned on 8-20-13. The Dietary floor was waxed on 8-24/25-13. The exhaust fan, steam table, spice containers and shelving were cleaned on 8-20-13. The broken egg was thrown away and the eggs were stored in a container on 8-20-13. The box of oats was thrown away on 8-20-13. Dietary staff follow infection control standards for hand washing in the dietary department.

Criteria 2 - A sanitation inspection was completed of the dietary department on 9-11-13 by the RD with all findings addressed as indicated.

-Hand sanitation observations were completed on all dietary department staff by Staff Development Nurse on 9-5-13, 9-6-13, 9-10-13, and 9-16-13 to determine that infection control standards are being followed.

Criteria 3 - Dietary staff have received inservice education on dietary sanitation issues including but not limited to: food storage requirements and the department cleaning schedules, as provided by the RD/DM on 9-11-13.

Criteria 4 - The CQI for the monitoring of dietary sanitation, which includes

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F 371	Continued From page 76 beside the microwave, and the Cook was observed to wipe perspiration from her face with a towel, and continued to serve food until stopped by the surveyor. The findings include: Review of the facility's policy titled, "Cleaning Floors", undated, revealed kitchen floors would be kept clean and sanitary. Review of the facility's policy titled, "Exhaust Fans", undated, revealed the exhaust fans would be cleaned quarterly. Review of the facility's policy titled, "Cleaning Steam Tables", undated, revealed the steam tables would be maintained in a clean and sanitary condition. Review of the facility's policy titled, "Food Safety and Sanitation", undated, revealed food would be stored and protected from contamination and growth of any pathogenic organisms. The policy stated foods would be protected from dust, flies, rodents, and other vermin. Review of the facility's policy titled, "Cleaning Cabinets and Drawers", undated, revealed cabinets would be free from food particles and dirt. Review of the facility's policy titled, "Handwashing", undated, revealed staff was required to wash their hands when their hands were soiled with body fluids. Observations during the initial tour of the kitchen on 08/20/13, at 9:40 AM, revealed:	F 371	monitoring of hand sanitation, will be utilized monthly under the supervision of RD or DM. All completed tools are reviewed by the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.	9-17-13
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F 371	<p>Continued From page 77</p> <ul style="list-style-type: none"> - The kitchen floors were observed to have black marks all over them. - The exhaust fan between the steamer table and the food preparation table was observed to have gray dust debris on it. - The steamer table was observed to have food particles floating in the water, - The spice containers and the shelf they were being stored on was observed to have a gray greasy film on them. - A broken egg was observed stored in the cooler in a box with other eggs. - The shelf between the stove and the dishwasher was observed to have a dried red food substance on it. <p>Observation during tray line on 08/20/13, beginning at 10:50 AM, revealed:</p> <ul style="list-style-type: none"> -The steamer table was observed to have food particles floating in the water. The Cook was observed to place trays with food in the steamer table. - A box of oatmeal was observed opened and uncovered sitting beside the microwave. - The Cook was observed on 08/20/13, at 11:00 AM to prepare resident food trays, wipe perspiration from her face with a towel, and then continued to serve food until stopped by the surveyor. <p>Interview with the Cook on 08/20/13 at 11:30 AM, revealed she was aware she should have washed her hands after wiping perspiration from her face. The Cook stated she had attended inservices from the facility on handwashing. Further interview revealed the steamer table was required to be cleaned daily and as needed. She stated she should have cleaned it prior to placing the food on the steamer table. The Cook also stated</p>	F 371	

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F 371	Continued From page 78 she was required to clean the shelves when needed. She stated she had not identified the shelves and the spice containers were in need of cleaning. The Cook stated she should have removed the broken egg from the box of eggs in the refrigerator, as broken eggs should not be in the refrigerator with other foods. In addition, the Cook stated all food lids should be closed and not left open. Interview with the Dietary Manager on 08/20/13 at 11:35 AM, revealed the egg should have been discarded and not left in the refrigerator. She stated the floors were in need of stripping and this was done by the Maintenance Supervisor who was aware, but had not set a definite date to strip the floors. The Dietary Manager stated the Cook was responsible to check daily to ensure cabinets and shelves were clean and the spice containers were clean. Further interview revealed she checked the refrigerators and shelves weekly on Mondays when the stock came in and had not identified any concerns. She indicated the Cook should have washed her hands after wiping perspiration from her face. The Dietary Manager stated she observed tray line daily and had not identified any concerns with handwashing. In addition, she stated the oatmeal box should not have been left open and she had not identified the open box of oatmeal until pointed out by the surveyor. Interview with the Registered Dietician (RD) on 08/21/13 at 2:25 PM, revealed the RD stated the floors were overdue for stripping and should have already been done. The RD stated the shelves and spice containers should not have been soiled and should be cleaned when needed. The RD stated the broken egg should have been cleaned	F 371			

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F 371	Continued From page 79 up immediately and discarded, as well as the sleamer table should have been cleaned prior to placing food trays in them. The RD revealed the Cook was responsible for ensuring the oatmeal box was sealed back properly and not left open. The RD stated all staff was required to wash their hands after wiping perspiration. Further interview revealed the Cook should have washed her hands and replaced her gloves prior to continuing to serve food. The RD stated she had not identified these concerns. Interview with the Maintenance Supervisor on 08/21/13 at 2:50 PM, revealed he had plans to strip the kitchen floors but no definite date had been set yet. The Maintenance Supervisor stated he had not been aware the exhaust fan in the kitchen was in need of cleaning. The Maintenance Supervisor stated he checked the exhaust fan every couple of months but was not aware of the last date he had checked the fan.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	F431 Criteria 1 - The expired vial of normal saline on the south nursing station emergency cart was replaced on 8-21-13. Criteria 2 - All facility crash carts were inspected on 8-21-13 by Administrative LPN to determine that all medications were prior to the expiration dates. -All facility medications including medication carts were inspected on 9-6-13 by the pharmacy to assure all medications are within the regulatory requirements. Criteria 3: Inservice education was provided for the Administrative LPN by the		

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F 431	<p>Continued From page 80 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, it was determined the facility failed to ensure a biological (Normal Saline) was stored in accordance with accepted professional principles in regards to expiration dates. A bottle of Normal Saline with an expiration date of 03/13/13 was stored on the South Nursing Station crash cart. A dated and signed log for the month of August was present on the Crash Cart.</p> <p>The findings include:</p> <p>Review of the facility's policy "Storage of Drugs and Biological", revealed all drugs and biological should be properly stored. All drugs and biological must be stored in the containers in which they were received. All drugs and</p>	F 431	<p>Administrator on 8-21-13 as to the need to complete daily inspections of the crash carts to determine that medications are maintained prior to their expiration dates. Licensed Nursing staff have been inserviced by the Administrative LPN including the Crash Cart Daily Checklist Form and directions on 9-4-13, 9-5-13, 9-6-13, 9-7-13, 9-10-13, 9-11-13, 9-12-13, 9-13-13, 9-14-13.</p> <p>Criteria 4 - A crash cart check list will be utilized nightly by the Licensed Nursing Staff to determine that supplies are maintained prior to their expiration date under the supervision of the DON. Findings will be reviewed by the CQI committee with development of an action plan for any issues identified.</p>	9-17-13
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F 431	Continued From page 81 biological should be stored in locked compartments and only authorized personnel have access to the keys. Observations of the South Nursing Station Crash Cart, on 08/22/13 at 10:45 AM, revealed a bottle of Normal Saline with an expiration date of 03/13/13. An interview conducted, on 08/22/13 at 10:45 AM, with Licensed Practical Nurse (LPN) #10 revealed the third shift nurse on the South Nursing Station checked the Crash Cart every evening and signed and dated the log. LPN #10 stated the nurse should be opening and checking the contents of the crash cart container every night. Interview conducted, on 08/23/13 at 7:35 PM, with the Director of Nursing (DON) revealed she made daily rounds to ensure that the crash charts were locked. She stated the normal saline should have been checked daily by the night shift nurse on both the North and South Nursing Stations. The DON explained that the expired Normal Saline should have been removed from the crash chart and replaced with a properly stored bottle of normal saline that was not expired.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	F441 Criteria 1 & 2 - The Melanie Spa tub was cleaned and disinfected. -Resident toothbrushes are stored in accordance with infection control standards of practice, with protective coverings. - Facility staff handle resident food items in accordance with dietary infection control standards of care, preventing contact with their bare hands, as determined by meal service observations		

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F 441	<p>Continued From page 82</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determined the facility failed to ensure the Infection Control Program was maintained to provide a safe, sanitary environment to help prevent the development and transmission of disease and infection. Observations on 08/20/13, of a brown ball shaped substance in the flushing drain of the Melanie</p>	F 441	<p>conducted weekly X 2 weeks, then monthly thereafter as performed by the DON, DM, or RD. Ongoing inservices were conducted with information obtained from the meal service observations.</p> <p>Criteria 3 All Nursing staff have received inservice education on the following infection control requirements including but not limited to: routine monitoring and cleaning/disinfecting of the Melanie Spa; covering of toothbrushes for storage; handling of food items in accordance with dietary infection control standards of care, preventing contact with their bare hands, as provided by the Staff Development Coordinator/designee on 8-26-13, 8-29-13, 8-27-13, 8-30-13, 9-4-13, 9-5-13, 9-5-13, 9-6-13, 9-7-13, 9-10-13, 9-11-13, 9-12-13, 9-13-13, 9-14-13, 9-16-13, 9-14-13.</p> <p>Criteria 4: The CQI indicator for the monitoring infection control standards will be utilized monthly X 2 months and then every six months in accordance with the established CQI calendar under the supervision of the DON, who will assign completion of the tool to nursing staff for reviewing of infection control standards. All completed tools are reviewed by the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.</p>	9-15-13	

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Spa; observation, on 08/20/13 during the lunch meal service revealed a Certified Nursing Assistant (CNA) and Certified Medication Aide (CMA) to use their bare hands to remove cornbread from the wax paper bag it was stored in when serving residents' meals, and one (1) of the CNAs was observed to do this again on 08/21/13 during the dinner meal service. Additionally, toothbrushes were observed lying uncovered on a sink and an electric toothbrush was lying uncovered on a shelf.

The findings include:

1. Observations on 08/20/13 at 10:50 AM, 11:15 AM, 11:50 AM, 3:05 PM and 3:45 PM revealed several brown ball shaped substances in the flushing drain of the "Melanie Spa".

On 08/20/13 at 5:00 PM, interview with the Director of Nursing (DON) revealed she was not aware that the Melanie Spa had been used for a toilet and that it was not sanitary to use the Spa for a toilet on a every day basis. The flushing drain was to be used for residents that may need to toilet themselves while sitting on the Spa chair during bathing; not for everyday toileting use. The DON revealed the charge nurses were supposed to monitor the CNA to make certain the Melanie Spa was cleaned after every shower. The Charge Nurse was unaware a resident was using the Melanie Spa Shower for a toilet.

2. Observation, on 08/20/13 at 12:35 PM, during the lunch meal service revealed Certified Medication Aide (CMA) #1 delivered a meal tray to Resident D. The CMA uncovered the resident's tray and with her bare hands took the resident's cornbread out of the package. The CMA was then

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F 441	Continued From page 84 observed to return to the food cart and without washing or sanitizing her hands proceeded to obtain Resident #11's food tray. The CMA was observed to open the resident's food tray, and then with her bare hands remove the resident's cornbread out of the package. Interview with CMA #1 on 08/22/13 at 10:50 AM, revealed the CMA had attended handwashing inservices provided by the facility and was aware she should have washed or sanitized her hands between residents and should not have touched the resident's foods with her bare hands. 3. Observation, on 08/20/13 at 12:25 PM, during the lunch meal service revealed CNA #1 to deliver a resident's tray to his/her room and remove a sandwich and a piece of cornbread from the wax paper packages with her bare hands. Additional observations, at 12:31 PM, and 12:38 PM revealed CNA #1 to remove the residents' cornbread from the wax paper package with her bare hands. Observation, on 08/21/13 at 5:45 PM, during the dinner meal service revealed CNA #1 removed a piece of cornbread from the wax paper package with her bare hands again. Interview, on 08/21/13 at 5:45 PM, during the observation, with CNA #1 revealed it was "okay" for her to use her bare hands to remove items from the package. She stated she had clean hands so this was not a problem. Interview with the DON, on 08/23/13 at 7:35 PM, revealed staff was required to wash or sanitize their hands between residents during meal service and were not to touch any food with their bare hands. The DON stated staff was required	F 441			

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F 441	<p>Continued From page 85</p> <p>to wear gloves or use tongs prior to handling food. The DON stated she had observed tray pass before, however did not monitor this on a daily basis. She stated the facility had not identified any concerns with handwashing between residents, or with observations of staff touching residents' food with their bare hands.</p> <p>4. Observations conducted on 08/20/13, during the initial tour of the facility at 9:30 AM, revealed two (2) unsampled residents (Unsampled Residents A and B) and one (1) extended sample resident (Resident #16), to have uncovered and unlabeled toothbrushes in their respective room. Unsampled Residents' A and B toothbrushes where observed to be uncovered, unlabeled, and positioned right next to each other in the restroom toothbrush holders. Resident #16's toothbrush was an electric toothbrush which was observed uncovered and unlabeled sitting on a shelf by his/her sink.</p> <p>A follow-up observation, on 08/22/13 at 8:45 AM, revealed Unsampled Resident A's and Unsampled Resident B's toothbrushes remained unlabeled, uncovered, and positioned right next to each other in their restroom. Resident #16's toothbrush remained unlabeled and uncovered on a shelf by his/her sink.</p> <p>Interview, on 08/22/13 at 11:05 AM, with CNA #9 revealed the residents' toothbrushes were to be kept in their rooms, in a plastic bag and they should be labeled and covered.</p> <p>Interview, on 08/22/13 at 11:20 AM, with CNA #18 revealed the residents' toothbrushes should be kept in a zip-lock bag in their bedside drawers, with their names and dates on the bag.</p>	F 441		

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F 441	Continued From page 86	F 441			
F 463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy and procedure, it was determined the facility failed to ensure a functioning call system was available in two (2) of three (3) community lavatories on the South Wing and in two (2) of three (3) community lavatories on the North Wing.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding call lights, undated, revealed it was the policy of the facility to provide call lights in toileting areas and bathing rooms that were equipped with a communication system to the nurses' stations. Residents had the right to have call lights answered promptly.</p> <p>Observation, on 08/20/13 at 1:00 PM, of the 400 Hall Community Bathroom on the North Wing revealed the bathroom had no emergency pull</p>	F 463	<p>F463</p> <p>Criteria 1 - The call system for the 100 Hall common bathroom and 600 hall shower room have been repaired. -An emergency call cord has been installed in the 400 hall community bathroom. -An emergency call cord has been installed in reach of the Melanie spa in the 300 hall shower room.</p> <p>Criteria 2 - The call system has been inspected on 9-11-13 by maintenance staff for all resident rooms and resident care areas to determine that it is accessible and working correctly. No issues were identified during this inspection.</p> <p>Criteria 3 - Maintenance staff have received in-service education on the need for routine monthly inspection of the call light system as provided by the Administrator on 9-7-13. The Maintenance Director or AIT will be responsible for these inspections.</p> <p>Criteria 4 - The CQI indicator for the monitoring of the correct functioning of the facility call light system will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the</p>		

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 56 EAST NORTH STREET MADISONVILLE, KY 42431		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 463	<p>Continued From page 87</p> <p>cord in place.</p> <p>Observation, on 08/20/13 at 1:10 PM, of the 600 Hall Shower Room revealed the emergency pull cord beside the toilet, when pulled, lit up the light over Room 601. Further observation revealed there was no emergency light over the entry door to the 600 Hall Shower Room on the North Wing.</p> <p>Observation, on 08/20/13 at 1:15 PM, of the 300 Hall Shower Room on the North Wing revealed the Melanie Spa was being used independently by Unsampled Resident-D for toileting. The Melanie Spa was observed to not have an emergency pull cord within reach of the residents using the Melanie Spa.</p> <p>Observation, on 08/20/13 at 1:20 PM, of the 100 Hall Community Bathroom on the North Wing revealed the bathroom had no emergency pull cord in place.</p> <p>Interview, on 08/23/13 at 6:50 PM, with the Maintenance Director revealed the 60 Hall Shower Room had never had an emergency light over the door to the Shower Room. The emergency cord had always been wired to Room 601. The Maintenance Director said the staff knew to check the Shower Room and Room 601 if the call light went off at the Nurses' Station, or if the light was on over Room 601.</p> <p>Interview, on 08/22/13 at 5:00 PM, with the Director of Nursing (DON) revealed Unsampled Resident-D was a bilateral above the knee amputee and it would not be safe for him/her to be using the Melanie Spa for a toilet independently without an emergency call light cord. The DON said she was unaware the</p>	F 463	<p>Director of Maintenance who will complete the tool or assign completion to the AIT. All completed tools are reviewed by the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.</p>	9-12-13

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F 463	Continued From page 88 resident was using the Melanie Spa for a toilet. The DON stated all bathing and toilet areas that residents used should have emergency pull cords, as a resident could fall and no one would know.	F 463		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review it was determined the facility's Administration failed to ensure the facility was administered in a manner which enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident. The facility's Administration failed to have oversight in the overall safe environment in order to evaluate the facility's "Falls Policy" to ensure the policy was effective for prevention of avoidable accidents. On 04/12/13, Resident #1 experienced a fall which resulted in a cervical fracture of the neck. Resident #1 had a history of falls, one of which resulted in a fracture to the resident's clavicle. Review of the investigations of Resident #1's falls revealed the facility's Administration failed to ensure thorough investigations were conducted for falls to identify the causative factors.	F 490	F490 Criteria 1 - The Care Plan and C.N.A care plan for residents #1, 4, 10, 11, 12, and 13 have been reviewed/revise by the Interdisciplinary care team to reflect the fall management interventions indicated by the residents' fall risk assessments, the facility fall log review, and Nurse Consultants suggestions for fall management interventions. Criteria 2 - The Administrator determined that all residents were reviewed for falls in the last 90 days. The 19 residents who have exhibited a fall within the past 90 days have had a new Fall Log completed by the Interdisciplinary care plan team to assist with tracking/trending patterns and issues with their individual falls. Care plans were revised based on the review and causal factors identified for these residents. Using the Fall Log and Fall Assessment information, the team completed review/revisions of the care plan and C.N.A care plan for each resident exhibiting a fall in the last 90 days to determine that these reflect the fall management interventions indicated. Criteria 3 - The Administrator determined that the facility has implemented a new Fall	

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F 490	<p>Continued From page 89</p> <p>Additionally, the facility's Administration failed to ensure care plans were revised to include interventions to avoid further falls and failed to ensure follow up to the investigations by the Director of Nursing (DON) as indicated in the facility's policy.</p> <p>The facility's failure to have an effective Administration, with oversight to ensure an overall safe environment, in order to evaluate the facility's "Falls Policy" to ensure the policy was effective in the prevention of avoidable accidents placed Resident #1 and other residents at risk for serious injury, harm, impairment, or death.</p> <p>Immediate Jeopardy was identified at 42 CFR 483.20, Resident Assessment, F-280; 42 CFR 483.25, Quality of Care, F-323; 42 CFR 483.75, Administration F-490 and F-520 all at a Scope and Severity of a "K".</p> <p>An acceptable Credible Allegation of Compliance, related to the Immediate Jeopardy, was received on 08/30/13. On 08/30/13, the Immediate Jeopardy was verified removed on 08/30/13 as alleged. However, non-compliance continued to exist at 42 CFR 483.20 Resident Assessment; 42 CFR 483.25, Quality of Care, F-323; and 42 CFR 483.75, Administration, F-490 and F-520 all with a Scope and Severity of an "E", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained effective systems to ensure residents remain free from avoidable accidents, the facility effectively implements their policy, and Administration oversight is provided.</p> <p>The findings include:</p>	F 490	<p>Scene Investigation form (initiated on 8-30-13) provided by the OIG at a Fall Management seminar, to help the facility to identify and address causative factors of resident falls. This form will be completed by Fall Team staff with each resident fall, to assist in determining the appropriate immediate interventions for the identified causative factors. The form will then be reviewed the next day by the Interdisciplinary team Monday - Friday, and the weekend RN supervisor on the weekends, to determine that all indicated interventions are in place, and if any additional interventions are indicated.</p> <p>-The Administrator determined that a new event follow up form will be completed after all incident investigations (initiated on 8-30-13) to assist the interdisciplinary team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form will note if the intervention(s) is successful, and if any modifications or new/additional interventions are indicated.</p> <p>-The Administrator determined that Fall team staff (Licensed Nurses, housekeeping/laundry staff) and all licensed nurses have received in-service education from the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the Investigation and the need to implement alternative interventions when those first attempted are unsuccessful on 8/26-30/13.</p>		

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F 490	<p>Continued From page 90</p> <p>Review of the facility's policy, "Falls Policy", undated, revealed the facility was to provide care and an environment that will allow every resident to be free from falls or injury to the best of the facility's ability. The policy stated the facility was to ensure each resident received adequate supervision and assistive devices to prevent accidents. The policy indicated if a resident experienced a fall, an Incident Report was to be filled out and a causative factor analysis was to be conducted to aid in identifying contributing factors. According to the policy, the Incident Report was to be reviewed by the Interdisciplinary Plan of Care (IPOC) team following an incident and the facility was to implement immediate changes in the care plan, if assessment indicated the need. The policy stated the Director of Nursing (DON) or designee was to follow up on the investigation, utilizing the IPOC team and Therapy Department for input.</p> <p>The facility failed to implement its written policy to provide adequate supervision and assistive devices to prevent accidents for five (5) of fifteen (15) sampled residents (Residents #1, #4, #11, #12 and #13) who experienced multiple falls between November 2012 and August 20, 2013.</p> <p>On 04/12/13, Resident #1 experienced a fall which resulted in a cervical fracture of the neck. Record review revealed Resident #1 had a history of falls, one of which had also resulted in a fracture to the resident's clavicle on 11/05/12. Review of Investigations into Resident #1's, #4's, #11's, #12's, and #13's falls revealed the facility's Administration failed to conduct thorough investigations into the falls and failed to thoroughly identify causative factors. Additionally,</p>	F 490	<p>-Facility staff who were not able to receive the in-service education by the completion of 8/30/13 (due to vacations, medical leave etc.), were required to complete the in-service prior to starting their next scheduled shift. This was achieved by: staff who had not completed the in-service education were not scheduled after 8/30/13 until completion of the information.</p> <p>Criteria 4 - The Administrator determined the following: Fall Team staff will investigate all falls utilizing the Fall Scene Investigation form, and immediately implement the interventions indicated by the investigation.</p> <p>-The Interdisciplinary Management team will review the Fall Team investigations and immediate interventions put in place for all falls daily during the week, with review completed by the weekend RN Supervisor on the weekends, to determine that all recommended interventions are in place and effective.</p> <p>-A CQI Meeting with the Medical Director and CQI team was held on 8/30/13 to review the facility Plan of Correction, and the new forms and procedures.</p> <p>-The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON, who will assign completion of the tool to nursing staff for reviewing of residents with falls. All completed tools are reviewed by</p>

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the facility's Administration failed to ensure care plans were revised to include interventions to avoid further falls and failed to ensure follow up to the investigation by the Director of Nursing (DON) as indicated in facility policy. (Refer to F-280 and F-323)

Interview, on 08/23/13 at 3:15 PM, with the Administrator revealed she was aware of Resident #1's fall on 11/05/12 at 6:25 AM, during which the resident fractured his/her clavicle, and the fall had been discussed in the Interdisciplinary Plan of Care (IPOC) team meeting. The Administrator stated Resident #1 had placed a pillow under his/her mattress and "just rolled right out" of the bed. She stated she was "pretty certain" Dycem (a non-slip mat used to grip items in place, and prevent any movement) had been placed under Resident #1's mattress. However, she was unable to provide documented evidence this was implemented and review of the resident's care plan revealed Dycem was not added as an intervention.

The Administrator indicated she was also aware of the falls Resident #1 experienced in December 2012. She stated on 12/04/12, Resident #1 experienced a fall when his/her fingerstick blood sugar (fsbs) was 75 milligrams (mg) per deciliter (dl). The Administrator stated the IPOC team determined Resident #1's insulin needed to be evaluated after this fall; however, she was unable to provide documented evidence Resident #1's insulin was evaluated after this fall, per the IPOC team recommendations. In regards to the 12/07/12 fall, the Administrator stated Resident #1 had fallen while transferring from the bedside commode (BSC). She stated the IPOC team determined staff needed to check the placement

F 490 the CQI committee in the CQI meeting, with action plan development for any findings which fail to meet the stipulated threshold.

-The nursing consultant will review fall investigations, and the associated interventions (including care plan and C.N.A care plan revisions) with each quarterly visit. Consultant reports will be reviewed by the CQI committee.

9-17-13

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of the BSC and the resident was to be re-assessed for the use of alarms. However, review of a Personal Alarm/Safety Assessment Form revealed an assessment for alarms was not performed until 12/10/12, three (3) days later, and after the resident had sustained another fall on 12/10/12.

Further interview, on 08/23/13 at 3:15 PM, with the Administrator revealed she attended the IPOC meetings Monday through Friday where falls were reviewed and discussed. If a resident experienced a fall an Incident Report was filled out and a "check off" list was also completed. She stated a Causative Factor Analysis form was completed at that time. The Administrator stated the fall was reviewed in the IPOC team meeting the next day unless it happened on a weekend in which case it would be reviewed on the following Monday. Per interview, the Administrator revealed all three forms of the three part investigation form (Incident Report Form, Causative Factor Analysis Form, and Fall Management-Immediated Interventions Form) were completed and stapled together after being reviewed in the IPOC team meeting. However, in regards to Residents #1's, #4's, #11's, #12's and #13's falls, the Administrator was unable to provide documented evidence the three part investigation form was completed for all falls, as per interview. There was no documented evidence of a thorough investigation into the falls to identify causal factors, and ensure revisions to the Comprehensive Care Plans to prevent avoidable accidents as indicated in the facility's "Fall Policy".

Interview, on 08/30/13 at 9:05 AM, with the Director of Nursing (DON) revealed she had only

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F 490	Continued From page 93 been employed by the facility since 04/29/13. She stated she had not performed follow up to the fall investigations since becoming DON. According to the DON, she had not monitored to ensure interventions, discussed in the IPOC team meetings, were placed on residents' Comprehensive Care Plans and Nurse Aide Care Plans and Implemented. Additionally, during the 08/23/13 at 3:15 PM interview, the Administrator revealed she was unable to provide documented evidence of the former DON's follow up to fall investigations as per facility policy. The facility provided an acceptable credible Allegation of Compliance (AoC) on 08/30/13 that alleged removal of the Immediate Jeopardy (IJ) on 08/30/13, based on the following: 1. Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed. 2. Nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team to assist with tracking and trending patterns and issues with their individual falls. Out of those residents reviewed, ten (10) care plans were revised based on the review and causal factors identified for the residents. Using the Fall Log and Fall Assessment information, the Interdisciplinary Management team completed the review and revision of the care plan and CNA Care Plan for the residents who had fallen in the past sixty (60) days, to determine these reflect the fall management interventions indicated by the residents' fall risk assessments, facility Fall	F 490		
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F 490 Continued From page 94
 Log and Nurse Consultant suggestions for fall management interventions. These items were completed 08/27/13.

3. A new Fall Scene Investigation form was implemented to assist the facility in identifying and addressing causative factors of residents' falls. The form was to be completed by the Fall Team staff with each resident fall, to assist in determining the appropriate immediate interventions for the identified causative factor. The Fall Team members would include the Charge Nurse, the CNA, Housekeeper, and/or Laundry personnel for the resident who had fallen. The Charge Nurse was to complete and sign the Fall Team Investigation Report upon completion of the form. All resident falls were to be reviewed by the Interdisciplinary Management team Monday through Friday with residents' Comprehensive Care Plan and CNA Care Plan updated as needed. The Weekend Registered Nurse (RN) Supervisor was to review all incidents including falls within twenty-four (24) hours when the Interdisciplinary Management team was not present, to determine that all indicated interventions were in place and to ensure additional interventions were added if indicated.

4. A new event follow up form was to be completed after all Incident/Fall investigations to assist the Interdisciplinary Management team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form would note if the interventions were successful, and if any modifications or new/additional interventions were indicated.

5. The Fall Team staff, licensed nurses,

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F 490 Continued From page 95
Housekeepers, and Laundry personnel were inserviced by the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the investigation, and the need to implement alternative interventions when those first attempted were unsuccessful. These inservices were conducted 08/26-29/13. Facility staff who were unable to attend these inservices by 08/30/13 (due to vacations, medical leave, etc.) were to complete the inservice prior to being allowed to work their next shift. These staff would not be placed on the work schedule until completion of the inservice.

6. A meeting of the facility's Continuous Quality Improvement (CQI) committee which included the Medical Director was held on 08/30/13 to review the Allegation of Compliance, the new forms and procedures.

7. The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures was to be utilized monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON.

8. The Nurse Consultant was to review fall investigations, and the associated interventions with each quarterly visit.

9. The CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter under the supervision of the Administrator.

On 08/30/13, the State Survey Agency verified the

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F 490	Continued From page 96 immediacy of the Immediate Jeopardy was removed and the facility implemented corrective actions as alleged in the AoC, effective 08/30/13 based on the following: 1. Review of the Interdisciplinary Management meeting notes dated 08/27/13 revealed Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed. 2. Additional review revealed nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team. Review revealed ten (10) residents' care plans were revised based on the Interdisciplinary Management team's review. 3. Review of the facility's new "Falls Procedure" revealed the Charge Nurse was to complete a Fall Scene Investigation form to assist the facility in identifying and addressing causative factors of residents' falls. Review revealed the Fall Scene Investigation was included in the "Fall Procedure" packet. Continued review of the "Fall Procedure" revealed the staff member either witnessing or discovering a resident's fall was to notify the Charge Nurse who would page the Fall Team to the location of the fall. The Charge Nurse would assess the resident for injuries and the Fall Team would assess the environment and resident for causative factors of the fall. The Charge Nurse was to complete the Incident Report, Fall Scene Investigation Report form, and implement any needed interventions and adjust the care plan accordingly. The Charge Nurse was to notify the Director of Nursing (DON), Administrator, Physician, and Responsible Party of the fall. The	F 490			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/30/2013
NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431	
(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 490	<p>Continued From page 97</p> <p>resident was to be assessed every shift for seventy-two (72) hours.</p> <p>4. Further review revealed the Incident Report and interventions were to be evaluated for effectiveness within twenty-four (24) hours by the Interdisciplinary Management team or the Registered Nurse (RN) Supervisor and any additional interventions were to be implemented. The Fall Team members would include on day shift the Charge Nurse, the Certified Nursing Assistant (CNA), and Housekeeper; on evening shift the Fall Team was to include the Charge Nurse, CNA, and Laundry personnel; on night shift the Fall Team was to include the Charge Nurse and CNA. Review revealed a new Event Report-Witness Statement Form was to be completed if an employee witnessed a fall.</p> <p>5. Review of inservice sheets revealed the following number of facility employees had been inserviced on the new Fall Procedures and forms: three (3) of the facility's four (4) RN's; sixteen (16) of the facility's seventeen (17) Licensed Practical Nurses (LPNs); twenty-one (21) of the facility's thirty-three (33) CNAs; five (5) of the facility's seven (7) Housekeepers; and two (2) of the facility's two (2) Laundry personnel were inserviced on the new fall procedures 08/27-29/13.</p> <p>Interviews were conducted on 08/30/13 with the following staff to verify the facility had educated them on the new Fall Procedures and to ensure their knowledge of the facility's new procedure and documents:</p> <p>Assistant Director of Nursing (ADON/Minimum Data Set (MDS) Coordinator at 2:55 PM;</p>	F 490	

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F 490	<p>Continued From page 98</p> <p>Weekend RN Supervisor #1, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM, and Weekend RN Supervisor #3, who worked the 10:00 PM to 6:00 AM shift, at 1:41 PM;</p> <p>LPN #3, who worked the 6:00 AM to 2:00 PM shift, at 1:19 PM; LPN #4, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM; LPN #2, who worked the 6:00 AM to 2:00 PM shift, at 2:15 PM; LPN #1, who worked the 10:00 PM to 6:00 AM shift, at 2:15 PM; LPN #11, who worked the 2:00 PM to 10:00 PM shift, at 2:38 PM; LPN #8, who worked the 2:00 PM to 10:00 PM shift, at 2:40 PM; LPN #5, who worked the 6:00 PM to 6:00 AM shift, at 2:42 PM; LPN #10, who worked the 2:00 PM to 10:00 PM shift, at 2:46 PM;</p> <p>CNA #9, who worked the 6:00 AM to 2:00 PM shift, at 1:10 PM; CNA #6, who worked the 6:00 AM to 2:00 PM shift, at 1:30 PM; CNA #8, who worked the 6:00 AM to 2:00 PM shift, at 1:45 PM; CNA #7, who worked the 6:00 AM to 2:00 PM shift, at 1:55 PM; CNA #4, who worked the 6:00 AM to 2:00 PM shift, at 2:00 PM; CNA #5, who worked the 6:00 AM to 2:00 PM shift, at 2:10 PM; CNA #3, who worked the 2:00 PM to 10:00 PM shift, at 2:20 PM; CNA #10, who worked the 2:00 PM to 10:00 PM shift, at 2:45 PM; CNA #18, who worked the 10:00 PM to 6:00 AM shift, at 3:06 PM; CNA #12, who worked the 2:00 PM to 10:00 PM shift, at 3:10 PM, and CNA #11, who worked the 2:00 PM to 10:00 PM shift, at 3:25 PM</p> <p>Housekeeper #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:38 PM; and Laundry Personnel #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:51 PM. All of the above staff were knowledgeable of the facility's new Falls Procedures, and Falls Team</p>	F 490		
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F 490	<p>Continued From page 99</p> <p>members and duties. All nursing staff interviewed were knowledgeable of the Fall Scene Investigation Report form and when to complete it. All staff verified they had received inservice education regarding these matters by the facility.</p> <p>Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed most of the facility's staff had received inservice education on the new Fall Procedure/Policy, the Fall Scene Investigation Report form, the revision to the Incident Report form. According to the Administrator, any staff who had not received the inservice education would not be allowed to work until they had received it and would not be put on the schedule to work until they had received the education.</p> <p>6. Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed the Medical Director had been informed of the Immediate Jeopardy findings and had been updated on the facility's Allegation of Compliance on 08/30/13 during the CQI Committee meeting. She stated the CQI Committee members had discussed the new forms and procedures the facility had implemented. The Administrator indicated the facility would use the CQI indicator for the monitoring of compliance with the facility fall management policies and procedures monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON. She stated the CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter. The Administrator stated a Nurse Consultant would visit quarterly and review fall investigations, and the associated interventions.</p>	F 490		

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F 490	<p>Continued From page 100</p> <p>Interview, on 08/30/13 at 12:33 PM, with the Medical Director revealed the facility's CQI Committee, which he was a member of, had met that morning and discussed the facility's AoC plan and what interventions had been put in place to correct the Immediate Jeopardy.</p> <p>7. Interview, on 08/30/13 at 3:10 PM, with the Director of Nursing (DON) revealed all falls for the past sixty (60) days had been reviewed and the care plans revised as necessary. The DON stated the Assistant Director of Nursing (ADON) would be responsible for updating Comprehensive Care Plans and CNA Care Plans during the Monday through Friday Interdisciplinary Management team meeting. She stated the Falls Policy had been revised and new Falls Teams had been implemented for each shift. The DON stated staff had been educated on the new policy, new forms, and Falls Teams duties. According to the DON, the CQI Committee had met that morning and the Medical Director had signed off on the facility's new policy, and new forms implemented by the facility.</p> <p>8. Interview, on 08/30/13 at 3:10 PM, with the facility's Nurse Consultant revealed she or another Nurse Consultant would be making quarterly visits to the facility to monitor. She stated residents' Comprehensive Care Plans and CNA Care Plans are now being brought to the Monday through Friday Interdisciplinary Management Team meeting and updated as interventions are discussed.</p> <p>9. The Nurse Consultant stated during the Interdisciplinary Management Team meeting a date would be set to review the revisions recommended by the team to ensure the new</p>	F 490	

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F 490	Continued From page 101 interventions were effective or see if additional interventions needed to be added. She indicated a Nurse Consultant would be coming to the facility on a quarterly basis to review falls and follow up performed, review the monthly CQI monitoring performed to ensure the AoC plan was followed. The facility remained out of compliance at a lower Scope and Severity of a "E", a pattern deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).	F 490		
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520	F520 Criteria 1 - The Care Plan and C.N.A care plan for residents #1, 4, 10, 11, 12, and 13 have been reviewed/revised by the Interdisciplinary care plan team to reflect the fall management interventions indicated by the residents' fall risk assessments, the facility fall log review, and Nurse Consultants suggestions for fall management interventions. Criteria 2 - The 19 residents who have exhibited a fall within the past 90 days have had a new Fall Log completed by the Interdisciplinary care plan team to assist with tracking/trending patterns and issues with their individual falls. Care plans were revised based on the review and causal factors identified for these residents. Using the Fall Log and Fall Assessment information, the team completed review/revisions of the care plan and C.N.A care plan for each resident exhibiting a fall in the last 60 days to determine that these	

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F 520	Continued From page 102 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility's Quality Assurance Program failed to identify quality issues related to fall investigations, causal factor identification, and failed to develop and implement appropriate plans of action to correct identified quality deficiencies. On 04/12/13, Resident #1 experienced a fall which resulted in cervical neck fractures. Resident #1, who was assessed to be at high risk for falls, had a known history of falls. The resident had a fall on 11/05/12 which resulted in a fractured clavicle, and three (3) falls in 12/12. Residents #4, #11, #12 and #13 also experienced falls from 11/2012 to 08/2013. Review of the falls investigations for all these residents revealed the facility had not thoroughly investigated the falls. The facility provided no documented evidence that the causal factors were identified for all falls. In addition, the facility failed to ensure Comprehensive Care Plans were revised to include effective interventions to prevent further falls for these residents. The facility also failed to effectively implement their Falls Policy. Additionally, the facility could provide no documented evidence the Quality Assurance Program had identified quality issues related to falls, and had developed action plans to prevent recurrence of residents' falls. The facility's failure to identify quality issues related to fall investigations, causal factor	F 520	reflect the fall management interventions indicated. Criteria 3 - The facility has implemented a new Fall Scene Investigation form (initiated on 8-30-13) provided by the OIG at a Fall Management seminar, to help the facility to identify and address causative factors of resident falls. This form will be completed by Fall Team staff with each resident fall, to assist in determining the appropriate immediate interventions for the identified causative factors. The form will then be reviewed the next day by the Interdisciplinary team Monday - Friday; and the weekend RN supervisor on the weekends, to determine that all indicated interventions are in place, and if any additional interventions are indicated. -A new event follow up form will be completed after all incident investigations to assist the interdisciplinary team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form will note if the intervention(s) is successful, and if any modifications or new/additional interventions are indicated. -Fall team staff and all licensed nurses have received in-service education from the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the Investigation and the need to implement alternative interventions when those first attempted are	

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F 520 Continued From page 103

identification, and failure to develop and implement appropriate plans of action to correct identified quality deficiencies placed Resident #1 and the other residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified at 42 CFR 483.20, Resident Assessment, F-280; 42 CFR 483.25, Quality of Care, F-323; 42 CFR 483.75, Administration F-490 and F-520 all at a Scope and Severity of a "K".

An acceptable Credible Allegation of Compliance, related to the Immediate Jeopardy, was received on 08/30/13. On 08/30/13, the Immediate Jeopardy was verified removed on 08/30/13 as alleged. However, non-compliance continued to exist at 42 CFR 483.20 Resident Assessment; 42 CFR 483.25, Quality of Care, F-233; and 42 CFR 483.75, Administration, F-490 and F-520 all with a Scope and Severity of a "E", as the facility had not completed the development and implementation of the Plan of Correction (PoC) to ensure the facility established and maintained effective systems to ensure residents remain free from avoidable accidents, the facility effectively implements their policy, and Administration oversight is provided.

The findings include:

Record review revealed on 04/12/13, Resident #1 experienced a fall which resulted in a cervical fracture of the neck. Review revealed Resident #1 had a history of falls. On 11/05/12, the resident had a fall which resulted in a fracture to the resident's clavicle and three (3) falls in 12/2012. Residents #4, #11, #12, and #13 also experienced falls from 11/2012 to 08/2013. Review of the falls investigations for all these

F 520 unsuccessful on 8/26-30/13.

-Facility staff who were not able to receive the in-service education by the completion of 8/30/13 (due to vacations, medical leave etc.), were required to complete the in-service prior to starting their next scheduled shift. This was achieved by: staff who had not completed the inservice education were not scheduled after 8/30/13 until completion on the information.

Criteria 4 - Fall Team staff (licensed nurses, housekeeping/laundry staff) will investigate all falls utilizing the Fall Scene Investigation form, and immediately implement the interventions indicated by the investigation.

-The Interdisciplinary Management team will review the Fall Team investigations and immediate interventions put in place for all falls daily during the week, with review completed by the weekend RN Supervisor on the weekends, to determine that all recommended interventions are in place and effective.

-A CQI Meeting with the Medical Director and CQI team was held on 8/30/13 to review the facility Plan of Correction, and the new forms and procedures.

-The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON.

-The CQI indicator for the monitoring of CQI program effectiveness will be utilized

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F 520	<p>Continued From page 104</p> <p>residents revealed the facility had not thoroughly investigated the falls. The facility provided no documented evidence the causal factors were identified for all falls. Review of the facility's, "Falls Policy" undated, revealed the facility was to provide care and an environment that would allow every resident to be free from falls or injury to the best of the facility's ability and ensure each resident received adequate supervision and assistive devices to prevent accidents. The policy stated falls were to be tracked and results reviewed in the monthly Quality Assurance Committee meeting.</p> <p>Interview, on 08/30/13 at 9:05 AM, with the Director of Nursing (DON) revealed she had only been employed by the facility since 04/29/13. She stated she was a member of the monthly CQI (Continuous Quality Improvement) which was the facility's Quality Assurance. The DON indicated falls statistics were discussed in the monthly meetings; however, she didn't recall there being an issue identified with the facility's Fall Program. According to the DON, she thought the facility's system for falls was effective. The DON stated the facility had a "limited number of residents with falls" and felt the falls had been managed and measures put into place to "limit" falls.</p> <p>Interview, on 08/30/13 at 12:33 PM, with the Medical Director revealed he was a member of the facility's Continuous Quality Improvement (CQI) Committee which met monthly. He indicated the facility's Administration had discussed the fall's policy in the CQI Committee meeting before; however, he was unable to recall when that had taken place. Additionally, the Medical Director stated he was unable to recall</p>	F 520	<p>monthly X 3 months, and then quarterly thereafter under the supervision of the Administrator. The nursing consultant will review the completed indicator, and CQI action plans with each quarterly visit, with findings/recommendations to be reviewed by the CQI committee.</p> <p>9-17-13</p>

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the last time the facility's Administration had discussed the fall system during the CQI Committee monthly meeting. According to the Medical Director, in the monthly CQI Committee meeting the total number of falls was discussed, but the individual falls and procedures were not discussed in depth.

Interview, on 08/23/13 at 3:15 PM, with the Administrator revealed falls information was taken to the monthly CQI committee meeting where the falls were "trended" quarterly. She stated the facility had "specific residents with multiple falls, not multiple residents with multiple falls". She stated falls would be tracked and trended; however, she was unable to provide documented evidence of this. Further interview, on 08/23/13 at 6:12 PM, with the Administrator revealed the Medical Records Clerk gathered all the falls information each month and broke the information down "per category". She stated this was the information taken to the monthly CQI committee meeting; however, there was no documented evidence of this as the discussion was not written down. She stated the CQI committee discussed patterns, trends, policies and procedures related to the falls system to see if it "worked" or if there was a failure. The Administrator indicated there had been no failure noted with the falls system. However, the Administrator was unable to provide documented evidence falls were being tracked and results were reviewed in the monthly Quality Assurance Committee meeting, per the facility's policy and procedure.

The facility provided an acceptable credible Allegation of Compliance (AoC) on 08/30/13 that alleged removal of the Immediate Jeopardy (IJ)

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F 520	<p>Continued From page 106 on 08/30/13, based on the following:</p> <ol style="list-style-type: none"> 1. Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed. 2. Nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team to assist with tracking and trending patterns and issues with their individual falls. Out of those residents reviewed, ten (10) care plans were revised based on the review and causal factors identified for the residents. Using the Fall Log and Fall Assessment information, the Interdisciplinary Management team completed the review and revision of the care plan and CNA Care Plan for the residents who had fallen in the past sixty (60) days, to determine these reflect the fall management interventions indicated by the residents' fall risk assessments, facility Fall Log and Nurse Consultant suggestions for fall management interventions. These items were completed 08/27/13. 3. A new Fall Scene Investigation form was implemented to assist the facility in identifying and addressing causative factors of residents' falls. The form was to be completed by the Fall Team staff with each resident fall, to assist in determining the appropriate immediate interventions for the identified causative factor. The Fall Team members would include the Charge Nurse, the CNA, Housekeeper, and/or Laundry personnel for the resident who had fallen. The Charge Nurse was to complete and sign the Fall Team Investigation Report upon completion of the form. All resident falls were to be reviewed by the Interdisciplinary Management 	F 520	
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F 520	<p>Continued From page 107</p> <p>team Monday through Friday with residents' Comprehensive Care Plan and CNA Care Plan updated as needed. The Weekend Registered Nurse (RN) Supervisor was to review all incidents including falls within twenty-four (24) hours when the Interdisciplinary Management team was not present, to determine that all indicated interventions were in place and to ensure additional interventions were added if indicated.</p> <p>4. A new event follow up form was to be completed after all Incident/Fall investigations to assist the Interdisciplinary Management team in reviewing and monitoring the effectiveness of fall management interventions after a fall. Documentation on the form would note if the interventions were successful, and if any modifications or new/additional interventions were indicated.</p> <p>5. The Fall Team staff, licensed nurses, Housekeepers, and Laundry personnel were inserviced by the DON and Staff Development on the comprehensive investigation of all falls utilizing the Fall Scene Investigation form, and the immediate implementation of the interventions indicated by the investigation, and the need to implement alternative interventions when those first attempted were unsuccessful. These inservices were conducted 08/26-29/13. Facility staff who were unable to attend these inservices by 08/30/13 (due to vacations, medical leave, etc.) were to complete the inservice prior to being allowed to work their next shift. These staff would not be placed on the work schedule until completion of the inservice.</p> <p>6. A meeting of the facility's Continuous Quality Improvement (CQI) committee which included the</p>	F 520	

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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F 520	<p>Continued From page 108</p> <p>Medical Director was held on 08/30/13 to review the Allegation of Compliance, the new forms and procedures.</p> <p>7. The CQI indicator for the monitoring of compliance with the facility fall management policies and procedures was to be utilized monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON.</p> <p>8. The Nurse Consultant was to review fall investigations, and the associated interventions with each quarterly visit.</p> <p>9. The CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter under the supervision of the Administrator.</p> <p>On 08/30/13, the State Survey Agency verified the immediacy of the Immediate Jeopardy was removed and the facility implemented corrective actions as alleged in the AoC, effective 08/30/13 based on the following:</p> <p>1. Review of the Interdisciplinary Management meeting notes dated 08/27/13 revealed Resident #1's Comprehensive Care Plan and Certified Nursing Assistant (CNA) Care Plan were reviewed to ensure no revisions were needed.</p> <p>2. Additional review revealed nineteen (19) residents who had experienced a fall in the past sixty (60) days had a new Fall Log completed by the Interdisciplinary Management team. Review revealed ten (10) residents' care plans were revised based on the Interdisciplinary Management team's review.</p>	F 520		
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F 520 Continued From page 109

F 520

3. Review of the facility's new "Falls Procedure" revealed the Charge Nurse was to complete a Fall Scene Investigation form to assist the facility in identifying and addressing causative factors of residents' falls. Review revealed the Fall Scene Investigation was included in the "Fall Procedure" packet. Continued review of the "Fall Procedure" revealed the staff member either witnessing or discovering a resident's fall was to notify the Charge Nurse who would page the Fall Team to the location of the fall. The Charge Nurse would assess the resident for injuries and the Fall Team would assess the environment and resident for causative factors of the fall. The Charge Nurse was to complete the Incident Report, Fall Scene Investigation Report form, and implement any needed interventions and adjust the care plan accordingly. The Charge Nurse was to notify the Director of Nursing (DON), Administrator, Physician, and Responsible Party of the fall. The resident was to be assessed every shift for seventy-two (72) hours.

4. Further review revealed the Incident Report and interventions were to be evaluated for effectiveness within twenty-four (24) hours by the Interdisciplinary Management team or the Registered Nurse (RN) Supervisor and any additional interventions were to be implemented. The Fall Team members would include on day shift the Charge Nurse, the Certified Nursing Assistant (CNA), and Housekeeper; on evening shift the Fall Team was to include the Charge Nurse, CNA, and Laundry personnel; on night shift the Fall Team was to include the Charge Nurse and CNA. Review revealed a new Event Report-Witness Statement Form was to be completed if an employee witnessed a fall.

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F 520	<p>Continued From page 110</p> <p>5. Review of inservice sheets revealed the following number of facility employees had been inserviced on the new Fall Procedures and forms: three (3) of the facility's four (4) RN's; sixteen (16) of the facility's seventeen (17) Licensed Practical Nurses (LPNs); twenty-one (21) of the facility's thirty-three (33) CNAs; five (5) of the facility's seven (7) Housekeepers; and two (2) of the facility's two (2) Laundry personnel were inserviced on the new fall procedures 08/27-29/13.</p> <p>Interviews were conducted on 08/30/13 with the following staff to verify the facility had educated them on the new Fall Procedures and to ensure their knowledge of the facility's new procedure and documents:</p> <p>Assistant Director of Nursing (ADON)/Minimum Data Set (MDS) Coordinator at 2:55 PM; Weekend RN Supervisor #1, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM, and Weekend RN Supervisor #3, who worked the 10:00 PM to 6:00 AM shift, at 1:41 PM;</p> <p>LPN #3, who worked the 6:00 AM to 2:00 PM shift, at 1:19 PM; LPN #4, who worked the 6:00 AM to 2:00 PM shift, at 1:26 PM; LPN #2, who worked the 6:00 AM to 2:00 PM shift, at 2:15 PM; LPN #1, who worked the 10:00 PM to 6:00 AM shift, at 2:15 PM; LPN #11, who worked the 2:00 PM to 10:00 PM shift, at 2:38 PM; LPN #8, who worked the 2:00 PM to 10:00 PM shift, at 2:40 PM; LPN #5, who worked the 6:00 PM to 6:00 AM shift, at 2:42 PM; LPN #10, who worked the 2:00 PM to 10:00 PM shift, at 2:46 PM;</p> <p>CNA #9, who worked the 6:00 AM to 2:00 PM</p>	F 520	

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F 520 Continued From page 111
 shift, at 1:10 PM; CNA #6, who worked the 6:00 AM to 2:00 PM shift, at 1:30 PM; CNA #8, who worked the 6:00 AM to 2:00 PM shift, at 1:45 PM; CNA #7, who worked the 6:00 AM to 2:00 PM shift, at 1:55 PM; CNA #4, who worked the 6:00 AM to 2:00 PM shift, at 2:00 PM; CNA #5, who worked the 6:00 AM to 2:00 PM shift, at 2:10 PM; CNA #3, who worked the 2:00 PM to 10:00 PM shift, at 2:20 PM; CNA #10, who worked the 2:00 PM to 10:00 PM shift, at 2:45 PM; CNA #18, who worked the 10:00 PM to 6:00 AM shift, at 3:06 PM; CNA #12, who worked the 2:00 PM to 10:00 PM shift, at 3:10 PM, and CNA #11, who worked the 2:00 PM to 10:00 PM shift, at 3:25 PM

Housekeeper #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:38 PM; and Laundry Personnel #1, who was working the 6:00 AM to 2:00 PM shift on 08/30/13, at 1:51 PM. All of the above staff were knowledgeable of the facility's new Falls Procedures, and Falls Team members and duties. All nursing staff interviewed were knowledgeable of the Fall Scene Investigation Report form and when to complete it. All staff verified they had received inservice education regarding these matters by the facility.

Interview, on 08/30/13 at 3:10 PM, with the Administrator revealed most of the facility's staff had received inservice education on the new Fall Procedure/Policy, the Fall Scene Investigation Report form, the revision to the Incident Report form. According to the Administrator, any staff who had not received the inservice education would not be allowed to work until they had received it and would not be put on the schedule to work until they had received the education.

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6. Interview, on 08/30/13 at 3:10 PM, with the

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F 520	<p>Continued From page 112</p> <p>Administrator revealed the Medical Director had been informed of the Immediate Jeopardy findings and had been updated on the facility's Allegation of Compliance on 08/30/13 during the CQI Committee meeting. She stated the CQI Committee members had discussed the new forms and procedures the facility had implemented. The Administrator indicated the facility would use the CQI indicator for the monitoring of compliance with the facility fall management policies and procedures monthly times two (2) months and then quarterly as per the established CQI calendar under the supervision of the DON. She stated the CQI indicator for the monitoring of the CQI program effectiveness was to be utilized monthly times three (3) months, then quarterly thereafter. The Administrator stated a Nurse Consultant would visit quarterly and review fall investigations, and the associated interventions.</p> <p>Interview, on 08/30/13 at 12:33 PM, with the Medical Director revealed the facility's CQI Committee, which he was a member of, had met that morning and discussed the facility's AoC plan and what interventions had been put in place to correct the Immediate Jeopardy.</p> <p>7. Interview, on 08/30/13 at 3:10 PM, with the Director of Nursing (DON) revealed all falls for the past sixty (60) days had been reviewed and the care plans revised as necessary. The DON stated the Assistant Director of Nursing (ADON) would be responsible for updating Comprehensive Care Plans and CNA Care Plans during the Monday through Friday Interdisciplinary Management team meeting. She stated the Falls Policy had been revised and new Falls Teams had been implemented for each</p>	F 520		

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F 520	<p>Continued From page 113</p> <p>shift. The DON stated staff had been educated on the new policy, new forms, and Falls Teams duties. According to the DON, the CQI Committee had met that morning and the Medical Director had signed off on the facility's new policy, and new forms implemented by the facility.</p> <p>8. Interview, on 08/30/13 at 3:10 PM, with the facility's Nurse Consultant revealed she or another Nurse Consultant would be making quarterly visits to the facility to monitor. She stated residents' Comprehensive Care Plans and CNA Care Plans are now being brought to the Monday through Friday Interdisciplinary Management Team meeting and updated as interventions are discussed.</p> <p>9. The Nurse Consultant stated during the Interdisciplinary Management Team meeting a date would be set to review the revisions recommended by the team to ensure the new interventions were effective or see if additional interventions needed to be added. She indicated a Nurse Consultant would be coming to the facility on a quarterly basis to review falls and follow up performed, review the monthly CQI monitoring performed to ensure the AoC plan was followed.</p> <p>The facility remained out of compliance at a lower Scope and Severity of a "E", a pattern deficiency with potential for more than minimal harm in order for the facility to develop and implement the Plan of Correction (PoC).</p>	F 520	

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01.

PLAN APPROVAL: 1957.

SURVEY UNDER: 2000 Existing.

FACILITY TYPE: SNF/NF.

TYPE OF STRUCTURE: One (1) story, Type III (200).

SMOKE COMPARTMENTS: Three (3) smoke compartments.

FIRE ALARM: Complete fire alarm system installed in 2005, with 28 smoke detectors.

SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.

GENERATOR: Type II generator installed in 1972. Fuel source is Diesel.

A standard Life Safety Code survey was conducted on 08/21/13. Brighton Cornerstone Health Care was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 000

The preparation and execution of this credible allegation of compliance 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. The facility reserves its right to dispute the facts and conclusions in any forum necessary and disputes that any action or inaction on its part created any deficient practice. The facility further disputes that the circumstances constituted immediate jeopardy to any resident. This credible allegation of compliance is prepared and execute solely because it is required by federal and state law.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Vicki Stomaska</i>	TITLE <i>Administrator</i>	(X6) DATE 9-22-13
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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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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, forty-two (42) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62)</p>	K 018	<p>K 018</p> <p>Criteria 1&2 – The latches on resident room doors 101, 201, 501, and 606 have been re-aligned to latch properly.</p> <p>Criteria 3: Facility maintenance staff have received inservice on 9-7-13 education on importance of doors latching properly.</p> <p>Criteria 4: The CQI indicator for the monitoring of facility door latches will be utilized monthly X2 months and then quarterly thereafter, under the supervision of the Administrator.</p>	9-8-13

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K 018 Continued From page 2
on the day of the survey. The facility failed to ensure five (5) corridor doors to the resident rooms latched properly.

The findings include:

Observations, on 08/21/13 between 2:04 PM and 3:30 PM with the Maintenance Supervisor and Administrator in Training, revealed the corridor doors to rooms 101, 102, 201, 501, and 606 would not latch properly.

Interview, on 08/21/13 between 2:04 PM and 3:30 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware these doors were not latching properly. They stated the humidity in the area affected the way the doors moved from time to time.

Reference: NFPA 101 (2000 edition)

19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or

K 018

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K 018	Continued From page 3 combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke doors that would self-close and resist the	K 027	K 027 Criteria 1&2: A self-closing smoke door has been installed in the corridor at room #318. Criteria 3: Facility maintenance staff have received inservice on 9-7-13 education on importance of sealed smoke barrier across corridors. Criteria 4: The CQI indicator for the monitoring the smoke doors in the corridors will be utilized monthly X2 months and then quarterly thereafter, under the		

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K 027	<p>Continued From page 4</p> <p>passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, forty-two (42) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure a door was installed in the corridor where the smoke barrier was located.</p> <p>The findings include:</p> <p>Observation, on 08/21/13 at 3:05 PM with the Maintenance Supervisor and Administrator in Training, revealed a smoke barrier located at room #318. The corridor was left open at this barrier with no door installed in the smoke barrier.</p> <p>Interview, on 08/21/13 at 3:05 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware that a smoke barrier must be sealed by doors where the barrier crossed the corridor.</p> <p>Reference: NFPA 101, 19.3.7.6* (2000 Edition) Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of</p>	K 027	supervision of the Administrator.	9-20-13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185013	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431		
(X4) IO 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	
K 027	Continued From page 5 the other.	K 027			
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained, per NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure the exit corridors in the old part of the facility were four (4) feet in width. The findings include: Observation, on 08/21/13 at 4:00 PM with the Maintenance Supervisor and Administrator in Training, revealed the corridors in two (2) smoke compartments to be less than four (4) feet in width. Interview, on 08/21/13 at 4:00 PM with the Maintenance Supervisor and Administrator in Training, revealed the facility used a FSES survey to offset this requirement. NFPA 101 (2000 edition) 19.2.3.3* Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving	K 039	K 039 A FSES Form has been completed on 9-18-13. The cost to correct this deficiency would be in excess of \$600,000 which would cause great hardship to the facility.	9-19-13	

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K 039	Continued From page 6 as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 039		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure they conducted an annual emergency lighting testing for the minimum requirement of at least 1-1/2 hour duration annually and 30 seconds monthly. The findings include: Life safety record review, on 08/21/13 at 3:15 PM with the Maintenance Supervisor and	K 046	Criteria 1&2: The emergency lights were tested on 9-16-13 for at least 1-1/2 hour duration without issue. Criteria 3: The facility maintenance staff have received inservice education on 9-7-13 the requirement for testing emergency lights for 1-1/2 hour duration annually and 30 seconds monthly. Criteria 4: The CQI indicator for the monitoring of testing emergency lights will be utilized monthly under the supervision of the Administrator.	9-17-13

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NAME OF PROVIDER OR SUPPLIER BRIGHTON CORNERSTONE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 55 EAST NORTH STREET MADISONVILLE, KY 42431
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K 046 Continued From page 7
 Administrator in Training, revealed that the emergency lights, with battery backup, located throughout the facility had not been tested for 30 seconds monthly and no 1-1/2 hour test was conducted within the last year.

Interview, on 08/21/13 at 3:15 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware the lighting had to be tested monthly and annually.

Reference: NFPA 101 (2000 edition)

7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.

7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the

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K 046	Continued From page 8 owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFFA 101 LIFE SAFETY CODE STANDARD	K 046			
K 056 SS=F	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The	K 056	K 056 Criteria 1&2: The furnace rooms located on 200 hall, 300 hall, 600 hall have had additional sprinkler heads installed on 9-7-13. Criteria 3: The facility maintenance staff have received inservice education on 9-7-13 the requirement for additional sprinklers in furnace rooms. Criteria 4: The CQI indicator for the monitoring adequate coverage sprinkler protection will be utilized monthly X2 months and then quarterly thereafter.	9-8-13	

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K 056	Continued From page 9 facility failed to ensure three (3) furnace rooms were properly sprinkler protected. The findings include: Observation, on 08/21/13 between 2:04 PM and 3:30 PM with the Maintenance Supervisor and Administrator in Training, revealed the furnace rooms located on 200 hall, 300 hall, and 600 hall did not have proper sprinkler protection on the opposite side of the furnace from the sprinkler head. Interview, on 08/21/13 between 2:04 PM and 3:30 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware the rooms containing the furnaces were not properly sprinkler protected. Reference: S&C 09-04 Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter09-04.pdf	K 056			
K 060 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Initiation of the required fire alarm systems is by manual means in accordance with 9.6.2 and by means of any required sprinkler system water flow alarms, detection devices, or detection systems. 19.3.4.2, 9.6.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves	K 060	K060 Criteria 1&2: Two water flow and tamper switches were connected to the building fire alarm system on 9-11-13. Criteria 3: The facility maintenance staff have received inservice education on 9-7-13 of the requirement for the riser to initiate the building fire alarm		

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K 060	<p>Continued From page 10</p> <p>located in the facility sprinkler system were electronically supervised by a lamper switch in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure all water control valves were electronically supervised on the sprinkler system.</p> <p>The findings include:</p> <p>Observation, on 08/21/13 at 2:04 PM with the Maintenance Supervisor and Administrator in Training, revealed the sprinkler system was being supervised by a light and a buzzer but was not monitored by the fire alarm.</p> <p>Interview, on 08/21/13 at 2:04 PM with the Maintenance Supervisor and Administrator in Training, revealed they were not aware the sprinkler riser electronic monitoring was required to initiate the fire alarm system.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems.</p> <p>9.6.2.1 Where required by other sections of this Code, actuation of the complete fire alarm system shall occur by any or all</p>	K 060	<p>system.</p> <p>Criteria 4: The CQI indicator for the monitoring the fire alarm system will be utilized monthly.</p>	9-12-13

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K 060	Continued From page 11 of the following means of initiation, but shall not be limited to such means: (1) Manual fire alarm initiation (2) Automatic detection (3) Extinguishing system operation	K 060		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, thirty-eight (38) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of sixty-two (62) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles.	K 076	K076 Criteria 1&2 – The 2 additional O2 tanks were removed from the smoke compartment. The Oxygen Company was contacted on 8-22-13 and directed to limit our inventory of tanks to no more than 12 tanks. Criteria 3: Facility staff have received inservice education that no more than 12, O2 tanks can be stored in a smoke compartment on 9-4-13, 9-5-13, 9-6-13, 9-7-13, 9-10-13, 9-11-13, 9-12-13, 9-13-13, 9-14-13, Criteria 4: The CQI indicator for the monitoring of O2 tanks will be utilized monthly under the supervision of the Administrator.	9-15-13

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K 076	<p>Continued From page 12</p> <p>The findings include:</p> <p>Observation, on 08/21/13 at 3:40 PM with the Maintenance Supervisor and Administrator in Training, revealed fourteen (14) oxygen tanks in the oxygen storage room. The oxygen tanks were being stored within five (5) feet of combustible boxes.</p> <p>Interview, on 08/21/13 at 3:40 PM with the Maintenance Supervisor and Administrator in Training, revealed they were unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible</p>	K 076		
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K 076 Continued From page 13
 construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.
 (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.
 (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.
 (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.
 (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.
 (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.
 (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.
 (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.

K 076